FP2020 MOMENTUM AT THE MIDPOINT

2015–2016

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FP2020
MOMENTUM AT THE MIDPOINT

2015–2016

Photo by Mulugeta Ayene
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Executive Summary

WHEN WOMEN ARE ABLE TO decide for themselves whether and when to have children, everyone benefits. The power to plan one's own family lies at the very root of human freedom, and of our ability to thrive, prosper, and build a sustainable future. Use of modern contraception makes family planning possible, yet more than 225 million women and girls in developing countries—particularly the poorest and most vulnerable—still have an unmet need for this basic health care service.[1]

Family Planning 2020 (FP2020) is dedicated to changing that fact. This initiative is built on the premise that the life-changing benefits of modern contraception should be available everywhere in the world, to every woman and girl. As an outcome of the 2012 London Summit on Family Planning, our goal is to enable 120 million additional women and girls to use contraceptives by 2020. Achieving this goal is a critical milestone to ensuring universal access to sexual and reproductive health and rights by 2030, as laid out in the Sustainable Development Goals, and is central to accelerating progress across all development sectors.

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Find the full digital report online:
Familyplanning2020.org/progress

This report marks the halfway point of the FP2020 initiative, and reflects the substantial progress made to date:

- There are now more than 300 million women and girls using modern contraception in the world's 69 poorest countries—a milestone that has taken decades to achieve.
- More than 30 million of those users have been added since 2012, when FP2020 was launched.
- In Eastern and Southern Africa, for the first time ever, more than 30% of women and girls are using a modern method of contraception.
- In West Africa, where contraceptive use has been historically low, the Ouagadougou Partnership has surpassed its goal of reaching 1 million additional users between 2011 and 2015, and is now aiming to reach 2.2 million additional users between 2015 and 2020.

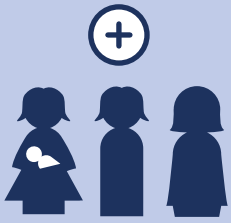
The work of the family planning community is having a positive impact, and the 30.2 million additional users of contraception is significantly more than the historical trend would predict. But it is still 19.2 million fewer users than we had hoped to reach by this time, indicating that we are off-track for our overall goal.

Nonetheless, the richness of the data now available enables us to peel back the layers and study the situation on a country-by-country basis. What emerges is a strikingly varied landscape of progress. A number of countries have registered immense gains in contraceptive use; other countries are moving more slowly; some countries appear stalled. The situation is illuminated by an S-Curve pattern, which depicts the general path of contraceptive uptake that countries have taken over the course of their development.

This knowledge is part of the toolkit we take into the second half of the initiative. We also bring with us a deeper understanding of how family planning services reach, or fail to reach, specific sub-populations of women and girls. The evidence base is growing for a wide range of issues and interventions, including youth-oriented approaches, method mix diversity, stock-outs, contraceptive discontinuation, rights-based programming, and postpartum family planning. The resulting insights

AS OF JULY 2016
AT THE MIDPOINT OF FP2020

MORE THAN
300 MILLION
WOMEN & GIRLS ARE USING MODERN CONTRACEPTION IN 69 FP2020 FOCUS COUNTRIES



30.2 MILLION
ADDITIONAL WOMEN & GIRLS ARE USING MODERN CONTRACEPTION COMPARED TO 2012

AS A RESULT OF MODERN CONTRACEPTIVE USE FROM JULY 2015-JULY 2016:

- **82 MILLION** UNINTENDED PREGNANCIES WERE PREVENTED
- **25 MILLION** UNSAFE ABORTIONS WERE AVERTED
- **124,000** MATERNAL DEATHS WERE AVERTED

IN 2015, DONOR GOVERNMENTS PROVIDED:

US$1.3 BILLION
IN BILATERAL FUNDING FOR FAMILY PLANNING


NAUTICA

Photo by Brent Stirton
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can help us shape more effective programs, investments, and policies to reach women and girls with the services they need.

With four years remaining to reach our 2020 goal, the FP2020 platform has been optimized to help countries and partners absorb the lessons learned and accelerate progress. The partnership continues to expand, with more than 90 commitment makers now on board—including 38[2] of our 69 focus countries. The governance structure of the initiative has been reorganized to provide increased country support, and a new youth seat on the Reference Group reflects the additional emphasis on the inclusion of young people throughout the partnership. Further efforts to strengthen accountability and improve coordination between partners also have the potential to yield important gains.

There are now more than 300 million women and girls using modern contraception in the world's 69 poorest countries—a milestone that has taken decades to achieve.

The path to 2020 is undeniably steep, but with the tools and knowledge at our disposal, we're poised to quicken the pace. The FP2020 partnership represents an unprecedented global commitment to the rights, health, and empowerment of millions of women and girls. By pulling together, eschewing business as usual, and capitalizing on the new resources and alliances that have emerged, we can deliver on the promise of the London Summit.

1. Singh S, Darroch JE and Ashford LS, Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014, New York: Guttmacher Institute, 2014.

2. This figure does not include South Africa, which made a commitment to FP2020 but is not one of the 69 focus countries. South Africa's GNI does not qualify it as one of the world's poorest countries, based on the World Bank 2010 classification using the Atlas Method.

From the FP2020 Reference Group Co-Chairs

THE MIDPOINT OF A JOURNEY brings a certain clarity of vision. Looking back at where we started, we can begin to appreciate how much ground we've covered and how the landscape has shifted around us. Looking ahead to our destination, we can gauge—with greater accuracy than ever—just how much effort it will take to get there. That dual perspective is what informs this year's Progress Report, delivered at the halfway point of the FP2020 initiative.

Our journey began at the 2012 London Summit for Family Planning, when the global community recommitted to the principle that all women, no matter where they live, should enjoy their human right to access safe and effective, voluntary contraceptive services and commodities. Leaders from around the world gathered in a demonstration of unity, pledging to put women and girls at the heart of the global development agenda. With an ambitious goal of delivering rights-based family planning services to an additional 120 million women and girls by the year 2020, the FP2020 movement was launched.

↖

Find the full digital report online:

Familyplanning2020.org/progress

Four years later, we've made important progress. Access to contraception is a growing development priority, including in countries where it had not previously been high on the agenda. Healthy timing and spacing of births is increasingly understood as a linchpin to realizing other human rights, to health and prosperity—indeed, as a key to unlocking every development goal. Contraceptive access is incorporated in the Sustainable Development Goals, the agenda that will guide the world's progress for the next 15 years. And our original FP2020 objective of "120 million additional users by 2020" is no longer a solitary goalpost in the distance, but stands as an essential benchmark on the global path to universal access by 2030.

But as we celebrate these advances, we also note the ways in which we're still falling short. Unless we speed up progress now, we will not fulfill our promise to women and girls for 2020, and our 2030 goals will be even further out of reach. Today's 300 million users of modern contraception is an extraordinary milestone, and testament to decades of dedicated work by the health and development sectors. But not all of our efforts to expand voluntary family planning are producing the results expected; not all of the women and girls we've pledged to reach are being served. These are the challenges we must confront in the second half of our journey.

A recurring theme throughout this report is *what we can do better*—whether that means strengthening a platform, broadening an evidence base, or expanding a service component. In the continuing spirit of the London Summit, we invite the entire family planning community to join us in this dialogue. What can we—all of us—*do better*? Looking ahead, we suggest three key areas of focus:

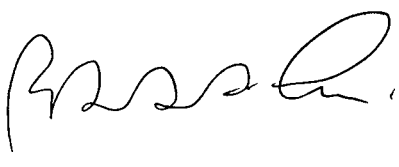
Accountability: What can we do to build better accountability mechanisms into our work, from tracking investments to assessing the impact of specific programs? How can we strengthen donor and government accountability for resource allocation, commodity security, and rights-based programming? On an individual level, what can each of us do in our institutional capacities to deliver on our commitments?

Partnerships: How can we coordinate more strategically and efficiently to support country objectives and tackle challenges that persist throughout the sector? How can we be more innovative in our partnering, stepping outside our silos to ensure that voluntary family planning reaches the most marginalized populations? How can donors be more effective partners to countries and in better alignment with each other?

Youth: What can we do to keep our promise to the world's young people? How can we translate increased country and donor commitment to youth into evidence-based programs at scale in both the public and private health sectors? How can we meaningfully partner with young people to deliver high-quality contraceptive services that meet their diverse needs and circumstances?

These are not questions that any one organization or country can answer alone. They will require the energy and cooperation of leaders, experts, advocates, and implementers throughout our global community. But that, too, is in the spirit of the London Summit.

Together we have already achieved great progress; together we can achieve even more. Our journey is not yet finished. The promise we made in London four years ago is still compelling, still urgent, and still unfulfilled. Millions of women and girls are waiting.



Dr. Babatunde Osotimehin
United Nations Under-Secretary-General

Executive Director
United Nations Population Fund

Dr. Chris Elias
President of Global Development

Bill & Melinda Gates Foundation

From FP2020's Executive Director

I SEE THE POWER of collaboration every day.

I see it when experts from different development sectors combine their skills to solve a common problem. I see it when colleagues from different organizations pool their institutional knowledge for the greater good. I see it when leaders at the top of the global hierarchy listen to the voices of those working at every level.

Collaboration is how we solve the hardest problems in the world. It's how real, lasting change finally happens. And it's what FP2020 is all about.

The vision for this platform has always been of a creative, inclusive, transparent space where everyone can contribute to the critical work of expanding access to contraception. Thanks to the vibrant participation of the family planning community, FP2020 has become a thriving hub for global collaboration. Now, as we enter the second phase of this initiative, we hope to bring that same collaborative energy to our country-level work.

↖ **Find the full digital report online:**
Familyplanning2020.org/progress

As we approached the FP2020 midpoint, we undertook a wide-ranging review of the partnership's progress to date. We studied what has and hasn't worked, where we are most effective, and what we can do better. We determined that a heightened degree of country engagement, combined with a continuing focus on global efforts, is one of the areas where FP2020 can add value in the remaining years of this initiative.

As a result, our strategic framework for 2016–2020 emphasizes supporting and reinforcing country-level activities. Over the next four years the Secretariat will strengthen our collaboration with countries to assist them in meeting their individual FP2020 goals, drawing on the participation and backing of our global partners. We've revamped our organizational structure, enhanced our technical capacity, and fine-tuned our model for country engagement. Strong involvement from our partners is facilitating targeted and direct technical support as countries develop, implement, and monitor their rights-based family planning strategies.

Human rights remain the through line of everything we do, and we work with our country and global partners to define, operationalize, monitor, and measure the impact of rights-based family planning. We're also working to mainstream youth participation at the country and global levels and ensure that young people's needs and perspectives are reflected in family planning programs, policies, and practices.

Data is a central pillar of the FP2020 initiative, and our refocused strategy includes an even greater emphasis on data use and performance monitoring and management. We're also expanding the ways in which FP2020 data are used: several countries are now able to use their data to formulate upcoming goals and objectives, and FP2020 data are included in the investment frameworks for the Global Financing Facility.

To capitalize on the tremendous wealth of experience, expertise, and wisdom in the family planning community, we have established a new Expert Advisory Community (EAC). The EAC is a volunteer network of more than 120 technical experts on a range of functional, regional, and country-specific family planning topics. EAC members help keep us informed on the evolving landscape, and can be mobilized to address specific challenges at the country and global level.

There is great power in collaboration. It isn't always easy and it takes time to develop relationships of trust and understanding, but together we've built a new way of working together and we're beginning to see the impact at all levels. It's collaboration as a regular mode of working, creating a community of practice where we can share our challenges and search together for solutions. FP2020 provides the space for that to happen.

> **The vision for this platform has always been of a creative, inclusive, transparent space where everyone can contribute to the critical work of expanding access to contraception.**

On a personal note, I can think of no one who has contributed more to FP2020's culture of collaboration than Jagdish Upadhyay, who retired this year from UNFPA. As the co-lead of FP2020's Country Engagement Working Group from 2013–2015, Jagdish was instrumental in launching a new era of cooperation between the major family planning aid agencies. Our work today continues his legacy.

I believe the next four years of FP2020 will bring great things. I'm confident in the potential of our partnership and our platform, and I'm excited to see where the boundless power of collaboration will take us.

Beth Schlachter
Executive Director
Family Planning 2020

Photo by Jonathan Torgovnik
Getty Images Reportage

Part 01

THE PACE OF PROGRESS

12-17 Introduction

18-23 Mobilizing Resources

24-25 Family Planning and the Sustainable Development Goals

Introduction

AS OF JULY 2016, at the midpoint of FP2020, the world's 69 poorest countries had reached a new milestone: for the first time in history, the number of women and girls using a modern method of contraception topped 300 million. That 300 million is more than just a statistic: it represents an unprecedented number of women and girls who are now able to take charge of their own health and shape their own lives and families.

The health infrastructure and expertise required to provide family planning services to 300 million individuals is immense, and in itself represents a tremendous accomplishment. It is particularly impressive in light of the fact that it was just 13 years ago, in 2003, that the number of contraceptive users in these countries reached 200 million.

The data in this year's report highlight the progress the family planning community has made since the 2012 London Summit on Family Planning, as measured by FP2020's 17 Core Indicators. The data also indicate some of the challenges remaining at global, regional, national, and subnational levels.

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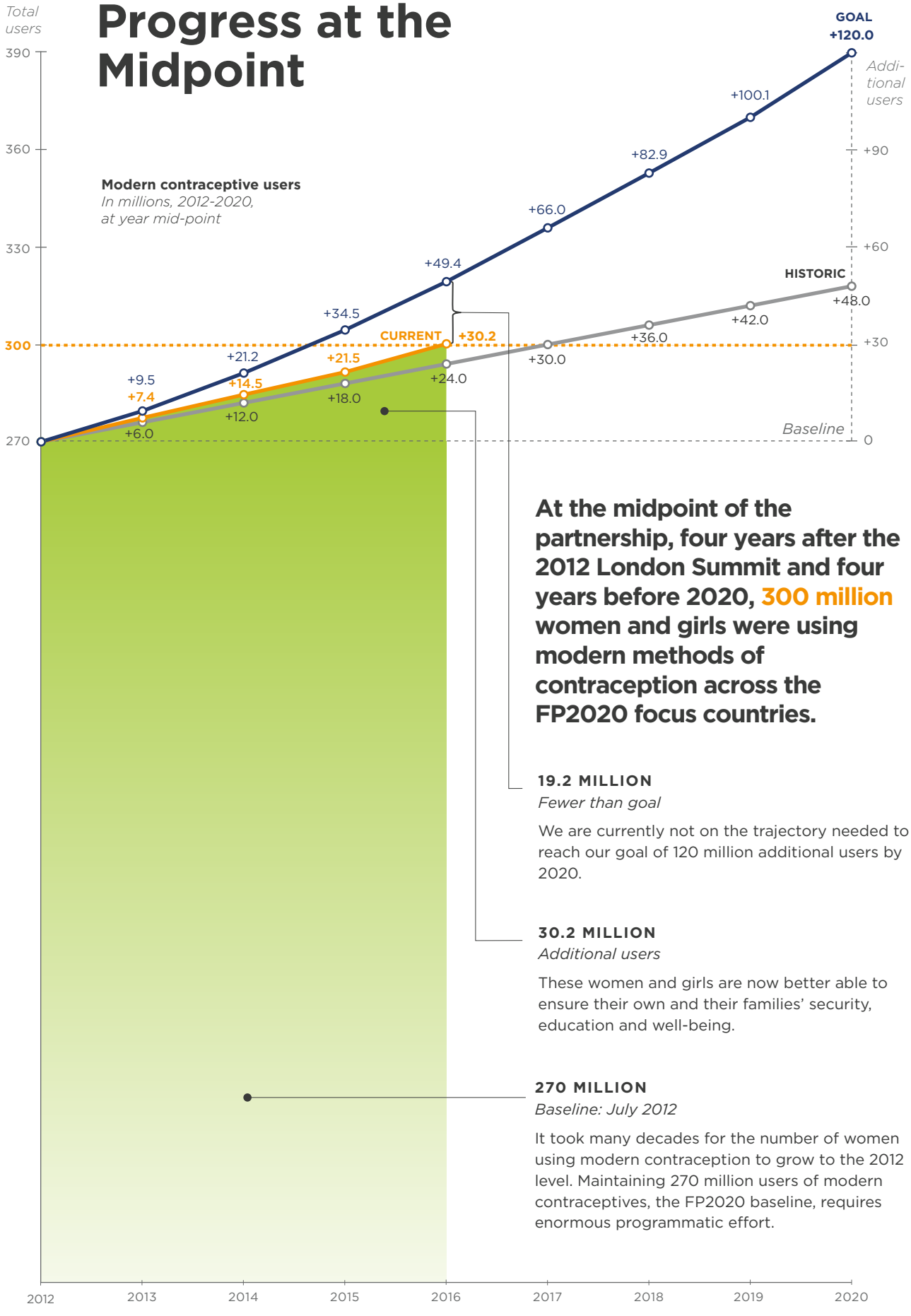
Find the full digital report online:
Familyplanning2020.org/progress

Progress at the Midpoint



At the midpoint of the partnership, four years after the 2012 London Summit and four years before 2020, 300 million women and girls were using modern methods of contraception across the FP2020 focus countries.

19.2 MILLION

Fewer than goal

We are currently not on the trajectory needed to reach our goal of 120 million additional users by 2020.

30.2 MILLION

Additional users

These women and girls are now better able to ensure their own and their families' security, education and well-being.

270 MILLION

Baseline: July 2012

It took many decades for the number of women using modern contraception to grow to the 2012 level. Maintaining 270 million users of modern contraceptives, the FP2020 baseline, requires enormous programmatic effort.

Family planning use in many countries is on the rise, and there are entire regions where contraceptive prevalence rates are on an upward swing. In regions where contraceptive use is already high, progress comes in the form of expanding service delivery and improving quality of care:

- In **Eastern and Southern Africa**, the region that has experienced the fastest growth in modern method use and the steepest decline in unmet need, for the first time more than 30% of women are using a modern method.
- In **West Africa**, where contraceptive use has been persistently low, several countries have strengthened their family planning programs and are beginning to see contraceptive prevalence rise. The nine West African countries of the **Ouagadougou Partnership** achieved their collective goal of 1 million additional users between 2011 and 2015, and have now established a more ambitious goal of 2.2 million additional users between 2015 and 2020.
- In several **Asian** countries, where rates of modern contraceptive use are relatively high and the population of women of reproductive age is very large, health systems already provide services to a huge number of individuals. There are more than 230 million users of modern methods in Asian FP2020 countries, and great effort is required just to sustain this level of service—much less reach the more than 90 million married or in-union women in Asia who still have an unmet need. Many of these countries, however, are taking steps to improve the quality of services and increase the range of methods available, while also aiming to expand services.

Collectively, the efforts of FP2020 countries and partners are having a positive impact on the use of contraception. The figure at left shows that compared to 2012, there are now 30.2 million additional users of modern methods—which is 25% higher than the historical trend would predict. Yet this progress, while significant, is still 19.2 million users short of the pace needed to reach our goal of 120 million additional users by 2020.

One way to accelerate progress is by sharpening the focus on country-level goals, challenges, and avenues for improvement. At an aggregate level, annual estimates provide the global community with a transparent means of tracking progress toward the overall FP2020 goal. At a country level, however, the 38 countries that have made FP2020 commitments are monitoring progress toward the goals they have set for themselves. These 38 countries are using FP2020 Core Indicator data, tools such as the S-Curve (see page 17), and other national and subnational data to understand their current trends and guide their actions over the coming years.

> **Halfway through the FP2020 initiative, we have an opportunity to accelerate progress by focusing on the challenges and opportunities that have already emerged.**

Kenya, for example, like many countries in Eastern and Southern Africa, is experiencing a period of rapid growth in its modern contraceptive prevalence rate (mCPR). Recent data indicate that Kenya is on track to achieve its FP2020 goal. But progress has been starkly uneven across the country: rates of use in many counties remain extremely low—as low as 5% mCPR among married women in northeastern counties, as compared to 67% in central counties—and the rate of contraceptive use among the poorest is half that of the rest of the population.[3] Family planning partners are coming together in technical working groups to look more closely at this data with an eye toward how to serve these hardest-to-reach populations.

Kenya's recent devolution, which shifted responsibility for health services from the federal government to 47 newly established counties, presents additional challenges—particularly for the procurement of contraceptives. As a coordination point between donors, government ministries, and service delivery and advocacy partners, the FP2020 platform is facilitating efforts to ensure that the government can procure sufficient contraceptives and that counties can provide high-quality family planning services.

Another example is India, the largest FP2020 country, with more than 130 million contraceptive users. India is currently completing analysis of its National Family Health Survey (NFHS-4), and once available, the full set of national and state-level data will provide an important opportunity to assess progress. But the government is already looking closely at its existing program data and aiming to provide a wider range of short-term and long-acting methods, including injectables, through the public sector. India is also expanding its investment in postpartum family planning and taking action to improve the quality of family planning services. In the coming year, the new NFHS-4 data will enable family planning partners in India to gain a better understanding of the progress to date and shape their programs and investments accordingly.

These are just two examples of how a deeper examination of each country's data can illuminate the existing situation and point to opportunities for action.

We can also accelerate progress by addressing the persistent challenges that span numerous countries. The analysis of Core Indicators in Section 03 highlights a number of key issues:

- Despite gains, there is still great **unmet need** for contraception. Many countries need to expand and improve the quality of services to satisfy current demand while also working to generate greater demand. The Sustainable Development Goals use ***demand satisfied with modern methods*** as a key indicator for family planning, and countries that don't meet their FP2020 goals will face a steep path to achieve the 75% demand satisfied called for by 2030.
- A diverse mix of contraceptive methods makes it more likely that women will be able to find a method that suits their needs and preferences. FP2020 data on **method mix** and contraceptive availability suggest that women in many countries do not have access to a full range of short-term, long-acting, and permanent methods.
- **Stock-outs** remain a pervasive problem with a profound impact on women's ability to use contraception. Too often the contraceptives that are supposed to be available simply aren't on the shelves. Particularly worrisome are countries that report a high percentage of facilities with stock-outs of the most commonly used methods.
- **Counseling** is an important aspect of rights-based family planning, and women need to be informed of the various contraceptive methods available and the potential for side effects. The data suggest that many countries need to improve counseling to enable more women and girls to exercise **informed choice**.
- Many women begin using contraceptives and then discontinue, putting themselves at risk of an unintended pregnancy. **Contraceptive discontinuation** rates are particularly high for short-term methods, including pills and injectables. Across countries with available data, almost 1 in 5 women using pills or injectables will discontinue use for method-related reasons.

WHAT WE CAN DO BETTER

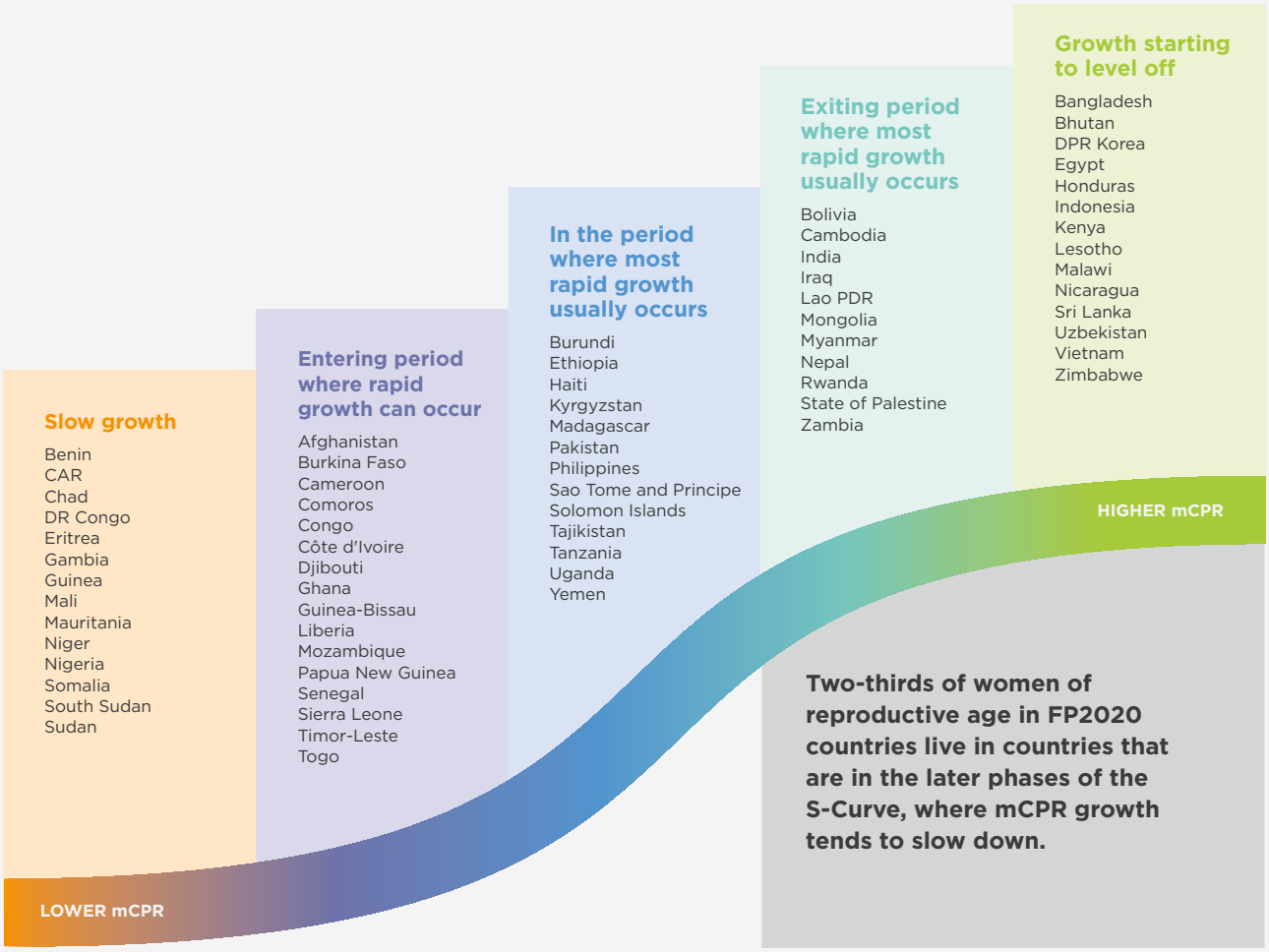
Partner more effectively to support country objectives and address persistent challenges, such as stock-outs, quality of care, method mix diversity, and contraceptive discontinuation.

Halfway through the FP2020 initiative, we have an opportunity to accelerate progress by focusing on the challenges and opportunities that have already emerged. The evidence base is growing for a wide range of issues and interventions, and the Core Indicators provide important data on the family planning landscape in each country. The resulting insights can help us shape more effective programs, investments, and policies to reach women and girls with the services they need.

3. Kenya Demographic Health Survey 2014. Available from: http://dhsprogram.com/publications/publication-FR308-DHS-Final-Reports.cfm

Putting Growth in Context: The S-Curve

THE S-CURVE PATTERN OF mCPR growth can help countries examine and understand their current growth rates. The S-Curve is based on historical patterns and suggests that countries grow at different rates based on their levels of contraceptive use.



- When mCPR is very low, countries tend to see slow annual growth in mCPR. Efforts are needed to change social norms around family planning, stimulate demand, and establish the infrastructure and providers to deliver quality family planning services.
- As demand grows and contraceptive use becomes more common, countries can enter into a period of rapid growth by focusing on ensuring contraceptive availability, high-quality services, and continued demand generation.
- Finally, when contraceptive use becomes very common and unmet need declines, growth in mCPR slows. Programs at this stage need to focus on long-term sustainability, continued improvements in service quality, expanding the range of methods available, and striving to reach underserved groups.

Mobilizing Resources

MOBILIZING THE FINANCIAL RESOURCES needed to sustain family planning services—for the 300 million women and girls using contraceptives today and for the 390 million we aim to reach by 2020—is a critical measure of FP2020 progress.

A significant share of the funding for family planning services and commodities comes from donor governments. Kaiser Family Foundation's analysis of bilateral donor funding for family planning indicates that for the first time since 2012, this funding has not increased. **Additional analysis of European donor trends from Countdown 2030 Europe is available in the digital report: www.familyplanning2020.org/progress.**

Private foundations also contribute important resources. Those that have made FP2020 commitments submit annual updates describing their programs and funding activities. Based on these reports, it is estimated that commitment-making foundations invested approximately US$190 million in 2015 to support family planning—ranking them on a level with the top donor countries.[4]

But donor funds are only part of what's being spent to provide family planning services. This year's report highlights new estimates of total family planning expenditures by different sectors in FP2020 countries, including donors, consumers, and domestic governments.

↖ **Find the full digital report online:**
Familyplanning2020.org/progress

4. Self-reported updates for all commitment makers are available at www.familyplanning2020.org/commitments/pages/commitment-makers.

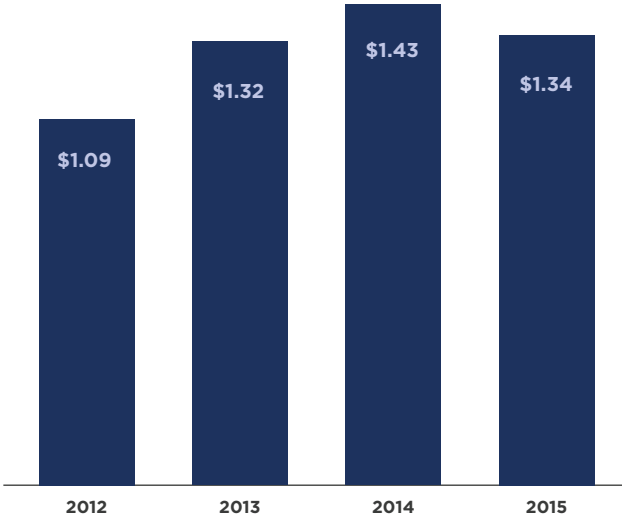
Donor Government Funding for Family Planning in 2015: Kaiser Family Foundation Analysis

2015 marks the fourth year of Kaiser Family Foundation's annual analysis of donor government funding for family planning.[5] After two years of increases, 2015 saw a decrease for the first time since this tracking effort began, with donor governments[6] providing US$1.3 billion for bilateral family planning—a 6% decrease below 2014 levels. The decrease was largely due to the appreciation of the US dollar, but also to actual decreases by several donors. At the same time, of the 8 donor governments profiled here that made commitments at the 2012 London Summit, 7 are still on track to meet those commitments.

This analysis is based on data from 29 governments who were members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) in 2015 and had reported Official Development Assistance (ODA) to the DAC.

International bilateral family planning assistance from donor governments: Disbursements, 2012-2015

In billions, USD



Note: Figures based on KFF analysis of donor government funding for family planning.

KEY FINDINGS FROM 2015

In 2015, donor governments provided US$1.3 billion for bilateral family planning programs and contributed US$392 million to the United Nations Population Fund's (UNFPA) core resources.

Bilateral funding:

- The US$1.3 billion provided by donors in 2015 represents a 6% decrease (-US$88.6 million) below 2014 (US$1.4 billion), and is essentially a return to the 2013 level (US$1.3 billion). It is the first time since this tracking effort began that funding has declined.
- The decline is largely due to the significant appreciation of the US dollar, resulting in the depreciation of most other donor currencies. For instance, in their currency of origin, five donors (Denmark, France, Germany, the Netherlands, and Sweden) increased funding and one donor (Canada) remained flat; funding from three donors (Australia, Norway, and the UK) declined in their currencies of origin. When the effects of the exchange rate fluctuations are removed, 2015 funding essentially matches 2014 levels.
- The US was the largest bilateral donor to family planning in 2015, providing US$638 million and accounting for almost half (47%) of total bilateral funding. The UK (US$269.9 million, 20%) was the second largest donor, followed by the Netherlands (US$165.8 million, 12%), France (US$68.6 million, 5%), and Sweden (US$66.0 million, 5%).
- The recent trends in donor government funding for family planning have been largely driven by the two largest donors, the US and the UK, which have accounted for approximately two-thirds of total funding over the period. Overall increases in family planning funding in 2013 and 2014 were due, in large part, to increases by these two donors. In 2015, as US funding remained flat and UK funding declined, total family planning funding decreased.

Progress toward FP2020 commitments:

- Among the 10 donors profiled in this analysis, 8 made commitments at the 2012 London Summit on Family Planning: Australia, Denmark, France,

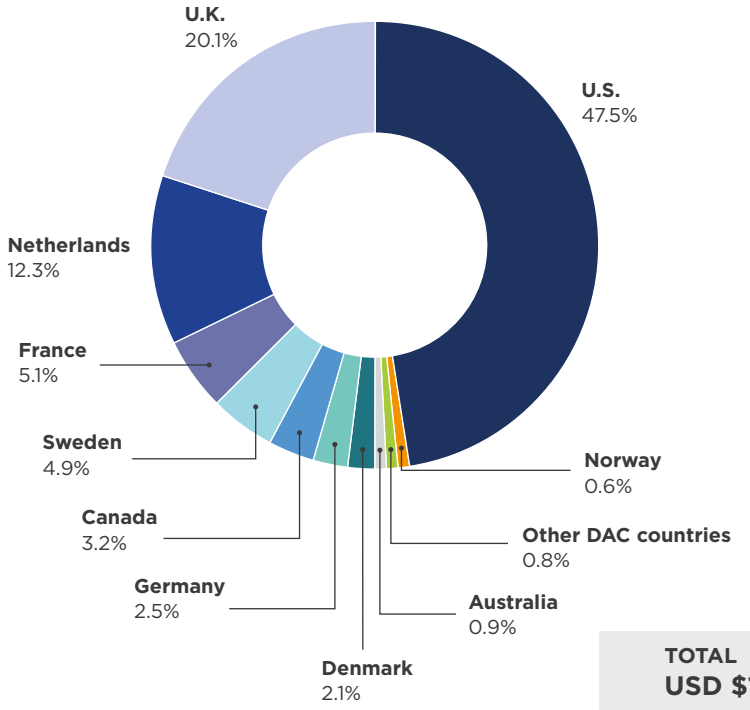
Germany, the Netherlands, Norway, Sweden, and the UK. Preliminary estimates indicate that 7 are on track toward fulfilling their commitments: Denmark, France, Germany, the Netherlands, Norway, Sweden, and the UK. Australia had made progress in prior years, but due to recent declines would need to significantly increase funding in order to fulfill its commitment.

↖ **The digital version** of the report includes more details on each donor's progress: www.familyplanning2020.org/progress.

Donor contributions to UNFPA:

- In addition to donor government bilateral disbursements for family planning—which include non-core contributions to UNFPA for family planning projects as specified by the donor—donors also contribute to UNFPA's core resources, which are meant to be used for both programmatic activities (family planning, population and development, HIV/AIDS, gender, and sexual and reproductive health and rights) and operational support.
- In 2015, donors contributed US$392 million to UNFPA's core resources. This too was a decline, at US$80 million below the 2014 level (US$472 million). As with bilateral funding, much of this decline can be attributed to the appreciation of the US dollar. In fact, when measured in the currency of origin, all of the donors profiled essentially maintained their contribution to UNFPA's core resources at the prior year level—with the exception of Denmark, which increased funding.
- In 2015, UNFPA spent an estimated US$341 million (or 42.7% of its resources) on family planning. Of the US$341 million, an estimated US$92 million came from core resources (resources meant to be used by UNFPA for both programmatic activities and operational support)

International family planning assistance: Donor governments as a share of bilateral disbursements, 2015



TOTAL
USD $1,344.0 MILLION
BILATERAL DISBURSEMENTS

Note: Figures based on KFF analysis of donor government funding for family planning.

and an estimated US$249 million came from non-core resources (resources earmarked for specific programmatic activities).

- Among the donor governments profiled, Sweden provided the largest core contribution to UNFPA in 2015 (US$57.4 million), followed by Norway (US$55.6 million), the Netherlands (US$39.7 million), and Denmark (US$39.6).[7]

Methodological note:

The financial data presented in this analysis represent disbursements defined as the actual release of funds to, or the purchase of goods or services for, a recipient. They were 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 Executive Board documents.

In some cases, it is difficult 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, we worked closely with the largest donors to family planning to identify such cross-sectoral family planning-specific funding where possible (see table notes). Going forward, it will be increasingly important to efforts to track donor government support for family planning to have such funding identified within other activity categories by primary financial systems.

For data in the currency of the donor country, please contact the researchers.

5. For purposes of this analysis, family planning bilateral expenditures represent funding specifically designated by donor governments for family planning as defined by the OECD DAC (see methodology), and include: stand-alone family planning projects; family planning-specific contributions to multilateral organizations (e.g., contributions to UNFPA Supplies); and, in some cases, projects that include family planning within broader reproductive health activities.

6. Donor governments include members of the OECD DAC only.

7. In 2015, Finland, which was not directly profiled in this analysis, provided the fifth largest core contribution (US$38 million) to UNFPA, followed by the US (US$30.8 million).

Donor government bilateral disbursements for family planning, 2012-2015*

In millions, USD

COUNTRY	2012	2013	2014	2015	NOTES
Australia	$43.2	$39.5	$26.6	$12.4	Australia identified AU$17 million in bilateral FP funding for the 2015-16 fiscal year 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. Data for 2015 are preliminary.
Canada	$41.5	$45.6	$48.3	$43.0	Bilateral funding is for combined family planning and reproductive health activities in FY15-16; family planning-specific activities cannot be further disaggregated.
Denmark	$13.0	$20.3	$28.8	$28.1	Bilateral funding is for family planning-specific activities in 2015.
France	$49.6	$37.2	$69.8	$68.6	Bilateral funding is new commitment data for a mix of family planning, reproductive health and maternal & child health activities in 2012-2015; family planning-specific activities cannot be further disaggregated.
Germany	$47.6	$38.2	$31.3	$34.0	Bilateral funding is for family planning-specific activities.
Netherlands	$105.4	$153.7	$163.6	$165.8	The Netherlands budget provided a total of US$429.4 million in 2015 for "Sexual and Reproductive Health & Rights, including HIV/AIDS" of which an estimated US$165.8 million was disbursed for family planning and reproductive health activities (not including HIV); family planning-specific activities cannot be further disaggregated.
Norway	$3.3	$20.4	$20.8	$8.1	Bilateral funding is for family planning-specific activities.
Sweden	$41.2	$50.4	$70.2	$66.0	Bilateral funding is for combined family planning and reproductive health activities; family planning-specific activities cannot be further disaggregated.
UK	$252.8	$305.2	$327.6	$269.9	In the financial year 2015/16, the UK spending on family planning was £179 million, which is essentially at the 2020 goal. This is an estimated figure, 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. Bilateral funding is for combined family planning and reproductive health.
US	$485.0	$585.0	$636.6	$638.0	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.
Other DAC Countries**	$11.0	$29.5	$9.0	$10.1	Bilateral funding was obtained from the Organisation for Economic Co-operation and Development (OECD) Creditor Reporting System (CRS) database and represents funding provided in the prior year (e.g., data presented for 2015 are the 2014 totals, the most recent year available; 2014 presents 2013 totals; etc.).
Total	**$1,093.6**	**$1,325.0**	**$1,432.7**	**$1,344.0**	

*For purposes of this analysis, family planning bilateral expenditures represent funding specifically designated by donor governments for family planning as defined by the OECD DAC (see methodology), and include: stand-alone family planning projects; family planning-specific contributions to multilateral organizations (e.g., contributions to UNFPA Supplies); and, in some cases, projects that include family planning within broader reproductive health activities. During the 2012 London Summit, donors agreed to a revised Muskoka methodology to determine their FP disbursements totals. This methodology includes some funding designated for other health sectors, including HIV, reproductive health (RH), 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.

**Austria, Belgium, Czech Republic, European Union, Finland, Greece, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, New Zealand, Poland, Portugal, the Slovak Republic, Slovenia, Spain, and Switzerland.

Estimating Expenditures on Family Planning

How much is being spent on family planning in FP2020 countries today? How much do we need to spend to reach our goal of enabling 120 million additional women and girls to use modern contraception by 2020?

The two questions are obviously interrelated. The first is about sustaining current levels of family planning service for the existing base of users—which now stands at 300 million women and girls. The second is about what it will take to expand that base from 300 million to 390 million—which is the total number of users envisioned by the FP2020 goal. (There were 270 million users of modern contraception in 2012. We have already added 30 million, leaving another 90 million still to be reached.)

WHAT WE CAN DO BETTER

Establish better tracking mechanisms to assess expenditures—within countries, by sector, and for different components of family planning programming—and develop a clear picture of the additional resources that are required.

But estimating total expenditures on family planning is complex, because a number of sectors are involved: international donors, domestic governments, NGOs, and consumers who spend money out of their own pockets. Ideally we would have expenditure information for each FP2020 country, but currently the data aren't available.

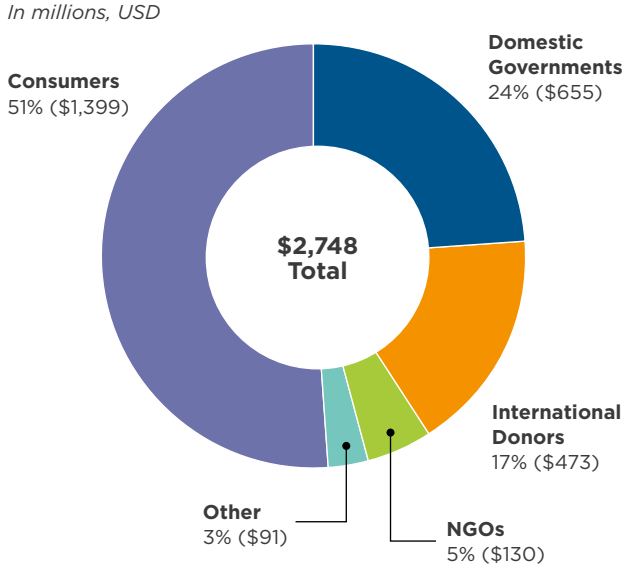
One approach to estimating family planning expenditures has been developed by Track20 and a group of experts convened as the International Family Planning Expenditure Tracking Advisory Group. This work uses global data on donor funding from the Kaiser Family Foundation, information on country-specific domestic government and NGO spending from the resource tracking project led by UNPFA and the Netherlands Interdisciplinary Demographic Institute (NIDI), and estimates of out-of-pocket spending by consumers developed by Track20. For 2014, total family planning expenditures in FP2020 countries is estimated at US$2.7 billion (see chart). Consumer spending makes up the largest share at 51% of the total, with domestic government resources second at 24%. Funding from international donors accounts for 17%.

These are, however, estimates. The family planning sector needs better tracking mechanisms to assess expenditures—within countries, by sector, and for different components of family planning programming—and develop a clear picture of the additional resources that are required.

The long-term sustainability of family planning financing will ultimately depend on greater domestic expenditures by governments, and a number of efforts are underway to track this spending. The section on Core Indicator 12 discusses this work and the challenges involved in estimating government expenditures at the country level (page 72).

Distribution of family planning expenditures by source of funds, 2014

In millions, USD



Note: The International Family Planning Expenditure Tracking Expert Advisory Group developed estimates of all family planning expenditures in FP2020 countries, drawing on data from KFF, UNFPA/NIDI, DHS, PMA2020, and Track20.

Family Planning and the Sustainable Development Goals

PROGRESS ON FAMILY PLANNING is inextricably linked with the Sustainable Development Goals (SDGs), which will guide the world's development agenda for the next 15 years. The Sustainable Development Goals represent a new development paradigm that embraces the concept of universality, linking the fate and wellbeing of all people and countries to one another. The 17 Sustainable Development Goals are organized into 5 themes: People, Planet, Prosperity, Peace, and Partnership.

Achieving the FP2020 goal of enabling 120 million additional women and girls to use contraceptives by 2020 is absolutely critical to meeting Sustainable Development Goals 3 and 5, which call for universal access to sexual and reproductive health and rights and gender equality.[8] But family planning is also vital to the other 15 goals. Family planning is an essential cross-sectoral intervention that can speed up progress in every aspect of development.[9] Whether or not women and girls have access to contraception will have an enormous—and perhaps determinative—impact on our ability to reach the Sustainable Development Goals in every country.

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Find the full digital report online:
Familyplanning2020.org/progress

8. FP2020's Core Indicator 4 is also an indicator for Sustainable Development Goals target 3.7; see pages 61-63.

9. Starbird E, Norton M, Marcus R. Investing in family planning: key to achieving the sustainable development goals. Glob Health Sci Pract. 2016;4(2):191-210. http://www.ghspjournal.org/content/4/2/191

Adapted with permission from Starbird E, Norton M, Marcus R. Investing in family planning: key to achieving the sustainable development goals. Glob Health Sci Pract. 2016;4(2):191-210. http://www.ghspjournal.org/content/4/2/191

Part 02

FP2020 PARTNERSHIP

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Introduction

AS A UNIQUE COLLABORATIVE PLATFORM, FP2020 sits at the nexus of global, regional, and national efforts to expand family planning. Our partners include multilateral development agencies, donor governments and private philanthropists, implementing partners, civil society stakeholders, and dozens of countries that are committed to improving access to family planning. Together we foster a culture of dialogue, innovation, and accountability that spans sectors and bridges geographical divides.

FP2020 is an outcome of the 2012 London Summit on Family Planning, when leaders from around the world agreed on an ambitious goal: to enable an additional 120 million women and girls in the world's 69 poorest countries to use modern contraception by the year 2020. The Summit generated 70 specific commitments by governments and other partners to support, expand, and fund voluntary, rights-based family planning. FP2020 is the initiative that carries forward the momentum of this enormous international effort.

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Find the full digital report online:
Familyplanning2020.org/progress

Photo by Toni Greaves
Bill & Melinda Gates Foundation

FP2020 Governance Structure

FP2020's governance structure is designed to link communities of stakeholders and promote creative collaboration between institutions and across sectors. There are four components: a Reference Group, a Secretariat, the Performance Monitoring & Evidence Working Group, and the Expert Advisory Community.

The Reference Group is responsible for overall strategic direction and coordination. Its 18 members represent national governments, multilateral organizations, civil society, donor foundations, and the private sector. The current co-chairs are Dr. Babatunde Osotimehin, executive director of the United Nations Population Fund (UNFPA), and Dr. Chris Elias, president of global development at the Bill & Melinda Gates Foundation.

The Secretariat is responsible for the day-to-day administration of FP2020. Reporting to the Reference Group and hosted by the United Nations Foundation, the Secretariat leads the implementation of FP2020's strategy for 2016–2020, with an emphasis on supporting country-level activities with the participation and backing of global-level partnerships.

The Performance Monitoring & Evidence Working Group (PME WG) includes many of the world's leading experts on family planning data. The PME WG provides technical advice and support for monitoring progress toward the FP2020 goal, promotes the use of data for knowledge sharing and to inform decision making, and contributes to the understanding of quantitative and qualitative evidence in key dimensions of family planning.

The Expert Advisory Community (EAC) is a volunteer network of more than 135 technical experts on family planning who can be mobilized to address specific challenges at the country and global level. Newly established in 2016, the EAC serves as a vital link of two-way communication between the Secretariat and the family planning expert community.

The Core Conveners of the FP2020 initiative are the Bill & Melinda Gates Foundation, the UK Department for International Development, the United Nations Population Fund, and the US Agency for International Development.

↖ **Learn more** about the work of the Core Conveners at www.familyplanning2020.org/progress.

FP2020 and the Global Development Architecture

FP2020 is aligned with United Nations Secretary-General Ban Ki-moon's *Every Woman Every Child* Global Strategy for Women's, Children's and Adolescents' Health, and a commitment to FP2020 is included as a commitment to *Every Woman Every Child*. FP2020 also coordinates with other global and regional initiatives in the reproductive health sector, including the Ouagadougou Partnership (OP), the Reproductive Health Supplies Coalition (RHSC), the Partnership for Maternal, Newborn & Child Health (PMNCH), and the World Bank's Global Financing Facility (GFF) and Sahel Women's Empowerment and Demographic Dividend Project (SWEDD).

FP2020 Rapid Response Mechanism

FP2020's Rapid Response Mechanism (RRM) provides fast resources to meet urgent, time-bound needs. Established in July 2014 by Bloomberg Philanthropies and FP2020, the fund disburses short-term grants in response to critical emergencies, sudden gaps, and unforeseen opportunities to expand access to family planning in FP2020 focus countries.

Since its inception the RRM has funded 41 projects in 27 countries, and disbursed a total of US$3,658,752 (as of August 2016). Current projects include advocacy efforts to secure policy and budgetary improvements, technical assistance to governments to improve the supply chain for contraceptive products, and non-routine training of community health workers to operationalize recent task shifting policies. The RRM is also funding three family planning projects in response to the Zika outbreak (see page 43).

↖ **Learn more** about the Rapid Response Mechanism at: www.familyplanning2020.org/RRM.

FP2020 Commitments

COMMITMENT MAKERS AND THEIR formal pledges to expand access to voluntary, rights-based, high-quality family planning are the foundation of FP2020. The partnership has grown steadily since the London Summit, and now reflects the policy, financial, and programmatic pledges of more than 90 commitment makers.

A demonstrable commitment to family planning strengthens the enabling environment that programs and policies need to thrive; it also energizes family planning stakeholders to recommit to meeting the reproductive needs of their constituents.[10] But commitments are just the beginning. To ensure that pledges are transformed into progress, commitment makers must follow through with implementation and hold themselves accountable for results. Whether at the global, regional, national, or subnational levels, commitments can be the first step in a concrete, measurable process of change.

The digital version of the report includes a special section with additional information about commitments: www.familyplanning2020.org/progress.

↖ **Find the full digital report online:**
Familyplanning2020.org/progress

10. High Impact Practices in Family Planning (HIPs). Galvanizing commitment: creating a supportive environment for family planning. Washington (DC): USAID; 2015. Available from: https://www.fphighimpactpractices.org/commitment

MORE THAN 90 PARTNERS.
ONE PARTNERSHIP.

New Commitments

Three additional countries joined the FP2020 partnership in the past year, bringing the total number of commitment-making countries to 38.[11] FP2020 is also pleased to welcome two new commitments from institutional partners, contributing fresh momentum and resources to the movement.

↖ **Read the full text** of the commitments at: www.familyplanning2020.org/progress.

AFGHANISTAN

The Government of Afghanistan committed to:

- Reduce unmet need for family planning by 10% by 2020;
- Increase the modern contraceptive prevalence rate to 30% by 2020;
- Allocate 25% of the national health budget specifically to reproductive health; and
- Develop a Family Planning National Costed Implementation Plan for 2017–2020.

LAO PDR

The Government of Lao PDR committed to:

- Increase the modern contraceptive prevalence rate from 42% to 65% by 2020;
- Reduce unmet need for contraception from 20% to 13% by 2020;
- Expand coverage and method mix for family planning services in health facilities with a focus on long-acting methods, such as implants and IUDs; and
- Revise the country's reproductive health policy to promote an enabling environment for family planning.

Renewed Commitments

Three FP2020 partners renewed their commitments this year with ambitious new objectives, pledging to build on the contributions they have already made and go even further: contributing more resources, delivering more services, reaching more women and girls.

↖ **Read the full text** of the commitments at: www.familyplanning2020.org/progress.

GERMANY

The Government of Germany renewed its original 2012 commitment and pledged to:

- Provide a minimum of €514 million until 2019 to rights-based family planning and reproductive health (25% of Germany's bilateral funding will likely be dedicated directly to family planning, depending on partner country priorities); and
- Support the government's Rights-based Family Planning and Maternal Health Initiative, which includes the aim of providing information and access to modern forms of family planning to 9 million couples.

VIETNAM

The Government of Vietnam committed to:

- Ensure universal access to family planning;
- Increase the modern contraceptive prevalence rate for married women (ages 15 to 49 years old) from 67.5% in 2015 to 70% by 2020;
- Develop and implement youth-friendly contraceptive services and methods; and
- Improve rights-based approaches to family planning services, establishing national standards for quality of care.

POPULATION SERVICES INTERNATIONAL

Population Services International—through its global network of country programs—committed to:

- Reach 10 million people under the age of 25 with modern contraceptive methods by December 2020; and
- Collaborate with young people to reimagine and redefine the way sexual and reproductive health and rights (SRHR) programs are designed, delivered, measured, and evaluated.

MARGARET PYKE TRUST, WITH THE POPULATION & SUSTAINABILITY NETWORK

Building upon the organization's expertise in providing the UK's most up-to-date sexual and reproductive health training courses for medical professionals, **the Margaret Pyke Trust, with the Population & Sustainability Network, committed to:**

- Expand training activities to reach 300 doctors and nurses in FP2020 focus countries, with training tailored to meet local capacity needs, reaching up to 9.5 million women and girls with an unmet need for family planning;
- Implement three programs that integrate sexual and reproductive health and rights within broader international development programs; and
- Advocate for the importance of universal access to comprehensive and voluntary family planning services and rights as a requirement to enable sustainable development.

11. This figure does not include South Africa, which made a commitment to FP2020 but is not one of the 69 focus countries. South Africa's GNI does not qualify it as one of the world's poorest countries, based on the World Bank 2010 classification using the Atlas Method.

INTERNATIONAL PLANNED PARENTHOOD FEDERATION

The International Planned Parenthood Federation renewed its original 2012 commitment and pledged to:

- Reach a further 39 million first-time users of modern contraception in the FP2020 focus countries between 2016 and 2020;
- Promote women's empowerment and the elimination of sexual and gender-based violence, female genital mutilation, and early and forced marriage; expand access to comprehensive sexuality education; strengthen sexual and reproductive health services in humanitarian settings; and run popular campaigns to mobilize support for SRHR and citizen-led accountability.

INTRAHEALTH INTERNATIONAL

IntraHealth International renewed its original 2012 commitment and pledged to:

- Reach 315,000 health workers annually with education, skills building, and supervisory, management, and policy support by 2020; and
- Apply its technical, programmatic, measurement, and advocacy resources and expertise to expanding equitable access for an increased number of frontline health workers globally and in 20 FP2020 priority countries, including the nine countries in the Ouagadougou Partnership, Democratic Republic of Congo, Ethiopia, India, Kenya, Liberia, Nigeria, Palestine, Tanzania, South Sudan, Uganda, and Zambia.

Country Support

WHEN COUNTRIES INVEST IN family planning, they are investing in their own future. Family planning is a transformational strategy that unleashes a cascade of benefits across sectors, leading to healthier and more prosperous women, children, families, and communities. The evidence is clear: family planning is one of the most powerful and cost-effective investments a country can make in its development.[12]

FP2020 links countries with a global community of donors, advocates, and experts who are committed to expanding high-quality, rights-based family planning. The FP2020 initiative provides a broad platform of multisectoral support and cooperation as countries pursue their family planning objectives and maintain continuity with their existing development priorities. FP2020 also promotes South-South collaboration, encourages broader and more inclusive conversations between countries, and cultivates the engagement of all sectors at the country and global levels.

↖ **Find the full digital report online:**
Familyplanning2020.org/progress

FP2020's revised strategy for 2016–2020 calls for an increased level of direct country support to accelerate progress in the remaining four years of the initiative. Building on the achievements of the former Country Engagement Working Group and with the collaboration of partners at the global and national levels, FP2020 is facilitating technical support in all thematic areas of rights-based family planning programming: demand creation; service delivery and access; contraceptive security; policy and enabling environment; financing; and stewardship, management, and accountability.

FP2020's focal points in each country include representatives from the government and two donor organizations, usually UNFPA and USAID. The focal points serve as the key representatives of FP2020 in-country, and coordinate with each other, the government, partners and other stakeholders, and the FP2020 Secretariat to drive progress on the country's family planning goals.

Every 12–18 months, FP2020 will convene Regional Focal Point Workshops in Asia, Anglophone Africa, and Francophone Africa (see page 36 for a report on the first set of workshops). A chief outcome of the workshop is each country delegation's action plan, which is aligned with the national family planning strategy or costed implementation plan (CIP). The action plan identifies next steps over a 12–18 month horizon, and functions as a shared working agenda for the focal points and other partners.

The CIP is a longer-range document: a multi-year roadmap that identifies a country's family planning goals, outlines strategies to achieve them, and estimates the cost of implementation. CIPs are country-owned documents that reflect the participation of numerous stakeholders, and serve as a vital tool to organize collaboration. All components of a country's family planning program should be addressed and budgeted in the CIP, with activities prioritized under different funding scenarios. USAID, UNFPA, and other FP2020 partners provide technical assistance and resources to support CIP development.

The revised country support and workshop processes are still in the early stages and will be fine-tuned as needed, but the model is already showing great promise for fostering closer collaboration and alignment within the FP2020 partnership.

Global Financing Facility

The World Bank's Global Financing Facility (GFF) for Reproductive, Maternal, Nutrition, Child and Adolescent Health (RMNCAH) is a multi-stakeholder partnership that supports country-led efforts to improve the health of women, children, and adolescents. The GFF's long-term vision is to mobilize additional resources domestically and internationally to fill funding gaps for RMNCAH, and to improve the efficiency of spending over time. Eligible countries are asked to prepare an investment case, which describes proposed improvements in RMNCAH and a prioritized set of investments required to achieve these results.

Because family planning is globally recognized as a "best buy" for RMNCAH, the GFF provides a unique opportunity for countries to secure funding for strategic family planning programs. The family planning community has made a concerted push to ensure that family planning is included in the GFF business plan and investment frameworks, with uneven success. As the GFF is operationalized, continued advocacy is needed to make sure that family planning is prioritized appropriately, that civil society is fully engaged, and that accountability mechanisms are in place.

FP2020 is supporting focal points in GFF countries with the specific information, tools, and data they need to include family planning in their country investment cases. The 2016 Regional Focal Point Workshops included sessions devoted to GFF, and in February FP2020 partnered with USAID, UNFPA, and the World Bank to conduct a GFF webinar for FP2020 focal points.

12. Stenberg K, Axelson H, Sheehan P, Anderson I, Gülmezoglu AM, Temmerman M, et al. Study Group for the Global Investment Framework for Women's Children's Health. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. Lancet. 2014;383(9925): 1333–1354.

Regional Focal Point Workshops

The first FP2020 Focal Point Workshop, held in March 2015 in Istanbul, was a partnership-wide event, bringing together focal points from 32 commitment-making countries. In 2016, as part of the revamped country support model, FP2020 transitioned to convening Regional Focal Point Workshops in Asia, Anglophone Africa, and Francophone Africa. The workshops were co-organized by USAID, UNFPA, and the FP2020 Secretariat, and provided a vital convening space for focal points to exchange technical expertise and have frank conversations about successes and challenges, regional issues, and country priorities.

Asia Regional Focal Point Workshop

JANUARY 2016

11 countries participated in the workshop in Denpasar, Indonesia

Anglophone Africa Regional Focal Point Workshop

APRIL 2016

13 countries participated in the workshop in Kampala, Uganda

Francophone Africa Regional Focal Point Workshop

MAY 2016

12 countries participated in the workshop in Abidjan, Côte d'Ivoire

The objectives of the workshops were to:

- Examine and review the most up-to-date country-specific data, including the methodologies and processes used to calculate and validate the data;
- Share lessons learned, ideas, and innovations to deliver rights-based programming that can be brought to scale to increase contraceptive access and use by key groups, including youth and the hardest to reach;
- Provide a platform for exchanges with technical experts and other focal points on best practices and promote South-South learning and relationships within the region;
- Exchange information about new and innovative financing efforts, including the Global Financing Facility and domestic resource mobilization initiatives;
- Establish a clear understanding of the roles of government and donor focal points and the FP2020 Secretariat, including outreach to other in-country partners; and
- Develop Country Action Plans with clearly delineated next steps for the focal points as well as the FP2020 Secretariat and other partners.

Over the course of the three regional workshops, commonalities surfaced across multiple countries and regions. The identified priorities include the need to build high-level political support for family planning in country; improving and expanding the use of data for decision making, including disaggregated data for youth; mapping resource mobilization, including domestic resources and World Bank financing mechanisms; scaling up long-acting reversible contraceptives (LARCs); improving supply chain and delivery systems; investing in demand-side and social and behavior change communications; and increasing private sector involvement.

Country Resources on the FP2020 Website

Each country page on the FP2020 website serves as a dynamic repository of family planning information, with key documents, data, resources, and news.

Visit **www.familyplanning2020.org/countries** and either click on the map or a country name to view each country's webpage.

Materials listed here are not all available for every country.

The newly revamped country pages also feature resources related to other global and regional partnerships, including:

PLANIFICATION FAMILIALE
Le Partenariat de Ouagadougou

WE SUPPORT EVERY WOMAN EVERY CHILD

LAC 2016 Conference

The Latin American and Caribbean region (LAC) has some of the highest modern contraceptive prevalence rates among low and middle-income countries. Dramatic gains have been made since the 1990s, with governments, civil society, and the private sector partnering to increase demand for family planning and improve service delivery. But there are still significant social and geographic inequalities in access to contraception. Entire populations are being left behind, including those in rural settings and indigenous peoples. Young people also face steep obstacles to getting the services they need.

The first **Latin America and Caribbean Conference to Reduce Inequalities in Sexual and Reproductive Health**, held in Cartagena in September 2016, marked the start of a new movement to address these issues. Representatives from 22 governments and civil society organizations convened for three days of political and technical dialogue, centered on generating commitments and identifying implementation strategies to tackle the region's most significant barriers to reaching marginalized populations.

FP2020 joined a coalition of partners in organizing the event, including ForoLAC, Profamilia, USAID, UNFPA, the Reproductive Health Supplies Coalition, Management Sciences for Health, Jhpiego, the Inter-American Development Bank, John Snow, Inc., and Population Action International.

The conference provided an important opportunity for existing partnerships to be renewed and for new connections to be made. For several participants, it was their first chance to learn about FP2020 and the work underway in Africa and Asia. Numerous links were forged across sectors, with colleagues from governments, multilateral organizations, civil society, and the private sector joining in discussions. The conference generated agreements on country and partner priorities and short-term action plans to take this critical work forward in the region.

Poster created by graphic artist Pataleta depicting the Latin America and Caribbean Conference to Reduce Inequalities in Sexual and Reproductive Health.
Photo by Humberto Trespalacios

Closing reception of the 2016 International Conference on Family Planning in Nusa Dua, Indonesia.
Photo courtesy of the Bill & Melinda Gates Institute for Population and Reproductive Health.

2016 International Conference on Family Planning

The fourth International Conference on Family Planning was held in Nusa Dua, Indonesia, in January 2016, drawing more than 3,000 participants from around the world. The theme was *Global Commitments, Local Actions*, with a strong focus on youth issues throughout—including a call to action from young people that their needs must be addressed as the key to sustainability in the SDG era. Programming tracks highlighted specific issues: youth needs and involvement; quality of care; the demographic dividend; advancing family planning through faith organizations; innovations in financing; advocacy and accountability; demand generation and social change; implementing best practices; and FP2020 progress and challenges.

FP2020 conducted the morning plenary on day 3 with the theme *Accelerating Progress: 2016-2020*. The conference also featured the launch of FP2020's new strategic direction, a panel session on FP2020 data, and an #FPVoices storytelling booth. The conference set the stage for FP2020's first Regional Focal Point Workshop in Asia, which convened immediately afterwards in Denpasar.

The 2016 ICFP was co-hosted by the Bill & Melinda Gates Institute for Population and Reproductive Health at Johns Hopkins Bloomberg School of Public Health and the National Population and Family Planning Board of Indonesia (BKKBN).

Rights and Empowerment

THE AMBITIOUS GOAL ANNOUNCED at the London Summit proved catalytic in many ways, ushering in renewed interest in and funding for family planning and eliciting global commitments to provide more women with access to the services and programs they want and need. Significantly, it also emphasized a new approach that called for using human rights principles as the foundation of all family planning activities, including those focused on generating demand, meeting unmet need, and improving quality of care. The promise of rights-based family planning (RBFP) programming has led global and country actors to interrogate their programs and practices to ensure that the rights of the client are upheld and that the principles of agency, access, availability of contraceptives, and quality of care are rigorously observed.

In the years since the London Summit, several guidelines for RBFP have been developed that provide principles, entry points, and solid programming advice to help countries and practitioners develop family planning programs that respect and protect human rights. These include frameworks from the World Health Organization, the Evidence Project, the Population Council, and EngenderHealth, as well as FP2020's Rights and Empowerment Principles for Family Planning (see box).

↖
Find the full digital report online:
Familyplanning2020.org/progress

These guidelines have drawn interest from country stakeholders because of their emphasis on serving individuals and communities while also acknowledging the importance of an enabling environment and supply-side factors.

A growing number of implementing partners are injecting a rights approach into new and existing programs, resulting in the first evidence about what it takes to operationalize RBFP and measure the difference it can make in programs, progress, and people's lives.

Several of the FP2020 Core Indicators provide a glimpse into issues of agency and autonomy, quality, availability, and informed choice across the 69 focus countries. The National Composite Index for Family Planning, a survey developed by Track20 in 2015, attempts to capture the extent to which national family planning programs address issues of quality, equity, and accountability, among others. Other FP2020 partners are also exploring ways of developing and—crucially—aligning indicators to monitor rights at the provider level. This growing body of research will help donors, countries, and program developers assess the validity of various RBFP approaches.

In June of 2016, the FP2020 Secretariat convened the "Realizing Sustainable Programming for Rights-based Family Planning" meeting in London, attended by representatives of donor organizations, implementing agencies, research groups, United Nations entities, and civil society. Participants shared current RBFP programing and monitoring efforts, heard the perspectives of key donors on how rights figure in their portfolios, explored the challenges and tensions inherent in this work, and identified approaches that will add a rights lens to new and existing programs.

Recognizing that the rights-based approach is a multi-sectoral concern, the FP2020 Secretariat, USAID, and the Interagency Gender Working Group (IGWG) co-convened a meeting on the nexus of gender and rights-based family planning, or reproductive empowerment. The discussion was held in May 2016 in Washington, DC, and focused on key considerations in gender norms and women's status and empowerment that can amplify the work on rights-based programming. Members of the HIV/AIDS community have also reached out to learn how they can engage, and there is increased interest in sharing these principles with the maternal and child health community.

Although the family planning sector is still in the early stages of capitalizing on the potential that a rights-based approach can bring, awareness and interest have reached a level that further progress is inevitable. The coming year will focus on further advancing the body of evidence and creating a community of practice where the robust exchange of ideas can occur virtually as

FP2020's Rights and Empowerment Principles for Family Planning

- Agency and Autonomy
- Availability
- Accessibility
- Acceptability
- Quality
- Empowerment
- Equity and Non-discrimination
- Informed Choice
- Transparency and Accountability
- Voice and Participation

↖ FP2020's Rights and Empowerment Principles for Family Planning were published in December 2014: **www.familyplanning2020.org/rightsprinciples.**

Photo by Jonathan Torgovnik
Getty Images Reportage

well as in person. FP2020 will support this work by convening and amplifying discussions, developing and sharing tools and resources, and driving forward our shared agenda:

- What does it mean to have a rights-based approach?
- Will quality of care work be folded into the rights-based approach, or will it continue to be separate and complementary?
- How can progress toward upholding rights be measured?
- Will a rights approach bring in more women and improve the sustainability of programming?
- How can governments put into place policies that support the rights-based frame?
- What are the most viable ways of creating implementation plans that support RBFP?
- How do service providers and program managers at every level get the training they need to ensure rights are in their programs?
- How can country plans measure how well rights have been observed?

As interest and expertise in this emerging area of family planning grow and strengthen, these questions, and more, will be answered.

Responding to Zika

The spread of the Zika virus highlights the critical importance of a rights-based approach to sexual and reproductive health care. The public health response must be grounded in the rights of women and girls to determine for themselves if and when they get pregnant, and to make informed decisions about what is best for them and their individual circumstances. An effective response should also embrace a holistic approach to sexual and reproductive health, with an emphasis on access to a range of high-quality contraceptive methods, including condoms and emergency contraception.

FP2020's Rapid Response Mechanism is funding three projects in response to the Zika outbreak. In Nicaragua, **Ipas** is focusing on reaching young people with information on contraception and Zika prevention. The project includes training of health care professionals on youth-friendly services, training of peer educators and extension workers on referral techniques and Zika messaging, and support for the Ministry of Health to develop and adopt a protocol on Zika treatment with a rights-based approach.

In Haiti, **Profamil** is working to increase access to family planning and information on Zika prevention among underserved populations. The project includes training of peer educators, a nationwide campaign on family planning and Zika, and mobile clinics to serve hard-to-reach areas. Also in Haiti, the **Hôpital Albert Schweitzer** aims to accelerate the use of contraceptives to mitigate the impact of the Zika virus and prevent birth defects in children during the peak of the epidemic. The project will reach at least 10,000 women and girls with information about the importance of family planning, the range of modern contraceptive options available, the potential dangers of Zika in pregnancy, and how Zika can be prevented.

Youth

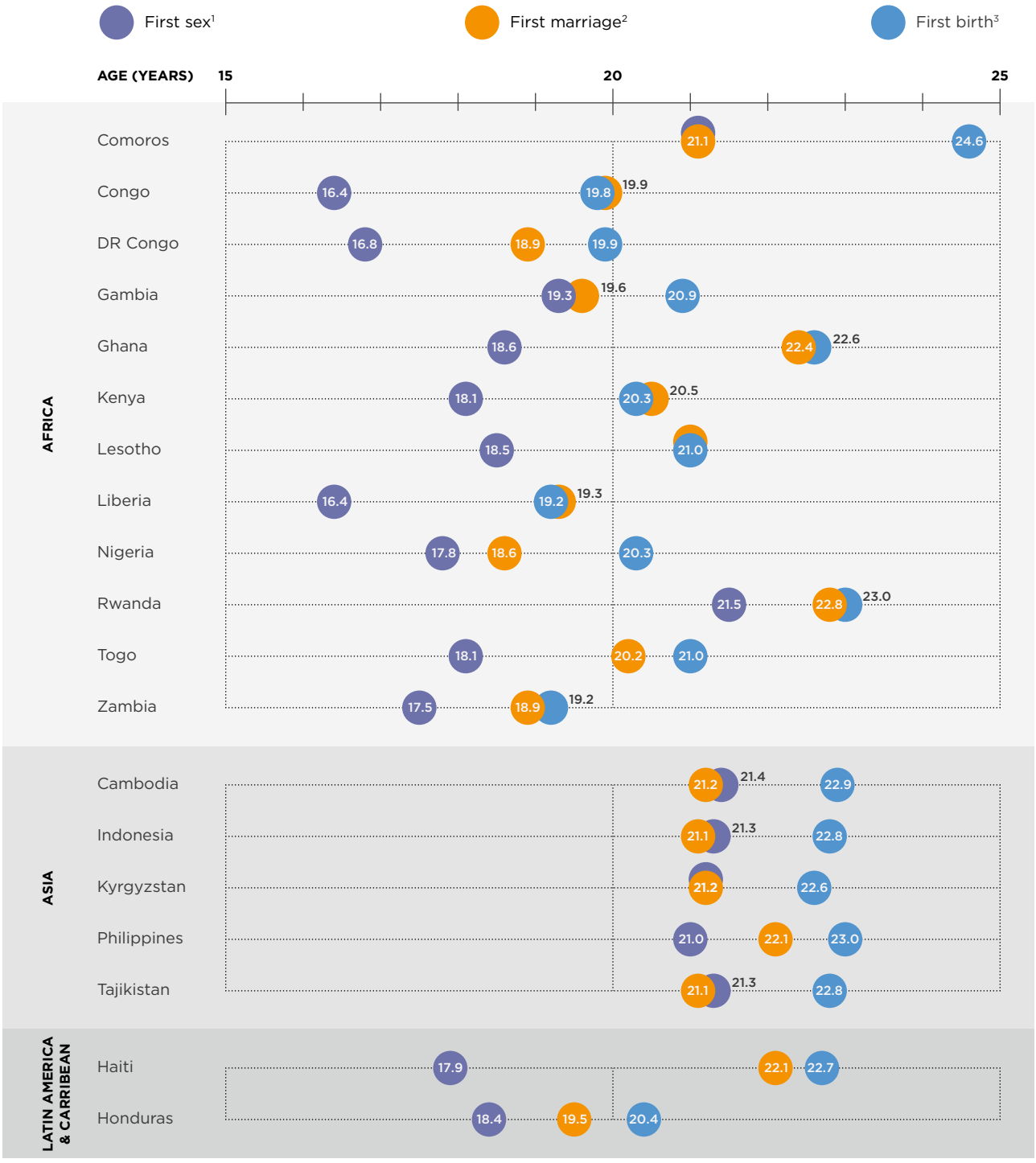
TODAY'S YOUTH POPULATION IS the largest in history: 1.8 billion individuals between the ages of 10 and 24, more than a billion of whom live in FP2020's 69 focus countries.[13] Many have an urgent need for contraceptive information and services, yet they are too often hindered by discrimination, stigma, poverty, and a lack of basic knowledge about sexual and reproductive health and rights. Reaching this age group with high-quality services that are tailored to their needs must be an essential priority for the entire family planning sector.

There is no one-size-fits-all solution to meeting the needs of young people, because there is no one story that fully encapsulates their experiences. The life trajectories of young people differ enormously across countries—and even within countries—with considerable variation in the timing and sequence of key events: the age they stop attending school, first have sex, get married, and/or give birth (see graph). These distinctions highlight the importance of developing approaches that are context-specific, timely, and effective. Ultimately, countries must examine their policies and settings, develop a process of evaluation and reevaluation that genuinely reflects a youth perspective, and implement evidence-based programs that work.

↖
Find the full digital report online:
Familyplanning2020.org/progress

13. United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, Key Findings and Advance Tables. Working Paper No. ESA/P/WP.241.

Median age at key life events among young women



[1] Median age at first sexual intercourse for women age 25-29, from DHS (2012-2015)
[2] Median age at first marriage for women age 25-29, from DHS (2012-2015)
[3] Median age at first birth for women age 25-29, from DHS (2012-2015)

FP2020 is contributing to these efforts in three main areas of activity:

- improving data on young people and encouraging the use of this data to inform strategic decision making;
- amplifying the voices of young people and supporting their inclusion in mainstream advocacy work in countries and within the FP2020 partnership and leadership structures; and
- cultivating the acceptance of evidence-based interventions for youth, including postpartum and post-abortion family planning and long-acting reversible contraceptives (LARCs).

LARCs include implants and IUDs, and are among the most well-supported evidence-based interventions for adolescents and young women. FP2020 serves as the site host for the **Global Consensus Statement on Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception**, which is supported by 50 endorsing organizations. The statement was developed by Path-finder International, its E2A project, PSI, MSI, and FHI 360 as a vehicle to generate awareness about the right of all young people to access a full range of contraceptive methods, including LARCs.

↖ **Read the statement at:**
www.familyplanning2020.org/youth-larc-statement

Most FP2020 partner countries include a focus on youth in their national family planning strategies, and FP2020 is developing technical resources to assist countries in framing youth-friendly programs. The emphasis is on interventions with demonstrated effectiveness that can be incorporated within existing service delivery channels (see box).

WHAT WE CAN DO BETTER

Examine youth policies and settings, develop a process of evaluation and reevaluation that genuinely reflects a youth perspective, and implement evidence-based programs that work.

To underscore FP2020's commitment to fostering cross-generational policy dialogue, a new youth seat was created on the Reference Group, currently held by Margaret Bolaji of Nigeria. FP2020 is also working to bolster the participation of youth advocates and strengthen the connections between global, regional, and national youth networks. By uniting, they can share experiences, develop formal advocacy activities, and coalesce on how to move policies, plans, and promises to solid action that improves the lives of young people.

14. High-Impact Practices in Family Planning (HIPs). Adolescent-friendly contraceptive services: mainstreaming adolescent-friendly elements into existing contraceptive services. Washington (DC): USAID; 2015. Available from: https://www.fphighimpactpractices.org/afcs

Adolescent-Friendly Contraceptive Services

The High Impact Practices (HIP) in Family Planning initiative identifies seven elements that have been shown to increase adolescent uptake of contraceptive services:[14]

Service Delivery:

- Training and supporting providers to offer nonjudgmental services to adolescents
- Enforcing confidentiality and ensuring audio and visual privacy
- Offering a wide range of contraceptive methods
- Providing free or subsidized services

Enabling Environment:

- Ensuring legal rights, policies, and guidelines that respect, protect, and fulfill adolescents' rights to contraception, regardless of age, sex, marital status, or parity
- Fostering support among communities and parents for adolescents to access contraceptive information and services
- Addressing gender norms

Photo by Robyn Russell
Universal Access Project, United Nations Foundation

How We Measure

FP2020 AND TRACK20 COLLABORATE closely to advance the family planning measurement agenda. Together, they work toward increasing the availability, visibility, quality, and use of family planning data.

FP2020 PERFORMANCE MONITORING & EVIDENCE WORKING GROUP (PME WG)

The FP2020 Performance Monitoring & Evidence Working Group (PME WG) provides technical guidance, analytic expertise, intellectual stewardship, and quality control for the FP2020 measurement and learning agenda. This includes harmonization and alignment of indicators and methodologies among partners, platforms, and frameworks, and ongoing assessment of the FP2020 Core Indicators to ensure they provide useful information and that any necessary adjustments are made. The group is comprised of demographers, researchers, statisticians, and other technical experts, and is supported by the FP2020 Secretariat's Data & Performance Management (DPM) team.

TRACK20

Track20, a project of Avenir Health, works with FP2020 commitment-making countries to identify, train, and support dedicated family planning monitoring and evaluation (M&E) officers. The M&E officers, who are trained by Track20, are usually technical staff from the country's Ministry of Health, Office of Population, or other relevant office, and act as point persons for family planning data. Track20 is working with M&E officers in 35 FP2020 commitment making countries.

M&E officers' day-to-day activities vary according to country needs—ranging from producing subnational estimates of key family planning indicators to providing M&E support for costed implementation plans (CIPs)—but in all countries, M&E officers liaise with country partners, encouraging the use of quality data, new methodologies, and tools for improved family planning programming and policy decision making.

As part of this effort, M&E officers are engaged in producing data for and organizing annual data consensus workshops led by the government. These workshops provide a platform for the government and partners to review available data, discuss data quality, produce annual estimates of the FP2020 Core Indicators, and assess progress toward a country's FP2020 goal. Data consensus workshops help ensure that annual monitoring is country-driven and promote transparency about the data and methodologies used in-country and internationally.

↖ **For more information** about Track20, please visit www.track20.org.

DEVELOPING ANNUAL ESTIMATES OF FP2020'S CORE INDICATORS

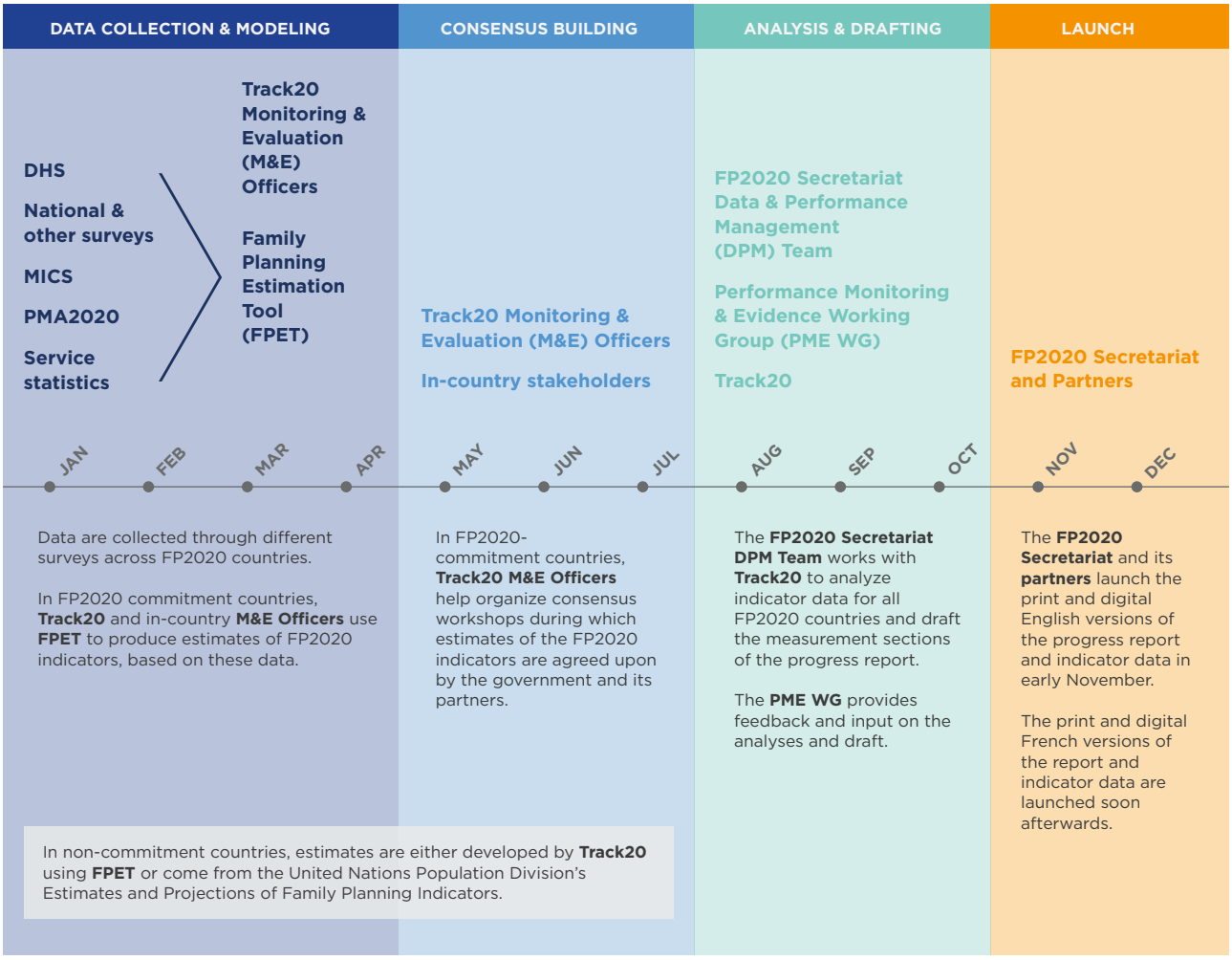
Traditionally countries have relied on estimates for mCPR and unmet need that are taken from population-based surveys, such as the Demographic Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS). Most countries wait several years between surveys to assess the impact of their efforts. FP2020 aims to produce annual estimates of progress, and to do so Track20 has developed

methods to take advantage of all available nationally representative surveys to develop annual estimates of FP2020's Core Indicators. In several countries, more rapid surveys as well as regularly collected service statistics from the health sector are providing new data on which to base these estimates. The figure below illustrates the process each year of developing annual estimates for the FP2020 Progress Report.

One new source of survey data comes from Performance Monitoring and Accountability 2020 (PMA2020), which is working in 10 FP2020 commitment-making countries.[15] PMA2020 uses mobile technology to collect rapid-turnaround survey data on key family planning indicators at individual, household, and facility levels. Partnering with local universities and research organizations, PMA2020 builds local capacity to train and deploy a cadre of resident female enumerators who conduct the surveys using smart phones every six months to a year. The project is providing unprecedented frequency of data in select FP2020 countries.

15. Burkina Faso, DR Congo, Ethiopia, Ghana, India, Indonesia, Kenya, Niger, Nigeria, Uganda

How we measure: From data source to Progress Report



Part 03

MEASUREMENT

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76-77 Contraceptive Discontinuation

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Introduction

AS A TIME-BOUND INITIATIVE with an ambitious goal, FP2020 places great emphasis on measuring progress, and from its inception has been committed to leading a transformation in the global monitoring of family planning data through a measurement and learning agenda.

The FP2020 measurement and learning agenda aims to improve the infrastructure and capacity for generating higher quality data for decision making. Working toward more frequent, improved, and aligned measurement of progress, FP2020 produces annual, internationally comparable estimates on different dimensions of family planning across the focus countries. Commitment making countries annually produce national estimates and review national and subnational data to shed light on where gains are being made, where efforts should be reinforced, where investments will have the most impact, and where more data and information are needed.

Our aim is that the FP2020 Core Indicators and data in this report will spark productive conversations about what needs to be done differently, and inspire action that accelerates progress to more fully meet women's and couples' family planning needs.

↖
Find the full digital report online:
Familyplanning2020.org/progress

Core Indicators

FP2020 USES A SUITE of quantitative metrics—Core Indicators—to monitor progress annually across focus countries. Estimates for the Core Indicators are produced annually by commitment making countries through a network of country-based M&E officers housed in government institutions. Countries receive training and technical support from Track20 to produce Core Indicator data and assess progress.

The Core Indicator definitions and data sources are shown in the table to the right, and additional information on methodologies can be found on the FP2020 and Track20 websites. The subsequent sections of the report highlight particular indicators, and estimate tables for the indicators can be found on pages 82-123. In addition, individual country profiles and Core Indicator sheets can be found on the FP2020 website.

↖
Find the full digital report online:
Familyplanning2020.org/progress

Core Indicators 13 and 17

Core indicators 13 and 17, couple-years of protection (CYP) and adolescent birth rate, are not featured in the body of the report this year but are included in the Estimate Tables. CYPs are calculated from routine data collected through Health Management Information Systems, and represent the work being done in-country to collect routine data and use this data to monitor program progress.

In addition, the data used to calculate CYPs was also used in 11 countries to inform current mCPR estimates (Core Indicator 2). The adolescent birth rate is of particular interest in countries with adolescent reproductive health interventions designed to reduce unintended pregnancy. This survey-based measure does not change much from year to year and so has not been highlighted.

Indicator No. 1 Number of additional users of modern methods of contraception *	**DEFINITION:** The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to 2012 **SCOPE:** Reported annually, for all 69 FP2020 focus countries (except Western Sahara) **SOURCE:** UN Population Division (for number of women of reproductive age); Family Planning Estimation Tool (FPET) for mCPR, using all available household surveys such as Demographic and Health Surveys (DHS), PMA2020, MICS, RHS, and comparable national sources, including service statistics where possible
Indicator No. 2 Contraceptive Prevalence Rate, Modern Methods (mCPR)*	**DEFINITION:** 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. **SCOPE:** Reported annually, for all 69 FP2020 focus countries (except Western Sahara) **SOURCE:** Family Planning Estimation Tool (FPET), using all available household surveys such as Demographic and Health Surveys (DHS), PMA2020, MICS, RHS, and comparable national sources including service statistics where possible
Indicator No. 3 Percentage of women with an unmet need for modern methods of contraception**	**DEFINITION:** 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 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. **SCOPE:** Reported annually, for all 69 FP2020 focus countries (except Western Sahara) **SOURCE:** FPET, using all available household surveys such as DHS, PMA2020, MICS, and RHS
Indicator No. 4 Percentage of women whose demand is satisfied with a modern method of contraception**	**DEFINITION:** 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. **SCOPE:** Reported annually, for all 69 FP2020 focus countries (except Western Sahara) **SOURCE:** FPET, using all available household surveys such as DHS, PMA2020, MICS, and RHS

Notes: *All Women **Married or in-Union Women

Indicator No. 5

Number of unintended pregnancies

DEFINITION: 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.

SCOPE: Reported annually, for all 69 FP2020 focus countries

SOURCE: Core Indicator 1–9 Calculator, using country, regional and global parameters from surveys and other sources

Indicator No. 6

Number of unintended pregnancies due to modern contraceptive use

DEFINITION: The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.

SCOPE: Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE: Core Indicator 1–9 Calculator, using country, regional and global parameters from surveys and other sources

Indicator No. 7

Number of unsafe abortions averted due to modern contraceptive use

DEFINITION: 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.

SCOPE: Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE: Core Indicator 1–9 Calculator, using country, regional and global parameters from surveys and other sources

Indicator No. 8

Number of maternal deaths averted due to modern contraceptive use

DEFINITION: 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.

SCOPE: Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE: Core Indicator 1–9 Calculator, using country, regional and global parameters from surveys and other sources

Indicator No. 9

Percentage of women using each modern method of contraception

DEFINITION: The percentage of total family planning users using each modern method of contraception.

SCOPE: Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE: Most recent survey, which may be: DHS, MICS, PMA2020, other national surveys

Indicator No. 10

Percentage of facilities stocked out, by method offered, on the day of assessment

DEFINITION: Percentage of facilities stocked out of each type of contraceptive offered, on the day of assessment.

SCOPE: 2014.5-2016: 36 countries (those with sufficient data)

SOURCE: UNFPA facility surveys; PMA2020 facility surveys; other facility surveys and LMIS data

Indicator No. 11a

Percentage of primary SDPs with at least 3 modern methods of contraception available on day of assessment

DEFINITION: The percentage of service delivery points (SDPs) that have at least 3 modern methods of contraception available on the day of the assessment. This indicator considers methods (such as injectables), not products (such as the 3-month or 6-month injectable) or brands (such as Depo-Provera).

SCOPE: 2015-2016: 8 countries (those with sufficient data)

SOURCE: UNFPA facility surveys; PMA2020 facility surveys

Indicator No. 11b

Percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment

DEFINITION: The percentage of secondary and tertiary service delivery points (SDPs) that have at least 5 modern methods of contraception available on the day of the assessment. This indicator considers methods (such as injectables), not products (such as the 3 month or 6 month injectable) or brands (such as Depo-Provera). The determination of which health facilities are defined as “secondary” or “tertiary” will be made at the country level, based on existing classifications.

SCOPE: 2015-2016: 8 countries (those with sufficient data)

SOURCE: UNFPA facility surveys; PMA2020 facility surveys

Indicator No. 12

Annual expenditure on family planning from government domestic budget

DEFINITION: Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government

SCOPE AND SOURCE: Not reported individually for countries this year due to challenges with data validation. See section on "Domestic Government Expenditures on Family Planning" (page 72) for more information.

Indicator No. 13

Couple-Years of Protection (CYP)

DEFINITION: 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.

SCOPE: 13 countries with sufficient available data, reported for 2015

SOURCE: Calculated from Logistics Management Information Systems (LMIS) or Health Management Information Systems (HMIS)

Indicator No. 14

Method Information Index

DEFINITION: An index measuring the extent to which women were given specific information when they received family planning services. 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 reported value is the percent of women who responded "yes" to all three questions.

SCOPE: 28 countries; reported for the year with the most recent national survey data, from 2012 to present

SOURCE: For each country, the most recent national survey (DHS, PMA2020)

Indicator No. 15

Percentage of women who were provided with information on family planning during recent contact with a health service provider

DEFINITION: The percentage of women who were provided information on family planning within the last 12 months through 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.

SCOPE: 27 countries; reported for year with most recent national survey data, from 2012 to present

SOURCE: For each country, the most recent national survey (DHS, PMA2020)

Indicator No. 16

Percentage of women who decided to use family planning alone or jointly with their husbands/ partners

DEFINITION: The percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner.

SCOPE: 17 countries; reported for year with most recent national survey data, from 2012 to present

SOURCE: For each country, the most recent national survey (DHS, PMA2020)

Indicator No. 17

Adolescent birth rate

DEFINITION: The number of births to adolescent females aged 15-19 occurring during a given reference period per 1,000 adolescent females.

SCOPE: 44 countries; reported for year with most recent national survey data, from 2012 to present

SOURCE: For each country, the most recent national survey (DHS, PMA2020, MICS)

Indicators 1-2

Additional Users and mCPR

BY JULY 2016, the end of FP2020's fourth year, there were 30.2 million additional users of modern methods of contraception as compared to July 2012, the time of the London Summit.

Core Indicator 1 (Estimate Table 1), number of additional users of modern methods of contraception, is the most direct measure of progress toward achieving the goal of adding 120 million additional users by the year 2020. Additional users are calculated by comparing the total number of users of modern contraception in any given year with the number of users there were in 2012. The total number of users of modern contraception is calculated using **Core Indicator 2 (Estimate Table 2), the prevalence of use of modern methods of contraception among all women**, and the total women of reproductive age in each country.

Each year new data improve our estimates of both the total number of users of modern contraception today as well as the number of users there were in 2012, the year of the FP2020 baseline. The release of new population data in the UN Population Division's 2015 World Population Prospects resulted in a revision of the estimated number of women of reproductive age both in 2012 and 2016. Today there are an estimated 894 million women age 15–49 in FP2020 countries, 61.5 million more than there were in 2012. Of these, more than 300 million are using a modern method of contraception, which amounts to 30.2 million additional women and girls who are using modern contraception.

Closer examination of Core Indicator 1 shows that more than half of the 30.2 million additional users of contraception are in Asia (16 million), which is not surprising as the most populous FP2020 countries are in that region. India alone is home to more than 130 million of the 300 million users of contraception in the focus countries. Because India is home to 38% of all women of reproductive age in the 69 focus countries, its progress has a large influence on progress toward the FP2020 goal of 120 million additional users. India has begun to release state and territory data from its NFHS-4, but the full results for national estimates and for all states and territories are not yet available. As a result, this year's estimate for India is based on data available from 17 states and territories combined with prior trends for the remaining areas. Based on this approach, India has added more than 7.6 million additional users since 2012, more than any other country but less than previously estimated. When available, the full set of national and state-level data will allow India to better assess progress toward its FP2020 goal and will help identify opportunities to expand access to a range of contraceptive methods and improve the quality of services.

Many of the largest FP2020 countries are seeing growth in the total number of contraceptive users as their populations grow. In Nigeria, for example, the population of women of reproductive age grows each year by more than 1 million, and family planning programs must serve a greater number of clients just to keep the proportion of users—the country's mCPR—constant. In several other countries, particularly in Asia and Latin America, contraceptive use is already relatively high and growth in mCPR has been very slow. Thus most of the growth in additional users in these regions has been due to an increase in the population of women of reproductive age rather than an increase in the proportion of the population using a modern method.

Other regions have seen more additional users added due to growth in mCPR. Contraceptive use is

generally lower in many African countries than in Asia or Latin America, so there is greater potential for reaching additional users through increasing mCPR (see page 17 for the discussion of the S-Curve of mCPR growth). Since 2012, focus countries in Africa have added 13 million additional users, or 44% of the total additional users across all focus countries, despite these countries representing only 27% of the total number of women of reproductive age. Looking forward, Africa is likely to continue to contribute a disproportionate number of additional users as both the population of women of reproductive age and mCPR increase and as desired family size in many countries declines.

Levels of contraceptive use vary widely across FP2020 countries, and have implications for how much acceleration countries can expect as they strive toward their FP2020 goals. Across the FP2020 countries, all women mCPR averaged 33.5% in 2016, compared to 32.4% in 2012 (weighted averages). Growth has varied greatly across regions, and progress in mCPR growth since 2012 is partly related to where countries lie on the S-Curve. At the midpoint of 2016, in 14 of the focus countries, mCPR was greater than 40%. In 29 countries, mCPR ranged from 20% to 40%, and in 26 countries, mCPR was less than 20%.

Many countries in Asia, including several of the largest FP2020 countries such as India, Indonesia, and Bangladesh, already had relatively high levels of contraceptive use in 2012 and have shown little growth in the proportion of women using a modern method since 2012. In contrast, many countries in Eastern and Southern Africa are in a period of great potential for mCPR growth. The region has seen the most rapid growth in mCPR since 2012, and for the first time ever, more than 30% of women and girls are using a modern method of contraception, up from 25% in 2012. Several countries in the region are among the most rapidly growing FP2020 countries, including Ethiopia, Kenya, Lesotho, Malawi, and Mozambique, each of which has seen mCPR rise by almost 5 percentage points or more since 2012. Looking forward, some of these countries are well-positioned for continued or even faster mCPR growth if they make the right investments in program expansion and improved service quality to meet their populations' family planning needs. Others may see their rapid progress naturally slow as mCPR reaches high levels, and these countries will need to look more carefully at their subnational data to guide further program investments.

Western and Central Africa had the lowest levels of contraceptive use in 2012, and historically the region has seen little progress in increasing mCPR. Recent estimates suggest that several Western African countries, including Senegal, Niger, and Benin, are now showing signs of increasing modern contraceptive use, and may with the right investments enter a period of rapid mCPR growth. Contraceptive use in several other countries in Western and Central Africa, however, still remains extremely low—under 10%—and shows no sign of growth. South-South exchange through the Ouagadougou Partnership and other platforms can help these lowest prevalence countries learn from the successes of their neighbors and encourage a focus on generating demand for family planning.

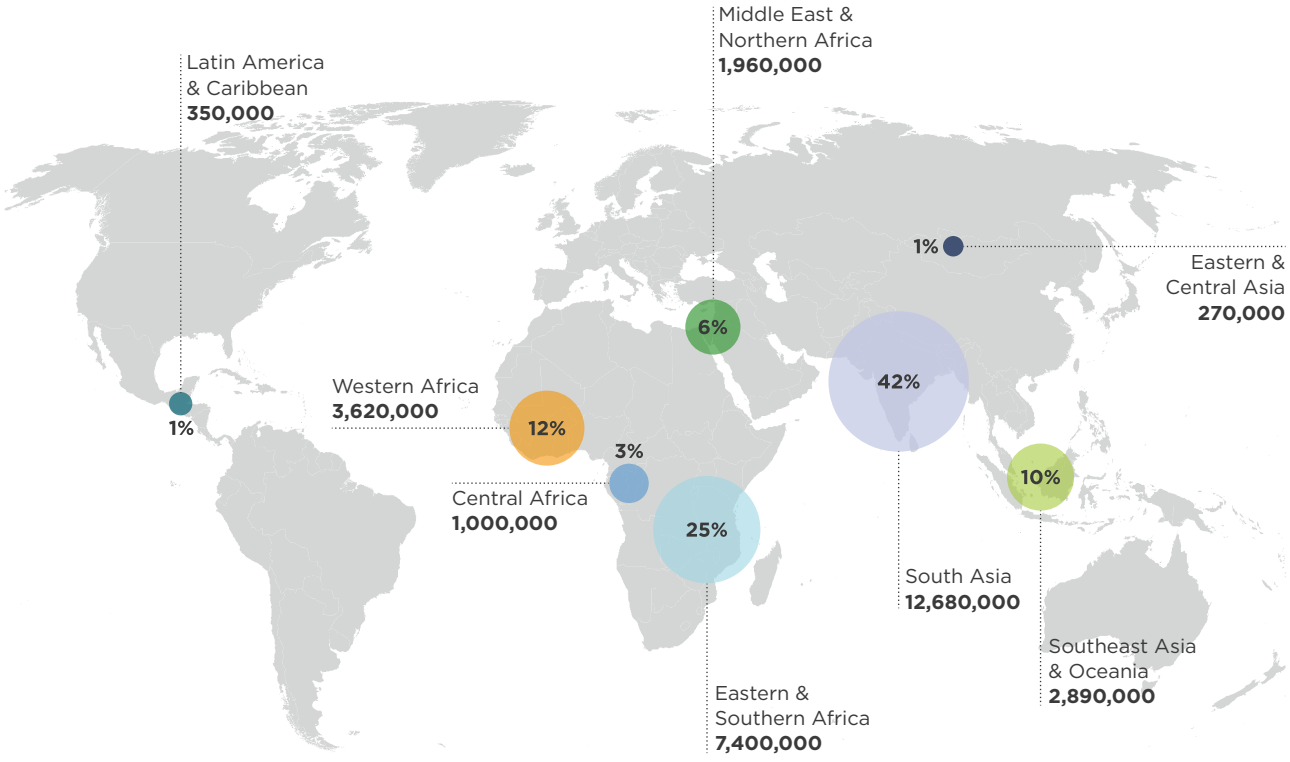
Re-estimating additional users using a rolling baseline

A "rolling baseline" is used to estimate the number of additional users: each year we recalculate the baseline estimate and every subsequent year's estimate of additional users as more survey data becomes available. This means that the number of additional users we presented in previous FP2020 Progress Reports has been re-estimated.

Our new estimates—of 21.5 million additional users in 2015 and 30.2 million in 2016—reflect data that were not available at the time of the last report, including a new round of population projections from the UN Population Division. The new estimates indicate fewer additional users in past years than previously estimated. It is important not to compare estimates in this report to those in the last report.

Additional users by region, 2016

30.2 million total additional users



Note: Due to rounding, regional-based total of additional users (30,170,000) differs slightly from country-based total presented in Indicator No. 1 Estimate Table (30,220,000).

All women versus married or in-union women mCPR estimates

FP2020's goal is based on the fundamental belief that all women, regardless of marital status, should have access to the high-quality family planning services of their choosing. Therefore, FP2020 monitors modern contraceptive use among all women, rather than only married or in-union women. This represents a global shift in how contraceptive prevalence is normally reported at both the international and national levels.

In this report, "all women" estimates are presented whenever possible; in some cases, however, information was only available for married or in-union women. To mark this distinction, you will see "all women" or "married or in-union women" next to the estimates to indicate which population was surveyed. When looking at mCPR data in this report, it is important to note which population is being measured because in most countries, mCPR for married or in-union women will be higher than mCPR for all women.

Indicators 3-4

Unmet Need and Demand Satisfied

ACROSS THE FP2020 COUNTRIES, we estimate that almost 134 million married or in-union women of reproductive age have an unmet need for modern methods of contraception in 2016.

While the first two Core Indicators look at modern family planning use, **Core Indicator 3 (Estimate Table 3), unmet need for modern contraception,** and **Core Indicator 4 (Estimate Table 4), demand satisfied for modern contraception**, take a wider view to also include women who want to avoid pregnancy but are not using modern contraception. These measures help to assess the degree to which governments and the global community are meeting the commitment to make family planning services available to all who want them. Core Indicator 4 is also an indicator for the Sustainable Development Goals (SDG) target 3.7,[16] which includes ensuring, by 2030, universal access to family planning.

Core Indicator 3, unmet need for modern contraception, captures women who are not using modern contraception, are at risk of becoming pregnant, and say that they do not want to have a child soon or that they do not want to have any more children.[17] It includes women currently not using a method as well as those using traditional methods, who are considered to have an unmet need for a more effective modern method. Most of the available data for this measure are currently available for married or in-union women, though in coming years FP2020 aims to provide annual estimates of unmet need and demand satisfied for all women.

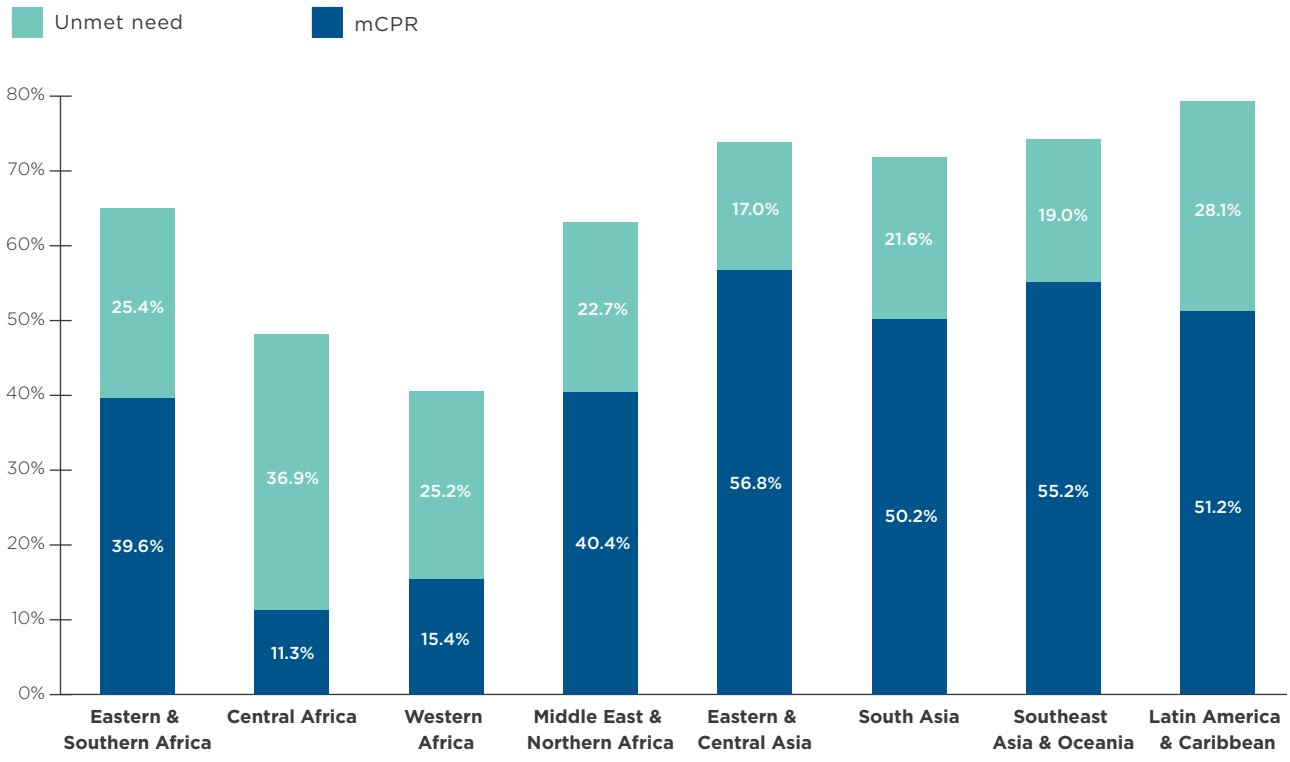
In 2016, 22% of married or in-union women of reproductive age across the FP2020 focus countries had an unmet need for modern methods of contraception. There are large variations among countries, ranging from 11% in Nicaragua to 40% in DR Congo. The high levels of unmet need for a modern method in DR Congo are partially due to high levels of traditional method use (13.7% of married or in-union women were using traditional methods in 2016).

The reasons for unmet need are complex. There are many potential reasons why a woman who does not want to become pregnant would not use modern contraception, including limited access to contraception, perceived health side effects, or social disapproval. Understanding the barriers to use within each country's context is important to ensure that programs are able to address the needs of women across different settings and situations. In addition, it is important to consider levels of unmet need within the context of a country's wider situation. Historic patterns tell us that in countries with very little contraceptive use and high fertility desires, unmet need tends to be low. Over time, as these dynamics change and contraceptive use begins to rise, unmet need often also rises—since the demand for contraception often outpaces a country's ability to expand contraceptive services to meet this increased demand.

Core Indicator 4, demand satisfied with a modern contraceptive method, is constructed based on mCPR and unmet need for modern methods, with total demand assumed to encompass current users and those with unmet need for modern methods. The proportion of these women using a modern method is termed "demand satisfied," and is also affected by the dynamics of unmet need.[18] In a country where unmet need is low because fertility desires remain high, overall demand for contraception will be lower—meaning a smaller number of users (i.e., a lower mCPR) can result in a relatively high demand satisfied (see box on next page).

Levels of demand satisfied with a modern method vary greatly across FP2020 countries. In 2016, there were 5 countries with demand satisfied of less than 25%, 27 countries with demand satisfied between 25% and 50%, 25 countries with demand satisfied

Demand for modern contraception: mCPR + unmet need (married or in-union women)



	Demand satisfied = mCPR/(mCPR + unmet need)						
61%	23%	38%	64%	77%	70%	74%	65%

Note: Total demand for modern contraception is calculated by adding mCPR (which represents individuals whose need for modern contraception is being met), and unmet need for modern contraception. Demand satisfied is calculated by dividing mCPR by total demand.

between 50% and 75%, and 11 countries with demand satisfied greater than 75%. As more countries accelerate toward their FP2020 goals, they will be better positioned to achieve higher levels of demand satisfied and reach the proposed SDG benchmark of 75% of demand satisfied with a modern method.

These three indicators are illustrated together in the figure above, which shows regional variations in mCPR, unmet need for modern methods, and demand satisfied with a modern method among married and in-union women in 2016.[19] It can be seen that overall demand (the height of the bar) is comprised of the combination of mCPR and unmet need, and is lowest in Western Africa and highest in Latin America and the Caribbean. Demand satisfied with a modern method, however, is the portion of the bar filled by mCPR, and is lowest in Central Africa and highest in Eastern and Central Asia.

16. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs

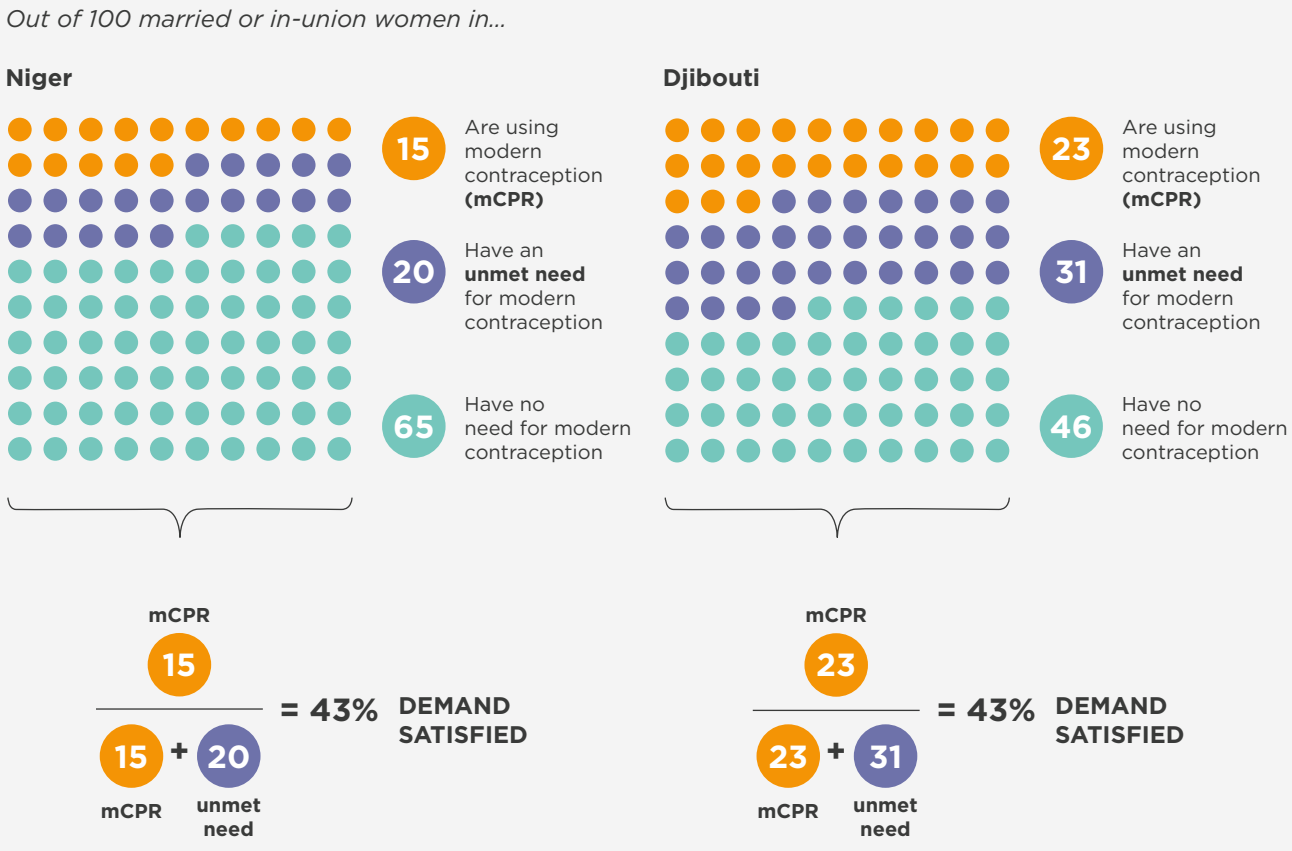
17. Women who are currently pregnant or postpartum amenorrheic whose pregnancy/last births were wanted at the time are considered not to be in need. However, pregnant or postpartum amenorrheic women whose pregnancy/last births were wanted later or not at all are considered to have an unmet need.

18. Fabic MS, Choi Y, Bongaarts J, Darroch JE, Ross JA, Stover J, et al. Meeting demand for family planning within a generation: the post-2015 agenda. Lancet. 2014;385:1928–31. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4393371/

19. Note: these figures represent weighted regional averages.

Understanding Demand Satisfied

THE COMPLEXITY OF THIS new SDG indicator can be illustrated by comparing Niger and Djibouti. Both countries had nearly identical levels of demand satisfied by a modern method in 2016 (42.5% and 43.3%), but modern contraceptive prevalence among married or in-union women in Djibouti is nearly one and a half times greater than in Niger. The reason for the relatively high demand satisfied in Niger despite this lower mCPR is that unmet need for modern contraceptives is low (19.5%) as compared to Djibouti (30.5%). As can be seen in the figure below, 35 out of 100 married or in-union women in Niger have a demand for modern contraception, compared to 54 out of 100 in Djibouti. This means that in Niger, the majority of married or in-union women (65 in 100) are considered to not have a need for family planning. Because of the much lower overall need in Niger, they are able to have a similar level of demand satisfied as Djibouti with much lower levels of contraceptive use. Based on experience from other countries, we expect the need for modern contraception to increase as fertility desires begin to shift, and more women want to limit their family sizes.



Note: Due to rounding, the numbers in this graphic do not exactly match mCPR, unmet need, and demand satisfied figures (married or in-union women) for Niger and Djibouti.

Indicators 5-8

The Impacts of Modern Contraceptive Use

FROM JULY 2015-JULY 2016, MODERN CONTRACEPTIVE use by 300 million women across the 69 focus countries averted an estimated 82 million unintended pregnancies, 25 million unsafe abortions, and 124,000 maternal deaths.

In 2016, we estimate

300,300,000

women are using a modern method of contraception across the 69 FP2020 countries

AS A RESULT OF MODERN CONTRACEPTIVE USE FROM JULY 2015-JULY 2016

82,080,000
unintended pregnancies were prevented

25,790,000
unsafe abortions were averted

124,000
maternal deaths were averted

Core Indicators 5 to 8 (Estimate Tables 5 to 8) tell us about the impact of modern contraceptive use and the consequences of non-use. This set of indicators provide powerful messages about why family planning is so important, and help us to contextualize the impact that contraceptive use is having on the lives of women. By choosing to use modern contraceptives, women are less likely to experience unintended pregnancies, unsafe abortions, and maternal mortality.

The figure on the left shows the total impact across the focus countries, based on Core Indicators 6, 7, and 8. As a result of the more than 300 million women using modern contraception, more than 82 million unintended pregnancies were prevented in 2016 compared to the number that would occur if no modern contraceptives were used. Preventing these unintended pregnancies has in turn averted 25 million unsafe abortions and 124,000 maternal deaths. These numbers represent the total impact of the more than 300 million women using modern contraception across FP2020 countries—not just the impact from the 30.2 million additional users of modern contraception in 2016.

It is important to recognize that even in 2012, existing contraceptive use was having a large impact: in that year, it is estimated that modern contraceptive use across the 69 focus countries averted 74 million unintended pregnancies. This means that in 2016, efforts to reach additional users and improve access to a range of methods have resulted in 8 million more unintended pregnancies averted than just 4 years ago (see figure below).

Despite the large impact that modern contraceptive use has on reducing unintended pregnancies, unsafe abortions, and maternal mortality, an estimated 42.8 million women still experienced an unintended pregnancy across FP2020 countries in 2016 (as shown by Core Indicator 5). Most of these unintended pregnancies were due to women not using modern contraception despite not wanting to get pregnant, while some were due to women who were using a modern method experiencing a contraceptive failure. As we look to 2020, more rapid acceleration toward the goal of reaching more women with modern methods will help ensure that fewer women experience unintended pregnancies and their potential consequences. But we must also continue to work to ensure that all women, including existing users, have access to a wide range of modern methods.

Impact of modern contraceptive use, 2012-2016

	2012	2013	2014	2015	2016	Additional impact in 2016[1]
Unintended Pregnancies Averted (Indicator 6)	74,060,000	76,000,000	77,900,000	79,740,000	82,080,000	**+8,020,000**
Unsafe Abortions Averted (Indicator 7)	23,310,000	23,910,000	24,490,000	25,060,000	25,790,000	**+2,480,000**
Maternal Deaths Averted (Indicator 8)	105,000	109,000	114,000	119,000	124,000	**+19,000**

Note: The impact in 2012 and subsequent years is a result of modern contraceptive use by the entire user base, not just additional users.

[1]Additional impact in 2016, relative to 2012, is due to increases in modern contraceptive use and changes in method mix.

Indicator 9

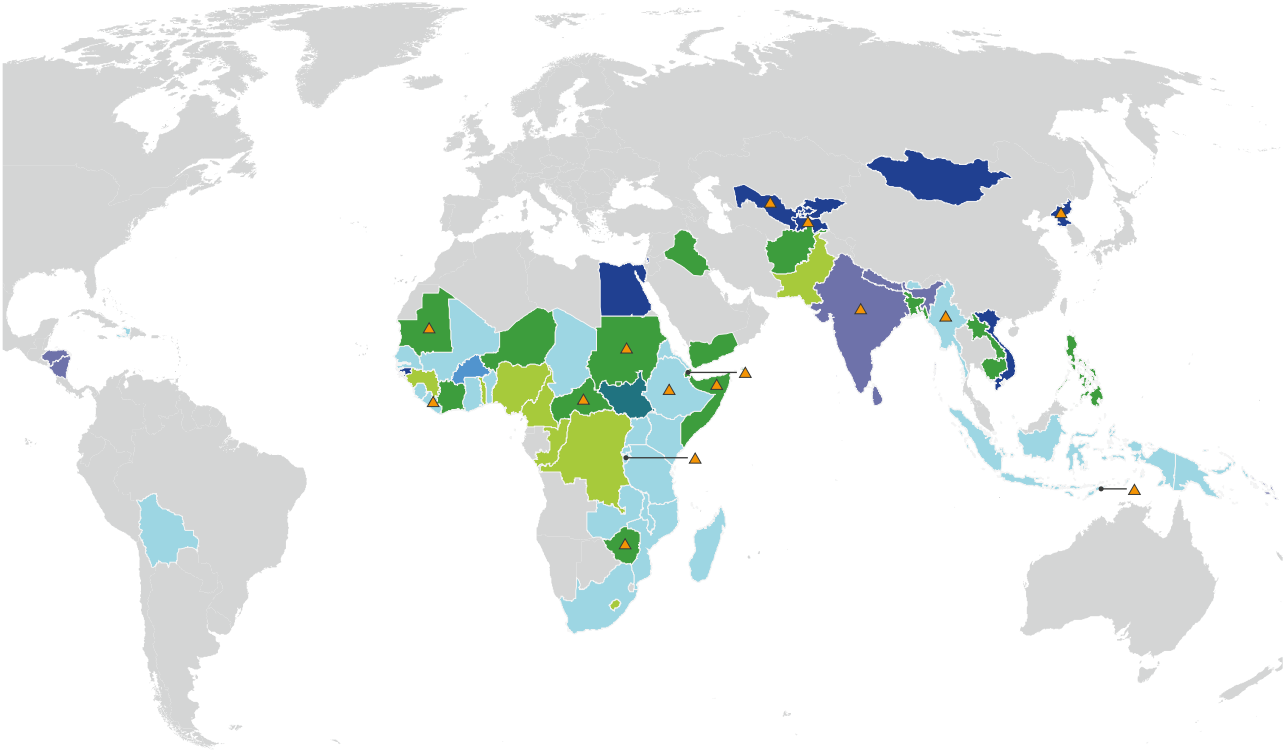
Modern Contraceptive Method Mix

CORE INDICATOR 9 (Estimate Table 9), modern contraceptive method mix, presents the distribution of modern contraceptive users by the method they use, based on the most recent survey data available. Patterns of contraceptive method mix are complex and reflect preferences affected by societal and cultural norms. Patterns may also reflect issues affecting availability and accessibility, including policies, cost, infrastructure, and provider training. This indicator provides a deeper look into the composition of Core Indicator 2, mCPR, highlighting those methods driving contraceptive use in a country and indicating where there may be issues of acceptability or accessibility of particular methods, or opportunities to expand access to a wider range of methods.

While there is no "right" method mix or "ideal" method, there is general agreement that providing access to a wide variety of methods is both a component of quality of care as well as an important principle of rights-based family planning. Availability of a range of options makes it more likely that women can choose a method that best suits their needs and preferences, and as a result, increases contraceptive use and satisfaction with the method.[20] A more diverse method mix also provides women with access to longer acting and more effective methods of contraception, reducing the risk of unintended pregnancy.

Looking across the focus countries, modern contraceptive method mix varies greatly, reflecting both women's preferences and the diverse contexts in which they live. The map at right shows the most commonly used modern method in each country (defined as the single method that makes up the largest proportion of the method mix). In 27 countries, injectables make up the largest proportion of the method mix—from Benin, where injectables make up just under 30% of the total method mix, to Ethiopia, where 76% of women using a modern method are using injectables. Countries with high method skew, where one method

Most common modern method by country



*Lactational Amenorrhea Method (LAM) was excluded from mCPR in Chad, CAR, Cameroon, and Somalia due to unusually high levels reported in MICS surveys.

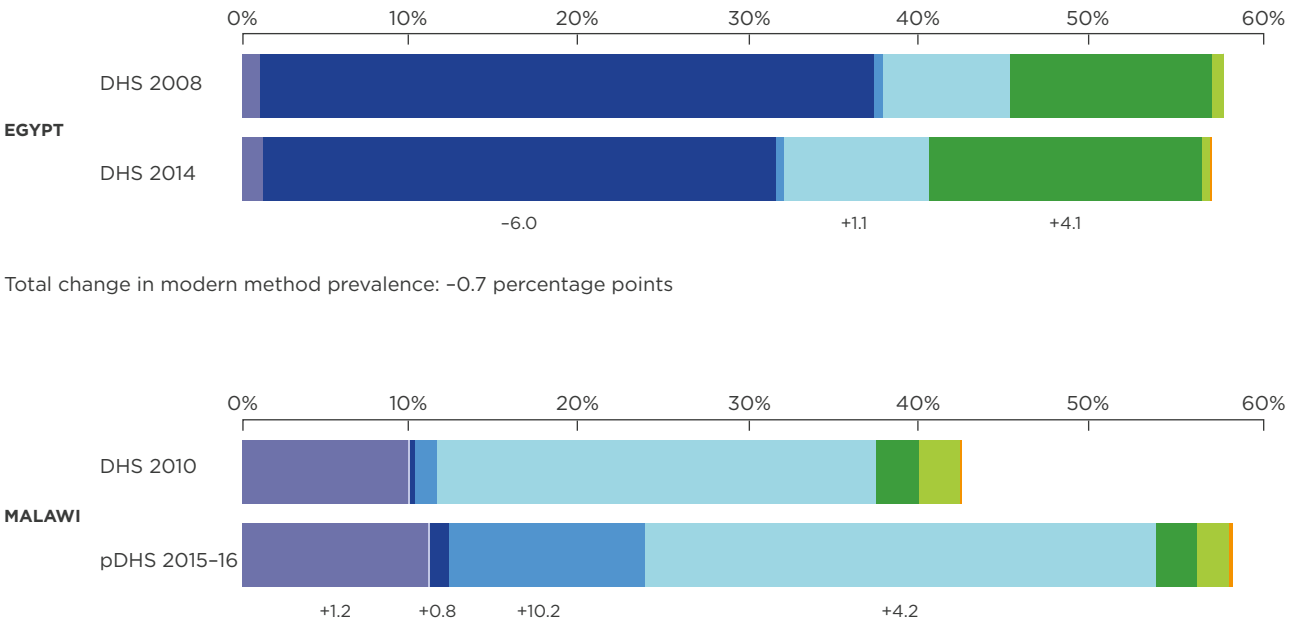
Note: Methods shown on the map make up the largest percentage of each country's method mix. When the prevalence of a single method is 60% or greater, we consider this to be a high level of method skew. See Indicator No. 9 Estimate Table for method mix by country.

dominates the method mix (making up 60% or more of modern method use), are indicated by a triangle. This can be indicative of preferences and sociocultural norms around particular methods, or it may signify challenges within the healthcare system, such as limited infrastructure, method stock-outs, or provider bias.

Of the 69 focus countries, 33 have sufficient data collected since the time of the London Summit to look at changes in method mix. We compared these countries' most recent surveys with data from their previous surveys of the same type. The average gap between surveys was 6.4 years, ranging from 1 to 16 years, and the average annual change in method prevalence was calculated for each method.

Some countries, like Malawi, saw dramatic growth in mCPR (up 14 percentage points over 5 years), driven by an increase in the prevalence of particular methods (implants and injectables) and a decline in traditional methods. Other countries, like Egypt, saw little change in mCPR but experienced shifts in the method mix, with growth in the use of pills and injectables somewhat offsetting declines in IUD use.

Change in modern method prevalence among married or in-union women between last two surveys



Total change in modern method prevalence: –0.7 percentage points

Total change in modern method prevalence: +15.9 percentage points

Note: The +/- figures below each graph show the percentage point change in method prevalence between the two surveys. Only changes greater than 0.5 percentage points are shown.

Among those 33 countries with recent trend data, 13 (or 40%) saw increases in the prevalence of LARCs between their two most recent surveys. The fastest growth was seen in Malawi, where LARC prevalence grew by 2 percentage points per year between 2010 and 2015. Kenya, Senegal, and Zimbabwe also saw substantial growth in LARCs, with increases in prevalence of more than 1 percentage point per year. The largest growth in LARC prevalence was seen among unmarried sexually active women in Senegal, where prevalence grew 11 percentage points between the 2012–13 DHS and the 2014 DHS, with growth in both IUDs and implants.

The methods currently seeing the fastest growth in prevalence are injectables and implants, a pattern continuing from last year's report. While increases in injectables generally continued to support their dominance in the method mix—or method skew in some countries—the growth in implants is increasing the diversity of the method mix in several countries.

20. Ross J, Stover J. Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009. Glob Health Sci Pract. 2013;1(2):203-212. http://dx.doi.org/10.9745/GHSP-D-13-00010.

Indicators 10-11

Contraceptive Stock-Outs and Availability

STOCK-OUTS REFER TO the temporary unavailability of family planning commodities at a health facility or store where they are supposed to be available. Stock-outs have an impact on contraceptive prevalence and method choice, and reducing contraceptive stock-outs is a critical measure of FP2020's success. FP2020 stock-out indicators were adopted in 2015 after a consultative process led by the RHSC that resulted in the harmonization of various methods of measuring stock-outs. FP2020 indicators reflect the availability of family planning commodities at the facility level at a point of time (the day of the survey), and measure stock-outs by method (Indicator 10) as well as stock-outs for a range of methods (Indicators 11a and 11b).[21]

Data on stock-outs at the facility level are improving but are still not available for the majority of FP2020 countries. The number of countries able to report on stock-outs each year is expected to continue to improve through facility surveys conducted by UNFPA and PMA2020 and well as through routine health information systems.[22]

What do we know about stock-outs by method?

The number of countries for which we have data for **Core Indicator 10, the percentage of facilities stocked-out of each type of contraceptive method offered on the day of assessment**, has more than doubled since last year when we first reported on this indicator, rising from 14 countries last year to 30 countries this year. This improvement is mainly due to the expansion of UNFPA Supplies surveys to more countries.

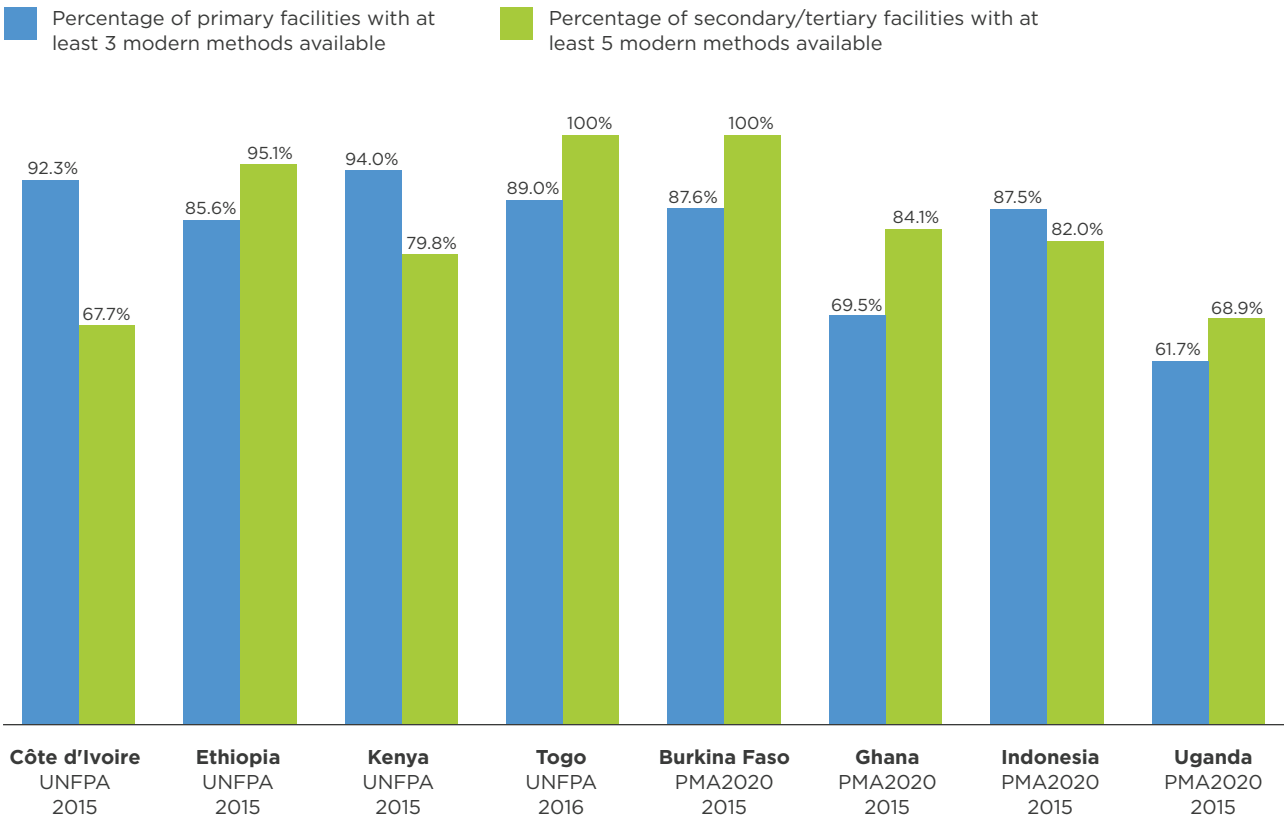
Despite these increases, many FP2020 countries still lack data, and few countries are able to monitor stock-outs routinely at the facility level. The figure on the next page shows by country the percentage of facilities stocked out by method offered. In general, stock-outs appear to be less frequent for the three most common methods dispensed at the primary level (condoms, pills, and injectables) than other methods. Of particular concern are the stock-outs highlighted in orange that indicate that facilities are stocked out of the most commonly used methods in that country. In Tanzania, for example, where injectables make up almost 40% of the method mix, 28% of surveyed facilities reported

Percentage of facilities stocked out, by method offered, on the day of assessment (Indicator 10)

	PERMANENT		LONG-ACTING		SHORT TERM				
	Female Sterilization	Male Sterilization	IUD	Implant	Injectables	Pill	Condom (Male)	Condom (Female)	Other (EC)
Bangladesh			1.7%	5.4%	1.0%	**0.8%**	1.1%		
Benin	0.0%	16.7%	0.0%	20.0%	**44.4%**	10.0%	13.6%	13.0%	20.0%
Bolivia			13.5%	50.6%	**8.4%**	13.4%	6.4%	69.7%	44.7%
Burkina Faso	5.5%	28.5%	5.5%	**3.9%**	**4.2%**	4.9%	6.7%	28.5%	
Burundi			39.1%	36.9%	**32.4%**	34.1%	32.9%	64.6%	49.8%
CAR	65.6%	85.7%	65.6%	41.7%	32.8%	**25.8%**	**30.3%**	43.7%	46.0%
Cote d'Ivoire	4.4%	4.4%	23.1%	14.3%	11.0%	**21.4%**	**31.3%**	28.0%	31.3%
DR Congo			25.0%	23.9%	25.6%	26.8%	**39.6%**	37.6%	40.5%
Ethiopia	29.2%	38.5%	22.1%	15.9%	**9.9%**	8.0%	12.4%	98.8%	42.7%
Ghana			7.9%	10.3%	**1.9%**	19.2%	16.9%		
Haiti	83.3%	88.6%	84.1%	39.4%	**12.9%**	9.1%	**7.6%**		
Honduras			36.4%	73.5%	**61.0%**	36.7%	30.3%	97.7%	
Indonesia			6.7%	9.7%	**6.2%**	2.6%	5.4%		
Kenya	74.5%	76.5%	35.6%	21.5%	**14.8%**	15.5%	20.1%	58.6%	55.2%
Lao PDR	80.3%	31.6%	38.7%	48.3%	**2.1%**	**3.1%**	15.0%	98.4%	85.1%
Liberia	14.6%	25.2%	33.0%	8.7%	**16.5%**	6.8%	10.7%	31.1%	54.4%
Mozambique	61.0%	80.0%	18.0%	19.0%	**8.0%**	**5.0%**	12.0%	46.0%	38.0%
Myanmar	14.0%		48.0%	67.0%	**14.0%**	**19.0%**	44.0%	49.0%	53.0%
Nepal			10.0%	9.5%	**1.0%**	0.5%	0.5%		
Niger	34.3%	52.5%	37.2%	3.3%	3.3%	**0.8%**	9.1%	26.4%	12.4%
Nigeria	28.7%	46.4%	7.2%	7.3%	6.3%	7.7%	**2.6%**	1.1%	15.1%
Rwanda	0.0%	6.8%	6.5%	0.6%	**0.6%**	1.8%	1.8%	39.6%	
Sao Tome and Principe	0.0%	0.0%	60.0%	0.0%	**0.0%**	**0.0%**	0.0%	80.0%	
Sierra Leone			37.3%	28.8%	**5.0%**	7.9%	9.9%	23.8%	42.6%
Sudan			26.3%	22.4%	35.6%	**28.2%**	32.2%		24.1%
Tanzania			16.0%	9.0%	**28.0%**	13.0%	11.0%	22.0%	24.0%
Togo	90.0%	95.0%	17.0%	12.0%	**6.0%**	14.0%	**9.0%**	38.0%	36.0%
Uganda	67.3%	69.7%	55.6%	46.8%	**11.1%**	39.3%	18.2%	70.5%	58.9%
Zambia				1.0%			52.0%		33.0%
Zimbabwe				2.2%	0.4%	**0.0%**	0.6%	1.0%	

Note: Blank areas indicate no data. Methods in **bold with orange bars** each make up 25% or more of the method mix in the country. See Indicator No. 9 Estimate Table for method mix by country. See Indicator No. 10 Estimate Table for data sources.

Method availability, primary and secondary/tertiary facilities (Indicator 11)



that no injectables were available on the day of the assessment. Stock-outs for LARCs, including IUDs and implants, remain high in some countries despite efforts to expand availability. Generally, methods that are less in demand—including female condoms, female and male sterilization, and emergency contraception—have the highest stock-out rates. The continued challenge of stock-outs requires governments and partners to address procurement and health supply chain bottlenecks and strengthen health information systems for timely monitoring, reporting, and action to avert stock-outs at the facility level.

In 2015, eight countries reported data for **Core Indicators 11a and b, the percentage of facilities at different levels (primary, secondary, or tertiary) that have a minimum range of modern methods in stock** for clients on any given day. This is twice as many countries as reported data last year, with UNFPA Supplies surveys providing information on this for the first time.

The results show that in none of the countries with data were at least three methods in stock at the surveyed primary level facilities at the time of the survey. Kenya (94%) and Côte d'Ivoire (92%) were the two countries with the highest percentage of primary facilities where at least three modern methods were available. Secondary and higher-level facilities show a wide range in method availability, with two countries, Togo and Burkina Faso, reporting 100% of such facilities having five or more modern methods in stock on the day of the survey.

21. Stock-outs of permanent methods, including male and female sterilization, refer to the supplies needed to perform these procedures.

22. UNFPA facility surveys are nationally representative and include both public and private sector. PMA2020 surveys are limited to the facilities monitored in the sampling area for household surveys, which is selected to be nationally representative. Routine systems in Zimbabwe and Bangladesh capture information only on the public sector, while routine systems in Nepal and Kenya also capture part of the private sector.

Indicator 12

Domestic Government Expenditures on Family Planning

MOBILIZING DOMESTIC RESOURCES FOR family planning is an important aspect of long-term sustainability of family planning services, and many governments have made commitments to increase domestic expenditures on family planning.

Several efforts are underway to track family planning expenditures, but the task is complicated by the nature of government expenditures. Some health expenditures are clearly identified in budgets as family planning—such as contraceptive commodities, family planning training, and communications programs—and these items are relatively easy to compile from expenditure reports. These items, however, represent only part of family planning expenditures by domestic governments, as the larger costs around personnel and facilities are usually shared across all health activities rather than identified with a particular service such as family planning. Another complication for tracking government family planning expenditures is that health expenditures may be made both by the national government and by subnational administrations such as states, provinces, or districts.

The World Health Organization collects data on health expenditures reported by national governments and makes this information available through its Health Expenditure Database. The goal of this program is to report health expenditures for all countries annually and by topic. Shared expenses are allocated to different diseases/purposes based on a standard approach, such as the proportion of health visits. Eventually we hope that this database will provide annual tracking of health expenditures with family planning-specific reports. To date, however, reports on family planning expenditures are available for only a small number of countries. By 2017 or 2018 this system should cover most FP2020 countries and will give a better picture of what governments are spending on family planning.

In the interim, a collective effort has been developed to try and fill this data gap by using data collected by UNFPA and NIDI on family planning expenditures from most FP2020 countries. Data are collected by national consultants through reviews of published reports and project documents and interviews with key organizations. Data include all expenditures that can be identified as family planning but do not include allocation of shared expenditures. For 2014 this project reported about US$1.1 billion in domestic government expenditures categorized as being spent on family planning in 51 FP2020 focus countries. In most countries, however, these estimates have not yet been validated by country governments, and large variations exist in whether countries account for just commodity expenditures or for larger health system expenditures related to family planning. Next year we hope to take advantage of country consensus meetings to have countries review and validate their expenditure estimates, with the aim of reporting country data next year. As the methodology for collecting domestic expenditures improves and becomes standardized across countries, we also hope to be able to report on trends over time in government expenditures on family planning.

Indicators 14–16

Measuring Rights: Counseling, Informed Choices and Decision Making

THE FUNDAMENTAL RIGHT OF women and girls to decide, freely and for themselves, whether, when, and how many children to have is central to the vision and goals of FP2020. Four years into the initiative, many efforts are underway to ensure that family planning programs are built on and respect rights principles.

Core Indicators 14, 15, and 16 measure facets of empowerment, informed choice, and quality of care, all of which are important aspects of rights-based family planning.

Core Indicator 16 measures the percentage of women who make family planning decisions either by themselves or jointly with their husbands or partners. Across countries that have had surveys since 2012, the indicator shows a high level of women's participation in contraceptive decision making, ranging from 71% in Comoros to 98% in Egypt and Rwanda.

It is important to note that in more than half of these countries (15 of the 29) at least 1 in 10 female users reported that they were not involved in important choices, such as whether and when to use contraceptives and what method to use. These data suggest that in many countries work remains to be done to ensure that all women and girls have the ability to make contraceptive decisions voluntarily and free of discrimination, coercion, or violence.

The results from Indicator 16, however, paint an incomplete picture of empowerment. Given that the indicator scores are fairly high and vary little across country and year, the indicator is likely not capturing many of the challenges related to decision making that contraceptive users face. Furthermore, Indicator 16 only measures the decision-making power of women who are currently using a method and gives no insight into the experiences of women who are not using a method or how that decision was made.

Other studies indicate some of the barriers that these women face, and a 2016 Guttmacher study on non-use indicates that opposition by partners or others is a challenge for married women with an unmet need for family planning.[23] On average, 9% of women in countries with available data cited opposition by partners or others as a reason for their contraceptive non-use, with the proportion as high as 27% in Timor-Leste and as low as 2% in Cambodia and Peru.

The quality of family planning counseling and services available to women is also an underlying factor affecting contraceptive use. Proper counseling provides women and girls with medically accurate information about their bodies and contraceptive options, and enables them to explore and choose among a range of methods as their sexual and reproductive health needs evolve over time. Counseling also helps contraceptive users understand potential side effects and find their preferred method.

Core Indicator 14, the Method Information Index (MII), serves as a proxy for quality of counseling and reflects the extent to which women are informed about side effects and alternate methods.

The MII is a summary measure constructed from three questions asked of current contraceptive users about the occasion when they obtained their current method:

1. Were you informed about other methods?
2. Were you informed about side effects?
3. Were you told what to do if you experienced side effects?

The MII value is the percentage of respondents answering "yes" to all three questions. For countries with sufficient data since 2012, we report the overall MII value, the MII value by method, and the percentage of women who positively answered each question.

In 2016, MII values range from 13.5% in Pakistan[24] to 71.8% in Zambia. Users of implants and IUDs tend to receive more information regarding their methods, and on the whole, women tend to be told of other methods more often than they are informed of side effects or how to handle them. A closer look into countries and methods with low MII values is needed to understand why providers are not sharing the information that is critical to informed consent.

Results from the 2016 Guttmacher study suggest that women are not being provided with the information they need to make informed choices about using contraceptives. It found that many women who do not use contraceptives because of infrequent sex or amenorrhea/breastfeeding—two of the most commonly cited reasons—may be underestimating their risk of becoming pregnant. For example, significant proportions of women who cited infrequent sex as a reason for non-use were sexually active in the last month. Similarly, the majority of women who cited postpartum amenorrhea and/or breastfeeding had given birth more than six months ago.

The Guttmacher study also found that a large proportion of women not using contraceptives are concerned about side effects or health risks. In 21 of the 52 countries included in the study, fear of side effects was the most common factor driving non-use. In most countries, it accounted for between 20 and 33 percent of women who wanted to avoid pregnancy but were not using contraceptives. These women are significantly more likely to have already used a modern method than women who cite other reasons for nonuse, suggesting that these fears come from women's actual experience with methods and service providers. Whether these fears stem from misinformation or real health risks associated with a given method, their pervasiveness highlights the importance of family planning counseling to address women's concerns and to assist them in selecting the method they feel is right for them.

Data from **Core Indicator 15, the proportion of women who received any kind of family planning**

A Closer Look: Contraceptive Non-Use

It is important to remember that a woman's decision to use contraception is shaped by a range of socio-economic, cultural, and geographic factors, and that the results of the Guttmacher study on non-use, which reflect answers to a single DHS question, may not fully capture this complexity. As its authors note, the study does not capture all reasons cited for non-use, rank these reasons by importance, or offer insight into the ways that multiple factors work in tandem to hinder use.

A closer look through qualitative research and in-depth quantitative studies is needed to more fully understand women's experiences and variation across and within countries, and to identify interventions that can effectively help women and girls fully exercise their reproductive rights.

A Closer Look: The National Composite Index for Family Planning

The NCIFP survey is designed to improve understanding of the policy and enabling environment for family planning, and was developed through a consultative process that included the FP2020 PME and Rights & Empowerment Working Groups, donors, and various implementation partners. With respondents from national family planning programs, NGOs, academic and research institutions, and international agencies, the survey attempts to measure the existence and implementation of policies, systems, and standards around quality, accountability, data use, equity, and strategy.

↖ **To learn more** and see the survey results, visit http://www.familyplanning2020.org/measurement-hub/fpe-ncifp.

information in the last year, either from a health worker in a facility or the field, also signal that many countries will need to dramatically expand family planning counseling, information, education, and communications if they hope to enable more women and girls to make informed contraceptive choices by 2020. Core Indicator 15 shows that across countries with available data, this percentage varies widely—from 6.6% in Guinea to 52.4% in Liberia.

The proportion can also vary by wealth quintile within countries. In some countries, such as DR Congo and Yemen, the proportion among the wealthiest quintile who report receiving information was larger than that of the poorest women. In others, including the Philippines, Togo, and Haiti, a larger percentage of the poorest women had received information compared to wealthy women. These numbers must be interpreted in context, as not all women want or need family planning counseling. But in more than half (15 out of 27) of the countries with data for this indicator, at least 75% of women reported not receiving any information on family planning in the last year.

While Core Indicators 14, 15, and 16 are limited in what they each reveal, they can paint a fuller picture when examined alongside each other. In Zambia, 72% of contraceptive users reported that they had been informed about side effects and alternatives to their current method—the highest proportion of women in any country. However, relatively lower proportions of women compared to other countries received information about family planning (30%) or reported that they alone or with their partner made the decision to use contraceptives (83%). Together these suggest that while most current users have been equipped with knowledge that is critical to informed choice, they may not be empowered to make contraceptive decisions for themselves.

In contrast, almost 95% of women in Indonesia made decisions about family planning by themselves or with a partner, but they may not have made those decisions based on full information about method options and side effects. Only 30% of women reported receiving information on other methods, side effects, and what to do about side effects.

Several FP2020 partners are involved in research and program efforts to operationalize rights and empowerment principles at the service delivery point—including offering improved counseling—and to measure the impact of these principles on contraceptive use. These efforts are critical to reducing discontinuation rates and sustaining and expanding contraceptive use through 2020 and beyond.

23. Sedgh G et al., Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/report/unmet-need-for-contraception-in-developing-countries

24. Survey data from Pakistan represents married women only.

Contraceptive Discontinuation

THE 300 MILLION USERS of family planning in FP2020 countries are not a static group. For various reasons, women and their partners may stop using a modern contraceptive method or may switch to a different method. Contraceptive discontinuation presents a challenge to achieving FP2020 goals, as data indicate that many women begin using contraceptives and then discontinue, putting themselves at risk of an unintended pregnancy. Analysis of DHS data available since 2012 from 21 countries shows that discontinuation rates are particularly high for short-term methods, including pills and injectables. Together the discontinuation rates for method-related reasons and other non-fertility related reasons suggest that more than 20% of users of each of these methods stopped use within 12 months.

A Closer Look: Contraceptive Discontinuation

This section of the report draws from a December 2015 report released by FP2020 and Population Council titled "Contraceptive Discontinuation: Reasons, Challenges, and Solutions." The report provides an in-depth look at reasons for discontinuation, interventions to reduce discontinuation and/or enhance switching to new methods, and measurement and monitoring of discontinuation. It presents evidence from a review of literature spanning 25 years, proposes a theory of change for addressing discontinuation, and outlines a research agenda to enhance understanding of the phenomenon.

↖ **To read the report**, please visit: www.familyplanning2020.org/discontinuation.

Twelve-month discontinuation rates by method and reason

Median values for 21 FP2020 countries with DHS surveys from 2012 to present

	IUD	Implants	Injectables	Pill	Condom
Method-Related Reasons[1]	6.8	4.9	18.2	19.7	10.3
Other Non-Fertility Related Reasons	0.8	0.2	3.3	4.1	6.3
Switching to Another Method	3.9	2.2	8.5	7.2	11.7

[1]Calculated by aggregating rates for the following reasons: 1) Method Failure 2) Side Effects, Health 3) Wanting a More Effective Method 4) Other Method Related Reasons

Although reasons for discontinuation vary, the most common reasons, other than fertility-related reasons (such as stopping use to get pregnant), are method-related. These include side effects/health reasons, method failure, and the desire for a more effective method. Some users discontinue use of one contraceptive method and switch to a different method. Method switching, which is most common for users of short-term methods, can occur for various reasons, such as a stock-out of the user's preferred method at a service delivery point. Not all method-switching is negative; a woman may decide to stop using a particular method in favor of one she prefers, or may switch from a less effective short-term method to a more effective long-term method that offers better protection from unintended pregnancy.

Other reasons for discontinuation may relate to the service environment in which contraceptives are provided: factors such as service quality, availability of methods, and referral mechanisms. Interventions are underway in FP2020 countries to address method and service-related reasons for contraceptive discontinuation, but measurement remains a challenge. Most of the currently available data on discontinuation comes from retrospective surveys and contraceptive calendars, which are not applicable to tracking client-specific method use over time. This information can be collected through health management information systems that track individual users longitudinally, as has been demonstrated by some private sector providers. Such systems hold promise for more effective monitoring and evaluation, but they have not been mainstreamed into public sector family planning programs.

Additional investments in data collection and monitoring and evaluation can yield better information about the dynamics of contraceptive use—information that can be used to develop and improve programmatic interventions aimed at reducing discontinuation. Achieving FP2020's ambitious goal and ultimately fulfilling the SDGs will require expanding access to family planning, but it also means ensuring that current users continue to have their contraceptive needs met. Addressing contraceptive discontinuation is critical to meeting these needs.

Methodology Notes

THE DATA PRESENTED IN this report reflect methodological choices which we believe yield the most accurate and relevant information for tracking progress toward FP2020 goals. As a time-bound initiative with an urgent goal, we measure progress from the 2012 London Summit until now, taking into account all available and serviceable data. Using modeling, we produce annual estimates of critical indicators and we re-estimate the trend of additional contraceptive users on an ongoing basis. This section provides more detail on the methodology behind the data in an effort to increase understanding, promote transparency, and support mutual accountability.

TIME PERIODS COVERED IN THIS REPORT

The estimates presented in this report measure annual progress, and for Indicators 1-8, represent the value as of the mid-point of each year (e.g., the 2016 estimates for Indicators 1 and 2 show additional users and mCPR as of July 2016). The baseline year of 2012 is presented as the mid-point of 2012, or July 2012, when the London Summit took place. This 2016 Progress Report marks the midpoint of the FP2020 initiative, four years after the 2012 London Summit and four years before 2020.

FAMILY PLANNING ESTIMATION TOOL (FPET)

The Family Planning Estimation Tool (FPET) is a statistical model that produces annual estimates of mCPR, unmet need, and demand satisfied. Traditionally countries have relied on estimates for mCPR and unmet need that are taken from population-based surveys, such as the DHS. However, most countries do not conduct such surveys annually. In addition, although routine family planning service statistics and/or data on contraceptive commodities distributed are available in most countries, they tend to not be used to monitor progress or make decisions at a program level.

FPET incorporates all available historical survey data for a country as well as service statistics (where determined to be of sufficient quality) to produce estimates of contraceptive prevalence and unmet need. By using all available data, and regional and global patterns of change, FPET is producing a better estimate of current levels of mCPR, unmet need, and demand satisfied for each FP2020 country than has been traditionally available for assessing changes in family planning.

↖ **More information on FPET** can be found at Track20's website at www.track20.org/pages/resources/track20_resources.

THE ROLLING BASELINE AND RE-ESTIMATING THE ENTIRE TREND

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 set the number of additional users at zero. For each reporting period, we 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, meaning we recalculate 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 (270 million).

Our new baseline calculation incorporates new surveys that give us a better sense of the current mCPR in a country as well as what the mCPR was in 2012. In addition, our new baseline calculation takes into account updated UN Population Division estimates that were released in 2015 and affect the number of women of reproductive age in 2012 and today. As a result we now consider the total number of contraceptive users in 2012 to be 12 million more than originally estimated in 2012. Were we to use the old estimate for 2012, this discrepancy could be misconstrued as 12 million additional users on top of the actual 30.2 million additional users.

Not only is our 2012 estimate updated, but so are our 2013 and 2014 estimates. This means that the number of additional users that we estimated for these years in our last report has also been re-estimated. Because of these changes, it is important not to compare numbers in this report to numbers in previous reports. Instead, this report publishes the entire 2012 to 2016 trend based on the most recent data, enabling comparison of changes over time. More information on the methodology for the rolling baseline can be found in a Track20 technical brief.[25]

DATA RECENCY

New data from surveys and service statistics become available over the course of the year, and 17 countries have new data available since last year's report. Due to variations in data sources, the strength and "recency" (how old the data are) of the estimates differ from indicator to indicator and country to country. The data in this year's report range in recency from 2006 to 2016 and are classified accordingly in the estimate tables: "very old" (before 2009), "old" (2009–2011) and "recent" (2012 to the present).

USING SERVICE STATISTICS TO IMPROVE ESTIMATES

Track20 uses service statistics to inform mCPR trend estimates for countries where these data meet the following criteria:

- consistent levels of reporting over time (so changes in volume of service statistics do not represent more facilities reporting, rather than an increase in service delivered);
- at least three years of consistent data, with at least one year overlapping with a survey so that the model can calibrate the two trends; and
- at least one year of service statistics reported after the most recent survey; if a survey is the most recent data point, the survey will be used to inform the mCPR trend.

In 2016, mCPR estimates were informed by service statistics for 11 countries.

25. Technical Brief: Rolling Baselines available at http://track20.org/download/resources/track20_materials/Technical%20Brief_Rolling%20Baseline%20%282015.03.13%29.pdf

FP2020 uses multiple data sources

Data limitations present a significant challenge to tracking key indicators on an annual basis. To produce reliable annual estimates despite gaps in data sources, FP2020 uses the Family Planning Estimation Tool (FPET). FPET projects estimates for mCPR, unmet need, and demand satisfied based on historic survey data from multiple sources. Below are the main data sources and number of surveys used to calculate the estimates in this report.

DHS

203 surveys

The Demographic Health Surveys (DHS) program, supported by USAID, began in 1984. It has provided assistance to more than 90 countries on over 300 surveys.

NATIONAL & OTHER

201 surveys

This group includes national surveys as well as smaller-scale international surveys, such as socio-economic or fertility surveys, and national health surveys.

MICS

83 surveys

The Multiple Indicator Cluster Survey (MICS), supported by UNICEF, began in 1995 and has carried out close to 300 surveys in more than 100 countries.

PMA2020

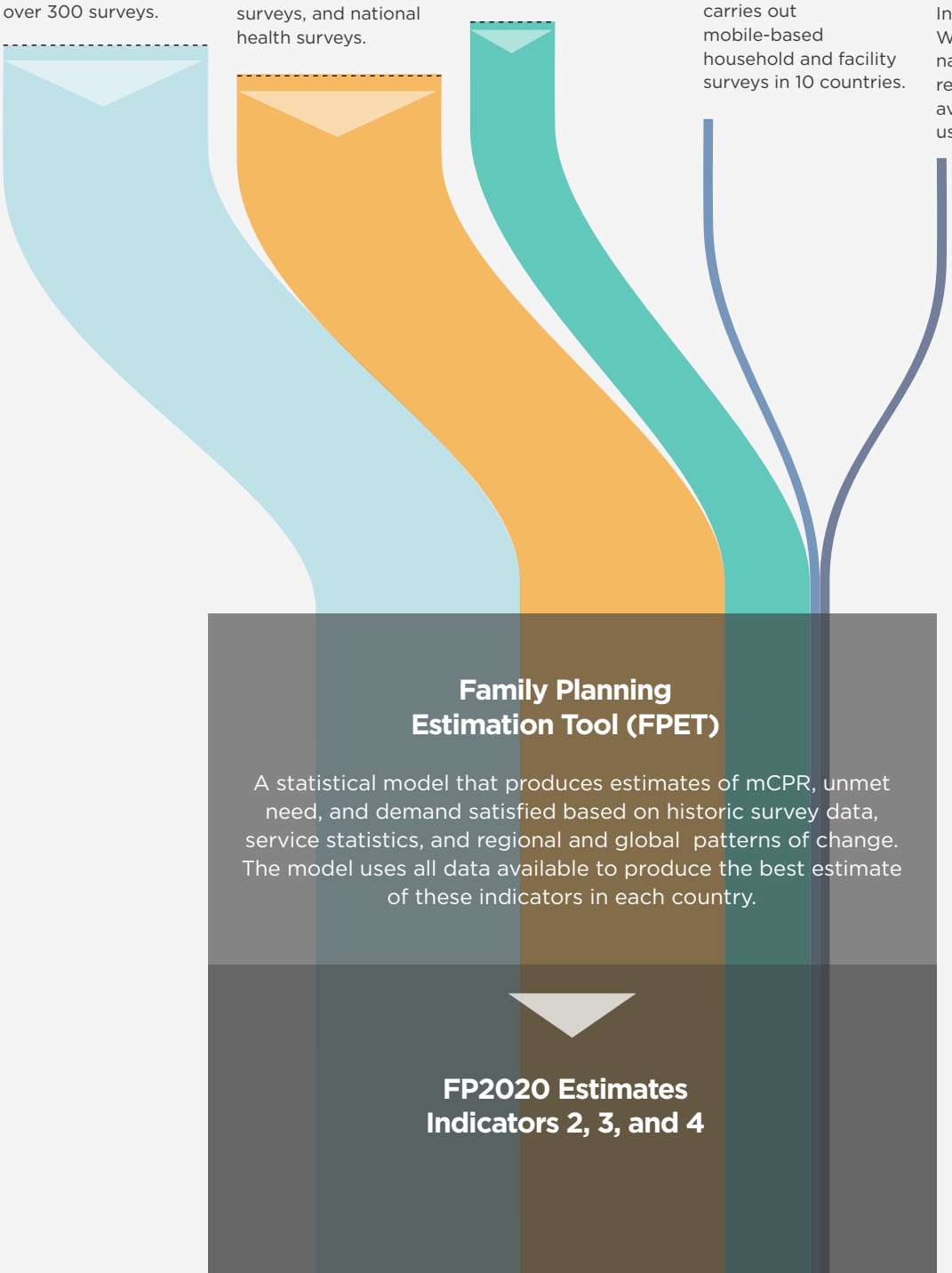
13 surveys

Performance Monitoring and Accountability 2020 (PMA2020), supported by the Bill and Melinda Gates Foundation, began in 2013 and carries out mobile-based household and facility surveys in 10 countries.

SERVICE STATISTICS

11 countries

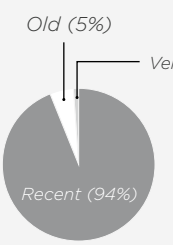
Routine data on FP client visits and/or commodities distributed to clients are collected through Health Management Information Systems. Where good quality, nationally representative data is available, it can be used in FPET.



Data recency

This chart shows countries based on the year of the most recent data source used in FPET- either a survey, or service statistics. The color of the box represents the type of data (based on the categories on the previous page).

2016	Burkina Faso	Indonesia				
2015.5	India	Tanzania				
2015	Afghanistan	Benin	Burundi	Côte d'Ivoire	Ethiopia	Ghana
	Kenya	Malawi	Mali	Mozambique	Nepal	Nigeria
	Pakistan	Senegal	Somalia	Togo	Uganda	Vietnam
2014.5	Chad	Congo	Rwanda			
2014	Bangladesh	Cambodia	Cameroon	Egypt	Guinea-Bissau	Kyrgyzstan
	Lesotho	Sao Tome and Principe	State of Palestine	Sudan	Zimbabwe	
2013.5	DR Congo	Zambia				
2013	Gambia	Liberia	Mongolia	Philippines	Sierra Leone	Yemen
2012.5	Madagascar					
RECENT 2012	Comoros	Djibouti	Guinea	Haiti	Niger	Tajikistan
2011.5	Honduras	Lao PDR	Nicaragua			
2011	Iraq	Mauritania				
2010	Bhutan	CAR	DPR Korea	Eritrea	South Sudan	
OLD 2009.5	Myanmar	Timor-Leste				
2008	Bolivia					
2006.5	Solomon Islands	Sri Lanka				
VERY OLD 2006	Papua New Guinea	Uzbekistan				



More than 9 out of 10 additional users live in a country with 'recent' data

ESTIMATE TABLES

DATA RECENCY

Since Core Indicator data come from multiple sources, there are variations in data recency across indicators and countries. To indicate how recent the latest available data are, some of the estimate tables in this report show one of three symbols next to country names:

 - **prior to 2009**

 - **2009–2011**

 - **2012 to present**

Introduction

FP2020'S 17 CORE INDICATORS are the foundation of our measurement agenda and strive to capture different dimensions of family planning, including access, availability, quality, equity, informed choice, and empowerment. Together they present a varied family planning landscape, across and within the 69 FP2020 focus countries. Though these indicators are reported in a standardized way across the focus countries, it is important to understand nuances between the indicators and the way they are presented in this report.

Some indicators are reported for all women (number of additional users and mCPR), while others are currently reported for married or in-union women (unmet need and demand satisfied), with the ultimate aim of reporting these indicators for all women as we develop a sound methodology for doing so. Some indicators are derived annually from modeling (Indicators 1–8), while others are based on the most recent survey (Indicators 9–11 and 14–17). In addition, we present some indicators disaggregated by age, urban/rural residence, and wealth quintile, to highlight disparities in contraceptive use, unmet need, and demand satisfied. The disaggregated data, however, are only available from the most recent surveys for married women, and so may not match with the annual estimates for these indicators.

The full data set for all indicators is available in the digital version of the Progress Report. This data is also available on the FP2020 website, which also has country-specific pages with information and downloadable data on each of the 69 FP2020 focus countries.

↖

Find the full digital report online:

Familyplanning2020.org/progress

Indicator No. 1

Number of additional users of modern methods of contraception

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Afghanistan	0	51,000	106,000	200,000	296,000
	Bangladesh	0	276,000	509,000	875,000	1,305,000
	Benin	0	41,000	91,000	135,000	171,000
	Bhutan	0	3,000	6,000	9,000	12,000
	Bolivia	0	29,000	58,000	89,000	119,000
	Burkina Faso	0	60,000	128,000	196,000	294,000
	Burundi	0	22,000	46,000	68,000	101,000
	Cambodia	0	47,000	92,000	142,000	191,000
	Cameroon	0	60,000	130,000	203,000	285,000
	CAR	0	12,000	22,000	36,000	48,000
	Chad	0	16,000	36,000	49,000	63,000
	Comoros	0	1,000	3,000	5,000	7,000
	Congo	0	7,000	13,000	21,000	39,000
	Côte d'Ivoire	0	48,000	22,000	87,000	155,000
	Djibouti	0	2,000	5,000	8,000	11,000
	DPR Korea	0	13,000	16,000	16,000	7,000
	DR Congo	0	63,000	230,000	405,000	568,000
	Egypt	0	142,000	292,000	569,000	812,000
	Eritrea	0	6,000	14,000	23,000	33,000
	Ethiopia	0	543,000	1,151,000	1,462,000	1,983,000
	Gambia	0	0	2,000	5,000	8,000
	Ghana	0	31,000	64,000	325,000	390,000
	Guinea	0	22,000	47,000	72,000	98,000
	Guinea-Bissau	0	4,000	8,000	13,000	18,000
	Haiti	0	27,000	51,000	79,000	106,000
	Honduras	0	23,000	45,000	68,000	90,000
	India	0	1,585,000	3,136,000	4,636,000	7,680,000
	Indonesia	0	692,000	885,000	764,000	1,160,000
	Iraq	0	102,000	197,000	294,000	388,000
	Kenya	0	290,000	589,000	948,000	1,154,000
	Kyrgyzstan	0	13,000	27,000	35,000	44,000
	Lao PDR	0	40,000	62,000	81,000	102,000
	Lesotho	0	14,000	28,000	36,000	42,000
	Liberia	0	21,000	33,000	45,000	60,000
	Madagascar	0	106,000	213,000	328,000	438,000
	Malawi	0	164,000	297,000	357,000	455,000

DEFINITION:
The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to 2012.

SOURCE:
UN Population Division (for number of women of reproductive age); Family Planning Estimation Tool (FPET) for mCPR, using all available household surveys such as DHS, PMA2020, MICS, RHS and comparable national sources, including service statistics where possible.

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Mali	0	62,000	133,000	170,000	210,000
	Mauritania	0	4,000	10,000	16,000	21,000
	Mongolia	0	1,000	4,000	7,000	8,000
	Mozambique	0	231,000	534,000	853,000	1,004,000
	Myanmar	0	140,000	276,000	415,000	554,000
	Nepal	0	125,000	246,000	364,000	493,000
	Nicaragua	0	10,000	21,000	29,000	42,000
	Niger	0	34,000	71,000	106,000	151,000
	Nigeria	0	0	570,000	1,184,000	1,628,000
	Pakistan	0	1,083,000	1,845,000	2,346,000	2,854,000
	Papua New Guinea	0	13,000	27,000	43,000	59,000
	Philippines	0	228,000	424,000	616,000	809,000
	Rwanda	0	39,000	81,000	120,000	162,000
	Sao Tome and Principe	0	0	1,000	1,000	2,000
	Senegal	0	81,000	142,000	182,000	215,000
	Sierra Leone	0	42,000	63,000	84,000	108,000
	Solomon Islands	0	1,000	2,000	3,000	4,000
	Somalia	0	4,000	12,000	19,000	28,000
	South Africa*	0	108,000	216,000	309,000	420,000
	South Sudan	0	8,000	18,000	31,000	42,000
	Sri Lanka	0	8,000	21,000	25,000	43,000
	State of Palestine	0	10,000	20,000	30,000	39,000
	Sudan	0	75,000	146,000	239,000	347,000
	Tajikistan	0	19,000	41,000	63,000	83,000
	Tanzania	0	167,000	354,000	544,000	798,000
	Timor-Leste	0	2,000	4,000	7,000	9,000
	Togo	0	21,000	41,000	65,000	86,000
	Uganda	0	94,000	187,000	438,000	613,000
	Uzbekistan	0	34,000	77,000	105,000	135,000
	Vietnam	0	0	0	0	0
	Yemen	0	83,000	166,000	249,000	334,000
	Zambia	0	85,000	154,000	228,000	300,000
	Zimbabwe	0	79,000	163,000	213,000	268,000
	Total	**0**	**7,390,000**	**14,540,000**	**21,510,000**	**30,220,000**
	Commitment-Making Countries	**0**	**6,650,000**	**13,060,000**	**19,170,000**	**27,020,000**

*Not included in totals.

Indicator No. 2

Modern contraceptive prevalence rate, mCPR (all women)

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Afghanistan	12.8%	13.0%	13.2%	13.9%	14.6%
	Bangladesh	42.2%	42.2%	42.1%	42.3%	42.7%
	Benin	10.9%	12.3%	13.9%	15.2%	16.1%
	Bhutan	46.9%	47.6%	48.1%	48.6%	49.1%
	Bolivia	27.2%	27.7%	28.3%	28.9%	29.4%
	Burkina Faso	15.7%	16.8%	17.9%	19.0%	20.7%
	Burundi	16.9%	17.4%	17.8%	18.1%	18.8%
	Cambodia	25.6%	26.4%	27.1%	27.9%	28.7%
	Cameroon	17.0%	17.7%	18.4%	19.2%	20.1%
	CAR	11.8%	12.6%	13.1%	13.9%	14.5%
	Chad	2.6%	3.1%	3.7%	3.9%	4.2%
	Comoros	10.4%	11.1%	11.7%	12.3%	13.1%
	Congo	22.6%	22.9%	23.0%	23.1%	24.2%
	Côte d'Ivoire	14.2%	14.8%	15.5%	16.2%	17.0%
	Djibouti	14.6%	15.6%	16.5%	17.7%	18.6%
	DPR Korea	42.2%	42.2%	42.1%	42.1%	42.1%
	DR Congo	8.1%	8.2%	8.8%	9.5%	10.0%
	Egypt	54.0%	53.9%	53.8%	54.2%	54.5%
	Eritrea	6.1%	6.6%	7.1%	7.6%	8.2%
	Ethiopia	21.3%	22.9%	24.7%	25.1%	26.4%
	Gambia	7.5%	7.1%	7.5%	7.9%	8.3%
	Ghana	18.6%	18.7%	18.8%	22.1%	22.6%
	Guinea	7.5%	8.1%	8.7%	9.3%	9.9%
	Guinea-Bissau	13.0%	13.6%	14.2%	14.9%	15.6%
	Haiti	21.5%	22.2%	22.6%	23.3%	23.8%
	Honduras	42.5%	42.6%	42.6%	42.8%	42.8%
	India	38.4%	38.3%	38.3%	38.2%	38.6%
	Indonesia	44.1%	44.7%	44.6%	44.0%	44.3%
	Iraq	22.9%	23.3%	23.6%	23.9%	24.3%
	Kenya	37.2%	39.0%	40.6%	42.7%	43.2%
	Kyrgyzstan	24.0%	24.8%	25.7%	26.1%	26.7%
	Lao PDR	28.3%	30.0%	30.7%	31.2%	31.7%
	Lesotho	40.8%	42.7%	44.5%	45.0%	45.5%
	Liberia	18.1%	19.7%	20.4%	21.0%	21.8%
	Madagascar	27.1%	28.1%	29.1%	30.1%	31.0%
	Malawi	39.6%	42.6%	44.6%	44.5%	45.3%
	Mali	9.9%	11.3%	12.9%	13.5%	14.1%

DEFINITION:
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.

SOURCE:
Family Planning Estimation Tool (FPET), using all available household surveys such as DHS, PMA2020, MICS, RHS and comparable national sources including service statistics where possible.

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Mauritania	6.5%	6.9%	7.2%	7.7%	8.0%
	Mongolia	34.0%	34.0%	34.3%	34.6%	34.7%
	Mozambique	16.9%	20.3%	24.7%	29.1%	30.6%
	Myanmar	30.3%	31.0%	31.7%	32.3%	32.9%
	Nepal	34.6%	35.5%	36.2%	37.0%	37.8%
	Nicaragua	51.0%	50.9%	50.9%	50.8%	50.9%
	Niger	10.8%	11.4%	11.9%	12.4%	13.0%
	Nigeria	12.1%	11.8%	12.9%	14.0%	14.7%
	Pakistan	17.1%	19.1%	20.3%	21.0%	21.6%
	Papua New Guinea	18.6%	18.9%	19.1%	19.5%	19.8%
	Philippines	23.1%	23.6%	23.9%	24.3%	24.7%
	Rwanda	26.3%	27.1%	27.9%	28.4%	29.0%
	Sao Tome and Principe	29.3%	29.9%	30.6%	31.1%	31.5%
	Senegal	11.7%	13.7%	15.0%	15.7%	16.1%
	Sierra Leone	17.1%	19.6%	20.4%	21.2%	22.1%
	Solomon Islands	22.5%	22.8%	23.1%	23.4%	23.8%
	Somalia	1.6%	1.7%	2.0%	2.2%	2.5%
	South Africa*	53.0%	53.3%	53.5%	53.7%	54.0%
	South Sudan	2.3%	2.5%	2.7%	3.1%	3.3%
	Sri Lanka	52.8%	52.9%	53.2%	53.3%	53.6%
	State of Palestine	21.7%	21.9%	22.2%	22.4%	22.5%
	Sudan	10.5%	11.0%	11.5%	12.1%	12.9%
	Tajikistan	18.4%	19.0%	19.7%	20.3%	21.0%
	Tanzania	25.6%	26.3%	27.0%	27.7%	28.9%
	Timor-Leste	14.6%	15.2%	16.0%	16.6%	17.2%
	Togo	15.6%	16.5%	17.2%	18.1%	18.7%
	Uganda	20.6%	21.0%	21.3%	23.4%	24.4%
	Uzbekistan	44.9%	44.9%	45.1%	45.1%	45.2%
	Vietnam	48.7%	48.2%	48.2%	48.2%	48.2%
	Yemen	17.0%	17.8%	18.5%	19.2%	19.9%
	Zambia	30.9%	32.3%	33.1%	33.9%	34.5%
	Zimbabwe	43.8%	44.8%	45.9%	46.0%	46.2%

*Not included in totals.

Indicator No. 3

Percentage of women with an unmet need for modern contraception

(married or in-union women)

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Afghanistan	27.6%	27.5%	27.4%	27.4%	27.5%
	Bangladesh	20.1%	20.1%	20.1%	20.0%	19.8%
	Benin	37.5%	37.3%	37.0%	36.7%	36.3%
	Bhutan	14.3%	13.9%	13.5%	13.2%	13.0%
	Bolivia	41.0%	40.3%	39.5%	38.6%	37.9%
	Burkina Faso	26.3%	26.1%	26.0%	25.8%	25.7%
	Burundi	31.9%	31.5%	31.2%	30.9%	30.2%
	Cambodia	31.1%	30.6%	30.0%	29.6%	29.2%
	Cameroon	33.3%	33.5%	33.5%	33.6%	33.5%
	CAR	31.3%	31.5%	31.6%	31.8%	31.9%
	Chad	24.4%	24.7%	25.0%	25.2%	25.5%
	Comoros	37.1%	36.9%	36.8%	36.6%	36.4%
	Congo	40.8%	40.0%	39.3%	38.6%	38.1%
	Côte d'Ivoire	28.6%	28.8%	29.0%	29.1%	29.2%
	Djibouti	31.7%	31.5%	31.2%	30.9%	30.5%
	DPR Korea	17.7%	17.7%	17.6%	17.6%	17.6%
	DR Congo	40.7%	40.7%	40.7%	40.8%	40.8%
	Egypt	14.3%	14.3%	14.3%	14.3%	14.2%
	Eritrea	30.5%	30.6%	30.7%	30.8%	30.9%
	Ethiopia	27.1%	26.3%	25.4%	25.3%	24.7%
	Gambia	26.3%	26.0%	26.2%	26.4%	26.5%
	Ghana	36.9%	35.9%	35.0%	34.0%	33.7%
	Guinea	24.7%	25.1%	25.3%	25.5%	25.8%
	Guinea-Bissau	22.2%	22.5%	22.7%	22.8%	23.0%
	Haiti	38.7%	38.0%	37.5%	36.9%	36.3%
	Honduras	20.2%	20.1%	19.9%	19.8%	19.7%
	India	20.9%	20.9%	20.9%	21.0%	20.8%
	Indonesia	13.4%	13.1%	13.3%	13.9%	13.8%
	Iraq	28.9%	28.6%	28.4%	28.1%	28.0%
	Kenya	25.1%	23.6%	22.1%	20.5%	20.1%
	Kyrgyzstan	20.7%	20.4%	20.2%	20.1%	19.9%
	Lao PDR	26.0%	25.5%	25.0%	24.6%	24.2%
	Lesotho	22.0%	20.8%	19.6%	19.1%	18.6%
	Liberia	33.0%	32.5%	32.3%	32.1%	32.0%
	Madagascar	25.2%	24.9%	24.6%	24.3%	23.9%
	Malawi	24.1%	21.6%	20.0%	19.9%	19.3%

DEFINITION:
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 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.

SOURCE:
FPET, using all available household surveys such as DHS, PMA2020, MICS and RHS.

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Mali	26.7%	26.7%	26.7%	26.8%	26.9%
	Mauritania	32.6%	32.5%	32.4%	32.4%	32.3%
	Mongolia	21.1%	21.2%	21.1%	20.9%	20.8%
	Mozambique	28.8%	28.8%	28.5%	27.9%	27.5%
	Myanmar	20.6%	20.3%	19.9%	19.5%	19.3%
	Nepal	26.8%	25.5%	24.8%	24.1%	22.2%
	Nicaragua	11.0%	11.0%	11.0%	11.1%	11.0%
	Niger	18.0%	18.4%	18.8%	19.2%	19.5%
	Nigeria	21.8%	21.6%	22.0%	22.4%	22.6%
	Pakistan	29.7%	29.1%	28.7%	28.6%	28.3%
	Papua New Guinea	33.1%	32.9%	32.7%	32.4%	32.2%
	Philippines	34.7%	34.2%	33.8%	33.4%	33.1%
	Rwanda	26.8%	25.8%	24.8%	24.1%	23.5%
	Sao Tome and Principe	37.8%	37.1%	36.4%	35.7%	35.0%
	Senegal	30.2%	28.9%	27.5%	26.1%	26.3%
	Sierra Leone	27.4%	26.9%	27.0%	27.0%	27.1%
	Solomon Islands	27.7%	27.5%	27.5%	27.4%	27.2%
	Somalia	32.6%	33.1%	33.6%	34.2%	34.8%
	South Africa*	13.2%	13.3%	13.4%	13.5%	13.6%
	South Sudan	30.8%	31.0%	31.1%	31.3%	31.5%
	Sri Lanka	23.1%	22.9%	22.8%	22.7%	22.4%
	State of Palestine	26.8%	26.8%	26.7%	26.6%	26.4%
	Sudan	29.3%	29.3%	29.3%	29.3%	29.4%
	Tajikistan	25.3%	25.2%	25.1%	24.9%	24.7%
	Tanzania	29.9%	29.3%	28.8%	28.2%	27.8%
	Timor-Leste	30.4%	29.9%	29.5%	29.1%	28.7%
	Togo	37.0%	36.5%	36.3%	36.1%	35.8%
	Uganda	37.6%	37.0%	36.5%	35.6%	34.8%
	Uzbekistan	13.6%	13.6%	13.5%	13.6%	13.5%
	Vietnam	17.3%	17.9%	17.8%	17.7%	17.7%
	Yemen	34.7%	33.9%	33.6%	33.2%	32.8%
	Zambia	26.6%	25.2%	23.3%	23.6%	23.0%
	Zimbabwe	13.8%	13.1%	12.4%	12.3%	12.2%

*Not included in totals.

Indicator No. 4

Percentage of women whose demand is satisfied with a modern method of contraception
(married or in-union women)

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Afghanistan	41.6%	42.1%	42.6%	43.9%	45.0%
	Bangladesh	73.2%	73.2%	73.2%	73.4%	73.7%
	Benin	20.4%	22.5%	24.8%	26.6%	28.0%
	Bhutan	81.0%	81.7%	82.3%	82.7%	83.1%
	Bolivia	48.9%	49.8%	50.8%	51.9%	52.8%
	Burkina Faso	40.2%	42.0%	43.7%	45.3%	47.6%
	Burundi	46.5%	47.4%	48.3%	48.9%	50.5%
	Cambodia	54.6%	55.7%	56.8%	57.9%	58.9%
	Cameroon	31.3%	32.0%	33.0%	33.9%	35.0%
	CAR	25.7%	26.7%	27.5%	28.5%	29.4%
	Chad	10.3%	11.8%	13.5%	14.3%	15.0%
	Comoros	28.7%	30.1%	31.3%	32.6%	34.1%
	Congo	33.2%	33.9%	34.4%	34.9%	36.3%
	Côte d'Ivoire	30.9%	31.6%	32.4%	33.4%	34.4%
	Djibouti	36.6%	38.2%	39.9%	41.7%	43.3%
	DPR Korea	77.9%	77.9%	78.0%	78.0%	78.0%
	DR Congo	16.1%	16.3%	17.3%	18.2%	19.0%
	Egypt	80.1%	80.0%	80.0%	80.1%	80.3%
	Eritrea	22.0%	23.1%	24.4%	25.8%	27.1%
	Ethiopia	53.3%	55.9%	58.6%	59.1%	60.8%
	Gambia	26.1%	25.3%	26.2%	27.1%	28.2%
	Ghana	38.1%	38.8%	39.6%	44.3%	45.0%
	Guinea	16.6%	17.4%	18.4%	19.3%	20.1%
	Guinea-Bissau	36.9%	37.7%	38.5%	39.5%	40.4%
	Haiti	44.6%	45.8%	46.7%	47.7%	48.7%
	Honduras	75.8%	75.9%	76.1%	76.3%	76.4%
	India	71.3%	71.3%	71.2%	71.1%	71.5%
	Indonesia	81.7%	82.2%	81.8%	80.9%	81.1%
	Iraq	57.7%	58.4%	58.9%	59.5%	59.9%
	Kenya	66.3%	68.6%	70.9%	73.4%	74.0%
	Kyrgyzstan	63.2%	64.3%	65.4%	65.9%	66.6%
	Lao PDR	62.3%	64.1%	65.0%	65.8%	66.5%
	Lesotho	70.8%	72.8%	74.8%	75.5%	76.2%
	Liberia	33.9%	36.1%	37.0%	37.9%	38.8%
	Madagascar	57.1%	58.3%	59.4%	60.6%	61.6%
	Malawi	68.0%	71.9%	74.3%	74.3%	75.2%

DEFINITION:
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.

SOURCE:
FPET, using all available household surveys such as DHS, PMA2020, MICS and RHS.

RECENCY	COUNTRY	2012	2013	2014	2015	2016
	Mali	27.6%	30.5%	33.3%	34.2%	35.0%
	Mauritania	24.7%	25.8%	26.9%	28.0%	29.0%
	Mongolia	70.4%	70.3%	70.6%	71.0%	71.2%
	Mozambique	35.4%	39.7%	44.8%	49.4%	51.0%
	Myanmar	69.0%	69.8%	70.7%	71.5%	72.1%
	Nepal	62.6%	64.3%	65.5%	66.6%	68.8%
	Nicaragua	87.3%	87.3%	87.3%	87.2%	87.3%
	Niger	40.0%	40.6%	41.3%	41.6%	42.5%
	Nigeria	32.9%	32.5%	34.1%	35.6%	36.5%
	Pakistan	47.5%	50.8%	52.6%	53.5%	54.5%
	Papua New Guinea	45.3%	45.8%	46.3%	47.0%	47.6%
	Philippines	51.7%	52.6%	53.3%	53.9%	54.5%
	Rwanda	62.7%	64.2%	65.7%	66.9%	67.9%
	Sao Tome and Principe	48.8%	49.8%	50.8%	51.7%	52.6%
	Senegal	34.8%	39.5%	43.0%	45.3%	45.8%
	Sierra Leone	31.8%	35.2%	36.0%	36.9%	37.8%
	Solomon Islands	51.9%	52.4%	52.8%	53.2%	53.8%
	Somalia	6.1%	6.5%	7.4%	8.1%	8.9%
	South Africa*	82.7%	82.7%	82.7%	82.6%	82.6%
	South Sudan	9.9%	10.7%	11.6%	12.8%	13.7%
	Sri Lanka	70.5%	70.8%	71.0%	71.1%	71.5%
	State of Palestine	62.0%	62.3%	62.7%	63.0%	63.2%
	Sudan	27.8%	28.9%	29.7%	30.9%	32.1%
	Tajikistan	51.7%	52.6%	53.6%	54.6%	55.6%
	Tanzania	49.8%	51.0%	52.2%	53.3%	54.6%
	Timor-Leste	44.1%	45.6%	47.1%	48.4%	49.7%
	Togo	30.5%	31.9%	32.9%	34.1%	35.1%
	Uganda	40.8%	41.6%	42.3%	45.2%	46.9%
	Uzbekistan	82.2%	82.2%	82.4%	82.3%	82.4%
	Vietnam	79.2%	78.5%	78.6%	78.7%	78.7%
	Yemen	44.5%	46.2%	47.4%	48.6%	49.8%
	Zambia	61.6%	63.8%	66.2%	66.4%	67.4%
	Zimbabwe	81.8%	82.9%	84.0%	84.1%	84.3%

*Not included in totals.

Indicator No. 5

Number of unintended pregnancies

RECENCY	COUNTRY	2012	2016
	Afghanistan	638,000	642,000
	Bangladesh	2,075,000	2,026,000
	Benin	130,000	138,000
	Bhutan	8,000	7,000
	Bolivia	314,000	318,000
	Burkina Faso	102,000	109,000
	Burundi	249,000	274,000
	Cambodia	189,000	191,000
	Cameroon	304,000	318,000
	CAR	57,000	59,000
	Chad	156,000	170,000
	Comoros	13,000	14,000
	Congo	71,000	74,000
	Côte d'Ivoire	345,000	413,000
	Djibouti	21,000	21,000
	DPR Korea	179,000	180,000
	DR Congo	1,372,000	1,493,000
	Egypt	972,000	952,000
	Eritrea	78,000	79,000
	Ethiopia	1,570,000	1,625,000
	Gambia	18,000	20,000
	Ghana	486,000	497,000
	Guinea	127,000	134,000
	Guinea-Bissau	28,000	29,000
	Haiti	249,000	247,000
	Honduras	152,000	152,000
	India	13,491,000	13,419,000
	Indonesia	2,696,000	2,607,000
	Iraq	411,000	445,000
	Kenya	975,000	1,015,000
	Kyrgyzstan	14,000	13,000
	Lao PDR	68,000	68,000
	Lesotho	57,000	57,000
	Liberia	83,000	88,000
	Madagascar	173,000	188,000
	Malawi	500,000	543,000
	Mali	177,000	189,000

DEFINITION:
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.

SOURCE:
Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY	COUNTRY	2012	2016
	Mauritania	67,000	70,000
	Mongolia	34,000	33,000
	Mozambique	276,000	294,000
	Myanmar	761,000	746,000
	Nepal	373,000	374,000
	Nicaragua	94,000	90,000
	Niger	125,000	144,000
	Nigeria	1,038,000	1,096,000
	Pakistan	2,083,000	2,126,000
	Papua New Guinea	77,000	80,000
	Philippines	2,150,000	2,192,000
	Rwanda	230,000	232,000
	Sao Tome and Principe	4,000	5,000
	Senegal	189,000	199,000
	Sierra Leone	55,000	56,000
	Solomon Islands	6,000	6,000
	Somalia	153,000	167,000
	South Africa*	976,000	964,000
	South Sudan	143,000	157,000
	Sri Lanka	198,000	187,000
	State of Palestine	50,000	54,000
	Sudan	617,000	643,000
	Tajikistan	33,000	33,000
	Tanzania	905,000	979,000
	Timor-Leste	20,000	20,000
	Togo	126,000	132,000
	Uganda	1,230,000	1,342,000
	Uzbekistan	72,000	69,000
	Vietnam	1,208,000	1,188,000
	Western Sahara	6,000	6,000
	Yemen	535,000	551,000
	Zambia	406,000	443,000
	Zimbabwe	317,000	317,000
	Total	**42,150,000**	**42,870,000**
	Commitment-Making Countries	**37,270,000**	**37,900,000**

*Not included in totals.
Note: The full estimate table, with figures for 2012-2016, is available in the digital version of the progress report at familyplanning2020.org/progress.

Indicator No. 6

Number of unintended pregnancies averted due to modern contraceptive use

RECENCY	COUNTRY	2012	2016
	Afghanistan	202,000	275,000
	Bangladesh	4,662,000	4,997,000
	Benin	57,000	95,000
	Bhutan	25,000	28,000
	Bolivia	189,000	221,000
	Burkina Faso	167,000	249,000
	Burundi	113,000	141,000
	Cambodia	276,000	327,000
	Cameroon	199,000	265,000
	CAR	31,000	43,000
	Chad	20,000	37,000
	Comoros	4,000	6,000
	Congo	47,000	55,000
	Côte d'Ivoire	187,000	223,000
	Djibouti	8,000	11,000
	DPR Korea	823,000	825,000
	DR Congo	331,000	459,000
	Egypt	3,298,000	3,523,000
	Eritrea	15,000	22,000
	Ethiopia	1,289,000	1,846,000
	Gambia	8,000	10,000
	Ghana	293,000	388,000
	Guinea	43,000	64,000
	Guinea-Bissau	12,000	16,000
	Haiti	151,000	178,000
	Honduras	244,000	269,000
	India	35,712,000	37,925,000
	Indonesia	7,698,000	7,999,000
	Iraq	454,000	551,000
	Kenya	1,056,000	1,375,000
	Kyrgyzstan	95,000	107,000
	Lao PDR	125,000	152,000
	Lesotho	52,000	63,000
	Liberia	47,000	64,000
	Madagascar	384,000	501,000
	Malawi	401,000	532,000
	Mali	96,000	154,000

DEFINITION:
The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.

SOURCE:
Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY	COUNTRY	2012	2016
	Mauritania	15,000	20,000
	Mongolia	75,000	78,000
	Mozambique	240,000	490,000
	Myanmar	1,189,000	1,340,000
	Nepal	723,000	864,000
	Nicaragua	231,000	243,000
	Niger	74,000	104,000
	Nigeria	1,072,000	1,450,000
	Pakistan	1,921,000	2,638,000
	Papua New Guinea	91,000	108,000
	Philippines	1,490,000	1,701,000
	Rwanda	196,000	240,000
	Sao Tome and Principe	3,000	3,000
	Senegal	106,000	165,000
	Sierra Leone	66,000	95,000
	Solomon Islands	8,000	9,000
	Somalia	8,000	15,000
	South Africa*	2,034,000	2,147,000
	South Sudan	11,000	19,000
	Sri Lanka	781,000	793,000
	State of Palestine	60,000	71,000
	Sudan	231,000	316,000
	Tajikistan	108,000	132,000
	Tanzania	734,000	938,000
	Timor-Leste	9,000	12,000
	Togo	66,000	89,000
	Uganda	430,000	595,000
	Uzbekistan	1,015,000	1,053,000
	Vietnam	3,333,000	3,324,000
	Yemen	246,000	326,000
	Zambia	273,000	352,000
	Zimbabwe	406,000	474,000
	Total	**74,060,000**	**82,080,000**
		Additional from 2012 Levels	*8,020,000*
	Commitment-Making Total	**65,430,000**	**72,620,000**

*Not included in totals.
Note: The full estimate table, with figures for 2012-2016, is available in the digital version of the progress report at familyplanning2020.org/progress.

Indicator No. 7

Number of unsafe abortions averted due to modern contraceptive use

RECENCY	COUNTRY	2012	2016
	Afghanistan	61,000	84,000
	Bangladesh	1,424,000	1,526,000
	Benin	18,000	30,000
	Bhutan	7,000	8,000
	Bolivia	71,000	84,000
	Burkina Faso	53,000	79,000
	Burundi	33,000	42,000
	Cambodia	96,000	113,000
	Cameroon	45,000	61,000
	CAR	7,000	10,000
	Chad	4,000	8,000
	Comoros	1,000	1,000
	Congo	10,000	12,000
	Côte d'Ivoire	60,000	71,000
	Djibouti	2,000	3,000
	DPR Korea	3,000	3,000
	DR Congo	76,000	105,000
	Egypt	1,519,000	1,623,000
	Eritrea	4,000	6,000
	Ethiopia	383,000	549,000
	Gambia	2,000	3,000
	Ghana	93,000	124,000
	Guinea	13,000	20,000
	Guinea-Bissau	4,000	5,000
	Haiti	25,000	29,000
	Honduras	97,000	107,000
	India	10,910,000	11,586,000
	Indonesia	2,676,000	2,781,000
	Iraq	87,000	105,000
	Kenya	314,000	409,000
	Kyrgyzstan	29,000	32,000
	Lao PDR	43,000	52,000
	Lesotho	10,000	12,000
	Liberia	15,000	20,000
	Madagascar	114,000	149,000
	Malawi	119,000	158,000
	Mali	30,000	49,000

DEFINITION:
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.

SOURCE:
Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY	COUNTRY	2012	2016
	Mauritania	4,000	6,000
	Mongolia	200	300
	Mozambique	71,000	146,000
	Myanmar	413,000	466,000
	Nepal	221,000	263,000
	Nicaragua	92,000	97,000
	Niger	23,000	33,000
	Nigeria	343,000	464,000
	Pakistan	587,000	805,000
	Papua New Guinea	4,000	5,000
	Philippines	518,000	591,000
	Rwanda	58,000	71,000
	Sao Tome and Principe	700	800
	Senegal	34,000	52,000
	Sierra Leone	21,000	30,000
	Solomon Islands	400	400
	Somalia	2,000	4,000
	South Africa*	389,000	411,000
	South Sudan	3,000	5,000
	Sri Lanka	238,000	242,000
	State of Palestine	11,000	13,000
	Sudan	106,000	145,000
	Tajikistan	33,000	40,000
	Tanzania	218,000	279,000
	Timor-Leste	3,000	4,000
	Togo	21,000	28,000
	Uganda	128,000	177,000
	Uzbekistan	310,000	321,000
	Vietnam	1,159,000	1,155,000
	Yemen	47,000	62,000
	Zambia	81,000	105,000
	Zimbabwe	77,000	90,000
	Total	**23,310,000**	**25,790,000**
		Additional from 2012 Levels	*2,480,000*
	Commitment-Making Total	**20,470,000**	**22,670,000**

*Not included in totals.
Note: The full estimate table, with figures for 2012-2016, is available in the digital version of the progress report at familyplanning2020.org/progress.

Indicator No. 8

Number of maternal deaths averted due to modern contraceptive use

RECENCY	COUNTRY	2012	2016
	Afghanistan	500	700
	Bangladesh	5,000	5,000
	Benin	100	200
	Bhutan	20	20
	Bolivia	200	200
	Burkina Faso	400	600
	Burundi	600	700
	Cambodia	200	200
	Cameroon	900	1,000
	CAR	200	200
	Chad	100	200
	Comoros	10	10
	Congo	100	100
	Côte d'Ivoire	800	1,000
	Djibouti	10	10
	DPR Korea	100	100
	DR Congo	1,000	2,000
	Egypt	1,000	1,000
	Eritrea	60	80
	Ethiopia	3,000	5,000
	Gambia	40	60
	Ghana	600	900
	Guinea	200	300
	Guinea-Bissau	50	70
	Haiti	300	300
	Honduras	100	100
	India	40,000	43,000
	Indonesia	14,000	14,000
	Iraq	100	100
	Kenya	4,000	5,000
	Kyrgyzstan	50	50
	Lao PDR	100	100
	Lesotho	100	200
	Liberia	200	300
	Madagascar	1,000	2,000
	Malawi	1,000	2,000
	Mali	400	700

DEFINITION:
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.

SOURCE:
Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY	COUNTRY	2012	2016
	Mauritania	60	90
	Mongolia	5	5
	Mozambique	900	1,000
	Myanmar	1,000	1,000
	Nepal	1,000	1,000
	Nicaragua	100	200
	Niger	300	400
	Nigeria	6,000	9,000
	Pakistan	2,000	3,000
	Papua New Guinea	100	100
	Philippines	800	900
	Rwanda	400	500
	Sao Tome and Principe	5	5
	Senegal	200	400
	Sierra Leone	700	1,000
	Solomon Islands	5	5
	Somalia	50	90
	South Africa*	2,000	2,000
	South Sudan	70	100
	Sri Lanka	100	100
	State of Palestine	10	20
	Sudan	800	1,000
	Tajikistan	20	30
	Tanzania	2,000	2,000
	Timor-Leste	10	10
	Togo	100	200
	Uganda	1,000	1,000
	Uzbekistan	200	200
	Vietnam	800	800
	Yemen	600	800
	Zambia	800	1,000
	Zimbabwe	1,000	1,000
	Total	**105,000**	**124,000**
		Additional from 2012 Levels	*19,000*
	Commitment-Making Total	**99,000**	**116,000**

*Not included in totals.
Note: The full estimate table, with figures for 2012-2016, is available in the digital version of the progress report at familyplanning2020.org/progress.

Indicator No. 9

Percentage of women using each modern method of contraception

		PERMANENT		LONG-ACTING	
RECENCY	COUNTRY	STERILIZATION (FEMALE)	STERILIZATION (MALE)	IUD	IMPLANT
	Afghanistan	9.1%	0.0%	7.1%	1.0%
	Bangladesh	8.5%	2.2%	1.1%	3.2%
	Benin	1.6%	0.0%	8.1%	21.8%
	Bhutan	10.9%	19.3%	5.7%	0.2%
	Bolivia	17.9%	0.4%	23.3%	0.0%
	Burkina Faso	0.5%	0.0%	2.9%	39.6%
	Burundi	1.0%	0.3%	10.6%	13.2%
	Cambodia	8.3%	0.4%	11.3%	5.7%
	Cameroon	1.2%	0.0%	1.9%	8.1%
	CAR	2.2%	0.0%	0.0%	2.2%
	Chad	5.0%	0.0%	0.0%	25.0%
	Comoros	6.1%	0.0%	0.0%	11.2%
	Congo	1.1%	0.0%	0.0%	2.2%
	Côte d'Ivoire	0.7%	0.0%	0.7%	0.7%
	Djibouti	0.0%	0.0%	0.0%	3.3%
	DPR Korea	4.9%	0.0%	94.0%	0.0%
	DR Congo	6.3%	0.0%	1.3%	6.3%
	Egypt	2.1%	0.0%	52.9%	0.9%
	Eritrea	1.9%	0.0%	5.8%	0.0%
	Ethiopia	0.4%	0.0%	2.9%	12.3%
	Gambia	6.2%	0.0%	4.6%	7.7%
	Ghana	2.1%	0.4%	2.1%	17.8%
	Guinea	1.4%	0.0%	2.8%	1.4%
	Guinea-Bissau	1.4%	0.0%	24.1%	22.8%
	Haiti	4.2%	0.5%	0.0%	5.1%
	Honduras	37.1%	0.5%	10.7%	0.0%
	India	75.5%	1.0%	3.2%	0.0%
	Indonesia	6.4%	0.2%	8.1%	7.5%
	Iraq	8.6%	0.0%	26.0%	0.3%
	Kenya	5.6%	0.0%	5.9%	18.2%
	Kyrgyzstan	3.3%	0.0%	56.1%	0.0%
	Lao PDR	10.7%	0.0%	3.7%	0.2%
	Lesotho	2.3%	0.0%	2.1%	2.5%
	Liberia	1.0%	0.0%	0.0%	11.2%

DEFINITION:
The percentage of total family planning users using each modern method of contraception.

SOURCE:
Most recent survey, which may be: DHS, MICS, PMA2020, other national surveys.

		SHORT-TERM						
RECENCY	COUNTRY	INJECT-ABLES	PILL	CON-DOMS (MALE)	LAM*	OTHER MODERN METHODS	SOURCE	POPULA-TION
	Afghanistan	24.9%	34.5%	16.8%	6.6%	0.0%	2015 pDHS	Married
	Bangladesh	23.0%	50.1%	11.9%	0.0%	0.0%	2014 DHS	Married
	Benin	29.0%	21.0%	9.7%	8.9%	0.0%	2014 MICS	Married
	Bhutan	44.2%	11.5%	8.4%	0.0%	0.0%	2010 MICS	Married
	Bolivia	30.8%	10.0%	15.0%	2.1%	0.4%	2008 DHS	All
	Burkina Faso	34.4%	13.4%	8.2%	0.0%	1.0%	2014-15 PMA2020 R1-R2	All
	Burundi	61.7%	9.6%	2.6%	1.0%	0.0%	2012 PMS	Married
	Cambodia	23.4%	45.3%	5.7%	0.0%	0.0%	2014 DHS	All
	Cameroon	28.0%	14.3%	46.0%	0.0%	0.6%	2014 MICS	Married
	CAR	5.4%	64.1%	26.1%	0.0%	0.0%	2010 MICS	Married
	Chad	52.5%	10.0%	7.5%	0.0%	0.0%	2014-15 pDHS	Married
	Comoros	37.8%	20.4%	19.4%	5.1%	0.0%	2012 DHS	All
	Congo	15.7%	25.4%	50.3%	4.9%	0.5%	2014-15 MICS	Married
	Côte d'Ivoire	13.6%	43.6%	35.7%	2.9%	2.1%	2011-12 DHS	All
	Djibouti	33.9%	60.6%	0.0%	0.0%	2.2%	2012 PAPFAM	Married
	DPR Korea	0.3%	0.3%	0.3%	0.0%	0.2%	2010 RHS	Married
	DR Congo	11.3%	8.8%	58.8%	0.0%	7.5%	2013-14 DHS	All
	Egypt	14.9%	28.1%	0.9%	0.0%	0.2%	2014 DHS	Married
	Eritrea	34.6%	19.2%	11.5%	26.9%	0.0%	2002 DHS	All
	Ethiopia	76.4%	6.5%	1.1%	0.0%	0.4%	2014 Mini-DHS	All
	Gambia	46.2%	23.1%	12.3%	0.0%	0.0%	2013 DHS	All
	Ghana	36.0%	16.1%	10.6%	0.4%	14.4%	2015 PMA2020 R4	All
	Guinea	22.5%	22.5%	33.8%	15.5%	0.0%	2012 DHS	All
	Guinea-Bissau	9.7%	10.3%	11.7%	16.6%	3.4%	2014 MICS	Married
	Haiti	54.2%	7.9%	26.9%	0.9%	0.5%	2012 DHS	All
	Honduras	26.1%	17.2%	8.4%	0.0%	0.0%	2011-12 DHS	All
	India	0.0%	8.0%	12.3%	0.0%	0.0%	2012-13 Multiple**	Married
	Indonesia	45.1%	22.6%	2.6%	0.0%	7.5%	2015 PMA2020 R1	All
	Iraq	8.6%	43.8%	5.3%	6.4%	1.1%	2011 MICS	Married
	Kenya	47.9%	14.1%	7.9%	0.3%	0.0%	2014 DHS	All
	Kyrgyzstan	0.5%	10.3%	26.1%	3.8%	0.0%	2014 MICS	Married
	Lao PDR	31.8%	49.5%	2.6%	1.4%	0.0%	2011-12 MICS/DHS	Married
	Lesotho	34.8%	18.8%	39.6%	0.0%	0.0%	2014 DHS	All
	Liberia	60.7%	21.4%	4.9%	0.0%	1.0%	2013 DHS	All

*Lactational Amenorrhea Method (LAM) was excluded from mCPR in Chad, CAR, Cameroon, and Somalia due to unusually high levels reported in MICS surveys.
**National Family Health Survey (NFHS4), and pooled Annual Health Survey (AHS) and District Level Household and Facility Survey (DLHS)

Indicator No. 9 (continued)

Percentage of women using each modern method of contraception

		PERMANENT		LONG-ACTING	
RECENCY	COUNTRY	STERILIZATION (FEMALE)	STERILIZATION (MALE)	IUD	IMPLANT
	Madagascar	4.2%	0.0%	2.1%	7.8%
	Malawi	17.8%	0.2%	1.7%	16.4%
	Mali	1.1%	0.0%	3.2%	25.5%
	Mauritania	2.0%	2.0%	9.0%	9.0%
	Mongolia	6.7%	0.0%	48.9%	1.0%
	Mozambique	1.7%	0.0%	1.7%	0.0%
	Myanmar	7.9%	0.9%	4.6%	0.2%
	Nepal	38.1%	10.0%	3.6%	2.8%
	Nicaragua	38.9%	0.5%	4.6%	0.0%
	Niger	0.9%	0.0%	0.9%	2.7%
	Nigeria	2.7%	0.0%	7.1%	2.7%
	Pakistan	33.2%	1.1%	8.8%	0.0%
	Papua New Guinea	35.8%	1.7%	0.0%	0.0%
	Philippines	22.9%	0.4%	9.3%	0.0%
	Rwanda	2.5%	0.4%	2.3%	16.2%
	Sao Tome and Principe	1.6%	0.3%	5.6%	6.7%
	Senegal	2.0%	0.0%	4.1%	23.8%
	Sierra Leone	1.4%	0.0%	1.0%	18.4%
	Solomon Islands	45.4%	1.0%	6.8%	0.0%
	Somalia	0.0%	0.0%	9.1%	0.0%
	South Africa	14.5%	0.6%	1.2%	0.0%
	South Sudan	5.9%	0.0%	0.0%	0.0%
	Sri Lanka	32.1%	1.3%	12.0%	0.6%
	State of Palestine	4.1%	0.0%	59.3%	0.0%
	Sudan	0.0%	0.0%	3.5%	2.6%
	Tajikistan	2.3%	0.0%	72.4%	0.0%
	Tanzania	10.6%	0.3%	2.8%	20.9%
	Timor-Leste	3.9%	0.0%	6.3%	3.9%
	Togo	1.2%	0.0%	3.6%	20.4%
	Uganda	5.9%	0.4%	1.2%	16.1%
	Uzbekistan	3.4%	0.2%	80.3%	0.2%
	Viet Nam	4.9%	0.2%	49.6%	0.4%
	Yemen	7.9%	0.3%	20.2%	2.1%
	Zambia	4.0%	0.0%	2.8%	12.9%
	Zimbabwe	2.2%	0.0%	0.5%	5.4%

DEFINITION:
The percentage of total family planning users using each modern method of contraception.

SOURCE:
Most recent survey, which may be: DHS, MICS, PMA2020, other national surveys.

		SHORT-TERM						
RECENCY	COUNTRY	INJECT-ABLES	PILL	CONDOMS (MALE)	LAM*	OTHER MODERN METHODS	SOURCE	POPULA-TION
	Madagascar	59.6%	19.8%	3.0%	3.6%	0.0%	2012-13 EN OMD	All
	Malawi	56.2%	3.8%	3.8%	0.0%	0.0%	2014 MICS	Married
	Mali	40.4%	27.7%	2.1%	0.0%	0.0%	2012-13 DHS	All
	Mauritania	13.0%	60.0%	4.0%	1.0%	0.0%	2011 MICS	Married
	Mongolia	7.7%	18.1%	17.7%	0.0%	0.0%	2013 SISS	Married
	Mozambique	35.5%	35.5%	24.8%	0.8%	0.0%	2011 DHS	All
	Myanmar	60.2%	25.2%	0.9%	0.2%	0.0%	2010 MICS	Married
	Nepal	27.5%	10.0%	7.8%	0.0%	0.2%	2014 MICS	Married
	Nicaragua	33.9%	14.8%	7.0%	0.0%	0.3%	2011-12 National	Married
	Niger	17.3%	45.5%	0.9%	31.8%	0.0%	2012 DHS	All
	Nigeria	22.3%	17.0%	40.2%	2.7%	5.4%	2013 DHS	All
	Pakistan	10.7%	6.1%	33.6%	5.7%	0.8%	2012-13 DHS	Married
	Papua New Guinea	36.9%	18.4%	7.3%	0.0%	0.0%	2006 National Survey	All
	Philippines	9.7%	50.0%	5.9%	1.3%	0.4%	2013 DHS	All
	Rwanda	50.6%	17.7%	8.0%	0.4%	1.7%	2014-15 DHS	Married
	Sao Tome and Principe	31.0%	39.6%	15.2%	0.0%	0.0%	2014 MICS	Married
	Senegal	38.8%	24.5%	6.1%	0.7%	0.0%	2014 DHS	All
	Sierra Leone	47.3%	24.6%	3.4%	3.4%	0.5%	2013 DHS	All
	Solomon Islands	32.2%	4.4%	9.8%	0.5%	0.0%	2006-07 DHS	All
	Somalia	18.2%	72.7%	0.0%	0.0%	0.0%	2006 MICS	Married
	South Africa	53.2%	17.9%	12.4%	0.2%	0.0%	2003 DHS	All
	South Sudan	23.5%	17.6%	23.5%	29.4%	0.0%	2010 SHHS2	Married
	Sri Lanka	28.5%	15.0%	10.4%	0.2%	0.0%	2006-07 DHS	Married
	State of Palestine	2.0%	18.1%	12.7%	3.6%	0.2%	2014 MICS	Married
	Sudan	12.2%	78.3%	0.0%	3.5%	0.0%	2014 MICS	Married
	Tajikistan	7.5%	8.6%	8.6%	0.6%	0.0%	2012 DHS	All
	Tanzania	39.3%	17.1%	7.5%	1.6%	0.0%	2014 DHS	Married
	Timor-Leste	75.0%	7.8%	0.8%	0.0%	2.3%	2010 DHS	All
	Togo	30.5%	11.4%	32.3%	0.0%	0.6%	2013-14 DHS	All
	Uganda	51.8%	8.2%	14.1%	0.0%	2.4%	2015 PMA2020 R3	All
	Uzbekistan	4.4%	3.7%	3.6%	4.2%	0.2%	2006 MICS	Married
	Vietnam	3.0%	20.9%	21.1%	0.0%	0.0%	2013-14 MICS	Married
	Yemen	14.4%	39.7%	1.7%	13.7%	0.0%	2013 DHS	Married
	Zambia	42.5%	24.6%	11.1%	1.5%	0.6%	2013-14 DHS	All
	Zimbabwe	15.1%	67.4%	9.4%	0.2%	0.0%	2010-11 DHS	All

*Lactational Amenorrhea Method (LAM) was excluded from mCPR in Chad, CAR, Cameroon, and Somalia due to unusually high levels reported in MICS surveys.

Indicator No. 10

Percentage of facilities stocked out, by method offered, on the day of assessment

	PERMANENT		LONG-ACTING	
COUNTRY	STERILIZATION (FEMALE)	STERILIZATION (MALE)	IUD	IMPLANT
Bangladesh			1.7%	5.4%
Benin	0.0%	16.7%	0.0%	20.0%
Bolivia			13.5%	50.6%
Burkina Faso	5.5%	28.5%	5.5%	3.9%
Burundi			39.1%	36.9%
CAR	65.6%	85.7%	65.6%	41.7%
Chad				
Congo				
Côte d'Ivoire	4.4%	4.4%	23.1%	14.3%
DR Congo			25.0%	23.9%
Ethiopia	29.2%	38.5%	22.1%	15.9%
Gambia				
Ghana			7.9%	10.3%
Haiti	83.3%	88.6%	84.1%	39.4%
Honduras			36.4%	73.5%
Indonesia			6.7%	9.7%
Kenya	74.5%	76.5%	35.6%	21.5%
Lao PDR	80.3%	31.6%	38.7%	48.3%
Liberia	14.6%	25.2%	33.0%	8.7%
Mauritania				
Mozambique	61.0%	80.0%	18.0%	19.0%
Myanmar	14.0%		48.0%	67.0%
Nepal			10.0%	9.5%
Niger	34.3%	52.5%	37.2%	3.3%
Nigeria	28.7%	46.4%	7.2%	7.3%
Papua New Guinea				
Rwanda	0.0%	6.8%	6.5%	0.6%
Sao Tome and Principe	0.0%	0.0%	60.0%	0.0%
Senegal				
Sierra Leone			37.3%	28.8%
Sudan			26.3%	22.4%
Tanzania			16.0%	9.0%
Togo	90.0%	95.0%	17.0%	12.0%
Uganda	67.3%	69.7%	55.6%	46.8%
Zambia				1.0%
Zimbabwe				2.2%

Note: Blank cells indicate no available data.

DEFINITION:
Percentage of facilities stocked out of each type of contraceptive offered, on the day of assessment.

SOURCE:
UNFPA facility surveys; PMA2020 facility surveys; other facility surveys and LMIS data.

	SHORT-TERM						
COUNTRY	INJECT-ABLES	PILL	CONDOMS (MALE)	CONDOMS (FEMALE)	OTHER MODERN METHODS (EC)	ANY MODERN METHOD*	SOURCE
Bangladesh	1.0%	0.8%	1.1%				2015-16 MOH*
Benin	44.4%	10.0%	13.6%	13.0%	20.0%	68.4%	2015 UNFPA
Bolivia	8.4%	13.4%	6.4%	69.7%	44.7%	55.8%	2015 UNFPA
Burkina Faso	4.2%	4.9%	6.7%	28.5%			2015 PMA2020
Burundi	32.4%	34.1%	32.9%	64.6%	49.8%	39.1%	2015 UNFPA**
CAR	32.8%	25.8%	30.3%	43.7%	46.0%		2015 UNFPA
Chad						76.6%	2015 UNFPA
Congo						82.0%	2015 UNFPA
Côte d'Ivoire	11.0%	21.4%	31.3%	28.0%	31.3%	62.0%	2015 UNFPA
DR Congo	25.6%	26.8%	39.6%	37.6%	40.5%	63.8%	2015 UNFPA*
Ethiopia	9.9%	8.0%	12.4%	98.8%	42.7%		2015 UNFPA
Gambia						58.9%	2016 UNFPA
Ghana	1.9%	19.2%	16.9%				2015 PMA2020
Haiti	12.9%	9.1%	7.6%			47.0%	2015 UNFPA
Honduras	61.0%	36.7%	30.3%	97.7%		30.8%	2015 UNFPA
Indonesia	6.2%	2.6%	5.4%				2015 PMA2020
Kenya	14.8%	15.5%	20.1%	58.6%	55.2%	81.0%	2015 UNFPA
Lao PDR	2.1%	3.1%	15.0%	98.4%	85.1%	39.9%	2015 UNFPA
Liberia	16.5%	6.8%	10.7%	31.1%	54.4%		2015 UNFPA
Mauritania						58.7%	2015 UNFPA
Mozambique	8.0%	5.0%	12.0%	46.0%	38.0%	60.0%	2015 UNFPA
Myanmar	14.0%	19.0%	44.0%	49.0%	53.0%		2015 UNFPA
Nepal	1.0%	0.5%	0.5%			5.2%	2015 UNFPA
Niger	3.3%	0.8%	9.1%	26.4%	12.4%	34.0%	2015 UNFPA
Nigeria	6.3%	7.7%	2.6%	1.1%	15.1%	48.5%	2015 UNFPA
Papua New Guinea						59.6%	2015 UNFPA
Rwanda	0.6%	1.8%	1.8%	39.6%		44.1%	2015 UNFPA
Sao Tome and Principe	0.0%	0.0%	0.0%	80.0%		16.7%	2015 UNFPA
Senegal						14.0%	2015 UNFPA*
Sierra Leone	5.0%	7.9%	9.9%	23.8%	42.6%	61.4%	2015 UNFPA
Sudan	35.6%	28.2%	32.2%		24.1%		2015 UNFPA
Tanzania	28.0%	13.0%	11.0%	22.0%	24.0%	40.0%	2014-15 SPA
Togo	6.0%	14.0%	9.0%	38.0%	36.0%		2015 UNFPA
Uganda	11.1%	39.3%	18.2%	70.5%	58.9%	85.5%	2015 UNFPA
Zambia			52.0%		33.0%		2015 RH Survey /SARA
Zimbabwe	0.4%	0.0%	0.6%	1.0%			2016 DTTU Report

*Stockouts reported over previous six months (from time of assessment), not just on day of assessment.
** Calculated from UNFPA survey data.
Note: Blank cells indicate no available data.

Indicator No. 11a

Percentage of primary SDPs with at least 3 modern methods of contraception available on day of assessment

Indicator No. 11b

Percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment

DEFINITION (11A):
The percentage of service delivery points (SDPs) that have at least 3 modern methods of contraception available on the day of the assessment.

DEFINITION (11B):
The percentage of secondary and tertiary service delivery points (SDPs) that have at least 5 modern methods of contraception available on the day of the assessment.

SOURCE:
UNFPA facility surveys; PMA2020 facility surveys.

COUNTRY	PERCENTAGE OF PRIMARY SDPS WITH AT LEAST 3 MODERN METHODS OF CONTRACEPTION AVAILABLE ON DAY OF ASSESSMENT	PERCENTAGE OF SECONDARY/TERTIARY SDPS WITH AT LEAST 5 MODERN METHODS OF CONTRACEPTION AVAILABLE ON DAY OF ASSESSMENT	SOURCE
Burkina Faso	87.6%	100.0%	2015 PMA2020
Côte d'Ivoire	92.3%	67.7%	2015 UNFPA
Ethiopia	85.6%	95.1%	2015 UNFPA
Ghana	69.5%	84.1%	2015 PMA2020
Indonesia	87.5%	82.0%	2015 PMA2020
Kenya	94.0%	79.8%	2015 UNFPA
Togo	89.0%	100.0%	2016 UNFPA
Uganda	61.7%	68.9%	2015 PMA2020

Indicator No. 13

Couple-Years of Protection (CYP)

DEFINITION:
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.

SOURCE:
Calculated from Logistics Management Information Systems (LMIS) or other service statistics sources.

COUNTRY	2012	2013	2014	2015	SOURCE
Côte d'Ivoire	674,336	746,400	806,561	869,835	Service statistics
Ethiopia	8,441,086	8,319,791	3,898,710	3,924,922	Health and health-related data and annual quantification data
Indonesia			48,452,903	45,856,646	BKKBN service statistics
Kenya	13,519	548,922	3,656,645	3,807,839	DHIS2
Madagascar	626,769	966,516	1,188,165	1,157,740	Health and demographic service statistics
Malawi	1,061,204	1,110,594	1,664,769	2,038,004	Logistics Management Information System
Myanmar		1,573,884	2,487,699	1,959,964	Ministry of Health
Niger	186,042	244,646	386,497	652,274	Directory of Statistics
Nigeria		713,856	1,001,655	1,232,704	Federal Ministry of Health National Health Management Information System
Rwanda	862,861	807,985	861,971	758,816	Ministry of Health, Rwanda Biomedical Center
Togo	233,684	270,007	289,442	329,146	Ministry of Health
Uganda	845,070	1,620,901	1,762,763	1,362,641	DHIS2
Zambia	641,952	957,616	1,254,078	1,117,341	DHIS2
Zimbabwe	1,025,854	1,149,763	1,473,275	1,389,189	DHIS2

Indicator No. 14

Method Information Index

	METHOD INFORMATION INDEX	PERMANENT	LONG-ACTING		SHORT-TERM	
COUNTRY	TOTAL	STERILIZATION (FEMALE)	IUD	IMPLANT	INJECTABLE	PILL
Burkina Faso	40.5%			48.8%	40.9%	43.5%
Cambodia	67.4%	62.5%	86.7%	80.4%	70.1%	59.2%
Comoros	36.2%			51.4%	30.0%	40.1%
DR Congo	28.4%	6.4%		50.4%	35.6%	12.0%
Egypt	28.8%	25.4%	30.4%	27.3%	30.0%	25.5%
Ethiopia	39.6%	41.4%*	60.2%	47.0%	36.5%	50.3%
Gambia	31.0%		29.9%*		33.5%	26.5%
Ghana	43.7%	35.7%*	61.6%*	62.4%	60.7%	29.7%
Guinea	31.3%			0.0%	29.1%	28.6%
Haiti	51.7%	30.0%		62.1%	54.3%	38.7%
Indonesia	30.4%	27.3%	39.7%	34.1%	31.2%	32.5%
Kenya	43.2%	36.2%	63.2%	54.7%	38.9%	34.3%
Kyrgyzstan	56.2%	26.9%*	59.5%	0.0%	0.0%	46.5%
Lesotho	27.0%	3.9%*	55.5%*	44.3%	26.7%	24.4%
Liberia	61.4%			75.6%	62.3%	51.9%
Mali	33.3%		50.1%*	41.8%	31.2%	25.4%
Niger	28.4%		0.0%	39.8%*	34.4%	25.5%
Nigeria	47.1%	23.8%*	64.4%	73.3%	52.5%	30.9%
Pakistan	13.5%	7.6%	20.6%		18.3%	11.2%
Philippines	52.1%	45.9%	69.5%		58.5%	50.5%
Rwanda	57.9%	23.9%	65.1%	61.4%	59.1%	53.0%
Senegal	64.8%		72.4%*	54.4%	74.2%	63.3%
Sierra Leone	69.8%	54.0%*	76.7%	78.0%	72.1%	59.7%
Tajikistan	59.4%		59.1%	0.0%	65.4%	60.7%
Togo	67.5%		72.0%	79.8%	68.8%	44.4%
Uganda	48.3%	46.9%		78.3%	45.7%	50.6%
Yemen	34.9%	22.0%	45.7%	44.8%	36.3%	30.9%
Zambia	71.8%	49.9%	82.3%	83.8%	73.8%	62.4%

*Small sample size (between 25 and 50).

Note: Blank cells indicate that the sample size was too small for inclusion or no data was available. No countries had a large enough sample size to analyze male sterilization.

DEFINITION:
An index measuring the extent to which women were given specific information when they received family planning services. The index is composed of three questions: 1) Were you informed about other methods? 2) Were you informed about side effects? 3) Were you told what to do if you experienced side effects? The reported Method Information Index value is the percent of women who responded "yes" to all three questions.

SOURCE:
For each country, the most recent national survey (DHS, PMA2020). Data reflect all women, except Egypt, Pakistan and Yemen, which reflect married or in-union women.

	RESPONSES TO INDIVIDUAL QUESTIONS AMONG USERS OF MODERN METHODS			
COUNTRY	TOLD OF OTHER METHODS	TOLD ABOUT SIDE EFFECTS	TOLD WHAT TO DO ABOUT SIDE EFFECTS**	SOURCE
Burkina Faso	71.1%	58.3%	48.9%	2015 PMA2020 R2
Cambodia	75.7%	79.6%	77.5%	2014 DHS
Comoros	62.2%	54.5%	45.7%	2012 DHS
DR Congo	50.8%	57.2%	47.5%	2013-14 DHS
Egypt	56.0%	45.0%	34.5%	2014 DHS
Ethiopia	62.2%	52.5%	43.3%	2015 PMA2020 R3
Gambia	57.5%	47.2%	41.8%	2013 DHS
Ghana	65.1%	58.5%	49.2%	2015 PMA2020 R4
Guinea	48.6%	48.6%	43.1%	2012 DHS
Haiti	64.6%	70.2%	63.7%	2012 DHS
Indonesia	57.6%	49.2%	36.8%	2015 PMA2020 R1
Kenya	70.4%	54.5%	51.9%	2014 DHS
Kyrgyzstan	64.6%	70.5%	67.1%	2012 DHS
Lesotho	62.6%	39.8%	36.5%	2014 DHS
Liberia	72.0%	75.0%	72.9%	2013 DHS
Mali	56.8%	53.1%	46.3%	2012-13 DHS
Niger	55.9%	39.6%	35.4%	2012 DHS
Nigeria	64.8%	60.3%	54.8%	2013 DHS
Pakistan	28.2%	34.0%	28.1%	2012-13 DHS
Philippines	71.4%	67.8%	67.9%	2013 DHS
Rwanda	79.5%	64.8%	68.5%	2014-15 DHS
Senegal	84.5%	72.7%	76.8%	2014 DHS
Sierra Leone	82.7%	75.7%	74.9%	2013 DHS
Tajikistan	68.1%	77.0%	71.8%	2012 DHS
Togo	82.7%	78.1%	74.6%	2013-14 DHS
Uganda	64.2%	62.1%	54.2%	2015 PMA2020 R3
Yemen	57.0%	55.7%	45.8%	2013 DHS
Zambia	83.3%	79.7%	78.1%	2013-14 DHS

*Small sample size (between 25 and 50).
**Among all women who responded to this set of three questions, not just among those who were told about side effects.
Note: Blank cells indicate that the sample size was too small for inclusion or no data was available. No countries had a large enough sample size to analyze male sterilization.

Indicator No. 15

Percentage of women who were provided with information on family planning during recent contact with a health service provider

DEFINITION:
The percentage of women who were provided information on family planning within the last 12 months through contact with a health service provider.

SOURCE:
For each country, the most recent national survey (DHS, PMA2020). Data reflect all women, except for Pakistan and Yemen, which reflect married or in-union women.

		INDICATOR BY WEALTH QUINTILE					
COUNTRY	PERCENTAGE OF WOMEN WHO WERE PROVIDED WITH INFORMATION ON FAMILY PLANNING DURING RECENT CONTACT WITH A HEALTH SERVICE PROVIDER	POOREST	POORER	MIDDLE	RICHER	RICHEST	SOURCE
Burkina Faso	37.1%	39.5%	45.6%	37.2%	35.4%	27.7%	2015 PMA2020 R2
Cambodia	29.6%	33.9%	33.0%	32.6%	29.9%	20.8%	2014 DHS
Comoros	16.2%	19.5%	17.7%	15.7%	13.9%	14.6%	2012 DHS
DR Congo	11.0%	7.2%	9.6%	9.3%	13.9%	14.1%	2013-14 DHS
Ethiopia	31.1%	34.2%	30.8%	29.5%	32.7%	28.5%	2015 PMA2020 R3
Gambia	9.7%	12.4%	11.9%	10.3%	8.1%	7.2%	2013 DHS
Ghana	26.5%	33.0%	27.5%	25.0%	23.7%	22.5%	2015 PMA2020 R4
Guinea	6.6%	5.6%	4.7%	6.1%	5.6%	10.4%	2012 DHS
Haiti	20.2%	24.9%	22.3%	25.0%	18.2%	14.4%	2012 DHS
Indonesia	18.3%	21.7%	17.0%	18.4%	18.7%	16.6%	2015 PMA2020 R1
Kenya	22.4%	22.0%	22.6%	24.1%	21.3%	22.2%	2014 DHS
Kyrgyzstan	23.6%	33.4%	28.2%	23.7%	22.8%	14.1%	2012 DHS
Lesotho	23.0%	23.7%	25.5%	23.0%	22.1%	22.1%	2014 DHS
Liberia	52.4%	47.0%	52.8%	58.2%	55.8%	48.4%	2013 DHS
Mali	16.4%	14.9%	13.7%	14.8%	19.0%	16.4%	2012-13 DHS
Niger	16.9%	11.3%	16.5%	19.5%	16.4%	19.8%	2012 DHS
Nigeria	12.5%	2.3%	6.1%	11.8%	17.8%	21.7%	2013 DHS
Pakistan	40.6%	39.7%	43.4%	45.8%	42.3%	31.7%	2012-13 DHS
Philippines	28.8%	45.2%	38.2%	30.6%	22.0%	15.7%	2013 DHS
Rwanda	32.2%	35.0%	35.6%	36.3%	33.4%	22.6%	2014-15 DHS
Senegal	22.2%	20.2%	21.4%	22.5%	24.8%	21.7%	2014 DHS
Sierra Leone	42.4%	41.3%	46.3%	48.0%	49.8%	29.6%	2013 DHS
Tajikistan	27.8%	25.3%	24.7%	28.4%	31.4%	29.2%	2012 DHS
Togo	20.1%	29.9%	24.5%	23.4%	16.4%	15.5%	2013-14 DHS
Uganda	39.0%	47.3%	37.1%	35.6%	39.8%	35.9%	2015 PMA2020 R3
Yemen	9.9%	7.1%	8.6%	11.1%	12.0%	10.4%	2013 DHS
Zambia	30.2%	34.0%	37.5%	33.3%	27.8%	22.1%	2013-14 DHS

Note: Bangladesh and Egypt are excluded from this indicator because the question was not asked in their surveys.

Indicator No. 16

Percentage of women who decided to use family planning alone or jointly with their husbands/partners

DEFINITION:
The percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner.

SOURCE:
For each country, the most recent national survey (DHS, PMA2020).

		INDICATOR BY WEALTH QUINTILE					
COUNTRY	PERCENTAGE OF WOMEN WHO DECIDED TO USE FAMILY PLANNING ALONE OR JOINTLY WITH THEIR HUSBANDS OR PARTNERS	POOREST	POORER	MIDDLE	RICHER	RICHEST	SOURCE
Bangladesh	91.1%	89.6%	91.6%	91.1%	92.0%	90.9%	2014 DHS
Burkina Faso	90.2%	99.2%	90.1%	92.4%	88.9%	86.7%	2015 PMA2020 R2
Cambodia	88.9%	88.3%	90.1%	88.6%	87.7%	89.8%	2014 DHS
Comoros	71.0%	72.0%	73.0%	71.0%	72.0%	69.0%	2012 DHS
DR Congo	85.0%	86.0%	85.0%	80.0%	81.0%	89.0%	2013-14 DHS
Egypt	98.0%	97.0%	97.0%	97.0%	97.0%	99.0%	2014 DHS
Ethiopia	85.5%	86.9%	80.8%	86.7%	85.3%	86.7%	2015 PMA2020 R3
Gambia	84.0%	84.0%	77.0%	89.0%	81.0%	87.0%	2013 DHS
Ghana	92.0%	86.2%	96.7%	96.5%	90.4%	89.0%	2015 PMA2020 R4
Guinea	92.0%	80.0%	97.0%	98.0%	95.0%	87.0%	2012 DHS
Haiti	91.4%	91.0%	92.0%	92.0%	91.0%	91.0%	2012 DHS
Indonesia	93.3%	93.2%	93.7%	93.3%	92.2%	94.2%	2015 PMA2020 R1
Kenya	89.4%	89.3%	87.2%	89.0%	90.1%	90.7%	2014 DHS
Kyrgyzstan	95.0%	94.0%	95.0%	96.0%	93.0%	97.0%	2012 DHS
Lesotho	93.1%	93.4%	93.7%	91.7%	91.0%	95.3%	2014 DHS
Liberia	89.0%	84.0%	86.0%	87.0%	92.0%	93.0%	2013 DHS
Mali	81.0%	85.0%	86.0%	79.0%	82.0%	79.0%	2012-13 DHS
Niger	77.0%	53.0%	75.0%	82.0%	81.0%	81.0%	2012 DHS
Nigeria	85.0%	80.0%	83.0%	82.0%	84.0%	86.0%	2013 DHS
Pakistan	92.0%	93.0%	94.0%	91.0%	92.0%	93.0%	2012-13 DHS
Philippines	92.0%	91.0%	93.0%	92.0%	93.0%	94.0%	2013 DHS
Rwanda	97.9%	97.6%	97.7%	97.2%	97.9%	99.0%	2014-15 DHS
Senegal	93.0%	84.0%	86.0%	94.0%	95.0%	96.0%	2014 DHS
Sierra Leone	82.0%	84.0%	78.0%	83.0%	82.0%	83.0%	2013 DHS
Tajikistan	86.0%	86.0%	80.0%	89.0%	82.0%	92.0%	2012 DHS
Togo	84.0%	82.0%	90.0%	87.0%	82.0%	81.0%	2013-14 DHS
Uganda	92.2%	90.3%	90.4%	97.0%	93.2%	90.0%	2015 PMA2020 R3
Yemen	93.1%	88.3%	91.3%	92.3%	94.0%	94.9%	2013 DHS
Zambia	83.0%	82.0%	82.0%	83.0%	83.0%	85.0%	2013-14 DHS

Indicator No. 17

Adolescent birth rate (ABR)

COUNTRY	ABR	SOURCE
Afghanistan	78	2015 pDHS
Bangladesh	113	2014 DHS
Benin	94	2014 MICS
Burkina Faso	147	2014-15 PMA2020 R1/R2
Cambodia	57	2014 DHS
Cameroon	119	2014 MICS
Chad	179	2014-15 pDHS
Comoros	70	2012 DHS
Congo	111	2014-15 MICS
DR Congo	138	2013-14 DHS
Egypt	56	2014 DHS
Ethiopia	74	2014 PMA2020 R2/R3
Gambia	88	2013 DHS
Ghana	62	2014-15 PMA2020 R3/R4
Guinea	146	2012 DHS
Guinea-Bissau	106	2014 MICS
Haiti	66	2012 DHS
Indonesia	48	2012 DHS
Kenya	96	2014 DHS
Kyrgyzstan	65	2014 MICS
Lesotho	94	2014 DHS
Liberia	149	2013 DHS
Mali	151	2015 MICS
Malawi	136	2015-16 pDHS
Mongolia	40	2013 MICS (SISS)
Nepal	71	2014 MICS
Niger	206	2012 DHS
Nigeria	122	2013 DHS
Pakistan	44	2012-13 DHS
Philippines	57	2013 DHS

DEFINITION:
The number of births to adolescent females, aged 15-19 occurring during a given reference period per 1,000 adolescent females.

SOURCE:
For each country, the most recent national survey (DHS, PMA2020, MICS).

COUNTRY	ABR	SOURCE
Rwanda	45	2014-15 DHS
Sao Tome and Principe	92	2014 MICS
Senegal	80	2015 pDHS
Sierra Leone	125	2013 DHS
State of Palestine	48	2014 MICS
Sudan	87	2014 MICS
Tajikistan	54	2012 DHS
Tanzania	135	2015-16 pDHS
Togo	84	2013-14 DHS
Uganda	131	2015 PMA2020 R2/R3
Vietnam	45	2013-14 MICS
Yemen	67	2013 DHS
Zambia	141	2013-14 DHS
Zimbabwe	110	2015 pDHS

Sources for model-based estimates (Indicators 1-8)

COUNTRY	MOST RECENT SURVEY USED IN FPET	SERVICE STATISTICS INCLUDED IN FPET	SOURCE FOR % PREGNANCIES THAT ARE UNINTENDED (USED FOR INDICATOR 5)
Afghanistan	2015 pDHS		Regional Average
Bangladesh	2014 DHS		2014 DHS
Benin	2014 MICS	Yes	2011-12 DHS
Bhutan	2010 MICS		Regional Average
Bolivia	2008 DHS		2008 DHS
Burkina Faso	2016 PMA2020 R3		2010 DHS
Burundi	2012 PMS	Yes	2010 DHS
Cambodia	2014 DHS		2014 DHS
Cameroon	2014 MICS		2011 DHS
CAR	2010 MICS		1994-95 DHS
Chad	2014-15 pDHS		2004 DHS
Comoros	2012 DHS		2012 DHS
Congo	2014-15 MICS		2011-12 DHS
Côte d'Ivoire	2011-12 DHS	Yes	2011-12 DHS
Djibouti	2012 PAPFAM		Regional Average
DPR Korea	2010 RHS		Regional Average
DR Congo	2013-14 DHS		2013-14 DHS
Egypt	2014 DHS		2014 DHS
Eritrea	2010 National Survey		2002 DHS
Ethiopia	2015 PMA2020 R3		2011 DHS
Gambia	2013 DHS		2013 DHS
Ghana	2015 PMA2020 R4		2014 DHS
Guinea	2012 DHS		2012 DHS
Guinea-Bissau	2014 MICS		Regional Average
Haiti	2012 DHS		2012 DHS
Honduras	2011-12 DHS		2011-12 DHS
India	2015-16 NFHS Survey		2005-06 DHS
Indonesia	2016 SUPAS		2015 PMA2020 R1
Iraq	2011 MICS		Regional Average
Kenya	2015 PMA2020 R3/R4 Pooled		2014 DHS
Kyrgyzstan	2014 MICS		2012 DHS
Lao PDR	2011-12 MICS/DHS		2011-12 MICS/DHS
Lesotho	2014 DHS		2014 DHS
Liberia	2013 DHS		2013 DHS
Madagascar	2012-13 National Survey Monitoring MDGs		2008-09 DHS
Malawi	2014 MICS (MES)	Yes	2010 DHS
Mali	2015 MICS		2012-13 DHS

COUNTRY	MOST RECENT SURVEY USED IN FPET	SERVICE STATISTICS INCLUDED IN FPET	SOURCE FOR % PREGNANCIES THAT ARE UNINTENDED (USED FOR INDICATOR 5)
Mauritania	2011 MICS		2000-01 DHS
Mongolia	2013 MICS (SISS)		Regional Average
Mozambique	2011 DHS	Yes	2011 DHS
Myanmar	2009-10 MICS		Regional Average
Nepal	2014 MICS	Yes	2011 DHS
Nicaragua	2011-12 National		2006-07 RHS
Niger	2012 DHS		2012 DHS
Nigeria	2013 DHS	Yes	2013 DHS
Pakistan	2012-13 DHS	Yes	2012-13 DHS
Papua New Guinea	2006 National		Regional Average
Philippines	2013 DHS		2013 DHS
Rwanda	2014-15 DHS		2014-15 DHS
Sao Tome and Principe	2014 MICS		2008-09 DHS
Senegal	2015 pDHS		2014 DHS
Sierra Leone	2013 DHS		2013 DHS
Solomon Islands	2006-07 DHS		Regional Average
Somalia	2006 MICS	Yes	Regional Average
South Africa	2003 DHS	Yes	2003 DHS
South Sudan	2010 MICS		Regional Average
Sri Lanka	2006-07 DHS		Regional Average
State of Palestine	2014 MICS		Regional Average
Sudan	2014 MICS		Regional Average
Tajikistan	2012 DHS		2012 DHS
Tanzania	2015-16 pDHS/MIS		2010 DHS
Timor-Leste	2009-10 DHS		2009-10 DHS
Togo	2013-14 DHS	Yes	2013-14 DHS
Uganda	2015 PMA2020 R3		2011 DHS
Uzbekistan	2006 MICS		1996 DHS
Vietnam	2013-14 MICS	Yes	2002 DHS
Western Sahara	No survey data available		Regional Average
Yemen	2013 DHS		2013 DHS
Zambia	2013-14 DHS		2013-14 DHS
Zimbabwe	2014 MICS		2010-11 DHS

DISAGGREGATED ESTIMATES

Modern contraceptive prevalence rate, mCPR

(married or in-union women)
Disaggregated from recent survey

	AGE IN 5 YEAR CATEGORIES						
COUNTRY	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Afghanistan	6.0%	15.3%	18.8%	22.6%	25.5%	25.3%	21.5%
Bangladesh	46.7%	54.5%	62.7%	64.7%	60.6%	45.2%	25.0%
Burkina Faso	11.7%	20.6%	24.1%	22.9%	20.7%	21.9%	9.8%
Cambodia	20.2%	34.4%	43.8%	47.5%	47.4%	38.4%	18.6%
Chad	2.3%	3.5%	5.4%	7.5%	6.6%	5.7%	2.8%
Comoros	13.5%	14.3%	14.9%	14.5%	16.8%	14.4%	5.3%
DR Congo	5.4%	8.2%	6.9%	10.3%	8.3%	7.8%	5.1%
Egypt	18.9%	40.9%	53.5%	62.8%	71.0%	69.9%	52.3%
Ethiopia	30.1%	42.4%	39.9%	35.8%	37.0%	32.7%	14.7%
Gambia	2.2%	5.7%	8.0%	10.2%	11.5%	9.6%	6.6%
Ghana	23.1%	34.4%	31.2%	31.4%	32.7%	19.0%	15.7%
Guinea	2.6%	3.9%	5.7%	6.2%	5.4%	4.3%	2.4%
Haiti	24.0%	34.1%	37.2%	35.9%	31.3%	26.6%	16.9%
Indonesia	51.8%	56.8%	59.2%	64.5%	62.8%	61.5%	46.5%
Kenya	36.8%	49.8%	57.3%	59.1%	57.7%	51.1%	37.2%
Kyrgyzstan	15.1%	27.2%	37.5%	49.3%	53.7%	49.6%	28.2%
Lesotho	35.3%	57.4%	65.3%	66.8%	70.1%	59.3%	39.4%
Liberia	13.2%	22.5%	22.9%	22.5%	20.3%	14.7%	6.2%
Mali	6.5%	10.0%	9.5%	11.8%	11.9%	10.5%	5.5%
Malawi	37.5%	54.8%	61.6%	64.0%	64.5%	60.1%	50.3%
Mongolia	27.6%	43.9%	51.5%	54.4%	56.4%	50.7%	26.0%
Nepal	16.6%	27.5%	40.9%	53.8%	62.2%	62.1%	51.9%
Niger	5.9%	12.6%	16.0%	14.3%	15.0%	8.8%	3.2%
Nigeria	1.2%	6.2%	8.8%	12.6%	13.6%	14.4%	8.3%
Pakistan	6.9%	14.9%	21.0%	31.4%	36.6%	33.3%	26.8%
Philippines	20.6%	34.3%	42.2%	44.9%	42.4%	38.6%	23.5%
Rwanda	32.8%	44.3%	50.9%	51.1%	51.0%	46.6%	29.5%
Sao Tome and Principe	27.6%	40.9%	42.0%	39.8%	37.1%	38.4%	17.7%
Senegal	5.5%	17.9%	20.7%	24.8%	26.6%	25.8%	16.6%
Sierra Leone	7.8%	13.6%	15.2%	20.1%	18.2%	16.5%	10.5%
State of Palestine	10.1%	26.6%	37.6%	49.5%	59.0%	58.5%	44.3%
Sudan	5.6%	10.5%	13.7%	12.8%	14.1%	11.3%	6.2%
Tanzania	13.3%	29.9%	35.8%	36.3%	37.2%	32.0%	27.6%
Tajikistan	1.8%	9.5%	24.8%	37.4%	43.9%	34.6%	17.0%
Togo	7.6%	15.3%	19.3%	19.3%	18.4%	18.5%	11.8%
Uganda	19.1%	24.9%	33.7%	29.6%	36.4%	36.6%	25.3%
Vietnam	29.4%	43.8%	56.4%	65.4%	66.1%	61.6%	43.4%
Yemen	12.1%	23.0%	32.8%	35.6%	34.5%	30.6%	22.9%
Zambia	35.8%	44.1%	48.6%	48.7%	47.1%	44.2%	27.5%
Zimbabwe	44.9%	63.7%	68.0%	70.2%	71.4%	66.2%	54.1%

	RESIDENCE		WEALTH					
COUNTRY	URBAN	RURAL	LOWEST	SECOND	MIDDLE	FOURTH	HIGHEST	SURVEY
Afghanistan	29.0%	17.0%	15.0%	16.1%	15.7%	22.0%	30.5%	2015 pDHS
Bangladesh	56.2%	53.2%	55.1%	54.9%	55.8%	51.9%	53.2%	2014 DHS
Burkina Faso	38.8%	16.6%	9.7%	18.3%	22.5%	19.1%	39.4%	2015 PMA2020 R2
Cambodia	32.8%	39.9%	39.6%	42.4%	38.3%	39.2%	34.6%	2014 DHS
Chad	10.1%	3.8%	3.8%	4.1%	4.3%	3.1%	10.6%	2014-15 pDHS
Comoros	20.6%	11.0%	10.9%	13.2%	14.1%	17.8%	14.2%	2012 DHS
DR Congo	14.6%	4.6%	3.3%	4.7%	4.5%	11.0%	17.2%	2013-14 DHS
Egypt	59.5%	55.5%	54.2%	54.3%	58.0%	58.1%	59.3%	2014 DHS
Ethiopia	50.5%	32.6%	28.0%	28.5%	33.3%	39.3%	53.9%	2015 PMA2020 R3
Gambia	11.8%	4.4%	4.2%	4.8%	5.5%	10.8%	15.1%	2013 DHS
Ghana	28.9%	29.0%	23.2%	36.0%	32.7%	26.3%	27.7%	2015 PMA2020 R4
Guinea	7.4%	3.5%	2.3%	3.9%	4.0%	5.0%	8.8%	2012 DHS
Haiti	31.3%	31.2%	29.7%	29.8%	34.8%	34.3%	27.5%	2012 DHS
Indonesia	57.4%	61.3%	57.0%	61.9%	63.2%	60.0%	54.5%	2015 PMA2020 R1
Kenya	56.9%	50.9%	29.2%	54.1%	59.5%	60.9%	57.7%	2014 DHS
Kyrgyzstan	41.4%	39.4%	40.5%	36.0%	37.6%	43.1%	42.9%	2014 MICS
Lesotho	65.2%	57.3%	49.9%	56.3%	62.3%	60.8%	65.9%	2014 DHS
Liberia	21.6%	16.3%	13.2%	16.5%	21.1%	24.5%	20.7%	2013 DHS
Mali	21.8%	6.8%	3.3%	5.0%	5.6%	12.8%	23.3%	2012-13 DHS
Malawi	61.4%	57.5%	53.2%	58.0%	58.8%	59.6%	60.6%	2015-16 pDHS
Mongolia	43.9%	55.3%	57.8%	49.8%	47.7%	44.8%	41.5%	2013 MICS (SISS)
Nepal	47.5%	47.1%	44.1%	46.8%	50.1%	48.9%	45.4%	2014 MICS
Niger	27.0%	9.7%	8.7%	7.7%	8.3%	12.8%	23.7%	2012 DHS
Nigeria	16.9%	5.7%	0.9%	3.7%	9.1%	14.4%	23.4%	2013 DHS
Pakistan	32.0%	23.1%	18.1%	22.9%	26.9%	30.3%	31.6%	2012-13 DHS
Philippines	37.8%	37.4%	32.9%	40.3%	41.4%	39.1%	33.9%	2013 DHS
Rwanda	51.1%	46.7%	44.9%	45.8%	48.1%	48.7%	50.0%	2014-15 DHS
Sao Tome and Principe	34.8%	42.6%	35.2%	36.8%	40.2%	39.6%	35.2%	2014 MICS
Senegal	30.3%	15.2%	11.9%	15.2%	21.9%	25.5%	32.3%	2015 pDHS
Sierra Leone	24.7%	12.3%	11.5%	11.5%	12.1%	19.2%	26.3%	2013 DHS
State of Palestine	43.4%	45.2%	37.6%	43.3%	43.0%	44.3%	52.2%	2014 MICS
Sudan	19.0%	8.7%	3.8%	4.9%	8.8%	16.7%	24.4%	2014 MICS
Tanzania	35.0%	30.6%	19.2%	29.4%	36.0%	40.2%	35.2%	2015-16 pDHS/MIS
Tajikistan	29.0%	24.8%	23.3%	22.7%	23.7%	25.8%	33.3%	2012 DHS
Togo	18.8%	16.3%	15.5%	16.7%	16.7%	16.4%	20.8%	2013-14 DHS
Uganda	37.9%	28.4%	18.0%	23.9%	27.9%	36.2%	45.2%	2015 PMA2020 R3
Vietnam	54.7%	58.0%	61.2%	58.9%	55.7%	53.0%	56.7%	2013-14 MICS
Yemen	40.2%	24.0%	13.6%	21.0%	30.5%	35.8%	42.2%	2013 DHS
Zambia	53.4%	39.0%	31.3%	39.3%	44.8%	49.5%	58.3%	2013-14 DHS
Zimbabwe	70.6%	63.0%	61.5%	61.3%	63.1%	68.6%	72.3%	2015 pDHS

Percentage of women with an unmet need for any method of contraception (married or in-union women)
Disaggregated from recent survey

	AGE IN 5 YEAR CATEGORIES						
COUNTRY	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Afghanistan	20.9%	27.2%	29.3%	27.5%	26.2%	18.6%	10.4%
Bangladesh	17.1%	14.7%	12.2%	11.2%	10.2%	8.4%	7.0%
Burkina Faso*	24.7%	29.2%	32.9%	28.4%	30.5%	32.1%	25.7%
Cambodia	14.9%	13.6%	11.4%	9.7%	12.9%	13.9%	14.5%
Chad	22.5%	24.9%	24.5%	25.0%	23.9%	21.6%	9.7%
Comoros	47.4%	42.9%	30.7%	34.6%	31.8%	20.0%	16.4%
DR Congo	30.8%	29.2%	30.4%	29.1%	27.8%	25.0%	12.4%
Egypt	9.0%	11.0%	11.9%	13.4%	12.6%	12.5%	15.9%
Ethiopia*	22.1%	15.7%	19.8%	23.1%	24.9%	26.7%	17.9%
Gambia	16.9%	23.5%	28.2%	25.6%	26.4%	27.8%	18.9%
Ghana*	48.7%	30.5%	29.6%	27.4%	27.6%	38.2%	23.7%
Guinea	23.4%	26.8%	21.9%	26.6%	23.6%	28.1%	12.4%
Haiti	56.6%	41.1%	34.9%	32.1%	35.8%	34.7%	23.8%
Indonesia*	9.2%	13.3%	13.2%	12.0%	17.0%	19.5%	20.0%
Kenya	23.0%	18.9%	14.9%	15.9%	18.5%	21.9%	16.8%
Kyrgyzstan	19.3%	22.0%	21.1%	19.5%	13.5%	16.6%	20.8%
Lesotho	28.9%	21.5%	17.4%	16.3%	15.1%	19.8%	14.1%
Liberia	46.6%	38.6%	33.5%	30.2%	31.4%	27.2%	11.4%
Mali	23.3%	24.5%	26.0%	30.5%	27.7%	27.2%	16.8%
Malawi	22.2%	18.4%	17.5%	19.2%	19.0%	19.7%	15.7%
Mongolia	36.4%	19.3%	16.2%	12.0%	11.1%	15.0%	25.5%
Nepal	47.7%	39.0%	31.4%	21.8%	17.8%	14.2%	10.5%
Niger	13.1%	18.4%	16.4%	16.2%	13.6%	18.9%	14.1%
Nigeria	13.1%	16.6%	16.8%	17.1%	17.6%	16.8%	11.5%
Pakistan	14.9%	20.6%	22.1%	21.4%	21.2%	19.7%	14.3%
Philippines	28.7%	22.2%	18.2%	14.7%	16.1%	16.8%	16.6%
Rwanda	3.6%	14.8%	18.1%	21.9%	22.0%	19.7%	13.8%
Sao Tome and Principe	42.2%	32.3%	36.6%	32.5%	30.0%	26.6%	30.6%
Senegal	20.8%	22.9%	21.8%	20.2%	25.9%	27.8%	15.0%
Sierra Leone	30.8%	25.9%	25.3%	23.3%	28.4%	24.1%	17.3%
State of Palestine	12.5%	15.3%	11.5%	10.1%	7.4%	8.5%	11.8%
Sudan	24.8%	25.0%	27.8%	30.2%	27.5%	26.6%	18.6%
Tanzania	23.0%	22.7%	23.4%	21.0%	22.9%	24.3%	14.8%
Tajikistan	12.8%	28.2%	28.3%	26.0%	20.1%	18.1%	12.3%
Togo	41.6%	39.5%	35.3%	35.1%	35.7%	28.3%	18.7%
Uganda*	32.5%	23.7%	30.3%	31.0%	36.1%	30.7%	20.5%
Vietnam	10.8%	11.4%	6.2%	6.1%	3.0%	5.7%	6.2%
Yemen	29.2%	29.2%	29.9%	28.6%	31.6%	25.8%	22.4%
Zambia	25.1%	22.0%	18.9%	20.8%	23.2%	23.0%	16.2%
Zimbabwe	12.6%	10.1%	10.0%	8.6%	11.1%	12.3%	11.6%

	RESIDENCE		WEALTH					
COUNTRY	URBAN	RURAL	LOWEST	SECOND	MIDDLE	FOURTH	HIGHEST	SURVEY
Afghanistan	24.2%	24.5%	26.8%	24.8%	24.5%	24.8%	21.3%	2015 pDHS
Bangladesh	9.6%	12.9%	13.2%	10.8%	11.4%	13.2%	11.3%	2014 DHS
Burkina Faso*	24.0%	30.6%	35.8%	30.4%	27.1%	28.2%	22.5%	2015 PMA2020 R2
Cambodia	10.8%	12.8%	17.0%	11.2%	13.5%	10.8%	10.1%	2014 DHS
Chad	26.1%	22.1%	23.2%	22.6%	21.3%	21.7%	26.4%	2014-15 pDHS
Comoros	24.3%	36.2%	42.1%	34.1%	33.6%	28.6%	25.0%	2012 DHS
DR Congo	28.4%	27.3%	28.4%	26.8%	28.3%	28.7%	26.1%	2013-14 DHS
Egypt	11.8%	13.0%	15.4%	15.0%	11.1%	11.1%	11.0%	2014 DHS
Ethiopia*	14.1%	22.7%	21.8%	27.5%	20.7%	21.3%	12.7%	2015 PMA2020 R3
Gambia	24.4%	25.4%	24.3%	26.7%	25.2%	24.8%	23.5%	2013 DHS
Ghana*	28.0%	32.5%	35.7%	32.6%	26.2%	26.1%	26.7%	2015 PMA2020 R4
Guinea	25.7%	22.9%	21.6%	21.3%	21.9%	27.1%	27.4%	2012 DHS
Haiti	34.1%	36.3%	35.8%	40.5%	34.9%	35.6%	31.0%	2012 DHS
Indonesia*	17.8%	13.7%	15.6%	14.6%	13.2%	15.2%	19.7%	2015 PMA2020 R1
Kenya	13.4%	20.2%	28.7%	23.2%	17.1%	12.0%	11.0%	2014 DHS
Kyrgyzstan	17.5%	19.8%	17.6%	20.1%	21.9%	19.5%	16.3%	2014 MICS
Lesotho	13.7%	20.7%	24.5%	23.1%	17.3%	17.0%	13.5%	2014 DHS
Liberia	29.5%	33.0%	35.1%	32.1%	31.9%	29.2%	26.6%	2013 DHS
Mali	23.9%	26.5%	25.1%	25.5%	28.3%	27.6%	23.4%	2012-13 DHS
Malawi	16.1%	19.2%	20.8%	19.7%	18.6%	18.3%	16.1%	2015-16 pDHS
Mongolia	17.2%	14.1%	14.5%	16.1%	16.7%	15.5%	17.2%	2013 MICS (SISS)
Nepal	22.9%	25.7%	27.2%	25.1%	24.9%	24.9%	24.3%	2014 MICS
Niger	17.3%	15.8%	17.7%	15.4%	15.2%	16.0%	15.9%	2012 DHS
Nigeria	14.9%	16.8%	14.3%	15.4%	20.0%	18.7%	13.0%	2013 DHS
Pakistan	17.1%	21.6%	24.5%	23.2%	19.0%	18.8%	15.3%	2012-13 DHS
Philippines	16.7%	18.2%	21.3%	16.7%	15.5%	16.1%	17.9%	2013 DHS
Rwanda	17.3%	19.3%	22.2%	21.3%	17.5%	17.6%	16.1%	2014-15 DHS
Sao Tome and Principe	34.0%	30.0%	33.6%	32.6%	31.0%	32.3%	33.7%	2014 MICS
Senegal	20.6%	23.7%	26.1%	22.7%	22.2%	19.5%	21.8%	2015 pDHS
Sierra Leone	26.1%	24.6%	23.8%	26.2%	25.3%	24.7%	25.0%	2013 DHS
State of Palestine	10.8%	10.8%	11.8%	10.3%	11.9%	11.4%	9.0%	2014 MICS
Sudan	24.4%	27.5%	n/a	n/a	n/a	n/a	n/a	2014 MICS
Tanzania	19.8%	23.2%	29.0%	24.3%	22.8%	18.3%	16.8%	2015-16 pDHS/MIS
Tajikistan	21.0%	23.4%	26.8%	21.7%	22.4%	24.2%	19.5%	2012 DHS
Togo	33.0%	34.0%	34.8%	34.0%	33.5%	35.8%	30.1%	2013-14 DHS
Uganda*	26.0%	29.8%	34.6%	30.3%	32.9%	25.0%	22.5%	2015 PMA2020 R3
Vietnam	5.9%	6.2%	7.4%	5.9%	6.7%	5.6%	5.1%	2013-14 MICS
Yemen	20.3%	32.7%	43.1%	33.7%	28.8%	22.4%	18.0%	2013 DHS
Zambia	16.7%	24.1%	25.2%	25.7%	23.3%	19.1%	12.6%	2013-14 DHS
Zimbabwe	9.4%	10.9%	14.1%	11.8%	9.0%	10.5%	6.7%	2015 pDHS

*PMA2020 surveys reflect unmet need for a *modern* method of contraception

Percentage of women whose demand is satisfied with any method of contraception (married or in-union women)
Disaggregated from recent survey

	AGE IN 5 YEAR CATEGORIES						
COUNTRY	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Afghanistan	27.1%	39.3%	41.6%	49.0%	52.6%	60.5%	69.0%
Bangladesh	74.9%	80.1%	84.7%	86.8%	87.7%	87.9%	84.4%
Burkina Faso*	30.0%	38.8%	39.3%	40.5%	35.6%	37.8%	27.5%
Cambodia	66.0%	77.8%	84.4%	87.5%	83.9%	81.1%	68.3%
Chad	11.5%	14.9%	19.3%	24.8%	23.2%	21.8%	24.0%
Comoros	29.3%	30.8%	41.0%	36.8%	39.3%	50.1%	33.9%
DR Congo	28.9%	39.9%	38.5%	46.3%	46.1%	47.2%	53.1%
Egypt	69.4%	79.4%	82.3%	82.8%	85.2%	85.0%	77.2%
Ethiopia*	52.7%	67.7%	62.1%	56.2%	54.0%	53.4%	43.8%
Gambia	16.4%	21.3%	23.0%	31.1%	31.3%	28.6%	29.0%
Ghana*	28.6%	45.3%	47.4%	48.6%	52.1%	31.8%	39.2%
Guinea	10.6%	15.6%	24.2%	21.1%	21.9%	15.8%	19.0%
Haiti	31.2%	46.7%	53.1%	55.0%	49.7%	48.6%	45.6%
Indonesia*	84.9%	80.3%	81.5%	83.4%	77.5%	75.4%	69.6%
Kenya	62.5%	73.8%	80.3%	80.0%	77.3%	73.0%	72.6%
Kyrgyzstan	47.4%	56.8%	65.0%	72.1%	80.9%	75.8%	58.4%
Lesotho	55.0%	72.9%	79.0%	80.4%	82.5%	75.0%	73.9%
Liberia	22.1%	37.4%	42.6%	43.0%	40.2%	38.1%	40.2%
Mali	22.4%	29.6%	27.7%	28.6%	30.9%	29.6%	26.3%
Malawi	63.1%	75.1%	78.1%	77.3%	77.8%	75.8%	76.6%
Mongolia	44.4%	70.9%	77.1%	83.1%	85.4%	80.4%	56.4%
Nepal	28.9%	43.2%	58.3%	72.3%	78.3%	82.0%	83.8%
Niger	34.9%	44.4%	52.2%	51.0%	54.7%	33.8%	21.6%
Nigeria	13.9%	36.6%	45.6%	52.7%	54.4%	56.3%	53.4%
Pakistan	41.0%	50.9%	58.5%	66.1%	69.3%	69.2%	70.7%
Philippines	56.0%	69.7%	76.2%	80.9%	79.2%	77.6%	70.5%
Rwanda	90.7%	76.1%	75.1%	71.5%	72.4%	74.3%	75.1%
Sao Tome and Principe	41.5%	56.8%	55.1%	58.0%	58.7%	59.8%	38.8%
Senegal	22.9%	45.4%	51.7%	57.5%	52.7%	50.7%	55.3%
Sierra Leone	20.1%	35.4%	38.5%	47.3%	40.9%	43.0%	42.5%
State of Palestine	55.5%	71.3%	82.0%	85.7%	90.8%	89.5%	83.4%
Sudan	21.9%	32.1%	36.1%	33.1%	36.2%	32.0%	30.6%
Tanzania	39.0%	60.9%	64.0%	68.0%	65.5%	62.4%	70.4%
Tajikistan	15.6%	26.1%	48.4%	61.1%	69.8%	67.6%	61.2%
Togo	16.7%	30.6%	38.1%	37.9%	37.4%	45.0%	41.5%
Uganda*	33.5%	43.0%	46.4%	42.8%	47.6%	52.7%	53.7%
Vietnam	78.1%	82.9%	92.0%	93.1%	96.7%	93.7%	91.4%
Yemen	31.2%	46.5%	54.9%	58.4%	56.2%	59.1%	56.6%
Zambia	59.9%	68.0%	73.5%	71.6%	69.2%	69.3%	67.0%
Zimbabwe	78.4%	86.5%	87.4%	89.3%	86.8%	84.6%	82.8%

	RESIDENCE		WEALTH					
COUNTRY	URBAN	RURAL	LOWEST	SECOND	MIDDLE	FOURTH	HIGHEST	SURVEY
Afghanistan	59.0%	43.3%	37.0%	41.3%	41.7%	50.9%	63.2%	2015 pDHS
Bangladesh	87.3%	82.6%	82.6%	85.3%	84.8%	82.0%	84.8%	2014 DHS
Burkina Faso*	58.4%	32.2%	19.5%	35.7%	39.9%	37.8%	60.0%	2015 PMA2020 R2
Cambodia	84.7%	81.4%	75.6%	83.2%	79.9%	84.2%	86.0%	2014 DHS
Chad	30.0%	16.2%	16.3%	16.1%	18.9%	13.9%	30.8%	2014-15 pDHS
Comoros	54.9%	28.4%	23.5%	33.5%	36.2%	45.3%	47.6%	2012 DHS
DR Congo	52.2%	36.1%	31.1%	38.1%	37.2%	43.4%	58.1%	2013-14 DHS
Egypt	83.8%	81.4%	78.4%	78.8%	84.3%	84.3%	84.8%	2014 DHS
Ethiopia*	75.4%	54.3%	50.2%	46.7%	57.1%	60.9%	78.0%	2015 PMA2020 R3
Gambia	34.8%	16.4%	16.1%	18.0%	18.6%	32.8%	41.2%	2013 DHS
Ghana*	46.2%	43.9%	36.5%	49.1%	49.2%	46.9%	46.3%	2015 PMA2020 R4
Guinea	25.3%	16.0%	12.2%	18.7%	17.5%	18.4%	27.2%	2012 DHS
Haiti	51.0%	48.2%	47.0%	43.7%	51.7%	51.6%	51.6%	2012 DHS
Indonesia*	75.7%	81.1%	77.3%	80.3%	82.3%	79.2%	72.8%	2015 PMA2020 R1
Kenya	82.4%	73.2%	52.0%	71.5%	78.7%	84.7%	85.5%	2014 DHS
Kyrgyzstan	71.1%	67.6%	70.7%	65.3%	64.1%	69.8%	73.6%	2014 MICS
Lesotho	82.7%	73.6%	67.3%	71.0%	78.3%	78.3%	83.0%	2014 DHS
Liberia	44.0%	33.7%	27.8%	34.7%	40.4%	47.3%	46.6%	2013 DHS
Mali	48.8%	21.1%	12.1%	17.3%	17.5%	33.0%	50.6%	2012-13 DHS
Malawi	79.7%	75.3%	72.2%	75.0%	76.3%	76.8%	79.5%	2015-16 pDHS
Mongolia	74.9%	80.9%	80.6%	76.8%	76.2%	77.5%	75.1%	2013 MICS (SISS)
Nepal	69.5%	65.6%	62.8%	65.9%	67.4%	67.3%	67.5%	2014 MICS
Niger	62.6%	41.7%	35.8%	36.3%	39.3%	48.9%	61.9%	2012 DHS
Nigeria	64.2%	33.6%	10.4%	24.9%	39.8%	55.2%	73.9%	2013 DHS
Pakistan	72.4%	58.8%	45.9%	56.1%	66.8%	68.8%	75.0%	2012-13 DHS
Philippines	77.2%	74.7%	70.1%	77.7%	79.3%	78.0%	73.7%	2013 DHS
Rwanda	76.6%	73.2%	68.6%	70.1%	75.7%	76.2%	77.9%	2014-15 DHS
Sao Tome and Principe	52.8%	60.4%	52.3%	54.3%	58.0%	57.6%	54.4%	2014 MICS
Senegal	61.6%	41.8%	35.3%	42.8%	52.7%	58.8%	60.8%	2015 pDHS
Sierra Leone	50.4%	34.6%	34.4%	31.6%	33.6%	45.3%	53.0%	2013 DHS
State of Palestine	84.0%	84.8%	80.7%	84.5%	82.5%	83.6%	88.1%	2014 MICS
Sudan	47.4%	26.4%	n/a	n/a	n/a	n/a	n/a	2014 MICS
Tanzania	70.0%	60.1%	43.2%	58.0%	63.7%	71.5%	74.4%	2015-16 pDHS/MIS
Tajikistan	60.0%	53.3%	48.2%	53.1%	52.9%	54.3%	64.8%	2012 DHS
Togo	40.0%	35.3%	32.7%	35.7%	36.4%	35.1%	44.9%	2013-14 DHS
Uganda*	54.0%	43.6%	29.0%	39.3%	41.9%	53.7%	61.2%	2015 PMA2020 R3
Vietnam	92.8%	92.4%	90.8%	92.9%	91.9%	93.0%	93.9%	2013-14 MICS
Yemen	70.1%	45.2%	25.2%	41.6%	54.0%	65.4%	73.4%	2013 DHS
Zambia	77.2%	64.5%	60.5%	62.8%	67.5%	73.3%	83.1%	2013-14 DHS
Zimbabwe	88.3%	85.5%	81.7%	84.1%	87.7%	86.8%	91.6%	2015 pDHS

*PMA2020 surveys reflect demand satisfied for a *modern* method of contraception.

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Appendix 1

FP2020 Structure as of October 2016

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Expert Advisory Community:

The EAC comprises a volunteer network of more than 135 technical experts on a range of functional, regional, and country-specific family planning topics that can be mobilized to address specific challenges at the country and global level and will serve as essential thought partners to the FP2020 Secretariat. It includes members from more than 70 organizations with family planning expertise in more than 50 of FP2020's 69 focus countries. The group's membership has the potential to grow as new opportunities for collaboration are identified.

↖ **Visit the website** for a full list of current EAC members: www.familyplanning2020.org/eac.

Appendix 2

Commitment Makers as of October 2016

Commitment-Making Countries:

Afghanistan
Bangladesh
Benin
Burkina Faso
Burundi
Cameroon
Côte D'Ivoire
Democratic Republic of Congo
Ethiopia
Ghana
Guinea
India
Indonesia
Kenya
Lao PDR
Liberia
Madagascar
Malawi
Mali
Mauritania
Mozambique
Myanmar
Nepal
Niger
Nigeria
Pakistan
Philippines
Rwanda
Senegal
Sierra Leone
Solomon Islands
Somalia
South Africa
Tanzania
Togo
Uganda
Vietnam
Zambia
Zimbabwe

Commitment-Making Institutions:

CIVIL SOCIETY

ActionAid
Advance Family Planning
CARE International
DSW (Deutsche Stiftung Weltbevoelkerung)
EngenderHealth
FHI 360
Guttmacher Institute
International Center for Research on Women (ICRW)
International Planned Parenthood Federation (IPPF)
IntraHealth International
Ipas
Jhpiego
Management Sciences for Health (MSH)
Margaret Pyke Trust, with the Population & Sustainability Network

Marie Stopes International (MSI)

PAI

Pathfinder International

Planned Parenthood Federation of America and Planned Parenthood Global

Population Council

Population Reference Bureau

Population Services International

Reproductive Health Supplies Coalition (RHSC)/ Advocacy and Accountability Working Group (AAWG)

Rotarian Action Group for Population and Development

Save the Children

WomanCare Global and PSI

FOUNDATIONS

Aman Foundation

Bill & Melinda Gates Foundation

Bloomberg Philanthropies

Brush Foundation

Children's Investment Fund Foundation

The David and Lucile Packard Foundation

The International Contraceptive Access Foundation

The William and Flora Hewlett Foundation

United Nations Foundation

MULTILATERALS/PARTNERSHIPS

Norway, Bill & Melinda Gates Foundation, and the United Kingdom

United Nations Population Fund (UNFPA)

The World Bank

World Health Organization (WHO)

PRIVATE SECTOR

Bayer HealthCare

Female Health Company

Merck for Mothers

Merck (MSD)

Pfizer

Commitment-Making Donor Countries

Australia
Denmark
European Commission
France
Germany
Japan
Netherlands
Norway
South Korea
Sweden
United Kingdom

Appendix 3
Acronyms

CIP	Costed Implementation Plan
CRS	Creditor Reporting System
CYP	Couple-years of Protection
DHS	Demographic and Health Survey
DPM	Data & Performance Management Team
EAC	Expert Advisory Community
EC	Emergency contraception
FP	Family planning
FP2020	Family Planning 2020
FPET	Family Planning Estimation Tool
GFF	Global Financing Facility
HIP	High Impact Practice
IGWG	Interagency Gender Working Group
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KFF	Kaiser Family Foundation
LAC	Latin American and Caribbean region
LAM	Lactational amenorrhea method
LARC	Long-acting reversible contraceptives
LMIS	Logistics Management Information Systems
mCPR	Contraceptive Prevalence Rate, Modern Methods
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MII	Method Information Index
MSI	Marie Stopes International
NGO	Nongovernmental Organization
NIDI	Netherlands Interdisciplinary Demographic Institute

ODA	Official Development Assistance
OECD DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
OP	Ouagadougou Partnership
PME WG	Performance Monitoring & Evidence Working Group (FP2020)
PMA2020	Performance Monitoring & Accountability 2020 (Project)
PMNCH	Partnership for Maternal, Newborn and Child Health
PSI	Population Services International
RBFP	Rights-based family planning
RHS	Reproductive Health Survey
RHSC	Reproductive Health Supplies Coalition
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RRM	Rapid Response Mechanism
SDP	Service delivery point
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
SWEDD	Sahel Women's Empowerment and Demographic Dividend Project
UN	United Nations
UNF	United Nations Foundation
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of reproductive age

Appendix 4

FP2020 Focus Countries

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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This report is dedicated with warmth and gratitude to Jagdish Upadhyay, who retired this year from UNFPA. Jagdish spent his career as a tireless advocate for women and girls everywhere, and his work has been instrumental in getting us to this point.

Family Planning 2020

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 additional women and girls to use contraceptives by 2020. FP2020 is an outcome of the 2012 London Summit on Family Planning and is based on the principle that all women, no matter where they live, should have access to lifesaving contraceptives. Achieving the FP2020 goal is a critical milestone to ensuring universal access to sexual and reproductive health care services by 2030, as laid out in Sustainable Development Goal 3. FP2020 is in support of the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health.

United Nations Foundation

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

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