



FP2020 CATALYZING COLLABORATION

2017-2018

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Condensed Print Version

THE FP2020 PROGRESS REPORT IS DIGITAL THIS YEAR.

The full report is online at familyplanning2020.org/progress.

This condensed print version contains only the material our partners find most useful to have in print. It includes highlights, previews of the online content, the financial report, and data analysis. Everything else is digital.



More in the Digital Report

Full **CONNECTIONS** Section

Full **PARTNERSHIP** Section

Additional graphics, case studies, and methodological notes in the **MEASUREMENT** Section

Full **ESTIMATE TABLES** Section

EXECUTIVE SUMMARY

Photo by
Eliza Powell
Marie Stopes
International

Collaboration is the animating principle of the Family Planning 2020 partnership. The spirit of collaboration is what enables disparate stakeholders to find common ground and join together in service of a shared vision.

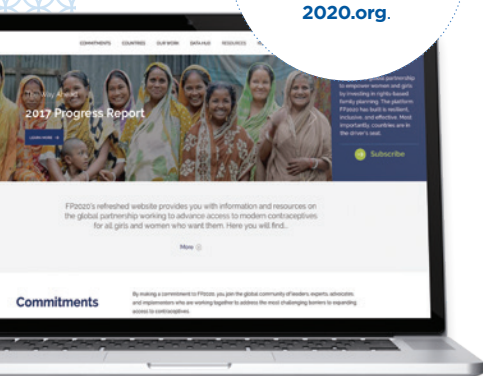
The FP2020 approach is to create an inclusive space where that can happen, even in today's uncertain political and financial environment: a space where policymakers and technical experts can connect, where countries and donors can align, where government officials and grassroots organizers can work together, where ordinary citizens can speak up and have their voices heard.

In the past six years, this collaborative approach has enabled our partners to bring rights-based family planning programs and voluntary contraception to millions more women and girls than would have been thought possible just a decade ago. Now we're taking that model to the next level. We're working closely with other sectors to identify overlapping goals and align our energies, leveraging the benefits that emerge when we pool our strengths. This is also the model that will serve us in the post-2020 world, as we move toward the vision of the Sustainable Development Goals.

For more information, visit the FP2020 website at familyplanning2020.org.

CONNECTING ACROSS SECTORS

Collaboration with other sectors has been a defining feature of the past year. FP2020's links with the maternal health community are growing deeper and stronger, at both the country and global level. Together with our partners in the humanitarian sector, we're expanding the body of work on family planning in crisis settings. The family planning and HIV communities, siloed for so long into different funding streams, are beginning to break down the barriers that have kept us apart. As universal health coverage assumes a central role in countries' long-range strategies, family planning partners are spending more time in discussions with ministries of finance and economic development.





*As of July 2018, the total number of women and girls using a modern method of contraception in the world's 69 poorest countries had grown to **more than 317 million.***

We're continuing to explore new pathways with the private sector, building off the innovative partnerships announced at last year's Family Planning Summit. Our partnerships with youth-led organizations are blossoming, as is our connection with faith communities. And our burgeoning relationship with the environmental sector is hugely promising, opening a pathway to achieving healthy people *and* a healthy planet.

REACHING MORE WOMEN AND ADOLESCENT GIRLS WITH BETTER-QUALITY SERVICES

More women and adolescent girls¹ than ever before are using family planning. As of July 2018, the total number of women and girls using a modern method of contraception in the world's 69 poorest countries had grown to more than 317 million. This is 46 million more users than in 2012, the year FP2020 was launched—an increase that is approximately 30% greater than the historic trend.

Along with growth in the total number of contraceptive users, we're also registering other measures of improvement. Substantially more women are now taking advantage of postpartum family planning. Long-acting reversible contraceptives (LARCs) are now more widely available, especially implants, and several countries are registering impressive uptakes in use. The mix of available contraceptive methods has improved significantly in 20 countries, meaning that more women are able to find the short-term, long-acting, emergency, or permanent method that suits their needs and preferences.

The data also illuminate the areas where we still have work to do. Women need full information about different contraceptive options and their possible side effects in order to make an informed choice about the method that best suits their needs. The data indicate there is significant room for improvement in the quality of counseling provided in most FP2020 countries. High-quality care and full, free, voluntary, and informed decision making are crucial aspects of rights-based family planning, as defined in FP2020's Rights and Empowerment Principles.

¹ All references in this report to girls should be understood to mean adolescent girls. While there are no universally accepted definitions of adolescence and youth, the United Nations understands adolescents to include persons aged 10-19 years and youth as those aged 15-24 years. Together, adolescents and youth are referred to as young people, encompassing the ages of 10-24 years. For statistical purposes, the following age groups are defined: 10-14, 15-19, and 20-24. See: <https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf>.

FUNDING FOR FAMILY PLANNING

The financing landscape for family planning continues to be uncertain. Global donor funding has risen slightly since the last report—from US\$1.20 billion in 2016 to US\$1.27 billion in 2017—but remains well below the peak of US\$1.43 billion in 2014. While overall US appropriations for development aid have remained stable, many programs that were formerly funded are no longer eligible under the Protecting Life in Global Health Assistance policy (PLGHA is an expansion of the Mexico City Policy). Other programs remain chronically under- or un-funded, or are struggling within a domestic context of devolution or insufficient government resources.

On a more positive note, for the first time we're able to present validated estimates of domestic government expenditures on family planning for 31 commitment-making countries. This is a groundbreaking achievement for the family planning sector, and represents years of work to establish the necessary methodologies to collect, analyze, and validate these estimates.

With a firmer grasp on domestic government expenditures, we're able to present a more accurate picture of total spending on family planning across the 69 FP2020 focus countries. We estimate that in 2016, total spending for family planning stood at US\$3.4 billion. Of this total, 48% was from donors, 34% was from domestic governments, 14% was out-of-pocket, and the remaining 4% was from corporations, NGOs, and other domestic organizations. It should be stressed that these are aggregate figures; the domestic government percentage is heavily weighted by a handful of large countries and should not be considered representative of most FP2020 countries.

THE FP2020 PARTNERSHIP

The FP2020 partnership continues to expand, with new commitments in the past year from **Egypt**, the **Kyrgyz Republic**, and **Sri Lanka**. This brings the total number of commitment-making countries to 44.² Commitments are a powerful tool for marshalling resources and galvanizing progress. The vast majority (93%) of additional users of contraception since 2012 are in FP2020 countries that have made a commitment to the partnership.

We also have new civil society partners, including **Promundo**, which focuses on male engagement, and several youth-led organizations that will be formalizing their commitments by the end of this year.

The Global Goods announced at the 2017 Family Planning Summit are continuing to unfold. The UNFPA

Supplies bridge funding mechanism was successfully operationalized in the first quarter of 2018, enabling countries to avoid procurement bottlenecks and stock-outs of contraceptive commodities. The Global Family Planning Visibility and Analytics Network (FP VAN), managed by the Reproductive Health Supplies Coalition, is set to be launched by the end of the year, with pilot country VANs in Malawi and Nigeria. DMPA-SC is being introduced, scaled-up, or piloted in 32 FP2020 countries, and the DMPA-SC Access Collaborative is providing technical support to over a dozen FP2020 countries.

This report includes an overview of the FP2020 Accountability Framework, which builds on the *monitor-review-act* framework used by the *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health*. We extend the framework to include a fourth process—*share*—to capture the way in which FP2020 promotes transparency and collaboration. Together these four processes form a cycle of learning, action, and continuous improvement.

LOOKING AHEAD

FP2020 is a success story. We're bending the curve and accelerating progress on family planning. We've helped put women's health back at the center of the global development agenda. We've reinvigorated a movement and sparked a thousand local initiatives, from the tiniest rural village to the largest metropolis. This partnership works.

But as much as we've accomplished, we recognize that our original ambitious goal of 120 million additional users of contraception will not be reached by 2020. Looking at projected trends, the hill is simply too steep to climb in the two short years remaining in this initiative. Although we've achieved many of our goals as a community and several countries are on track to reach their specific FP2020 objectives, in other areas we're lagging. It will take a few years longer to reach 120 million—but we will reach it. Our commitment is as strong as ever. The FP2020 goal remains a critical milestone on the road to 2030 and the Sustainable Development Goal of universal access to family planning.

With the launch of this report, the FP2020 Reference Group is inviting the global family planning community to begin considering a post-2020 vision. We'll be asking the community to speak, to decide what comes next. The process of defining and shaping that post-2020 framework will be inclusive, dynamic, and participatory.

Above all, it will be a collaboration.

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.

THE FP2020 PARTNERSHIP

FP2020 COUNTRIES



FP2020 COUNTRIES set the agenda for progress with their commitments to develop, support, and strengthen their family planning programs.

DONOR GOVERNMENTS



DONOR GOVERNMENTS furnish essential resources through bilateral aid, technical assistance, thematic funds, and loan facilities.

FOUNDATIONS



FOUNDATIONS provide funding to launch new projects and sustain existing programs.

CIVIL SOCIETY ORGANIZATIONS



CIVIL SOCIETY ORGANIZATIONS include implementing partners, service providers, advocacy groups, and technical experts.

MULTILATERAL INSTITUTIONS



MULTILATERAL INSTITUTIONS include the World Bank, the World Health Organization, and the United Nations Population Fund.

PRIVATE SECTOR



PRIVATE SECTOR partners include contraceptive manufacturers, media corporations, and companies that provide workplace health care.

CORE CONVENERS



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.

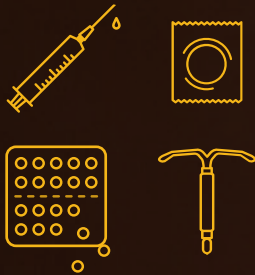
FP2020 contributes to the goals of the **EVERY WOMAN EVERY CHILD** Global Strategy for Women's, Children's and Adolescents' Health, and a commitment to FP2020 is in support of the *Every Woman Every Child* movement.

The **FP2020 SECRETARIAT** is hosted by the United Nations Foundation.



REACHING MORE WOMEN AND GIRLS

AS OF
JULY 2018



317

MILLION women and girls are using modern contraception in 69 FP2020 focus countries

+46



MILLION additional women and girls are using modern contraception compared to 2012

AS A RESULT
OF MODERN
CONTRACEPTIVE
USE

*from July 2017
to July 2018*

119

MILLION unintended pregnancies were prevented

20

MILLION unsafe abortions were averted

137

THOUSAND maternal deaths were averted

IN 2017, DONOR
GOVERNMENTS
PROVIDED


\$1.27

BILLION USD in bilateral funding for family planning





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FROM THE FP2020 REFERENCE GROUP CO-CHAIRS

Photo by
Carly Learson
UNFPA

With 2020 approaching fast, the FP2020 community is at a pivotal moment. Our goalpost is in view and we're accelerating into the final stretch. Momentum is high. At the same time, we're starting to look ahead to what comes next. What happens *after* 2020?

We all know that, while 2020 will mark the endpoint of this specific initiative, it won't really be a finish line. We've achieved many of the goals we set as a community, and progress is ahead of the historical trend. For the first time, more than 317 million women in the world's poorest countries are using modern contraception. But there are many areas where our efforts have fallen short. It's estimated that, across all developing countries, 214 million women who want to delay or prevent pregnancy are not using a method of modern contraception.³

And so we have an opportunity to set a new vision: one that is ambitious, specific, and achievable.

Our north star is *universal access to family planning*, which the Sustainable Development Agenda calls for achieving by 2030. Our post-2020 vision will need to map out exactly where we're going—collectively and as individual countries—and how to get there. And we'll need a new framework that, like FP2020, is grounded in human rights, partnership, and collaboration.

This is something for us to think through together as a community. The process of defining and building consensus on a post-2020 vision needs to be transparent, focused, and inclusive, incorporating a diversity of perspectives from a wide range of stakeholders.

³ Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017. Fact Sheet, New York: Guttmacher Institute, 2017.



“We have an opportunity to create a new vision that will realize the initial promise of FP2020 and take it further, ensuring that more women and girls all over the world can reach their full potential.”

Over the next months the FP2020 Reference Group will begin gathering insights and recommendations from the global community on what that post-2020 framework might look like. These are some of the questions we’ll be asking:

- How can we build on the historic progress made by the FP2020 movement? How can we sustain that momentum and link it to the longer horizon?
- We know that success begins at the country level. How can we make our next framework even more country-owned and country-led?
- Women and girls must be at the heart of development. How can we ensure that our plans and goals resonate with what women and girls really need?
- How can we better link our efforts to global trends and initiatives, including universal health coverage and the changing landscape for development finance?

This is our moment to go beyond linear thinking. We have an opportunity to create a new vision that will realize the initial promise of FP2020 and take it further, ensuring that more women and girls all over the world can reach their full potential.

The FP2020 partnership has been a historic success. Our country-led, globally backed development model is saving women’s lives, advancing sexual and reproductive health and rights, and transforming communities across the world. This is powerful work for the global family planning community to build on.

We’re excited about what we’ve achieved so far, and full of optimism about how much more we can do. This community’s commitment to women and girls is unwavering, and we must keep working until universal access is a reality for the millions of women and girls still waiting. Let’s keep going.

Dr. Chris Elias
President of Global Development
Bill & Melinda Gates Foundation

Dr. Natalia Kanem
Executive Director
UNFPA

FROM FP2020'S

EXECUTIVE DIRECTOR

Photo by
Jonathan Torgovnik
Getty Image Reportage

In last year's report, we told the story of the FP2020 partnership. This year, we're turning that inside-out. Instead of talking about all the things that are part of family planning, we're focusing on all the things that family planning *is part of.*

We've dedicated an entire section of the digital report to showcasing the cross-sectoral collaboration that we believe is the future of development.

It's fitting that we're launching this report at the fifth International Conference on Family Planning (ICFP). With the theme of "Investing for a Lifetime of Returns," the 2018 ICFP is all about how family planning pays multiple dividends across the board—in health, quality of life, empowerment, economic growth, security and stability, and environmental sustainability. The corollary is that something as effective as family planning shouldn't be walled off or siloed. It needs to be integrated into all our development strategies.

The collaborations that have flourished over the past year are an incredibly important step forward. And the year ahead promises more of the same. Through a fellowship supported by CARE, we are working closely with humanitarian partners to support the provision of family planning in crisis settings, and with country partners, to include family planning in domestic resilience strategies. In July, FP2020 co-hosted a panel at the International AIDS Conference—the first time we've participated in the conference—and we're now starting to map out how we can align our work with partners in that sector. We're also one of the co-sponsors of next year's Women Deliver Conference (June 2019) and are helping to lead two programming tracks: one on "Improving Access to Family Planning and Reproductive Health Services" and another on "Girls' and Women's Health, Safety, and Well-Being in Humanitarian Settings."



“Only by joining forces can we unlock the progress that will enable every girl and woman, every child and adult, to thrive—and to transform our communities and our planet.”

It seems the spirit of collaboration is energizing us all.

Collaboration is of course the paradigm of the Sustainable Development Agenda: mutually reinforcing goals, integrated development, alignments in funding. I believe the partnerships that are growing or emerging now show how that paradigm will actually function. Each sector or discipline has its own essential expertise, reservoir of knowledge, and longstanding relationships. None of that should be lost. Integrated development means more seats at the table, and an opportunity for all of us to move forward together.

But it takes time to build the relationships of trust that enable this kind of collaboration. FP2020’s convening power means that we can use this platform to align our work and create more opportunities for sectors to work together. That’s one of the greatest strengths of FP2020, and something I hope we can carry forward into the post-2020 framework.

The truth is that none of us can achieve our development goals without a multisectoral approach. The Sustainable Development Agenda calls on us all to recognize that our fates are intertwined. Only by joining forces can we unlock the progress that will enable every girl and woman, every child and adult, to thrive—and to transform our communities and our planet.

Beth Schlachter
Executive Director
Family Planning 2020

Learn more about FP2020’s rights-based approach at familyplanning2020.org/rightsinfp.





FAMILY PLANNING + EMPOWERMENT

Family planning helps empower women and girls to take charge of their own lives.

Photo by Frederic Courbet
Bill & Melinda Gates Foundation

FAMILY PLANNING + MATERNAL HEALTH

Family planning is an important contributor to maternal health, leading to better health outcomes for mothers and their babies.

Photo by Brent Stirton
Bill & Melinda Gates Foundation



SECTION 01

CONNECTIONS

Global development is changing. In the era of the Sustainable Development Goals, countries and partners are moving toward integrated, collaborative approaches that span multiple sectors. This calls for holistic strategies that allow us to combine our strengths and tackle our challenges together.

Success also requires that we identify catalysts: key interventions with the ability to spark big changes across the board. Family planning is one of those catalysts.

FAMILY PLANNING + HIV/AIDS

Combining family planning with HIV/AIDS services and other reproductive health care makes for stronger programs that respond to the complexity of an individual's health needs.

Photo by Jonathan Torgovnik
Getty Images Reportage



FAMILY PLANNING + ENVIRONMENTAL SUSTAINABILITY

Family planning is a natural partner to the environmental movement, with programs that improve health while protecting fragile ecosystems.

Photo by Jean Wimmerlin



FAMILY PLANNING + CRISIS RESPONSE

In humanitarian and fragile settings, family planning is an essential lifesaving intervention and crucial for building resilience.

Photo by Rita Nehme
IRC



FAMILY PLANNING + UHC

Including family planning within universal health coverage ensures everyone gets the care they need and the programs themselves are sustainable.

Photo by Kate Holt
MCHIP Photo



Voluntary, rights-based family planning—ensuring that women have the ability to make their own choices about whether, when, and how many children to have—is a game changer.

Why is family planning so powerful? Because women and girls are a powerful force for development. Unlocking that potential is a linchpin strategy for any country aiming to improve the health of its citizens, break the cycle of poverty, grow the economy, and even cope with climate change.

In these chapters of our digital report we explore the vital connections between family planning and other sectors. We share examples of progress from FP2020 countries and partners, and highlight new collaborations that are just now taking shape. We also review the legal, social, and health care frameworks necessary to ensure that family planning programs are rights-based and truly meet the needs of women and girls.

The era of siloed development is ending. Our goals, and our solutions, are connected.

MORE IN THE DIGITAL REPORT

Eight chapters on cross-sectoral collaboration

Project spotlights from FP2020 countries

First-person stories and quotes

FP2020's Rights and Empowerment Principles

FAMILY PLANNING + YOUNG PEOPLE

Access to family planning enables adolescents and youth to fulfill their potential.

Photo by Natasha Fillion
Bill & Melinda Gates Foundation



FAMILY PLANNING + FAITH

Family planning dovetails with faith-based efforts to promote good health, strong families, and stable communities.

Photo provided by Olusola Obajimi



SECTION 02

PARTNERSHIP



MORE IN THE DIGITAL REPORT

FP2020 country and regional updates, including regional focal point workshops

New country commitments

2017 Family Planning Summit and Global Goods update

FP2020 Accountability Framework details

FP2020 is a global community of partners working together to advance rights-based family planning.

FP2020 partners collaborate to strengthen and expand family planning programs in countries, identify and implement best practices, train health workers, collect and analyze data, improve global and local supply chains, develop and introduce new contraceptive methods, advocate for the young and the marginalized, and insist everywhere on the rights of women and girls to shape their own lives.



Attendees at the FP2020 Third Asia Regional Focal Point Workshop in Kathmandu, Nepal, October 1-4, 2018. The FP2020 Secretariat convenes focal point workshops for each regional portfolio every 18 months. The digital report has more on the workshop in Nepal, along with details on the most recent **Anglophone Africa Regional Focal Point Workshop** (November 2017 in Malawi) and the most recent **Francophone Regional Focal Point Workshop** (March 2018 in Cameroon).



Photo Courtesy of
Jonathan Torgovnik
Getty Images Reportage

COUNTRY UPDATES

FP2020 countries set the agenda for progress with their commitments to develop, support, and strengthen their family planning programs. FP2020 links countries with a global network of partners to develop programs that are grounded in human rights, informed by best practices, funded through sustainable financing streams, and integrated with the country's wider overall development strategy.

A total of **44 FP2020 focus countries** have joined the partnership since 2012. The FP2020 Secretariat organizes country support into three portfolios: Anglophone Africa, Francophone countries, and Asia. Our digital report features updates on each portfolio and highlights from the past year for each country. We also present new commitments from **Egypt**, the **Kyrgyz Republic**, and **Sri Lanka**.

FAMILY PLANNING SUMMIT

11 JULY 2017 - LONDON

For Safer,
Healthier and
Empowered
Futures
#HerFuture

2017 FAMILY PLANNING SUMMIT: ONE YEAR ON

The Family Planning Summit in July 2017 generated a groundswell of new energy and new and revitalized commitments to family planning. The Summit mobilized global attention to urgent issues—including youth access to contraception and the critical need for family planning in humanitarian settings—and served as the launching pad for major new collaborations on contraceptive method choice, supply chain strengthening, sustainable financing, and engagement with corporate and private sector partners.

Our digital report features progress updates on this work, with a special focus on the **Global Goods** announced at the Summit. The Global Goods are a diverse set of group initiatives designed to strengthen rights-based family planning and reproductive health care.

FP2020 ACCOUNTABILITY FRAMEWORK

The FP2020 movement as a whole and all FP2020 partners are ultimately accountable to the women and girls we serve.

Like *Every Woman Every Child*, with which it is aligned, FP2020 is an aspirational movement.

The partnership is entirely voluntary. Governments and institutions make formal commitments, but there are no legal or financial mechanisms to enforce compliance. Ultimately, partners themselves are accountable for the promises they make and the actions they take.

Nevertheless, the FP2020 platform provides an accountability framework for tracking and promoting progress, both globally and for each individual commitment maker. Our digital report includes a full discussion of the FP2020 Accountability Framework, briefly excerpted below.

WHAT DO WE MEAN BY ACCOUNTABILITY?

The FP2020 movement as a whole and all FP2020 partners are ultimately accountable to the women and girls we serve. They are the reason FP2020 exists. Our overarching goal is to meet the needs of women and girls in a diverse range of circumstances with high-quality, rights-based family planning services. In practice, accountability mechanisms in the FP2020 framework function on two separate but linked levels:

- **Outcome tracking** focuses on ultimate results: are the family planning needs of women and girls being met? The FP2020 Core Indicators—a suite of 18 quantitative metrics estimated and compiled annually—provide data on various dimensions of family planning usage and availability in the 69 FP2020 focus countries. The Core Indicators thus serve to gauge whether family planning outcomes are improving, in each country and across all 69 focus countries.
- **Commitment tracking** focuses on the specific commitments made by FP2020 partners to support, expand, and fund rights-based family planning. Are the programs being implemented? Are the funds being disbursed? Are the policy changes being enacted? And, importantly, do the goals and objectives need to be revised to ensure that partners are investing in the most cost-effective programs and responding to the real needs of women and girls?

MONITOR, REVIEW, ACT, SHARE

The FP2020 accountability framework builds on the **monitor-review-act** framework used by *Every Woman Every Child*. We extend the framework to include a fourth process—**share**—to capture the way in which FP2020 promotes transparency and collaboration. Together these four processes form a cycle of learning, action, and continuous improvement.

Outcome tracking and **commitment tracking** both cycle through the monitor-review-act-share sequence. The two accountability levels also function together in a feedback loop. Data on outcomes guide the work on commitments; progress on commitments is in turn reflected in improved outcomes.

FIGURE 1 FP2020 ACCOUNTABILITY FRAMEWORK

SECRETARIAT ROLE: MONITOR, REVIEW, ACT, SHARE



This diagram highlights the elements of the FP2020 accountability framework that are tracked, undertaken, or supported by the FP2020 Secretariat. Many if not all of the Secretariat's efforts to advance transparency and accountability are implemented in partnership with others in the family planning community, including experts on measurement and resource tracking. The full FP2020 accountability framework also includes in-country processes, donor and partner processes, and other mechanisms not shown on this diagram.

FP2020's accountability framework is in support of the broader SRMNCAH agenda and contributes to the Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health.

FINANCING FOR FAMILY PLANNING



MORE IN THE DIGITAL REPORT

FP2020 country financial commitments

Global Financing Facility

Countdown 2030 Europe analysis

Interactive graphics and additional charts on bilateral funding, including US

Expenditure graphs for Bangladesh, Indonesia, Kenya, and Senegal

Methodology notes

Family planning programs in FP2020 countries are funded by a range of sources, from development aid furnished by international donors to out-of-pocket purchases made by ordinary citizens.

Part of FP2020's core mandate is to unlock global resources for family planning—including funding for humanitarian crises and resilience efforts—while supporting the development of sustainable financing within each country.

For the past six years we have reported annually on bilateral donor funding for family planning. During that time we've also worked to develop better tracking of family planning expenditures in FP2020 focus countries. With this year's report we present the most comprehensive view yet of the total financial landscape.

- **Domestic government expenditures** on family planning are being reported this year for the first time, with validated data from 31 commitment-making countries (FP2020's **Core Indicator 12**). This is a groundbreaking achievement for the family planning sector. It has taken years of work and a wide-ranging effort to establish the necessary methodologies to collect, analyze, and validate these expenditures.
- **Global donor funding** has risen slightly since the last report—from US\$1.20 billion in 2016 to US\$1.27 billion in 2017—but remains below the peak of US\$1.43 billion in 2014. Five donors increased their disbursements in 2017: Canada, Denmark, the Netherlands, Sweden, and the UK. Funding is continuing to shift across the sector as a result of the Protecting Life in Global Health Assistance policy (PLGHA is an expansion of the Mexico City Policy). Funding shortfalls at UNFPA imperil a number of programs, including sexual and reproductive health care for populations affected by crises.⁴

⁴ United Nations Population Fund (UNFPA). Humanitarian Action: 2018 Overview. New York: UNFPA; 2018.



With this year's
report we present the
**most comprehensive
view yet of the total
financial landscape.**

28 Tablets
Desogestrel
Tablets BP
famylette

- With better data on domestic government expenditures, we're able to present a more accurate picture of **total spending on family planning** across all 69 FP2020 countries. **We estimate that in 2016, total spending for family planning stood at US\$3.4 billion.** Of this total, 48% was from donors, 34% was from domestic governments, 14% was out-of-pocket, and the remaining 4% was from corporations, NGOs, and other domestic organizations. It should be stressed that these are *total* figures; the domestic government percentage is heavily weighted by seven large countries (India, Indonesia, Bangladesh, Pakistan, Egypt, the Philippines, and Kenya, which account for half of all domestic expenditures), and should not be considered representative of most FP2020 countries.

➔ **The digital version of the report includes additional features and graphs along with full notes on methodology and sources.**

DOMESTIC GOVERNMENT EXPENDITURES ON FAMILY PLANNING

Domestic government expenditures reflect a government's commitment to its family planning program and the prospects for its long-term financial sustainability. Domestic expenditures are defined as all government expenditures that support family planning, including commodity purchases, demand creation campaigns, investments in training and research, and service delivery.

Some government expenditures, such as commodity purchases, are relatively easy to track, since they are often separate line items in the chart of accounts. Other expenditures, such as shared spending for personnel and facilities, are much more difficult to capture.

After several years of effort to establish the necessary methodologies and to collect and analyze the data, FP2020 is reporting validated domestic expenditures for family planning for the first time. The expenditures reported in **Table 1** come from four different sources (full details in the digital report):

- **Official government reports.** The Government of India prepares a comprehensive assessment of family planning expenditures and furnishes that estimate to FP2020.
- **WHO/SHA.** WHO has been implementing data collection on health expenditures under the System of Health Accounts (SHA) 2011 for several years as part of a joint effort with the Organisation for Economic Co-operation and Development (OECD) and Eurostat.
- **FPSA (Family Planning Spending Assessment).** Track20 has been collaborating with the Centre for Economic and Social Research (Nairobi, Kenya) to collect data on FP expenditures using a modified version of health accounts that focuses strictly on family planning.
- **UNFPA/NIDI.** UNFPA and NIDI (Netherlands Interdisciplinary Demographic Institute) have been tracking domestic government expenditures for family planning since 2014.

The 31 countries in **Table 1** represent 77% of all modern contraceptive users in FP2020 focus countries. Domestic expenditure amounts range from over US\$200 million annually in India and Bangladesh to less than US\$50,000 in Gambia and Mauritania.

TABLE 1 DOMESTIC GOVERNMENT EXPENDITURES ON FAMILY PLANNING (CORE INDICATOR 12)

COUNTRY	ESTIMATE	YEAR	SOURCE
Afghanistan	\$1,130,000	2016	UNPFA/NIDI
Bangladesh	\$225,000,000	2016	FPSA
Benin	\$220,000	2016	UNPFA/NIDI
Bhutan	\$122,000	2016	WHO/SHA
Burkina Faso	\$8,130,000	2016	WHO/SHA
Burundi	\$976,000	2013	WHO/SHA
Cameroon	\$2,770,000	2016	UNPFA/NIDI
Côte d'Ivoire	\$7,470,000	2016	WHO/SHA
Djibouti	\$738,000	2014	WHO/SHA
DR Congo	\$9,100	2016	WHO/SHA
Ethiopia	\$21,000,000	2014	WHO/SHA
Gambia	\$19,000	2013	WHO/SHA
Guinea	\$1,100,000	2016	WHO/SHA
Guinea-Bissau	\$140,000	2011	WHO/SHA
India	\$249,000,000	2016	Government of India
Indonesia	\$196,000,000	2016	FPSA
Kenya	\$19,000,000	2016	FPSA
Lao PDR	\$920,000	2016	WHO/SHA
Madagascar	\$3,100,000	2013	WHO/SHA
Mali	\$160,000	2016	WHO/SHA
Mauritania	\$15,000	2012	WHO/SHA
Myanmar	\$2,880,000	2016	UNPFA/NIDI
Nepal	\$2,230,000	2016	UNPFA/NIDI
Niger	\$8,060,000	2016	WHO/SHA
Nigeria	\$8,520,000	2016	WHO/SHA
Sao Tome and Principe	\$154,000	2013	WHO/SHA
Senegal	\$3,360,000	2016	FPSA
Sri Lanka	\$13,700,000	2013	WHO/SHA
Togo	\$1,340,000	2014	WHO/SHA
Uganda	\$2,260,000	2016	WHO/SHA
Zimbabwe	\$18,100,000	2016	UNPFA/NIDI

Notes:

WHO/SHA: System of Health Accounts prepared by national consultants in collaboration with the World Health Organization

UNPFA/NIDI: United Nations Population Fund and Netherlands Interdisciplinary Demographic Institute Resource Tracking Project on Family Planning Expenditures

FPSA: Family Planning Spending Assessments conducted by national consultants in collaboration with Track20

DONOR GOVERNMENT FUNDING FOR FAMILY PLANNING IN 2017: KAISER FAMILY FOUNDATION ANALYSIS

Donor governments have historically accounted for approximately 50% of total funding for family planning. Tracking this funding provides important insights into resource availability, trends over time, and potential gaps. Following the London Summit on Family Planning in 2012, the Kaiser Family Foundation (KFF) began conducting an annual analysis of donor government funding for family planning activities.

This established a baseline that could be used to track funding levels over time and to assess specific donor government progress in meeting FP2020 commitments. Continuing this effort takes on added relevance following the 2017 Family Planning Summit, which resulted in new and renewed commitments by many donors.

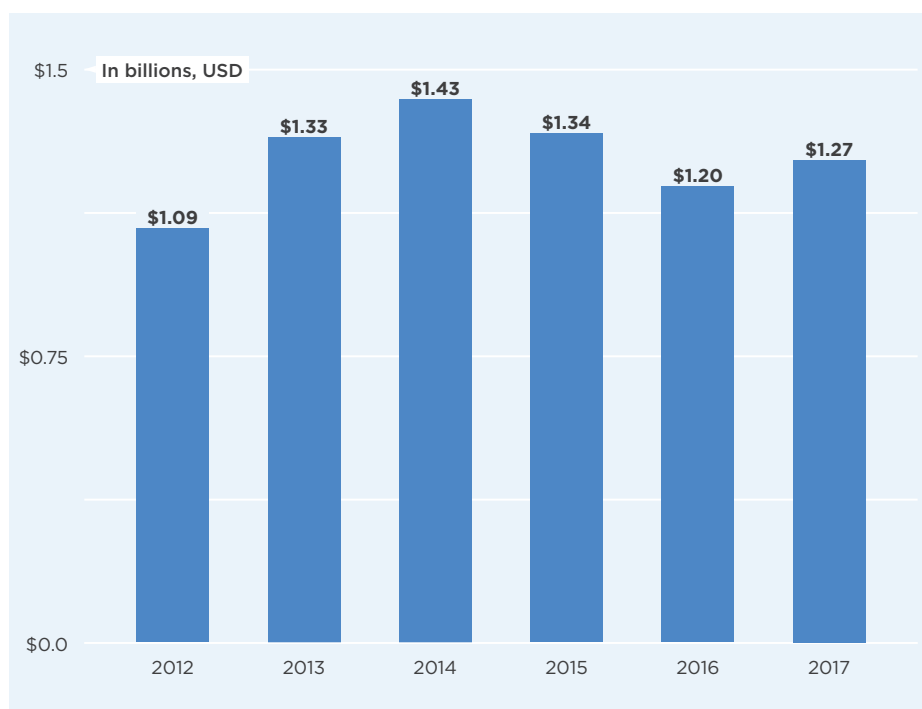
These findings are based on analysis of data from 30 governments that were members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) in 2017 and had reported Official Development Assistance (ODA) to the DAC. Data for 10 of these governments, which account for 99% of all donor government funding for family planning, were collected directly from these governments; data for the remaining donors were obtained from the OECD Credit Reporting System (CRS). Key findings from 2017 are as follows:

BILATERAL FUNDING

- Bilateral family planning funding from donor governments increased after two years of declines, rising from US\$1.20 billion in 2016 to US\$1.27 billion in 2017. This is an increase of US\$74 million or 6%, as measured in current terms, even after accounting for inflation and currency fluctuations (see [Figure 2](#)). Still, funding remained below the peak of 2014.⁵

FIGURE 2
INTERNATIONAL
BILATERAL
FAMILY
PLANNING
ASSISTANCE
FROM DONOR
GOVERNMENTS:
DISBURSEMENTS,
2012-2017

Note: figures based on Kaiser Family Foundation analysis of donor government funding for family planning.



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 note in the digital report), and include: standalone 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.

TABLE 2 DONOR GOVERNMENT BILATERAL DISBURSEMENTS FOR FAMILY PLANNING, 2012-2017*

In millions, USD

COUNTRY	2012	2013	2014	2015	2016	2017	NOTES
Australia	\$43.2	\$39.5	\$26.6	\$12.4	\$24.9	\$25.6	Australia has now identified AU\$33 million in bilateral FP funding for the 2016-17 fiscal year using the FP2020-agreed methodology, which includes funding from non-FP-specific activities (e.g., HIV, reproductive health, 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 contributions to multilateral institutions. However, it was not possible to identify and adjust for funding to other non-FP-specific activities in most cases.
Canada	\$41.5	\$45.6	\$48.3	\$43.0	\$43.8	\$69.0	Bilateral funding is for family planning and reproductive health components of combined projects/activities in FY17-18. Reproductive health activities without family planning components are not reflected. This is a preliminary estimate.
Denmark	\$13.0	\$20.3	\$28.8	\$28.1	\$30.7	\$33.1	Bilateral funding is for family planning-specific activities.
France	\$49.6	\$37.2	\$69.8	\$68.6	\$39.9	\$19.2	Bilateral funding is new commitment data for a mix of family planning, reproductive health, and maternal and child health activities in 2012-2017; family planning-specific activities cannot be further disaggregated. 2017 data is preliminary.
Germany	\$47.6	\$38.2	\$31.3	\$34.0	\$37.8	\$36.8	Bilateral funding is for family planning-specific activities.
Netherlands	\$105.4	\$153.7	\$163.6	\$165.8	\$183.1	\$197.0	The Netherlands budget provided a total of US\$471 million in 2017 for "Sexual and Reproductive Health & Rights, including HIV/AIDS," of which an estimated US\$197 million was disbursed for bilateral family planning and reproductive health activities (not including HIV).
Norway	\$3.3	\$20.4	\$20.8	\$8.1	\$5.7	\$2.2	Bilateral funding is for family planning-specific activities, narrowly defined under the corresponding DAC subsector 13030. Overall bilateral Norwegian support to Population and Reproductive Health activities including family planning was NOK312.5 million (US\$37.8 million) in 2017, an increase of NOK135.1 million (43%) over 2016 levels.
Sweden	\$41.2	\$50.4	\$70.2	\$66.0	\$92.5	\$109.2	Bilateral funding is for combined family planning and reproductive health activities; family planning-specific activities cannot be further disaggregated. None of Sweden's top-magnitude health activities appears to reflect an exclusive family planning specific subsector focus, indicative of the integration of FP activities into broader health initiatives in ways similar to those employed by some other governments. It thus may not be possible to identify exact amounts of Swedish bilateral or multi-bi FP financing.
UK	\$252.8	\$305.2	\$327.6	\$269.9	\$204.8	\$282.4	In the financial year 2017/18, total UK spending on family planning was £243.3 million. This is a provisional estimate, using the FP2020-agreed methodology, which includes funding from non-FP-specific activities (e.g., HIV, reproductive health, maternal health, and other sectors) and a percentage of the donor's core contributions to several multilateral organizations. For this analysis, UK bilateral FP funding of £212.9 million was calculated by removing unrestricted 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. The nominal 2014-16 US\$ decrease is significantly exchange rate-related. Bilateral funding is for combined family planning and reproductive health, consistent with the agreed-on methodology. A final estimate will be available after DFID publishes its annual report for 2017/18 in 2019.
US	\$485.0	\$585.0	\$636.6	\$638.0	\$532.7	\$488.7	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	\$3.3	\$9.6	Bilateral funding was obtained from the Organisation for Economic Co-operation and Development (OECD) Credit Reporting System (CRS) database and represents funding provided in the prior year (e.g., data presented for 2017 are the 2016 totals, the most recent year available; 2016 presents 2015 totals; etc.).
TOTAL	\$1,093.6	\$1,325.0	\$1,432.7	\$1,344.0	\$1,199.2	\$1,272.7	

*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: standalone 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, 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, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, New Zealand, Poland, Portugal, the Slovak Republic, Slovenia, Spain, and Switzerland.

Note: Some of the figures for 2016 are different from the figures reported last year due to data updates after the 2017 report was published. Donor amounts in table do not exactly sum up to total amounts due to rounding.

- Funding increased from five donors (Canada, Denmark, the Netherlands, Sweden, and the UK), remained flat for two (Australia and Germany), and decreased for three (France, Norway, and the US). See [Table 2](#).
- The decrease by the US in 2017 (from US\$532.7 million in 2016 to US\$488.7 million in 2017) was largely due to a delay in disbursements and does not reflect a decline in US appropriations, which have been stable for several years.⁶
- Even with the decrease in funding from the US, it remained the largest bilateral donor to family planning in 2017, accounting for 38% of total bilateral funding. The UK was the second largest donor (US\$282.4 million, 22%), followed by the Netherlands (US\$197.0 million, 15%), Sweden (US\$109.2 million, 9%), and Canada (US\$69.0 million, 5%).
- Among the donors profiled, three increased funding to UNFPA's core resources (Denmark, Norway, and Sweden), five remained flat (Australia, Canada, Germany, the Netherlands, and the UK), and two decreased (France and the US, the latter of which did not provide any funding in 2017).
- Sweden provided the largest core contribution to UNFPA in 2017 (US\$63.8 million), followed by Norway (US\$50.8 million), Denmark (US\$43.2 million), and the Netherlands (US\$37.4 million).
- UNFPA reports that in 2017 it spent an estimated US\$303 million (or 40.2% of its resources) on family planning. Of this, an estimated US\$102 million came from core resources (resources meant to be used by UNFPA for both programmatic activities and operational support) and an estimated US\$183 million came from non-core resources (resources earmarked for specific family planning programmatic activities).⁷

DONOR CONTRIBUTIONS TO UNFPA

- In addition to bilateral disbursements for family planning—which may include non-core contributions to UNFPA for family planning programs such as UNFPA Supplies—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) as well as operational support.
- Donor government contributions to UNFPA's core funding totaled US\$344.4 million in 2017, as compared to US\$347.8 million in 2016. In FY17 the US administration invoked the Kemp-Kasten amendment to withhold funding—both core and non-core contributions—to UNFPA. In the prior year (FY16), US contributions to UNFPA had totaled US\$69 million, including US\$30.7 million in core resources and an additional US\$38.3 million in non-core resources for other project activities. (See KFF's "UNFPA Funding & Kemp-Kasten: An Explainer.") UNFPA reports that the loss of specific project funds from the US has had impacts on programming, and UNFPA continues to forecast future funding gaps for their strategic plan.

LOOKING AHEAD

At the first London Summit on Family Planning in 2012, eight of the donor governments profiled in this report made commitments: Australia, Denmark, France, Germany, Netherlands, Norway, Sweden, and the UK. All of these donors subsequently renewed their commitments by the time of the follow-up Family Planning Summit in 2017, and a new donor, Canada, made its first commitment. Up until that point, all donors—with the exception of Australia—had either fulfilled or were on track to fulfill their 2012 commitments. FP2020 and KFF will continue to work with donor governments to track funding for family planning going forward, and next year's report will include an assessment of progress toward fulfilling the new and renewed commitments made in 2017.

➔ [See the digital report for notes on methodology.](#)

⁶ By law, annual US government appropriations for development assistance, including for family planning activities, may be disbursed over a multi-year period.

⁷ Personal communication, UNFPA, September 2018.

ESTIMATES OF TOTAL FAMILY PLANNING EXPENDITURES ACROSS THE 69 FP2020 COUNTRIES

The main sources of funds for family planning expenditures are domestic governments, international donors, and payments by consumers who access services in the private sector.

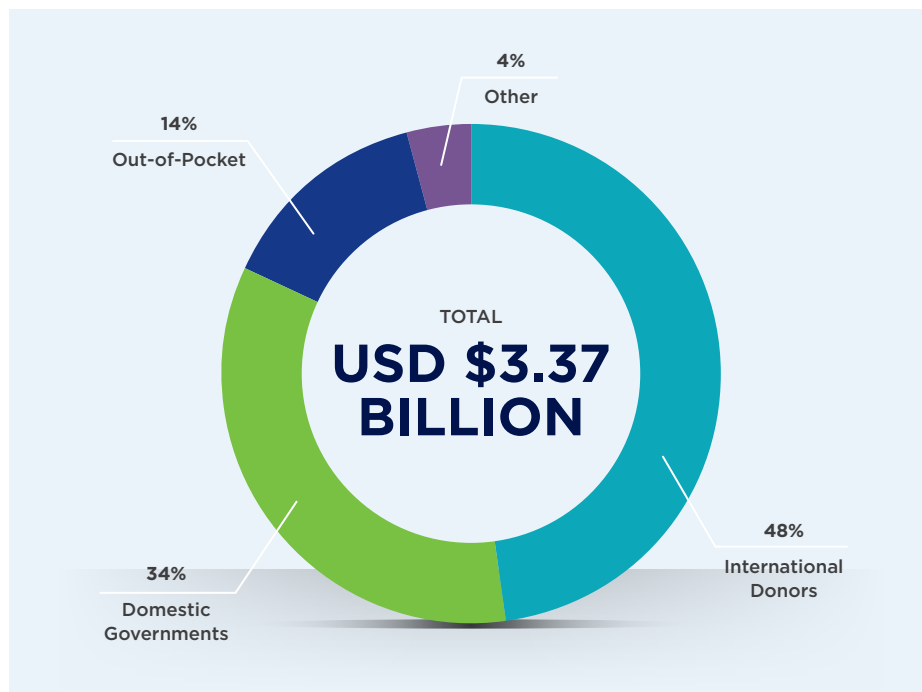
Information on domestic government expenditures is described in the previous section. Information on international donor financing for family planning is available from five sources: Kaiser Family Foundation (KFF), UNFPA/NIDI, Institute for Health Metrics Evaluation (IHME), Deutsche Stiftung Weltbevölkerung (DSW)/Euromapping, and Countdown Europe 2030. The Expert Advisory Group on International Family Planning Expenditures recommends using the KFF estimates for bilateral government donors and the IHME estimates for private foundations. The Bill & Melinda Gates Foundation reports its expenditures directly to FP2020.

Track20 develops estimates for out-of-pocket payments (OOP) by consumers who purchase family planning services from the private sector. The number of users relying on the private sector can be estimated from the total number of users of modern contraceptive methods (as presented in this report), Demographic Health Survey (DHS) data on method mix, and the proportion of users of each method who rely on the private sector. Estimates of the annual out-of-pocket spending per person are derived from several sources. They include DHS reports for eight countries (Egypt, India, Kenya, Madagascar, Niger, Pakistan, Philippines, and Uganda), PMA2020 reports for nine countries (Burkina Faso, Ethiopia, Ghana, Indonesia, Kenya, DRC, Niger, Nigeria, and Uganda), and PSI FPWatch reports data for five countries (Ethiopia, Nigeria, DRC, Myanmar, and India). Proxy countries are used for countries without data.

The online report includes country-specific graphs for Bangladesh, Indonesia, Kenya, and Senegal, illustrating the variation in expenditure patterns across countries.

FIGURE 3
DISTRIBUTION OF FAMILY PLANNING EXPENDITURES IN 69 FP2020 COUNTRIES BY SOURCE OF FUNDS, 2016

Note: figures based on analysis by Track20 and the Expert Advisory Group on International Family Planning Expenditures.



SECTION 03

MEASUREMENT

MORE IN THE DIGITAL REPORT

Special Analysis:
Understanding Data on
Adolescents and Youth

Interactive data graphics

Country case studies on
India and Nepal

Estimate Tables

Methodology notes

Learn more about the
**Special Analysis:
Understanding Data
on Adolescents
and Youth** in the
digital report.



As a time-bound initiative with ambitious goals, FP2020 is committed to measuring progress since the 2012 London Summit.

By improving the infrastructure and capacity to generate and use more frequent, high-quality data for decision making, FP2020 and its partners are transforming the monitoring of family planning.

The FP2020 annual progress report reflects countless efforts at multiple levels: from the women agreeing to respond to questionnaires, to the country-level technical working groups tracking progress, to the global-level efforts to align indicators and measures across surveys. The results of these efforts are comparable annual estimates on key dimensions of family planning across the 69 FP2020 focus countries: the FP2020 Core Indicators.

The annual process of producing and reviewing data, building consensus, and reporting at national and global levels is one of the true successes of the FP2020 partnership, and is helping countries, donors, and civil society organizations better use the wealth of family planning data that exists for program decisions and investments. At the same time, this process is identifying data gaps and the need for continued improvements in data systems and measurement.

CORE INDICATORS

The FP2020 Core Indicators are based on a results framework designed to measure aspects of the enabling environment for family planning, the process of delivering services, the output of those services, expected outcomes, and the impact of contraceptive use. Together, this complementary and interrelated set of indicators provides a foundation for monitoring family planning progress across the 69 FP2020 focus countries. In addition to the FP2020 Core Indicators, countries track additional measures—specific to their context and data systems—to improve and expand their family planning programs.



Photo by
Frederic Courbet
*Bill & Melinda
Gates Foundation*

Our aim is that the analyses and indicator estimates presented in this report will spark productive conversations about progress and what can be done differently, highlight what we are still struggling to measure, and inspire action that accelerates progress toward FP2020 goals, the *Every Woman Every Child Global Strategy*, and ultimately the Sustainable Development Goals.

➤ [Additional information on the FP2020 Core Indicators, including a results framework, and the methodologies used to produce the estimates is available in the digital report.](#)

FIGURE 4 FP2020 ANNUAL MEASUREMENT AND REPORTING PROCESS

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
<p>DATA COLLECTION & MODELING</p> <p>Data are collected through different sources across FP2020 countries.</p> <p>In FP2020 commitment countries, Track20 Monitoring & Evaluation (M&E) Officers use all available surveys, service statistics (where of sufficient quality), and the Family Planning Estimation Tool (FPET) to produce estimates of FP2020 Core Indicators.</p> <p>In non-commitment countries, estimates are either developed by Track20 using FPET or come from the United Nations Population Division's Estimates and Projections of Family Planning Indicators.</p>				<p>CONSENSUS BUILDING</p> <p>In FP2020 commitment countries, Track20 M&E Officers help organize data consensus meetings during which estimates of the FP2020 Core Indicators are agreed upon by the government, its partners, and in-country stakeholders.</p> <p>These estimates are sent to Track20, which compiles Core Indicator data for all 69 FP2020 countries.</p>			<p>ANALYSIS & DRAFTING</p> <p>The FP2020 Secretariat Data & Performance Management (DPM) Team works with Track20 to analyze Core Indicator data for all FP2020 countries and draft the measurement section of the progress report.</p> <p>The FP2020 Performance Monitoring & Evidence Working Group (PME WG) provides feedback and input on the analyses and draft.</p>			<p>LAUNCH</p> <p>The FP2020 Secretariat and its partners launch the print and digital English versions of the progress report and Core Indicator data.</p> <p>The print and digital French versions of the report and Core Indicator data are launched soon afterwards.</p>	

PROGRESS ON CONTRACEPTIVE USE AND NEED

The other way to increase additional users is through increasing the proportion of women who choose to use modern contraception; that is, increasing the contraceptive prevalence rate.

The number of women and girls using modern methods of contraception in the 69 FP2020 focus countries continues to rise, and as of July 2018 had reached more than **317 million.**

Core indicator 1, the most direct measure of progress toward achieving the goal of 120 million additional modern method users by 2020, estimates that there are 46 million additional users of modern contraception compared to 2012. This growth is approximately 30% greater than the historic trend.

An increase in additional users of modern contraception implies that a country is not only maintaining its existing base of users (as of 2012), but is also attracting new or returning users.

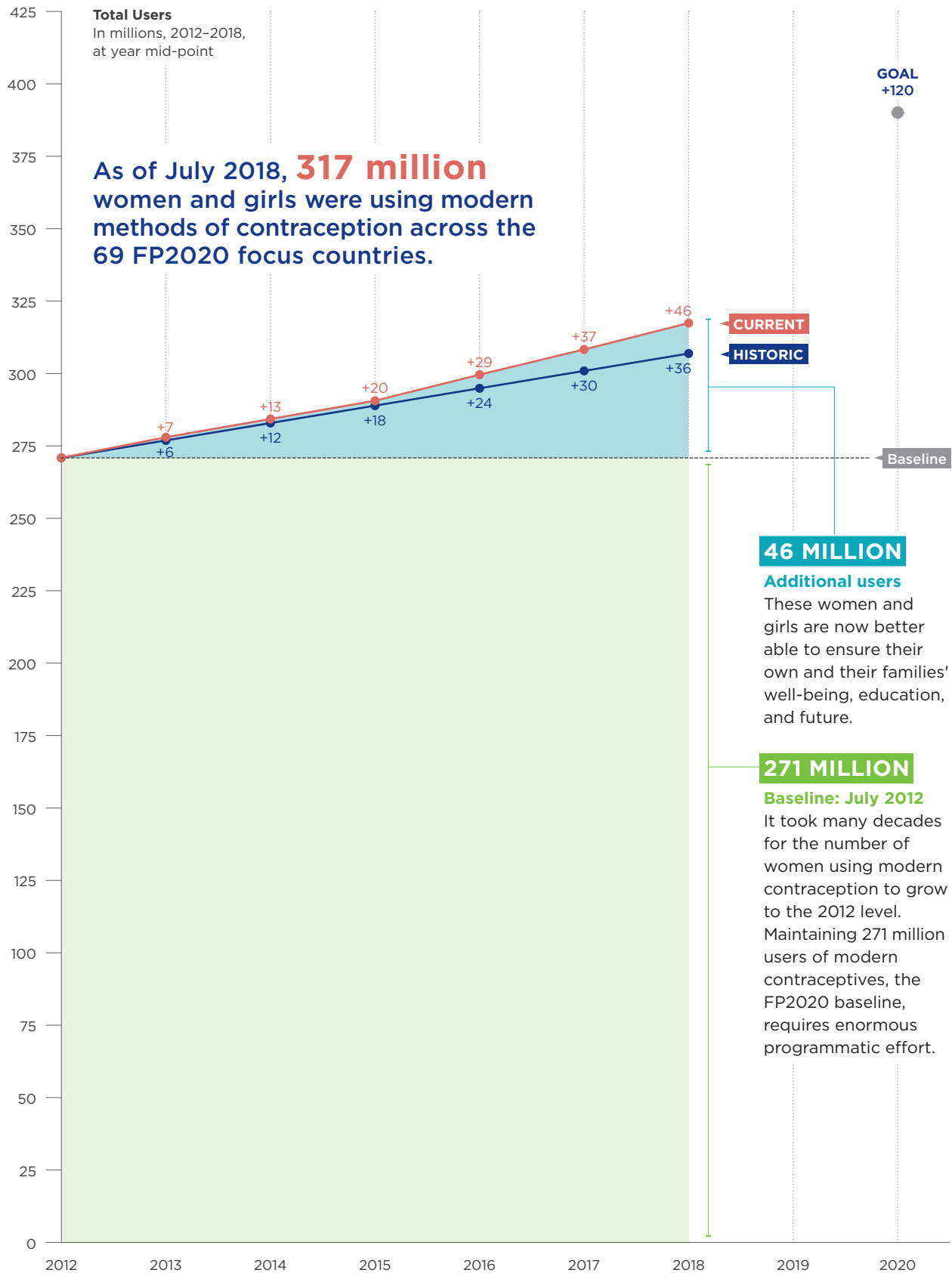
The number of additional users of modern methods can increase in two ways. One is through population growth, without a change in the *proportion* of women who choose to use contraception. As of 2018, there are 924 million women of reproductive age (15–49) in the 69 FP2020 focus countries, compared to 834 million in 2012: an increase of 90 million, or 11%.⁸ Half of this population growth is from just five countries (India, Nigeria, Pakistan, Ethiopia, and Bangladesh). In these countries, just keeping up with population growth means that even with no change in contraceptive prevalence, many more women are now using a modern method.

The other way to increase additional users is through increasing the proportion of women who choose to use modern contraception; that is, increasing the contraceptive prevalence rate.

Changes in contraceptive use are influenced by a variety of factors within countries, including levels of current contraceptive use, fertility intentions, sexual activity (both within and outside of marriage), and demand for contraception. The 69 FP2020 focus countries were selected because they were the poorest in 2012, but these countries are quite diverse in terms of their contraceptive prevalence, levels of unmet need, and investment in family planning programs prior to the FP2020 initiative. Because of these diverse starting points, generalizing about progress across all 69 focus countries is difficult. Change can, however, be meaningfully explored when looking at individual countries or subgroups of countries.

⁸ United Nations (UN), Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2017 Revision. New York: UN; 2017.

FIGURE 5 TOTAL AND ADDITIONAL USERS OF MODERN CONTRACEPTION, 2012–2018



Examining progress from a regional perspective helps to illustrate different patterns and trends and contextualize the changes that are occurring.

Core Indicator 1 is largely driven by the population dynamics of countries, with more than half of the 46 million additional users of contraception in Asia (26 million). Asia includes four of the five most populous FP2020 focus countries: India, Indonesia, Pakistan, and

Bangladesh. Because of their size, progress in Asian countries has a large influence on progress toward the overall FP2020 goal of 120 million additional users.

Core Indicator 2, the modern contraceptive prevalence rate (MCPR) among all women of reproductive age, indicates the proportion of women and girls using a modern method.

FIGURE 6 ANNUAL MCPR GROWTH BY REGION

This graphic shows the average annual percentage point increase in MCPR (among all women) from 2012–2018, for all FP2020 countries, grouped by region. It also shows weighted regional averages and the overall average for all FP2020 countries.

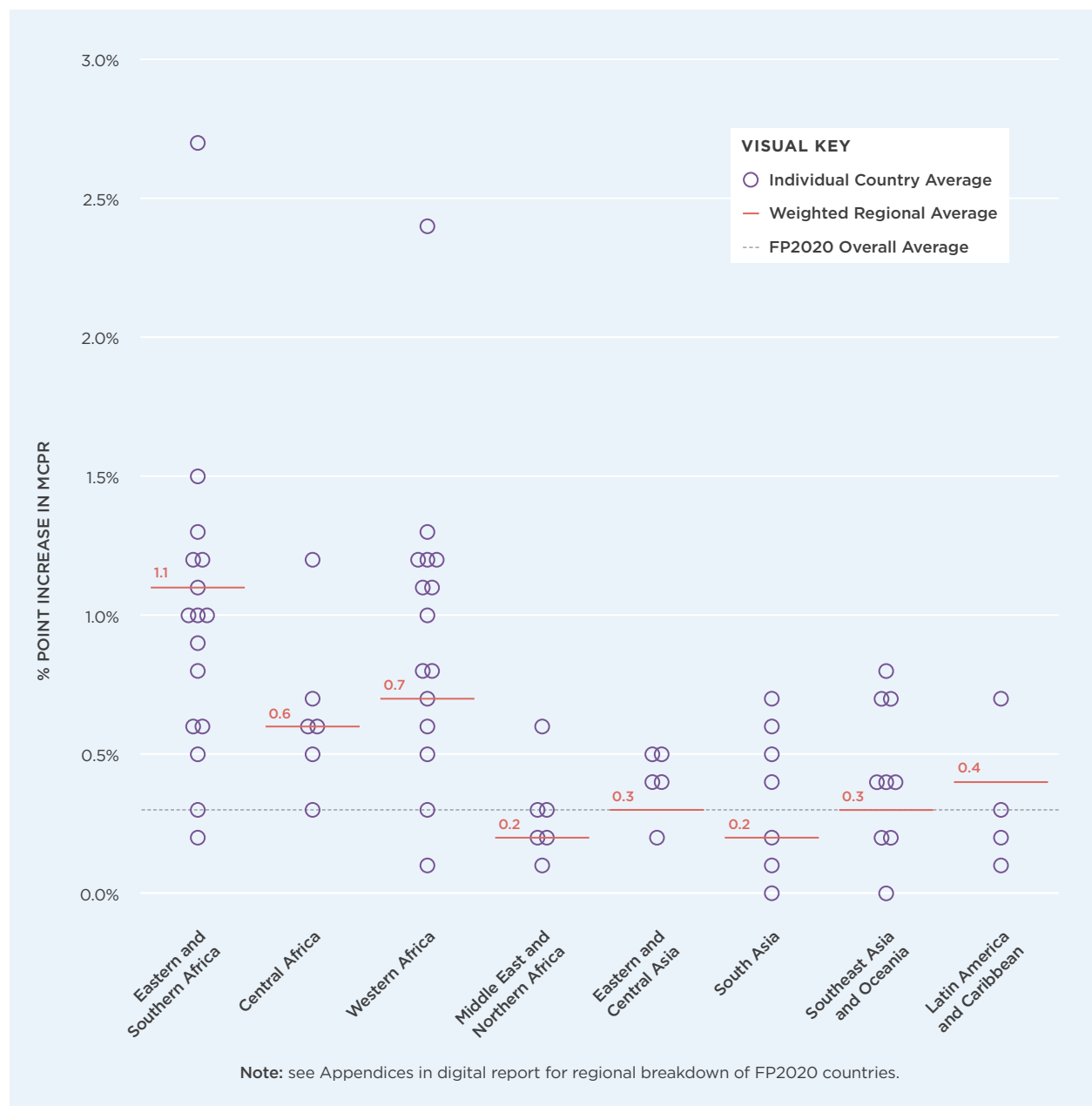


FIGURE 7
S-CURVE PATTERN
OF MCPR GROWTH

The S-Curve pattern of MCPR growth helps 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.

LOWER PREVALENCE:
SLOW GROWTH

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.

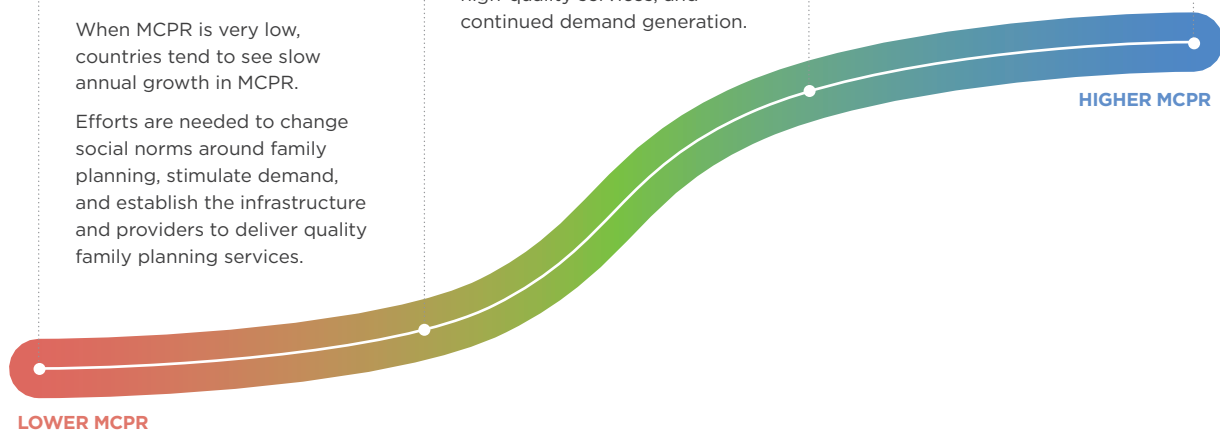
PERIOD WHERE RAPID
GROWTH CAN OCCUR

As demand grows and contraceptive use becomes more common, countries can enter into a period of rapid growth by focusing on ensuring availability of an expanded range of contraceptive methods, high-quality services, and continued demand generation.

HIGHER PREVALENCE:
GROWTH SLOWING
AND LEVELING OFF

Finally, when contraceptive use becomes very common and unmet need declines, MCPR growth 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.



There are significant regional variations in this indicator and the pace at which it moves. Although FP2020 focus countries are only a subset of the countries in each region, their patterns tend to reflect the larger regional picture. In FP2020 focus countries in Asia, 38% of all women of reproductive age are using a modern method as of July 2018, and growth is just 0.2 percentage points per year. In contrast, the pace of MCPR growth in FP2020 focus countries in Africa has been much faster over the last several years. As of July 2018, 24% of women of reproductive age in these countries are using a modern method; growth is 1.1 percentage points per year in Eastern and Southern Africa and 0.7 percentage points per year in West Africa.

Looking at progress from a country perspective provides additional insight into the variability of growth in contraceptive use. **Figure 6** shows both the weighted regional averages of the annual percentage point change in MCPR and the degree to which countries are dispersed around that average. Using West Africa as an example, the graph shows a regional average of 0.7 percentage point growth per

year, with four countries falling below the average and 11 countries either equal to or above the average. Because this average is weighted by the size of the female population of reproductive age, large countries that are growing slowly will have a disproportionate effect on growth. In the case of West Africa, the population of women of reproductive age in Nigeria makes up roughly half of all women of reproductive age in the region. Although Nigeria's MCPR is growing at approximately the average rate of FP2020 focus countries as a whole (0.3 percentage points per year), it is the second slowest growing country in its region. Without Nigeria included, the growth rate for West Africa is 1 percentage point per year, almost the same as Eastern and Southern Africa.

Another way of looking at progress is by examining a graphic of the S-Curve pattern of MCPR growth, which is based on historical patterns and illustrates different rates of growth at different levels of contraceptive use. As depicted in **Figure 7**, countries with lower MCPR tend to have slow growth, countries in the middle tend to have higher rates of growth, and countries with higher MCPR tend to grow slowly.

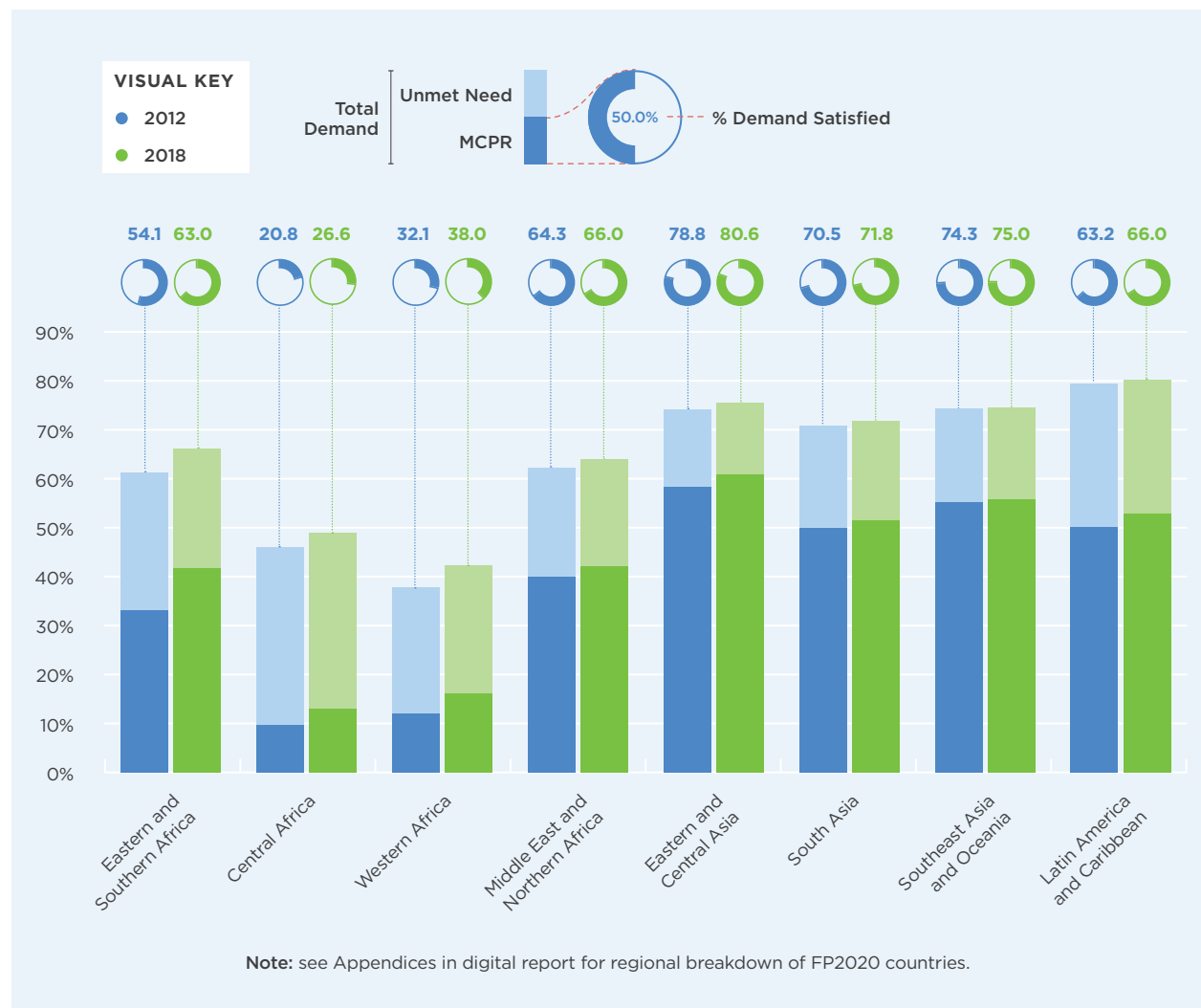
The S-Curve concept provides a guide for countries to assess priorities and contextualize expectations for growth in contraceptive prevalence. Although each country will have a unique S-Curve pattern, the overall journey from low to high MCPR will be similar. In general, countries with lower prevalence (bottom of the S-Curve) should prioritize demand generation and shifts in social norms, while ensuring and expanding access to family planning services. The middle part of the S-Curve is when growth accelerates and there is an opportunity to maintain higher growth over time. Countries at this stage should ensure that high-quality services are available to support an expanded range of contraceptive

choices. As countries transition to higher prevalence (top of the S-Curve), priorities should be shifted to further focus on expanding method choice, reducing inequity, and ensuring sustainability through domestic financing options for their family planning programs. These options include engaging the private sector, ensuring national health insurance coverage of contraceptives, and securing financing for domestic procurement of contraceptives.

Among lower prevalence countries, where growth in the short term is expected to be slow, progress can sometimes better be measured by looking at changes in unmet need: **Core Indicator 3**. An increase in unmet

FIGURE 8 UNMET NEED AND DEMAND SATISFIED, BY REGION (2012 & 2018)

This graphic shows unmet need for, and demand satisfied with, a modern contraceptive method among married women (**Core Indicators 3 and 4**), for FP2020 regions in 2012 and 2018. It also shows the relationship between total demand, MCPR, unmet need, and demand satisfied: total demand = MCPR + unmet need; demand satisfied = MCPR/total demand.



need (the percentage of women who want to delay or limit pregnancies, but who are not currently using a modern method) can be a sign of changes in social norms, reflecting a greater desire to delay or limit pregnancies and rising demand for contraception.

Unmet need includes women not currently using a modern method as well as those using traditional methods, who are considered to have an unmet need since modern methods are more effective at preventing pregnancy.⁹ Unmet need should not be interpreted as a direct measure of lack of access. There are many potential reasons why a woman who does not want to become pregnant would not use modern contraception. These include limited access to modern methods as well as a wide range of other issues, such as perceived health side effects or social disapproval. Understanding the barriers to use within each country's context is important to ensure that programs can address the needs of women across different settings and situations.

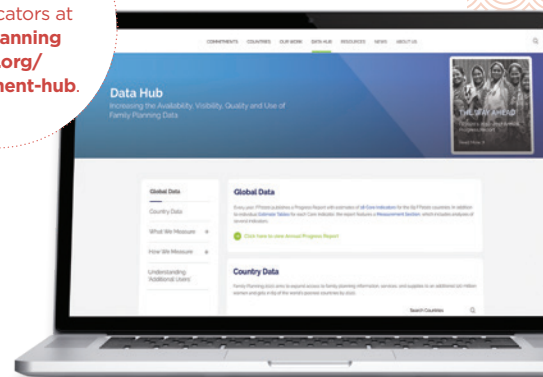
Core Indicator 4, demand satisfied with modern contraception, takes a wider view to assess the degree to which governments and the broader family planning community are meeting the commitment to make family planning services accessible to all who want them. **Core Indicator 4** is also an indicator for the Sustainable Development Goals (SDG) target 3.7, which includes ensuring universal access to family planning by 2030.

Core Indicator 4 is constructed based on MCPR and unmet need for modern methods, with total demand assumed to encompass current modern 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.¹⁰ Generally, countries have a high proportion of total demand satisfied with modern methods when modern contraceptive use is high and unmet need is low. Countries with low levels of contraceptive use and low unmet need, however, can also have a relatively high proportion of demand satisfied.

There is still much work to be done for countries to successfully meet the suggested SDG target of at least 75% demand satisfied with modern methods. Among the 69 FP2020 focus countries, 15 are currently on track to meet this target by 2020 if current trends continue. Regionally, there is great variation in terms of progress toward satisfying existing demand. The greatest change since 2012 is seen in Eastern and Southern Africa, where the high growth in MCPR has driven a nine percentage point increase in demand satisfied. Central and West Africa have also seen increases, but in these regions the growth in MCPR is accompanied by increasing levels of unmet need—a complex dynamic that represents both changing fertility intentions and improvements in family planning programs. Asia has seen marginal change, as is expected at higher levels of prevalence.

The regional averages in **Figure 8** provide a high-level snapshot of progress toward achieving the FP2020 goal of 120 million additional women and girls using modern contraception by 2020. However, it is important to remember that these aggregate numbers belie the complexity of country dynamics. Additional data on each country and reports on progress toward their commitments are available online through the FP2020 country pages: familyplanning2020.org/countries.

Learn more about FP2020 Core Indicators at familyplanning2020.org/measurement-hub.



⁹ 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.

¹⁰ 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/>

CONTRACEPTIVE METHOD CHOICE

Health care facilities, trained providers, and contraceptive methods need to be both available and accessible.

Ensuring that women and girls have the ability to make a full, free, voluntary, and informed choice in selecting the method that will best meet their needs is essential to expanding contraceptive use in the 69 FP2020 focus countries.

Multiple factors can affect the decision-making process: an individual may have to consider questions of cost, effectiveness, and side effects of the various methods, along with partner and family pressure, societal norms, and religious prohibitions on specific methods or on contraceptive use in general. Further constraints include stock-outs at accessible facilities, limited information on the full range of methods, a lack of trained providers, and prohibitive local and national policies on family planning.

Access to complete information and a full range of contraceptive methods is a fundamental element of FP2020's Rights and Empowerment Principles for family planning. While no one indicator can completely measure full, free, voluntary, and informed choice, FP2020 annually monitors several indicators linked to these principles as they relate to method choice. These indicators measure different dimensions of rights-based family planning and offer perspective on the complexities of the decisions facing women, girls, and couples when choosing to use a method of contraception.

➔ [Visit familyplanning2020.org/rightsinfp](https://familyplanning2020.org/rightsinfp) for the Rights and Empowerment Principles for Family Planning.

A FULL RANGE OF FAMILY PLANNING METHODS SHOULD BE AVAILABLE AND ACCESSIBLE

Health care facilities, trained providers, and contraceptive methods need to be both available and accessible. Barriers such as cost, distance, limited provider training, and stock-outs may limit the ability of women to access services to meet their family planning needs and choose from a full range of available methods. **Core Indicator 10** (stock-outs) and **Core Indicator 11** (method availability) reflect the availability of individual methods and the range of available methods at a facility at a point in time (the day of a facility survey), providing an indication of supply-side barriers to women's ability to access contraception. Stock-outs refer to the temporary unavailability of contraceptive commodities (or supplies and/or trained staff in the case of sterilization) at a health facility where the method or service is offered. Method availability measures the number of methods available at primary and secondary/tertiary facilities respectively.

Stock-outs have the effect of restricting choice; when a woman arrives at a facility to access family planning services, her options are limited to what is available that day. This may result in a woman choosing a method that is not as well suited to her needs and preferences, or simply leaving without a method. Ensuring that a minimum number of methods are available at various levels of the health care system guarantees that individuals and couples have multiple options to choose from when selecting contraception.

Among the 28 countries providing stock-out data by method for 2017,¹¹ the level of stock-outs ranged widely: from Benin, Burundi, Nigeria, and Sao Tome and Principe, where fewer than 10% of facilities were stocked out of a given method on the day of assessment, to Haiti and Cameroon, where more than 80% of facilities were stocked out of all of the 9 assessed methods on the day of assessment (**Figure 9**). Stock-outs may be particularly problematic for the most popular or commonly-used methods, especially short-term methods that require frequent revisits to maintain protection against unintended pregnancy. In Mauritania, for example, around 10% of married women (which constitutes two-thirds of modern contraceptive users) rely on pills as their method of contraception. Yet 53% of facilities were stocked out of pills on the day of assessment in 2017, meaning that many women who came for pills on that day could not access their method of choice.

Stock-outs in 2017 of the most common method in use ranged from very low levels (1% of facilities stocked out of pills in Lao PDR and 2% of facilities stocked out of implants in Burkina Faso) to extremely high levels (93% of facilities stocked out of condoms in Cameroon and 89% of facilities stocked out of injectables in Haiti). In the aggregate, stock-outs of the most commonly used method are relatively low, with a median of 8% of facilities stocked out of the most common method across the 28 countries. This may suggest that many countries are successfully monitoring key commodities within supply chains to ensure access to the most commonly used and in-demand methods, but it could also indicate that stock availability is driving method choice.

Across the FP2020 focus countries with data on method availability (**Core Indicator 11**) in 2017, availability was relatively high, with an average of 78% of primary level facilities offering 3+ methods and having them in stock on the day of assessment, and 79% of secondary/tertiary facilities offering 5+ methods and having them in stock on the day of assessment. At the primary level, only four countries saw fewer than 50% of facilities with 3+ methods available on the day of assessment: Cameroon, Lao PDR, Liberia, and Mauritania. Three countries—Bolivia, Côte d'Ivoire, and Mauritania—saw fewer than 50% of secondary and tertiary facilities with 5+ methods available on the day of assessment. In contrast, nine countries saw more than 90% of primary facilities offering 3+ methods, and 10 countries saw more than 90% of secondary/tertiary facilities offering 5+ methods. These data do not indicate the availability of specific methods or method types (short vs. long-acting or permanent methods), but do suggest that in some countries, women's ability to choose from a full range of contraceptive methods may be constrained at various levels of the health care system.

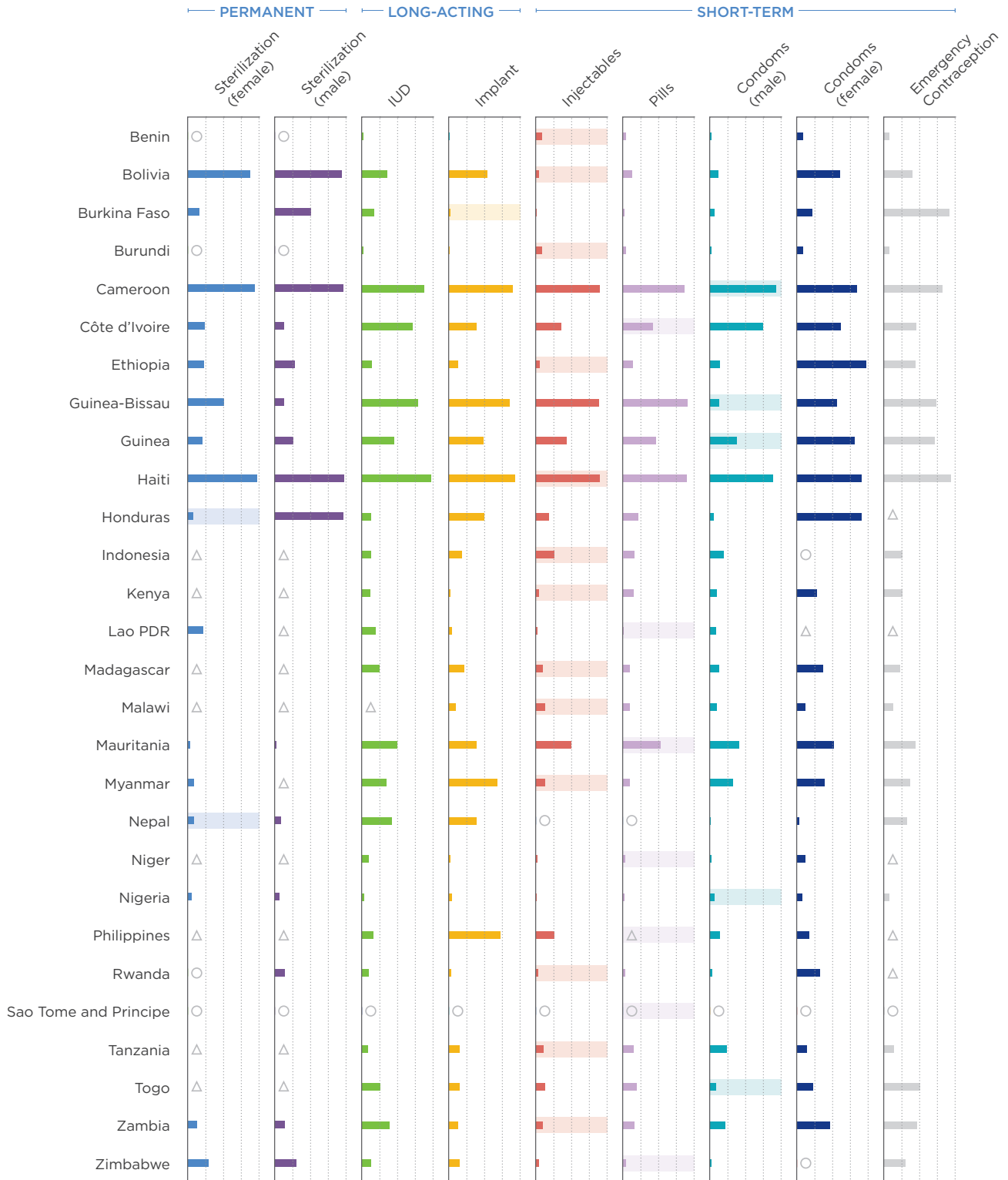
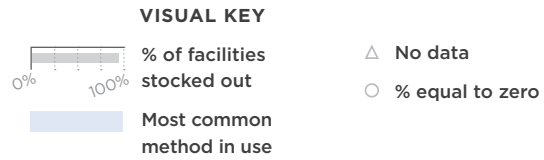
For more information, visit the FP2020 website: familyplanning2020.org.



¹¹ Methods assessed for stock-outs were: female sterilization, male sterilization, IUD, implant, injectable, pill, male condom, female condom, and emergency contraception.

FIGURE 9 PERCENT OF FACILITIES STOCKED OUT OF OFFERED METHOD (CORE INDICATOR 10)

This graphic shows the percentage of facilities in each country that were stocked out of methods they offer on the day of assessment.



INDIVIDUALS SHOULD BE EMPOWERED TO MAKE THEIR OWN DECISIONS ABOUT WHETHER AND WHICH METHOD TO USE

Women and girls must be free to make their own decisions about their reproductive health care and to seek contraceptive services without risk of discrimination, coercion, or violence. Across the 40 FP2020 focus countries with available data, on average 90% of women report that the decision to use family planning was made on their own or jointly with their partners: **Core Indicator 16**. The data show women's participation in contraceptive decision making among contraceptive users is high in many countries, including upwards of 98% of women using a method in Egypt, Myanmar, and Rwanda. (There are a few outliers: in Comoros, for example, almost 30% of contraceptive users did not participate in the decision to use family planning.)

Indicator 16, however, paints an incomplete picture of contraceptive decision making and is a limited measure of empowerment. Given that the indicator scores are high and vary little across countries and years, the indicator may not be capturing many of the challenges that women face in deciding to use contraceptives and selecting a method. 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 and how that decision was made. Data on contraceptive decision making among non-users should be available in the near future as a result of updates to the DHS women's questionnaire, and may shed more light on the decision-making dynamics women face in making their own choices about their reproductive health care and family planning.

QUALITY CARE SHOULD SUPPORT INDIVIDUALS TO MAKE AN INFORMED CHOICE

To ensure that women and girls can determine the contraceptive method that best meets their needs, health care workers must provide appropriate information about the full range of contraceptive options as well as counseling on those options.

Core Indicator 14, the Method Information Index (MII), measures the extent to which women are informed about side effects and alternate methods. The index is based on three questions asked of current contraceptive users: (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?

Across the 39 FP2020 focus countries with available data since 2012, the highest MII score was in Zambia, where 72% of respondents answered positively to all three questions. The lowest MII score was seen in Pakistan, where only 14% of respondents reported receiving information on other methods and side effects when choosing their current method. Looking at the individual question scores across countries, a greater percentage of women reported receiving information on other methods (average across countries of 64%) than being informed about side effects (57%) or how to handle them (52%).

On average, users of implants and IUDs have the highest total MII values (56% and 58% respectively), while users of female sterilization have the lowest (33%). Understanding the context is important in interpreting these values. For example, newly introduced or revitalized methods, such as implants, may be accompanied by recent provider training that is associated with higher quality counseling. In such cases, users of implants would be expected to report higher MII scores. Conversely, users who received their current method several years ago (such as the copper IUD or female sterilization) may report lower MII scores because the quality of counseling at that time did not reflect current standards of care. The average MII of 43% across the 39 FP2020 focus countries with data indicates substantial room for improvement in counseling and quality of care. These are crucial aspects of rights-based family planning, and improvements in quality of care are strongly linked to higher rates of contraceptive use.¹²

OUTCOMES OF CONTRACEPTIVE CHOICE: CONTRACEPTIVE DISCONTINUATION AND SWITCHING, AND MODERN CONTRACEPTIVE METHOD MIX

The right to full, free, voluntary, and informed choice includes the right to switch contraceptive methods as needed or to discontinue contraceptive use entirely. As women move through their reproductive lives, contraceptive discontinuation is expected: during attempts to get pregnant, during periods of infrequent sex or a partner's absence, following a marital separation, or when a woman determines that she is infertile or has completed menopause. Method discontinuation can also be indicative of barriers to free and informed choice, especially when women discontinue for reasons other than lack of need. Health concerns and side effects, inconvenience of using a method, lack of access, and opposition from a husband are just a few of the reasons that women report for discontinuation.

¹² RamaRao, Saumya, Marlina Lacuesta, Marilou Costello, Blesilda Pangolibay, and Heidi Jones. 2003. "The link between quality of care and contraceptive use." *International Family Planning Perspectives* 29(2): 76-83. <https://www.guttmacher.org/journals/ipsrh/2003/06/link-between-quality-care-and-contraceptive-use>

FIGURE 10 METHOD INFORMATION INDEX SCORE BY REGION AND METHOD

This graphic shows the average Method Information Index total score for five FP2020 regions, as well as the overall average, by method.

METHOD INFORMATION INDEX (CORE INDICATOR 14)

The index measures 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?

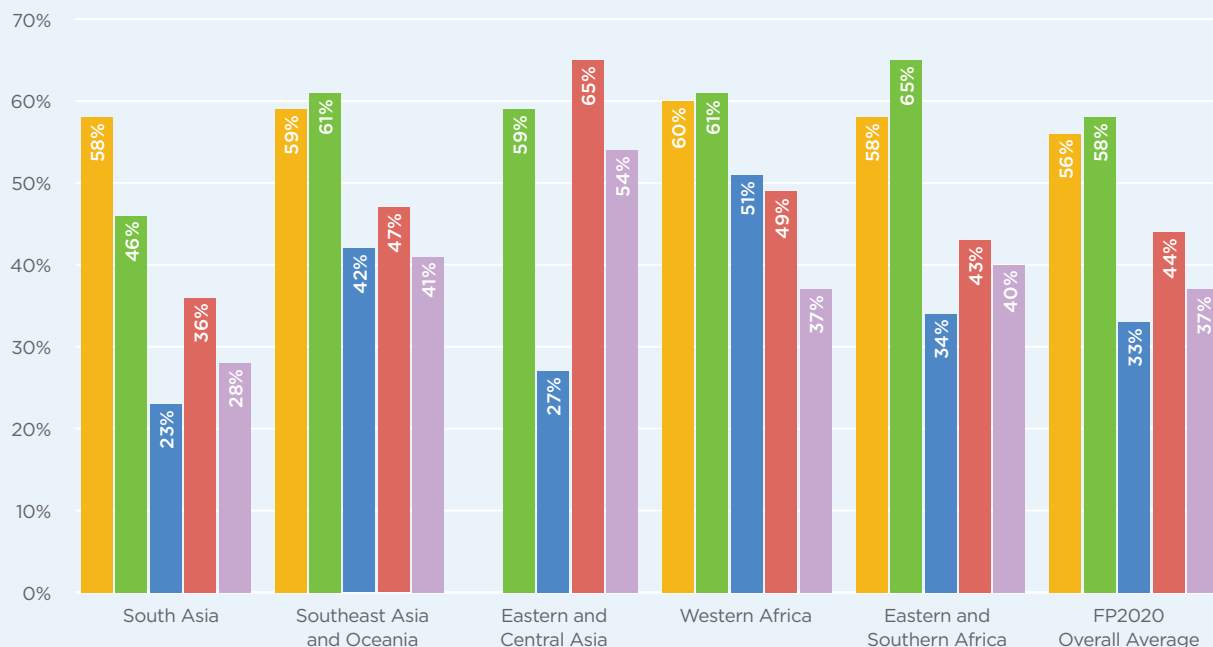
The **total** score reflects the percent of women who responded yes to all three questions. The numbers in this graphic reflect the total index score.

VISUAL KEY

- Implant
- IUD
- Female Sterilization
- Injectable
- Pill

Long-Acting Methods

Short-Term Methods



Note: Latin America and Caribbean, Central Africa, and Middle East and Northern Africa were excluded from these regional averages as they had only 1-2 countries with available data. No data were available for implants for Eastern and Central Asia. See Appendices in digital report for regional breakdown of FP2020 countries.

In 2017, FP2020 added an indicator for Contraceptive Discontinuation and Method Switching (**Core Indicator 18**) to reflect the churn of contraceptive use (as women and their partners start using contraception, stop for various reasons, and switch methods) and draw attention to potential issues with method provision that may result in discontinuation. Discontinuation rates are only available from the DHS and are calculated from data on episodes of contraceptive use from the contraceptive calendar. Across FP2020 focus countries with available data on discontinuation, the highest rates of first year discontinuation are generally seen among short-term methods: on average 37% for injectables, 42% for pills, and 40% for condoms.

Analysis of 32 FP2020 focus countries with survey data since 2012 shows average rates of discontinuation of short-term methods while in need that are greater than 20%, meaning that more than a fifth of episodes of use of these methods stopped within 12 months, despite the user still potentially needing contraception. These rates may point to challenges women face in accessing methods that require resupply, may point to their dissatisfaction with these methods, or may be related to side effects, among other possible reasons. Rates of discontinuation while in need of long-acting reversible contraceptives are generally lower, with an average of 12% of IUD episodes of use and 8% of implant episodes of use stopped within the first year of use. This may indicate higher satisfaction or better counseling associated with these methods, but could also point to limitations on access to IUD and implant removal.

Rates of method switching can provide other insights. A woman may decide to stop using a particular method in favor of one she prefers or that has fewer side effects, or she may switch from a less effective short-term method to a more effective long-term method that offers better protection from unintended pregnancy. In these instances, method switching reflects a woman's right to choose from a broad range of methods. Very low rates of method switching could

suggest that women are more satisfied with the given method, but could also suggest that women may not be able to act on their preferences to change methods or that method availability is limited. The highest rates of method switching are seen with short term methods; an average of 11% of condom use episodes, almost 10% of pill use episodes, and 8% of injectable use episodes end with a switch to another method within the first year of use. Lower rates of switching are seen with long-acting reversible contraceptives: an average of approximately 5% of IUD episodes and 3% of implant episodes end with a switch in method within the first year.

MODERN CONTRACEPTIVE METHOD MIX

Modern contraceptive method mix presents the distribution of modern contraceptive users by the method they use, based on the most recent survey data available. **Core Indicator 9** illustrates the cumulative outcome of all the factors involved in each woman's contraceptive choice. These include enabling factors, such as method availability and receipt of full information on contraceptive methods and side effects, and limiting factors, such as policies, social norms, and stock-outs.

While there is no "right" or "ideal" method mix, there is consensus that a wide variety of methods should be available to meet the varied and changing needs of individuals and couples, including short-term, long-acting reversible, and permanent methods.¹³ Based on modern method mix data, an estimated one-third (23) of FP2020 focus countries have 5 or more modern methods in use,¹⁴ representing at least one permanent, one long-acting reversible, and one short-term method. In 8 of the 69 FP2020 focus countries, both types of long-acting reversible contraception (IUDs and implants) are used by more than 5% of modern users, indicating some level of availability and choice in reversible methods. Expanding the number of methods available increases the likelihood that individuals and couples can choose a method that meets their needs as they move through the reproductive life cycle, including reversible methods to delay or space pregnancies and permanent methods once desired fertility has been reached.

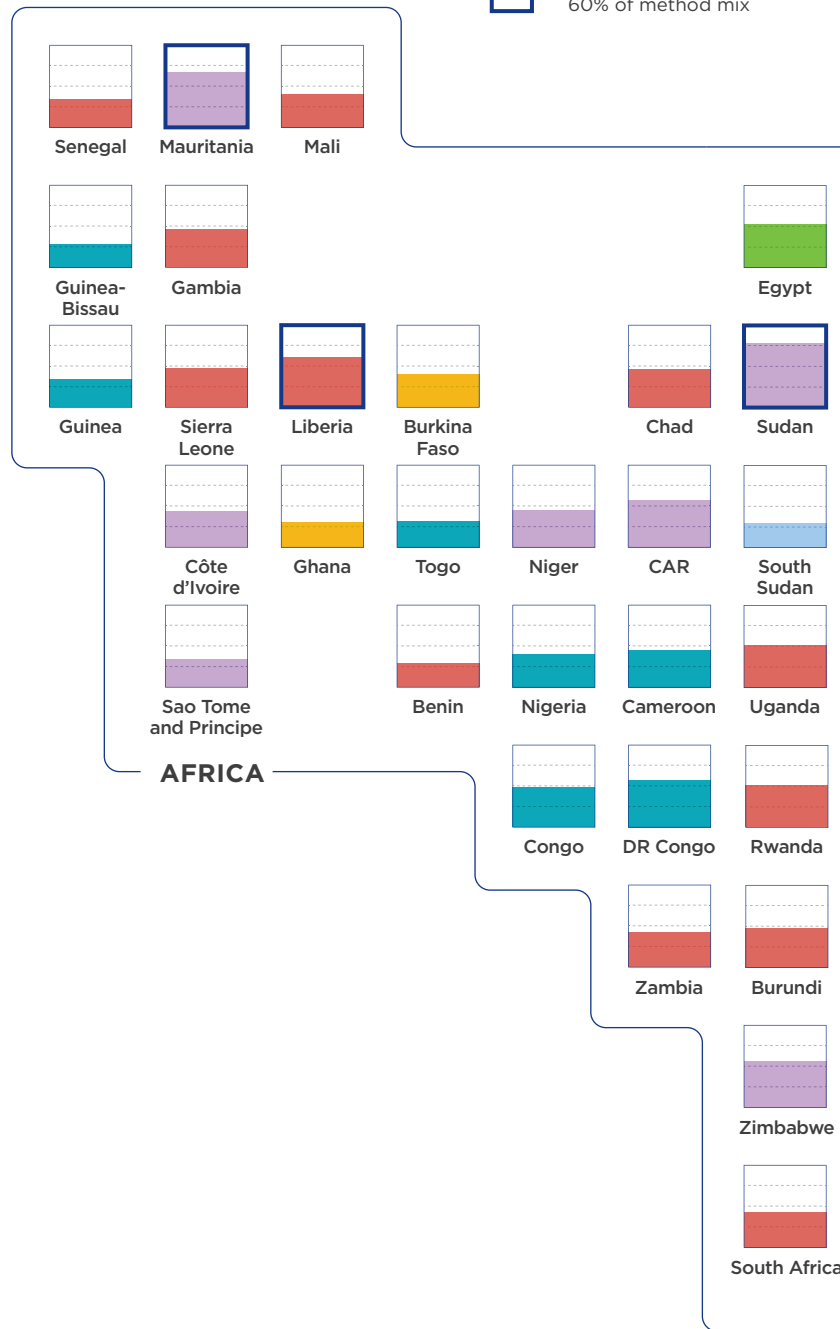
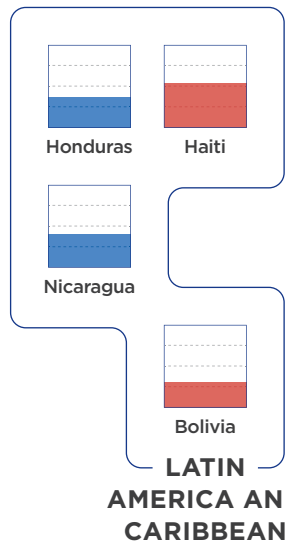
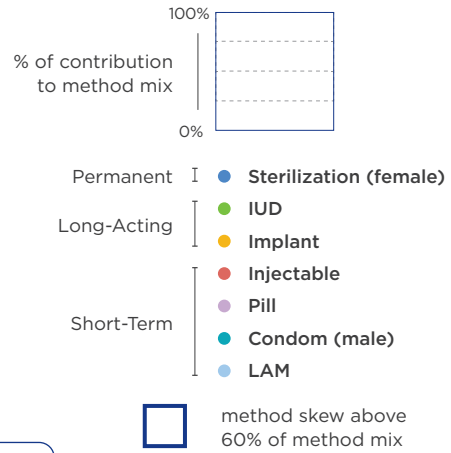
¹³ WHO. Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations. World Health Organization, Geneva: 2014. http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/

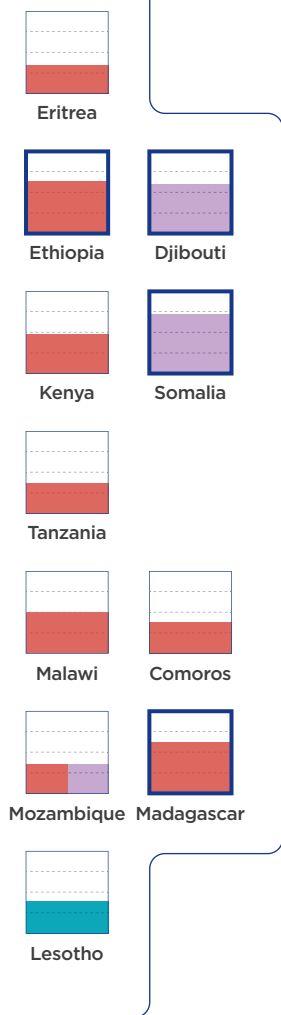
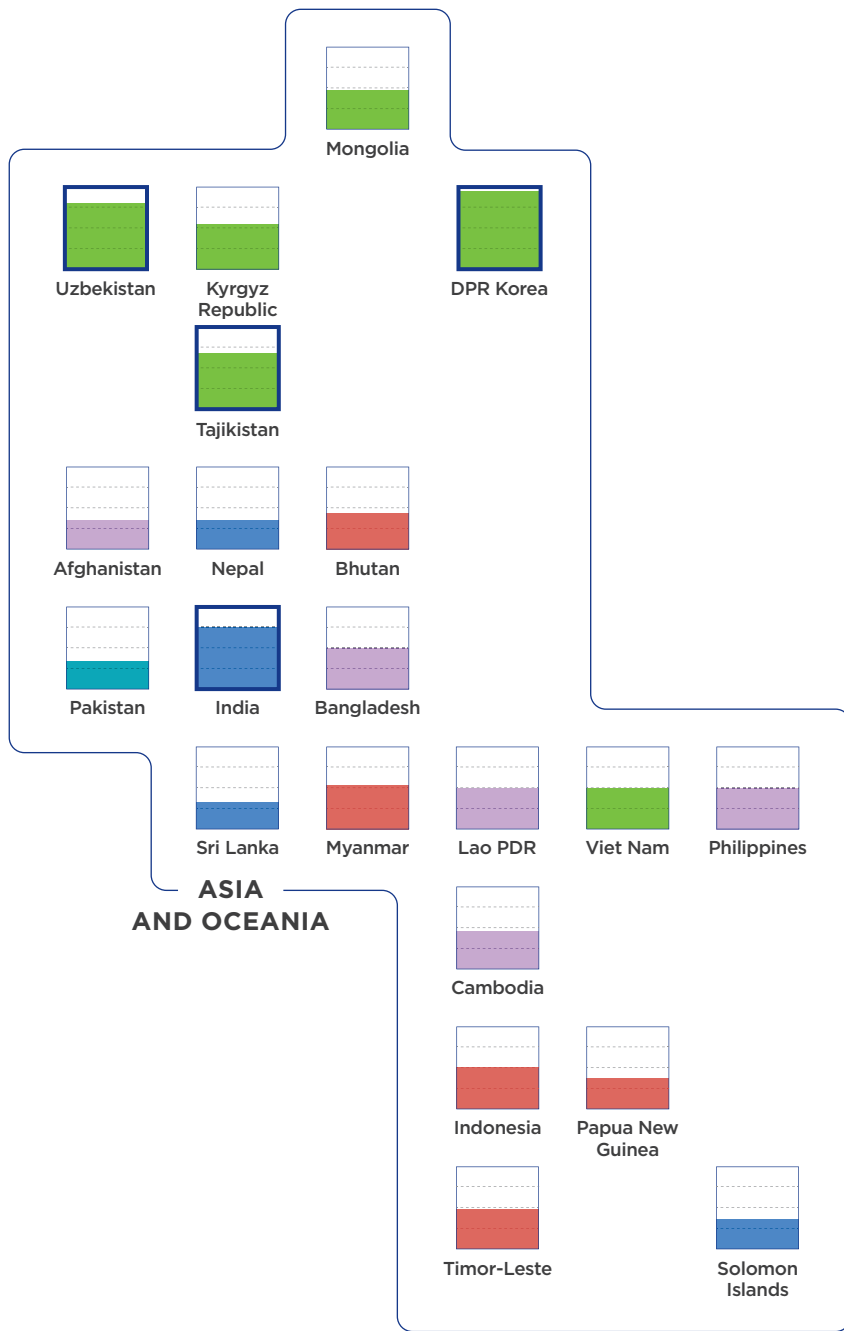
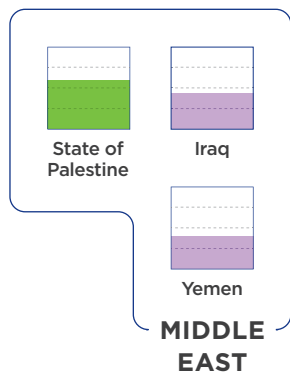
¹⁴ "Methods in use" is defined here as methods representing greater than 5% of modern use (>5% of users using). Methods included are: female sterilization, male sterilization, IUD, implant, injectable, pill, male condom, female condom, lactational amenorrhea method (LAM), diaphragm, foam or jelly, standard days method (SDM), and emergency contraception (EC). Note that no country had greater than 5% of users using female condom, diaphragm, foam or jelly, SDM, or EC. "Other modern methods" was excluded as it represents an aggregate of individual methods.

FIGURE 11 MOST COMMON METHOD

This map shows the most commonly used modern method in each country and the percentage of the method mix it constitutes. Countries in which one method makes up more than 60% of the method mix are considered to have high method skew.

VISUAL KEY





Modern contraceptive method mix varies greatly across the FP2020 focus countries, reflecting both individuals' and couples' preferences and the diverse contexts in which they live. Among the 69 FP2020 focus countries, injectables are the most common method in use in 26 countries, followed by pills in 17 countries, male condoms in 9 countries, and IUDs in 8 countries. Female sterilization is the most common method in use in 6 countries (Honduras, India, Nepal, Nicaragua, Solomon Islands, and Sri Lanka), ranging from 32% of modern contraceptive use in Sri Lanka up to 75% in India. Substantial method skew, where one method makes up 60% or more of the method mix—as seen in India with female sterilization, or in Ethiopia, where 63% of modern contraceptive users rely on injectables—can be indicative of individual preferences as well as socio-cultural norms that promote or discourage particular methods. Skew toward a particular method may also be strongly driven by the health care system, contraceptive availability, and how and where women access contraceptives. Limited health infrastructure or a shortage of health care providers may send women to shops and pharmacies, where they are generally limited to pills and condoms, while public sector implementation of task-sharing may dramatically expand access and use of methods like implants and injectables.

Across FP2020 focus countries there have been shifts in method mix since 2012, with implants assuming a greater portion of modern use and female sterilization declining in proportion to other modern methods across nearly all countries with available data. Despite these shifts, the most common method in use in each country has remained largely unchanged over time. For women and girls across the 69 FP2020 focus countries, the decision to use a contraceptive method is complex and influenced by a wide range of factors, some of which are in response to short-term changes and interventions (stock-outs, method availability, quality counseling) and some of which are slower to change (individual preferences, fertility desires, and community norms). Changes in method mix can indicate where those programmatic changes and interventions are successfully expanding access to information and increasing the availability of a broad range of methods, but lack of change shouldn't

necessarily be interpreted as a lack of progress. In many countries, the most common method in use may continue to be popular because it best meets the needs of women in that specific country context. Understanding how these many determinants of contraceptive choice fit together is best done with an understanding of country context and dynamics.

SUMMARY

Measuring full, free, voluntary, and informed contraceptive choice among individuals and couples across the 69 FP2020 focus countries is a complicated endeavor. A range of factors—from the availability of different methods to the provision of quality counseling to the involvement of partners or healthcare providers in decision making—may simultaneously encourage and inhibit the ability of women and girls to make decisions about their reproductive health and chose a method that best meets their needs. While no one metric can fully capture all the dimensions of contraceptive choice, FP2020 is working to monitor key elements and enabling factors of rights-based family planning. It is essential that these measurement efforts continue and grow as the community improves its understanding of the interconnected drivers of contraceptive choice. The process of monitoring these indicators draws attention to progress, and lack thereof, among FP2020 focus countries and helps to ensure that the rights of women and girls are central to family planning programming. In addition, the emphasis on rights-based family planning and ensuring women and girls have access to a full range of contraceptive methods is fundamental to countries' ability to reach their goals of increasing contraceptive prevalence. Global analysis has shown that increasing the number of methods available and expanding women's access to a broad range of methods have significant potential to increase contraceptive use.¹⁵ Successful family planning programs must continue to strive to fulfill the right to full, free, voluntary, and informed contraceptive choice.



The digital version of this report also includes a case study on Nepal.

¹⁵ 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. <https://doi.org/10.9745/GHSP-D-13-00010>

Successful family planning programs
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Photo Courtesy of
Paula Bronstein
The Verbatim
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FP2020 is a diverse, inclusive, and results-oriented partnership encompassing a range of stakeholders and experts with varying perspectives. As such, the views expressed and language used in the report do not necessarily reflect those of some members of the partnership.



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.

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