FP2020
THE WAY AHEAD

2016 – 2017

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FP2020
THE WAY AHEAD

2016 – 2017

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Bill & Melinda Gates Foundation

HOW TO USE THIS REPORT

FP2020 works by supporting country-level activities with the backing and participation of global-level partnerships.

SECTION 01

FP2020 in Countries opens with a conceptual map of the FP2020 process in commitment-making countries, outlining how family planning programs are designed, implemented, monitored, and funded. Subsequent chapters describe the FP2020 country support structure and explore the major elements of a family planning strategy. Progress notes are highlighted throughout, including commitments announced at the 2017 Family Planning Summit.

SECTION 02

FP2020 and Global Partners focuses on the role of the FP2020 partnership in cultivating international support for rights-based family planning. The 2017 Family Planning Summit is featured here, with a summary of the commitments made and the group initiatives ("Global Goods") announced. This section also reports on bilateral funding and global expenditures for family planning, and provides an update on FP2020's role in the global health architecture.

SECTION 03

Measurement presents analyses of Core Indicators for FP2020 focus countries, drawing on the latest estimates. The section also includes an overview of FP2020's measurement agenda and a discussion of methodologies. The final section of the report features tables with estimates for the 18 Core Indicators.

The digital edition of this report is interactive and includes additional content: **familyplanning2020.org/progress**.

IN MEMORIAM

DR. BABATUNDE OSOTIMEHIN

1949 – 2017

"Sexual and reproductive health and rights are universal human rights! **They are an indivisible part of the broader human rights and development equation.** Their particular power resides in the fact that they deal with the most intimate aspects of our identities as individuals and enable human dignity, which is dependent on control of our bodies, desires, and aspirations."

Executive Director
United Nations Population Fund
2011 – 2017

Co-Chair
FP2020 Reference Group
2012 – 2017

INTRODUCTION

EXECUTIVE SUMMARY

In an era of mounting global uncertainty, the mission of FP2020 remains as pertinent and compelling as ever. Every woman and girl must be able to exercise her basic human right to control her own reproductive health. Access to safe, voluntary family planning is fundamental to women's empowerment. It's also fundamental to achieving our global goals for a healthier, more prosperous, just, and equitable world. Rights-based family planning programs have a greater ripple effect than almost any other development investment, from saving lives and improving health to strengthening economies, transforming societies, and lifting entire countries out of poverty. It is the surest path to the future we want.

This report includes a step-by-step overview of how FP2020 countries, donors, and partners work together **to implement programs that are grounded in human rights principles, based on evidence and data, and accountable to stakeholders.**

Over the past five years, FP2020 has pioneered a country-led, globally-backed development partnership that will help us travel that path. Our partners have reached millions of women and girls with the services they want and need, and collaborated across countries and sectors to build stronger, more diverse and sustainable family planning programs. This report discusses the state of the FP2020 partnership, provides progress notes on our work, and points to the way ahead.

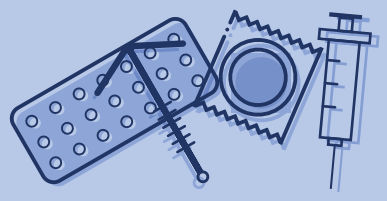
REACHING MORE WOMEN AND GIRLS

- As of July 2017, more than 309 million women and girls in the 69 FP2020 focus countries are using a modern method of contraception. This is 38.8 million more than were using contraception in 2012, when FP2020 was launched—an increase that is approximately 30% above the historical trend. Through the dedicated efforts of governments, policymakers, program implementers, service providers, and donors, the health systems in FP2020 countries are becoming better aligned to meet the needs of an ever-increasing number of women and girls.
- Africa accounts for almost half of the additional users of contraception. As of July 2017, 16 million additional women are using a modern method of contraception in the FP2020 countries of Africa as compared to 2012. The rate of contraceptive use is also growing rapidly: since 2012, the modern contraceptive prevalence rate (MCPR) among all women in the region has increased from 19.5% to 23.4%, with the fastest growth occurring in Eastern and Southern Africa.

AS OF JULY 2017

309.3 MILLION

WOMEN AND GIRLS ARE USING MODERN CONTRACEPTION IN 69 FP2020 FOCUS COUNTRIES



+38.8 MILLION ADDITIONAL WOMEN AND GIRLS ARE USING MODERN CONTRACEPTION COMPARED TO 2012

AS A RESULT OF MODERN CONTRACEPTIVE USE FROM JULY 2016 TO JULY 2017

84 MILLION UNINTENDED PREGNANCIES WERE PREVENTED

26 MILLION UNSAFE ABORTIONS WERE AVERTED

125 THOUSAND MATERNAL DEATHS WERE AVERTED

IN 2016, DONOR GOVERNMENTS PROVIDED

US$ 1.1 BILLION IN BILATERAL FUNDING FOR FAMILY PLANNING

- More than half of the additional users of contraception are in Asia: 21.9 million. Asia includes four of the five most populous FP2020 countries—India, Indonesia, Pakistan, and Bangladesh—and progress in these countries has a large influence on the total number of additional users. Because MCPR rates are already higher, the rate of contraceptive use is growing more slowly than in Africa, ranging from 0.2 to 0.4 percentage points per year across regions of Asia. In 2017, we estimate that 38% of all women of reproductive age in Asia are using a modern method.

Family planning has an enormous impact on the lives and health of women and girls, as well as on their families, communities, and countries. From July 2016 to July 2017, the use of modern contraception in FP2020 focus countries prevented 84 million unintended pregnancies, 26 million unsafe abortions, and 125,000 maternal deaths.

THE GLOBAL CONTEXT

Shifts in the political landscape over the past year have created an uncertain funding environment for family planning programs. The Mexico City Policy, reduced funding to UNFPA, and changing priorities in the US imperil many programs. The threat to women's health, and to our shared vision of the future, is undeniable.

At the same time, new global initiatives are emerging and some donors are increasing their investments. Worldwide, there is broader recognition of family planning as a development priority. The FP2020 partnership continues to grow, spanning dozens of countries and bringing together national governments, multilateral

agencies, philanthropic foundations, civil society organizations, and private sector partners who all share a powerful commitment to rights-based family planning.

In July 2017, the Family Planning Summit welcomed 25 new partners to FP2020 and generated 74 new and revitalized FP2020 commitments. The Summit was also the occasion for the announcement of 11 Global Goods: groundbreaking group initiatives designed to solve persistent challenges across the family planning sector. These initiatives promise to channel more resources into capacity building, forge pathways to sustainable domestic financing, resolve commodity spending gaps, strengthen global and domestic supply chains, ensure that adolescents are counted and their needs are met, and address the needs of women and girls in crisis settings.

The range and depth of commitments announced at the Summit reflect the growing understanding that rights-based family planning is essential to global development. FP2020 is aligned with the *Every Woman Every Child* Global Strategy for Women's, Children's and Adolescents' Health, and FP2020 commitments to extend the lifesaving benefits of modern contraception play a vital role in contributing to the Global Strategy's goal of ending all preventable deaths of women, children, and adolescents within a generation. Contraceptive access is incorporated in the Sustainable Development Goals, and FP2020's goal of reaching 120 million women and girls is a critical benchmark on the global path to universal access by 2030.

COUNTRY PROGRESS

With new commitments this year from Chad, Haiti, and South Sudan, the FP2020 partnership now includes 41 of our 69 focus countries.[a] As a country-led movement backed by the participation and support of global partners, FP2020 functions as the central platform for progress on family planning. This report includes a step-by-step overview of how FP2020 countries, donors, and partners work together to implement programs that are grounded in human rights principles, based on evidence and data, and accountable to stakeholders. Examples of progress in political advocacy, financing strategies, service delivery, supply chain strengthening, social and behavior change, data usage, and youth outreach are highlighted.

MEASUREMENT

FP2020's measurement agenda is revolutionizing the family planning sector, enabling governments, donors, and civil society organizations to use data for program decisions and investments. This year's report highlights a number of findings:

- **Goal tracking:** Countries are increasingly using data to assess and adjust their family planning programs, and there are now 12 countries within reach of achieving the goals for MCPR growth they established as part of their FP2020 commitments.
- **Wealth disparities:** Among the 19 countries with two comparable surveys of wealth quintile data since the launch of FP2020, 17 have seen an increase in MCPR among the lowest wealth quintile—and in 14 countries that increase has been faster than the national average.
- **Unmet need:** In Eastern and Southern Africa, unmet need for modern methods has dropped by more than 3 percentage points since 2012—by far the largest change of any FP2020 region.
- **Method mix:** Injectables are the most common method in use in 28 countries, followed by pills in 16 countries, condoms in 9 countries, and IUDs in 8

countries. Implants and injectables are continuing to increase in prevalence.
- **Contraceptive discontinuation:** A new indicator for contraceptive discontinuation will provide a better understanding of when and why women stop using contraceptives or switch to a different method.

FP2020's measurement agenda also contributes to the Unified Accountability Framework for the *Every Woman Every Child* Global Strategy.

THE WAY AHEAD

Family planning is both a basic right and a life-changing, transformational health service with the potential to accelerate progress across all our development goals. The FP2020 platform has proven to be effective, flexible, and resilient in the face of change. Although the current funding environment for family planning is in flux, our vision of the future remains clear.

We believe that every woman and girl must be empowered to shape her own life. We know that rights-based family planning is a critical element to empowerment. And we are confident that the FP2020 approach—country-led, grounded in human rights principles, buttressed by data and evidence, and accountable to all—is the way ahead.

Photo by
Emily Major-Girard
Photoshare

a. 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.

INTRODUCTION

FROM THE FP2020 REFERENCE GROUP CO-CHAIRS

The 2017 Family Planning Summit in July was a tremendous high point for the entire FP2020 community: a global moment of solidarity, celebration, and renewal. We gathered to take stock of how far we've come, make plans for the road ahead, and renew our pledge to ensure that women and girls are able to decide for themselves whether and when to use modern contraception. A total of 74 commitment makers stepped forward with new and renewed commitments to fund, expand, and support rights-based family planning—including 25 new partners making FP2020 commitments for the first time. It was the single largest expansion of the FP2020 partnership since this movement began.

But the past year has also been marked by uncertainty and sorrow.

In June, just weeks before the Summit, we lost a colleague, a friend, and a guiding light of the family planning movement, Dr. Babatunde Osotimehin. As the executive director of UNFPA, Dr. Osotimehin also served as the co-chair of the FP2020 Reference Group from the earliest days of this initiative. His wise and impassioned leadership was an example for us all. Dr. Osotimehin dedicated his life to the rights of women and girls. He believed profoundly that every woman and girl on earth must be empowered to grow, thrive, and shape her own life. We carry his legacy with us in our hearts and in our work.

This community is **united, resilient, and ready to meet the future.**

The family planning community has also been buffeted by political transitions that signal changes to the international development framework—changes that will, at best, prove challenging for our sector. The expanded Mexico City Policy (which restricts funding to more reproductive health organizations than ever before), reduced funding to UNFPA, and shifting donor priorities create an uncertain environment for family planning and broader health programs around the world.

These uncertainties compound existing challenges that we are already working hard to overcome: developing country-led sustainable financing models for family planning; strengthening the supply chain for commodities and expanding the range of high-quality contraceptives available; meeting the reproductive health needs of adolescents and youth; and reaching the hardest to reach—the poor, the marginalized, and the displaced.

But as the Summit demonstrated so clearly, this community is united, resilient, and ready to meet the future. The outpouring of energy and commitment at the Summit was exhilarating. It was a privilege to witness the dedication of the family planning stalwarts—the policymakers, program managers, service providers, and advocates—who work tirelessly year in and year out to build strong, sustainable, rights-based family planning programs. It was inspiring to hear the voices of young people who are stepping up to take charge of their own futures. Most encouraging of all, perhaps, was the realization of how far we've come since 2012:

- Countries are setting the pace of progress, leading the way with commitments that are more detailed, targeted, actionable, and measurable than ever before.
- FP2020 partners are poised to deploy next-generation solutions in supply chain strengthening, financing, data collection, and contraceptive technology.
- Adolescents and youth are now front and center on the agenda, with dozens of commitments prioritizing their needs. Young people are also *leading* the agenda: participating in high-level forums, conducting new research, and engaging in advocacy efforts with decision makers.
- New initiatives from governments and donors are tightly targeted to fill gaps, shore up weak spots, and deliver more services to more women and girls, even in humanitarian settings.
- The 11 groundbreaking Global Goods announced at the Summit have the potential to catalyze progress across the entire family planning sector.

And the Summit in London wasn't the only exciting breakthrough of the year. SheDecides, launched in reaction to the Mexico City Policy, is evolving into a global movement to support and defend women's rights. Canada's Global Adolescent Health Conference inaugurated the development of a global roadmap for adolescent health. The African Union's Year of the Demographic Dividend reflects the growing recognition that better health for young people, including access to voluntary family planning, is crucial for development. And *Every Woman Every Child* launched the 2020 Partners' Framework, which aligns action and accelerates progress across the entire *Every Woman Every Child* movement.

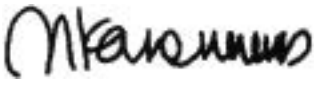
All this is evidence of the broad, deep, sustaining strength of the family planning and reproductive health communities. There may be uncertainties on the horizon, daily outrages in the headlines, and challenges we should have solved a long time ago, but our community's dedication to women and girls is stronger than ever.

For FP2020, the way ahead is clear. We have dozens of new Summit commitments to follow through on. We're going to keep a sharp focus on rights, accountability, the financing landscape, and the evolving global pathway that links FP2020 progress to universal access to reproductive health by 2030. We're going to support our partner countries, who are the leaders of this movement and the pacesetters of progress. And we will leave no one behind. We will redouble our efforts to reach those who are too often overlooked: adolescents and youth, the poor and the marginalized, women and girls in crisis settings.

Together we're going to step boldly into the next phase of this movement.

As we do so, let's remind ourselves that FP2020 is more than just a working platform for development. We are a community dedicated to the rights of women and girls, and we affirm those values every day. We believe that every woman and girl, no matter where she lives, deserves the chance to grow and thrive, to work and earn, to plan her own family and shape her own future. FP2020 builds on more than 50 years of dedicated work by the global reproductive health sector to bring contraception within reach of women and girls around the world. This community carries that movement forward—now more than ever.

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



Dr. Natalia Kanem
Executive Director
UNFPA

INTRODUCTION

FROM FP2020'S EXECUTIVE DIRECTOR

This year's report is the story of our partnership. A partnership that is growing, vibrant, and unique.

FP2020 is a country-led movement to empower women and girls by investing in rights-based family planning. That's revolutionary. It's what we've built together over these last five years—and it's what's going to take us into the future.

The past year has been full of highs and lows, but what has come through so clearly is the strength and resilience of this partnership. Durability and flexibility are built into this initiative from the ground up, ensuring that we can weather external changes and adapt to new situations. FP2020 brings country and global partners together in an unprecedented and incredibly powerful way.

And by FP2020, I mean all of us. The governments, the donors, the implementing partners, the advocates, the youth leaders—all of us. We are all FP2020. We are all in this together, all working to realize our shared vision of the future. That's why this year's report includes voices from throughout the partnership. In these pages you'll hear from some of the many government ministers, technical experts, and civil society leaders who are part of the FP2020 movement.

FP2020 brings country and global partners together in an unprecedented and incredibly powerful way.

We're also dedicating a portion of the report this year to explaining how the FP2020 partnership works. The platform we've built is resilient, inclusive, and effective. In the FP2020 approach, countries are in the driver's seat. The development framework is aligned with country goals, and supports programs that are grounded in a rights-based approach, founded on evidence-based practices, underpinned by a robust measurement agenda, and accountable to stakeholders. South-South collaboration is also a vital element, and our regional workshops provide an essential forum for countries to engage with and learn from each other.

Collaboration across sectors and across institutions is another defining feature of the FP2020 platform. FP2020 provides space for governments and civil society to connect, for experts to share their knowledge, for donors to align their investments for maximum effectiveness, and for the global family planning community to take joint action on critical issues.

A partnership that is united can weather any storm. But we can do more than that: by working more closely together than ever, we can deliver on the revolutionary promise that is FP2020.

Beth Schlachter
Executive Director
Family Planning 2020

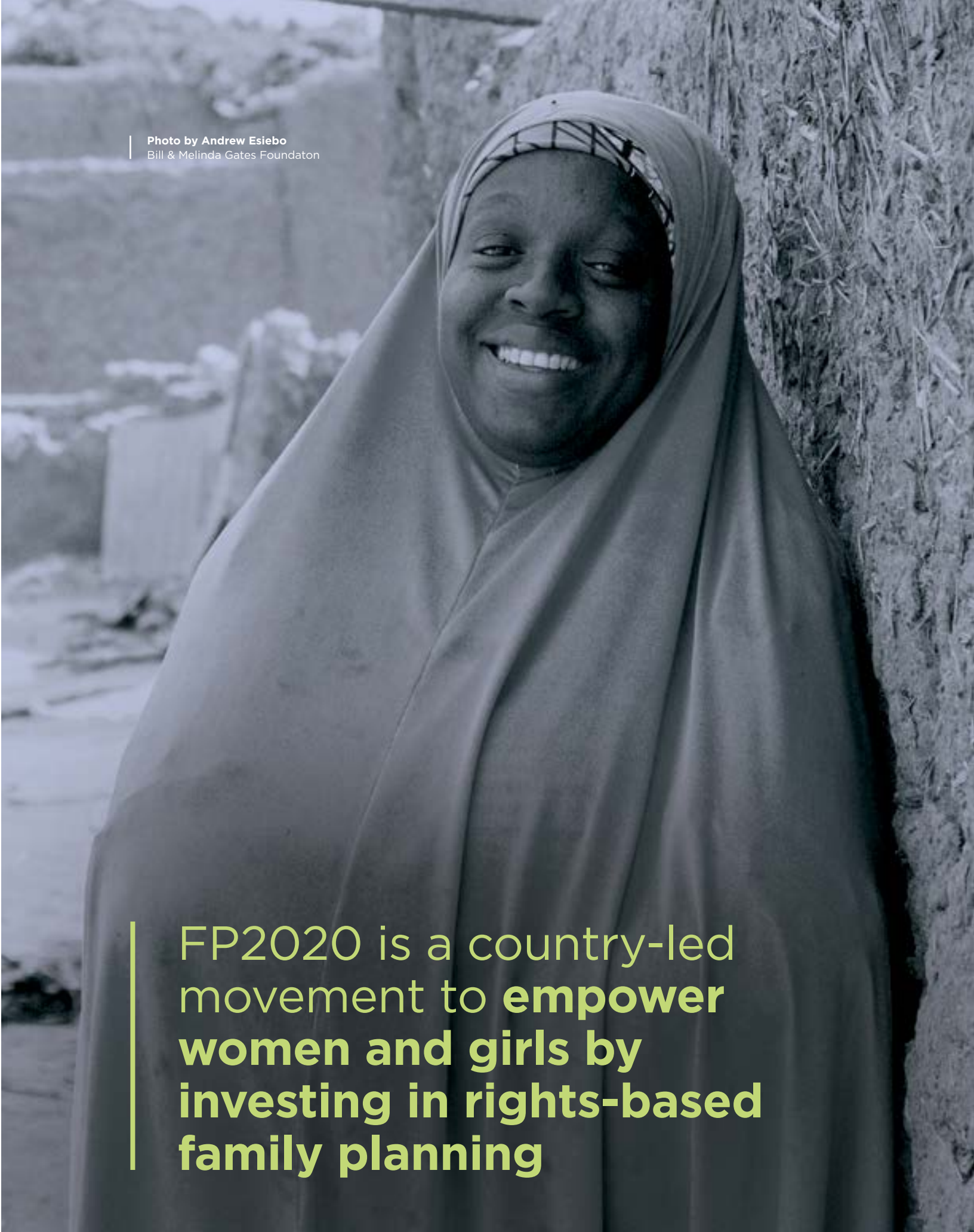


Photo by Andrew Esiebo
Bill & Melinda Gates Foundaton

FP2020 is a country-led movement to **empower women and girls by investing in rights-based family planning**

Photo by Riccardo Gangale
Bill & Melinda Gates Foundation

INTRODUCTION

THE FP2020 PARTNERSHIP

FP2020 is a global community of partners working together to advance rights-based family planning. We are dedicated to ensuring that women and girls are empowered to decide, freely and for themselves, whether, when, and how many children to have. Our partnership was launched at the 2012 London Summit on Family Planning, with the goal of enabling 120 million additional women and girls in the world's poorest countries to use voluntary modern contraception.

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.

OUR VISION

FP2020 is built on the premise that the life-changing benefits of modern contraception should be available everywhere in the world. The vision that draws us forward is of a future where every woman and girl is able to take charge of her own life, plan her own family, and determine her own destiny. We aim to realize that vision through country-led family planning programs that are grounded in a rights-based approach, informed by broad stakeholder engagement, implemented using evidence-based practices, underpinned by a robust measurement agenda, funded through sustainable financing streams, and accountable to all.

FP2020 progress is key to realizing the promise of *Every Woman Every Child*, and is inextricably linked with the Sustainable Development Goals agenda. Access to family planning is also a prerequisite for capturing the demographic dividend. FP2020 envisions rights-based family planning programs as the cornerstone of a country's wider development strategy to improve reproductive, maternal, newborn, child, and adolescent health (RMNCAH).

WHO WE ARE

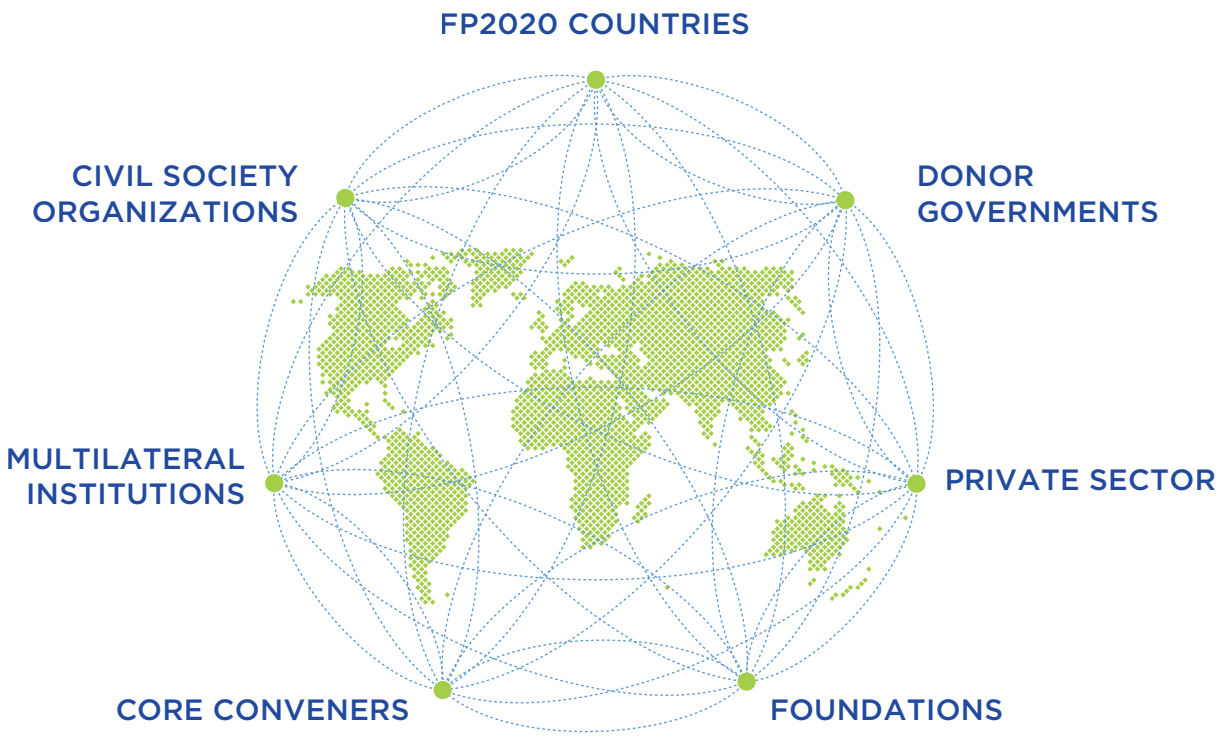
Our partners include FP2020 focus country and donor governments, civil society organizations (including youth-led organizations and networks), multilateral institutions, foundations, and private sector partners.

The Core Conveners of the FP2020 initiative are the Bill & Melinda Gates Foundation (BMGF), the UK Department for International Development (DFID), the United Nations Population Fund (UNFPA), and the US Agency for International Development (USAID). FP2020 is hosted by the United Nations Foundation.

The FP2020 Reference Group is responsible for overall strategic direction and coordination of the initiative. Its 23 members represent governments, multilateral institutions, civil society, foundations, and the private sector. The current co-chairs are Dr. Natalia Kanem, executive director of the United Nations Population Fund, and Dr. Chris Elias, president of global development at the Bill & Melinda Gates Foundation.

The Secretariat is responsible for the day-to-day administration of the initiative. The Secretariat works with partners to provide country support, collaborate on data and performance management, advocate for the rights of women and girls, share

The FP2020 Partnership



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

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

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

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

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

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

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.

and expand best practices, build and maintain momentum within the global family planning movement, and support partners in delivering on commitments.

Measurement partners include the **Performance Monitoring & Evidence Working Group**, **Track20**, **PMA2020**, the **Demographic Health Survey**, and others who work to align and improve family planning measurement. FP2020 collaborates closely with Track20 and with governments in FP2020 countries to collect, analyze, and use data to monitor progress and improve family planning strategies and plans.

The Expert Advisory Community is a volunteer network of more than 140 technical experts on family planning who can be mobilized to address specific challenges at the country and global level.

FP2020 Focal Points in each country include representatives from the government, donor agencies, and civil society. These focal points serve as the key representatives of FP2020 in-country, and coordinate with each other, the government, other partners and stakeholders, and the FP2020 Secretariat to drive progress on the country's family planning goals.

Photo by Prashant Panjiar
Bill & Melinda Gates Foundation

01 | FP2020 IN COUNTRIES

How FP2020 Works

A country-led approach to developing rights-based family planning programs that are sustainable, accountable, and supported by data and evidence

1

p. 21

The FP2020 process begins when a country makes a **commitment**. The FP2020 partnership connects countries with the FP2020 Secretariat and a global network of partners, donors, and experts.

COUNTRY COMMITMENT TO FP2020

2

p. 25

A team of **focal points** representing the government, civil society, and core partners work with the FP2020 Secretariat and stakeholders to drive progress on the country's FP2020 goals.

3

p. 39

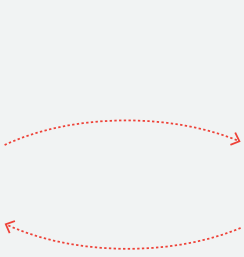
Track20 works with the government to identify, train, and support dedicated M&E officers. **Annual data workshops** provide a platform to review data and assess progress toward the country's FP2020 goals.

4

p. 35

FP2020 support is aligned with the country's family planning **costed implementation plan** or other national strategy. The government collaborates with stakeholders and FP2020 partners to develop and implement the plan.

The costed implementation plan covers the major elements of a family planning program, which can be grouped into six thematic areas.



5

p. 26

Every 18 months the focal points attend **FP2020 regional focal point workshops** with experts, partners, the FP2020 Secretariat, and other country teams. Each team develops an Actions for Acceleration plan.

6

p. 26

The **Actions for Acceleration plan** is a short-term agenda of immediate next steps in alignment with the costed implementation plan. The focal points develop a new action plan at each workshop.

Harnessing the Future

A successful family planning program lays the groundwork for sustainable development and a healthier, more prosperous future (p. 67).

Rights - p. 31

A rights-based approach serves as the overarching framework for the entire program.

- **Financing** p. 43
- **Enabling Environment** p. 49
- **Social and Behavior Change** p. 51
- **Service Delivery** p. 53
- **Supply Chain** p. 59
- **Monitoring and Accountability** p. 39

High Impact Practices - p. 61

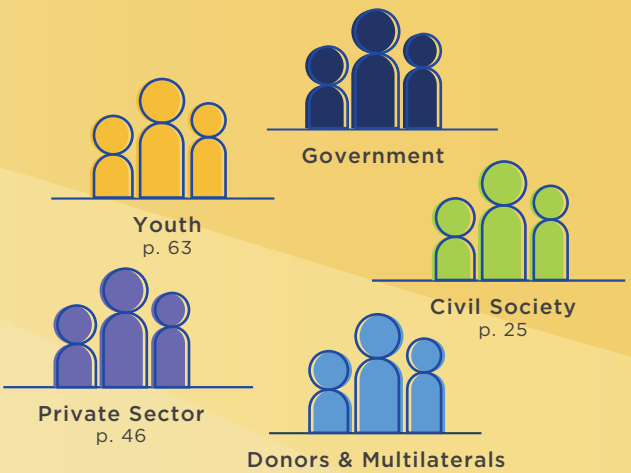
Evidence-based interventions can be used throughout for maximum effectiveness.

Data - p.39

Accurate data provide a solid foundation for a country's family planning program, from setting goals and developing the costed implementation plan through monitoring annual performance. Track20 and the FP2020 Secretariat work with the government to translate data into information for decision-making.

Family Planning Stakeholders

Broad-based stakeholder engagement is essential at every step, from design through implementation and monitoring.



CHAPTER 01

MAKING THE COMMITMENT

LEARN MORE

Read the full country commitments at: **familyplanning2020.org/countries**.

The FP2020 process begins when a country makes a formal commitment to the FP2020 partnership. The commitment is a specific statement of intent, outlining the country's strategic goals and its plans to develop, support, and strengthen its family planning program. As such, it functions as a blueprint for collaboration, providing partners with a shared agenda and measurable goals.

When countries commit to FP2020, they are charting a course for the future. Rights-based family planning is a transformational strategy that will lead to healthier and more prosperous women, children, families, and communities. FP2020 contributes to the *Every Woman Every Child* Global Strategy for Women's, Children's and Adolescents' Health, and family planning is a powerful driver of progress across the entire Sustainable Development Goals agenda. Rights-based family planning is also essential to unlocking the demographic dividend.

The FP2020 process in countries is designed to foster transparency and accountability at every step. The FP2020 partnership links countries with a global network of partners, donors, experts, and advocates who are committed to developing sustainable programs that are grounded in human rights, informed by best practices, and integrated with the country's overall development strategy.

NEW FOCUS COUNTRY COMMITMENTS

A total of 41 FP2020 focus countries have joined the partnership since 2012, including three new commitments announced at the Family Planning Summit in July 2017:

CHAD

The Government of Chad committed to:

- Increase the modern contraceptive prevalence rate among all women from 5% to 8% by 2020;
- Reach 115,000 additional users between 2017 and 2020, and additional users among adolescents and youth; and
- Accelerate the operationalization of the *National Development Plan 2017–2020*.

Chad is developing a new national framework for the demographic dividend, with a focus on advocacy, resource mobilization, and the right to family planning access for adolescents and youth. Chad will establish a rights-based approach to family planning programming, with particular focus on training providers, ensuring a wide method mix with free informed choice, and mobilizing the community. Chad will also invest in comprehensive sexual education for youth, strengthen its data systems, introduce efficient supply chain strategies, and create a budget line for contraceptive commodities.

HAITI

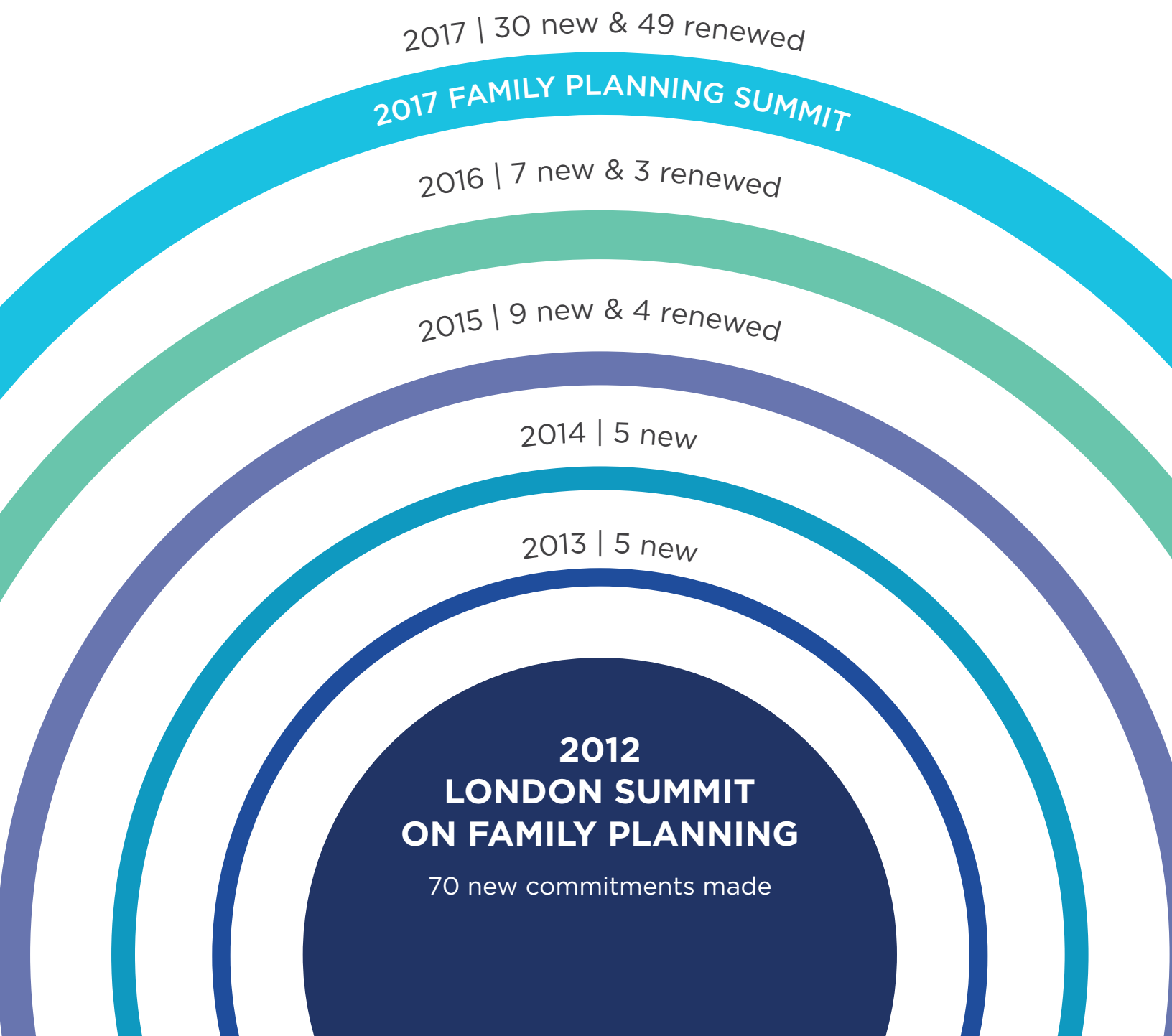
The Government of Haiti committed to:

- Reduce the unmet need by 10% and increase the modern contraceptive prevalence rate among all women by 10%;
- Strengthen the maternal health care continuum by integrating postpartum and

Page 17 Photo by Adrian Brooks
Photoshare

A Growing Partnership

More than 125 Commitment Makers



post-abortion family planning and improving links between family planning and HIV/AIDS and immunization programs;
- Expand service delivery, including to the last mile, and offer a complete modern method mix (including long-acting and permanent methods) at the community level;
- Establish a legal framework for the sexual and reproductive health of adolescents and youth;
- Integrate a budget line in the Ministry of Public Health budget to increase the resources allocated to family planning/reproductive health; and
- Contribute a progressive amount up to 5% toward the purchase of contraceptives by 2020.

Haiti will create an inter-ministerial committee working on reproductive health, including the Ministry of Public Health (which will be in charge of monitoring); the Ministry of National Education and Professional Training; the Ministry for the Status of Women and Women's Rights; the Ministry of the Interior and Territorial Communities; the Ministry of Youth, Sports and Civic Action; and the Ministry of Social Affairs.

SOUTH SUDAN

The Government of South Sudan committed to:
- Improve the availability of and access to family planning information and services through the provision of rights-based integrated sexual and reproductive health services;
- Increase the modern contraceptive prevalence rate among married women from 5% (2016 estimate) to 10% by 2020; and
- Reduce the maternal mortality ratio by 10% by 2020.

The Government of South Sudan is committed to removing institutional and social-cultural barriers to sexual and reproductive health for all and to sensitizing its population to improve universal access to rights-based, comprehensive family planning services by 2020.

REVITALIZED COUNTRY COMMITMENTS

At the Family Planning Summit in July 2017, 33 FP2020 countries chose to revitalize their existing commitments with renewed and expanded pledges: outlining new objectives, dedicating larger budget allocations, delivering more resources, and reaching more women and girls.

Bangladesh
Benin
Burkina Faso
Burundi
Côte d'Ivoire
DR Congo
Ethiopia
Ghana
Guinea
India
Indonesia
Kenya
Liberia
Madagascar
Malawi
Mali
Mauritania
Mozambique
Myanmar
Nepal
Niger
Nigeria
Pakistan
Philippines
Rwanda
Senegal
Sierra Leone
Somalia
Tanzania
Togo
Uganda
Zambia
Zimbabwe

"[As an FP2020 commitment-maker] we found ourselves connected to the world; we are actively representing Afghanistan in the global fora and sharing our successes and challenges with others; learning and replicating best practices considering our country context; and at the country level, our key partners' roles have been streamlined and our partnerships have been strengthened."

—

DR. ZELAIKHA ANWARI

Reproductive Health Director, Ministry of Public Health

Afghanistan

CHAPTER 02

CONNECTING WITH FP2020 SUPPORT

As soon as a country joins the FP2020 partnership, stakeholders from the family planning sector form a small FP2020 focal point team. The focal points are individuals representing the government (typically the Ministry or Department of Health), donor agencies (in most countries this is UNFPA and USAID, with DFID, BMGF, Global Affairs Canada, and Agence Française de Développement in some countries), and, as of 2017, civil society. In many countries the focal points are already working closely together, and the FP2020 structure provides a new way for global partners to support their efforts.

The FP2020 focal points serve as the key representatives of the FP2020 movement in-country. They coordinate with each other, the government, other partners and stakeholders, and the FP2020 Secretariat to drive progress on the country's family planning goals. The FP2020 Secretariat works closely with each focal point team to identify challenges and accelerate implementation.

The focal point system is grounded in the recognition that a strong country-led partnership, with broad stakeholder engagement across multiple sectors, is the most effective means of mobilizing progress on an ambitious family planning strategy.

CIVIL SOCIETY FOCAL POINTS

When the FP2020 focal points were first established in 2013, the country teams included only representatives from the government and donor agencies. This past year we began the process of expanding each country team to include a civil society focal point as well.

Civil society organizations (CSOs) are essential partners in the family planning sector. They are service providers, technical experts, policy advisors, youth leaders, community representatives, and the crucial implementing partners who help governments realize their family planning strategies. Including a CSO representative on the focal point team better reflects how family planning programs and in-country technical partnerships really work.

The focal point expansion was launched in early 2017 with FP2020 countries in Asia, in time for the Second Asia Regional Focal Point Workshop in May (page 29). Following feedback from the launch in Asia, nominations for civil society focal points in the Anglophone Africa countries were finalized in time for their regional workshop in November in Malawi. (See the next page for more on the workshop system.) The nine countries of the Ouagadougou Partnership already have civil society focal points who will now serve in that same capacity for FP2020; nominations for the remaining Francophone countries were finalized in the latter half of 2017.

ALIGNING WITH THE COSTED IMPLEMENTATION PLAN

FP2020 support is aligned with the country's FP2020 commitment and with its costed implementation plan (CIP). The CIP is a multi-year roadmap for implementing the country's long-range family planning strategy and achieving its FP2020 goals. Some countries have already developed their CIPs before officially committing to FP2020; those that have not are offered technical assistance with the process. See page 35 for an in-depth discussion of CIPs.

FOCAL POINT WORKSHOPS

The FP2020 Secretariat convenes regional workshops for focal point teams in Asia, Anglophone Africa, and the Francophone countries every 18 months. These workshops are at the heart of what FP2020 does, providing the space and technical assistance for countries to refine and assess their rights-based family planning strategies. The workshops are attended by technical experts, global partners, representatives from the FP2020 core conveners, and focal point teams from all the commitment-making FP2020 countries in the region.

The goals of each focal point workshop are threefold:

- Accelerate progress on the country's family planning goals by developing an action plan in alignment with the CIP (see below).
- Broaden the evidence base by cultivating South-South collaboration as well as knowledge exchange between countries and technical experts.
- Strengthen FP2020 collaboration with partners and stakeholders in-country, within regions, and across the global partnership.

ACTIONS FOR ACCELERATION

Each focal point team develops its Actions for Acceleration plan (commonly referred to as an action plan) at their regional focal point workshop. The action plan is aligned with the country's FP2020 commitment and CIP, and outlines the immediate priorities for the next 18 months. It functions as a shared working agenda for the FP2020 focal points, their partners and stakeholders in-country, and the FP2020 Secretariat.

Because the action plan is a short-term document, with a new one developed at each workshop, it's flexible enough to address changing conditions and emerging priorities. The action plan identifies immediate objectives that need to be achieved in order to accelerate progress on the country's family planning commitments and strategy. The action plan also facilitates resource matching and technical assistance as pivotal priorities emerge and are identified.

BANGLADESH: ACTIONS FOR ACCELERATION 2017-2018

Bangladesh's family planning strategy is guided by its *Costed Implementation Plan for the National Family Planning Program 2016-2020* (the CIP), which outlines a multi-year process to achieve the country's FP2020 goals. Bangladesh's current Actions for Acceleration plan is a working agenda developed by the FP2020 focal point team. It covers the period from mid-2017 to late 2018, and details specific activities that will support progress on the CIP.

For example, one of the objectives identified in the CIP is to strengthen the national family planning program through cross-sectoral partnerships and collaborations. The goal by 2020 is to have in place "effective partnerships between government, NGOs, and community stakeholders."

To make progress on this objective, the action plan called for a civil society forum on family planning to be convened in 2017. The focal points representing UNFPA and EngenderHealth took the lead on organizing what became a joint CSO/government Partnership Workshop, held in October 2017. More than 30 Bangladesh CSOs attended the workshop to learn more about the country's FP2020 program and explore opportunities for civil society to be involved. The next step will be to formalize the collaborations and partnerships discussed at the workshop.

Action plans are also useful for highlighting unexpected issues. In April 2017, a fire at Bangladesh's central family planning warehouse destroyed most of the contraceptive commodities that were stored there. The focal points included a line item in the action plan identifying the urgent need to replace these commodities. The issue was resolved with assistance from UNFPA and an additional budget allocation from the government.

Read Bangladesh's *Actions for Acceleration 2017–2018* at: familyplanning2020.org/bangladesh.

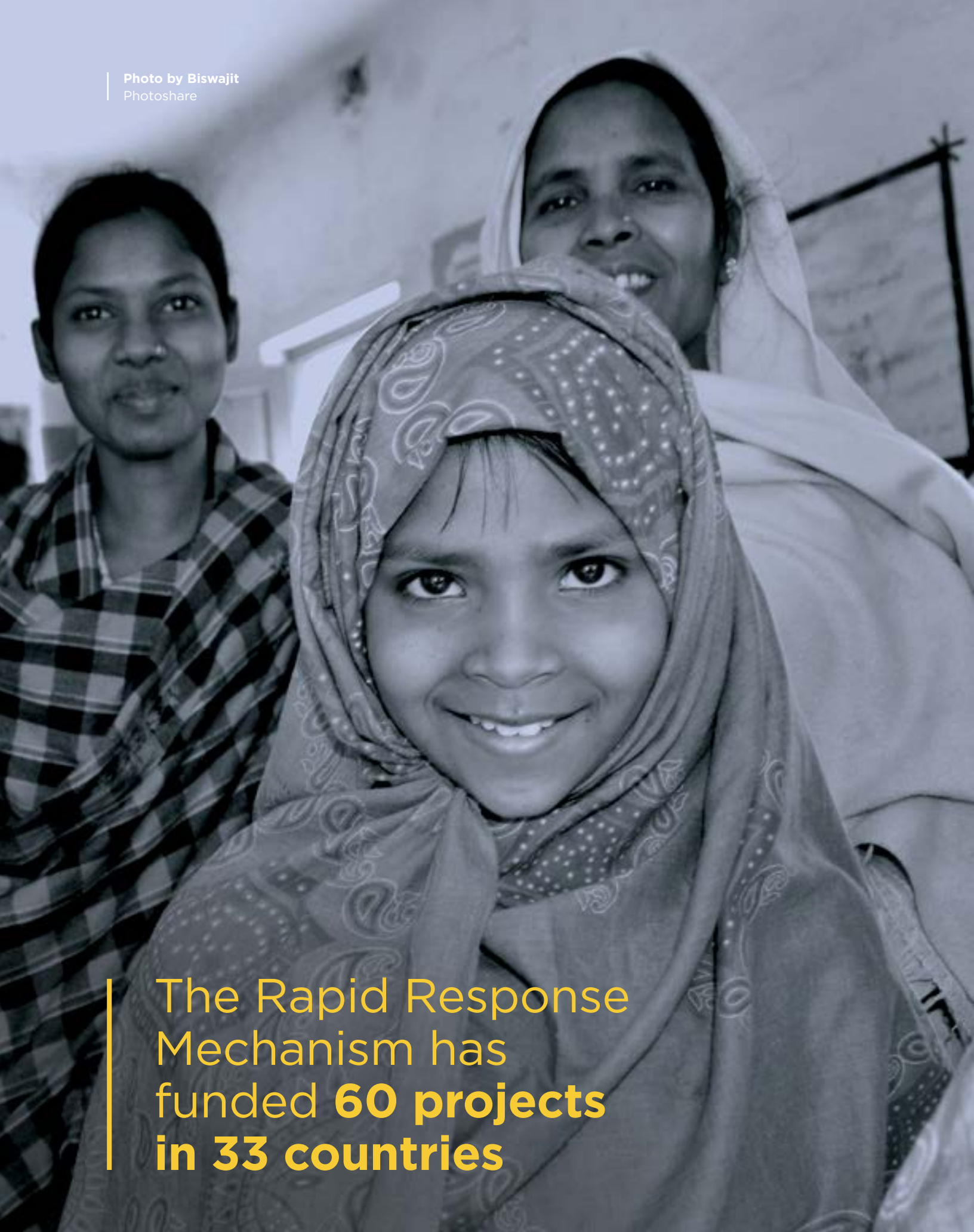


Photo by Biswajit
Photoshare

The Rapid Response Mechanism has funded **60 projects in 33 countries**

THE RAPID RESPONSE MECHANISM

The Rapid Response Mechanism (RRM) is an important element of FP2020's country support efforts, providing resources quickly to meet time-sensitive needs and opportunities. Established in July 2014 by Bloomberg Philanthropies and FP2020, and subsequently joined by the Bill & Melinda Gates Foundation and an anonymous donor, the fund disburses short-term, high-impact grants in FP2020 focus countries. Since its inception, the RRM has funded 60 projects in 33 countries and disbursed a total of US$5,031,928 (as of August 2017).

The RRM funds projects that will expand rights-based family planning programs in FP2020 focus countries. In countries that have made an FP2020 commitment, the RRM also supports specific needs that are identified in the commitment, action plan, or costed implementation plan. Grantees include local grassroots partners as well as international NGOs.

Visit our Rapid Response Mechanism microsite at: familyplanning2020.org/RRM.

CASE STUDY: NIGERIA

Nigeria's 2012 London Summit commitment included adopting a task-shifting policy and training frontline health workers to deliver a range of contraceptives. When Nigeria launched its *Nigeria Family Planning Blueprint (Scale-Up Plan)* for 2014–2018, the training of community health workers was highlighted as a priority. But the first rounds of training were delayed due to resistance from nurses' unions, who felt their profession could be threatened.

In 2015 Nigeria approved a task-shifting policy that would authorize trained community health workers to provide long-acting reversible contraceptives (LARCs). To jumpstart the process, FP2020 awarded an RRM grant to the Clinton Health Access Initiative (CHAI) for a pilot project. CHAI trained 290 community health workers on LARCs in three states, and successfully demonstrated to national stakeholders that task-shifting had no effect on the role of traditional providers such as nurses and doctors.

A year later FP2020 awarded a second grant, this time to Marie Stopes Nigeria, to train 60 health extension workers on LARCs and build a pool of competent master trainers in five states.

In 2017 the FP2020 focal points in Nigeria confirmed that the task-shifting policy had been deemed a success, and that the government was following through on its 2012 commitment to invest additional resources in training.

CASE STUDY: VIETNAM

Vietnam joined the FP2020 partnership in 2016 with a commitment to ensure universal family planning access and youth-friendly services. An RRM grant to Pathfinder International is supporting technical assistance to the Government of Vietnam to develop a costed implementation plan. Another RRM grant, to UNFPA, is underway to provide family planning services to young migrant workers—one of the priorities outlined in Vietnam's FP2020 commitment. A third RRM grant, to the Vietnam Public Health Association, supported 15 youth representatives to develop a youth recommendation brief and to host and facilitate discussions at the 9th Asia Pacific Regional Conference on Sexual and Reproductive Health and Rights.

SPOTLIGHT

THE ASIA REGIONAL FOCAL POINT WORKSHOP IN MANILA

FP2020's second Asia Regional Focal Point Workshop was held in Manila on May 8–10, 2017. The workshop was attended by delegates from 11 countries—Afghanistan, Bangladesh, India, Indonesia, Lao PDR, Myanmar, Nepal, Pakistan, the Philippines, the Solomon Islands, and Vietnam—along with representatives from UNFPA, USAID, DFID, BMGF, the World Health Organization, and a range of other technical partners.

The chief objective was for each country team to develop an action plan: a working agenda to drive progress on the country's family planning goals. Action plans are aligned with a country's FP2020 commitment and family planning CIP, and are designed to identify the key priorities to be addressed in the next 18 months. Each of the 11 country teams emerged from the workshop with a fully drafted action plan, which they took back to their governments, stakeholders, and partners for validation and finalization.

EXPERT PANELS

Implementing a rights-based approach to family planning was the central focus throughout the workshop. The first day set the tone, with a human rights expert walking the group through what rights-based family planning means and what it looks like programmatically. The emphasis was on the concrete: how do we use rights as a lens to develop programs? What are the outcomes we're looking for?

Subsequent sessions continued the theme of real-world, hands-on application: understanding data and using it effectively to guide programming and investments; implementing evidence-based high-impact practices; designing programs that meet the needs of young people; and mobilizing resources for family planning, including domestic government investment, private sector channels, and the Global Financing Facility.

SOUTH-SOUTH EXCHANGE

FP2020 focal point workshops are always a venue for South-South exchange, and this workshop was no exception. Presentations by country teams included:

- **Afghanistan** on the process of implementing its country action plan
- **Bangladesh** on effective data utilization, reaching married adolescents, and its experience with the Global Financing Facility
- **India** on securing state budget allocations for family planning
- **Indonesia** on mobilizing private sector resources
- **Lao PDR** on the experience of developing a costed implementation plan
- **Myanmar** on its Global Financing Facility investment case
- **Nepal** and the **Solomon Islands** on in-country coordination
- **Pakistan** on improving supply chain and delivery systems
- **Philippines** on reproductive rights and commodity sourcing
- **Vietnam** on market segmentation and its survey of adolescent and young adult sexual health

Page 30 Photos by FP2020 Secretariat

CIVIL SOCIETY

This was the first FP2020 workshop to include civil society focal points in each country delegation, alongside focal points representing the government and donor agencies. The workshop also solidified an emerging practice of following each FP2020 regional, technical, or Reference Group meeting with a day-long forum for local CSOs, dedicated entirely to in-depth learning and planning around in-country advocacy (see box).

CSO FORUM

The workshop was followed by a one-day Civil Society Organization (CSO) Forum, attended by an estimated 90 representatives from Philippine civil society. The CSO Forum was co-hosted by FP2020 and the Reproductive Health Advocacy Network, a consortium of civil society organizations championing the reproductive health and rights of the Filipino people.

The purpose of the forum was to develop a coordinated CSO plan of action to tackle obstacles to the Responsible Parenthood and Reproductive Health Law, which continues to be stymied by a temporary restraining order imposed by the Supreme Court. Topics on the agenda included:

- The state of the family planning program, including legal issues, financing, and operational context
- The current government's direction and strategies
- CSO engagement in family planning as providers, community mobilizers, and advocates
- How FP2020 works and how the platform can be leveraged by government and CSOs

The day also featured a series of technical discussions on high impact practices, using data for advocacy, rights-based family planning, and how to interact with country focal points.

CHAPTER 03

PUTTING RIGHTS AT THE CENTER

LEARN MORE

Visit our Rights-Based Family Planning microsite at: **familyplanning2020.org/rightsinfp**.

Human rights are at the core of FP2020's vision and mission. Our goal isn't just to reach 120 million additional women and girls with family planning; it's to ensure that each one of those women and girls is able to exercise her basic rights to self-determination, health, dignity, and equality. The fulfillment of human rights is not separate from FP2020 progress; it is FP2020 progress.

RIGHTS PRINCIPLES IN FAMILY PLANNING

Human rights are the inalienable entitlements of all people, at all times, and in all places. As articulated in the Universal Declaration of Human Rights and affirmed in treaties, human rights are legal obligations with the status of international law. Reproductive rights embrace certain human rights, and have been identified, agreed upon, and affirmed by international consensus in conference documents and declarations.

There are three main pillars of rights-based family planning:
- **Right to reproductive self-determination**
- **Right to sexual and reproductive health services, information, and education**
- **Right to equality and non-discrimination**

The illustration on the next page shows how these three pillars form the basis of **FP2020's Rights and Empowerment Principles**, and how FP2020's Core Indicators measure various dimensions of rights-based family planning. More information and resources are available at FP2020's Rights-Based Family Planning microsite.

WHY IT MATTERS

Addressing rights is uniquely important in family planning programs. Family planning involves gender and power dynamics as well as religious and cultural sensitivities. And because family planning has demographic implications, governments set goals for use. Without a rights-based focus, the potential for coercion and abuse exists.

MOVING FROM NUMBERS TO PEOPLE

A rights-based approach to family planning is one in which all phases of a program are viewed through the lens of respecting, protecting, and fulfilling rights: establishing policy, conducting needs assessment, planning, implementation, monitoring, evaluation, and problem management. Rights-based family planning is driven by the needs and rights of the people the program is meant to serve, rather than the program's numeric goals.

This doesn't mean that numbers are unimportant. Numeric goals set a direction for progress and provide a yardstick for measuring it. The key is in remembering that the numbers are just indicators. The real success of a program lies in how well it meets the needs of the people it serves.

Human rights and related principles that apply to family planning have been affirmed by international consensus in treaties, conference documents, and declarations.

The three pillars of reproductive rights are grounded in these international conventions.

RIGHT TO REPRODUCTIVE SELF-DETERMINATION

Individuals and couples can choose whether, when, and how many children to have.

RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES, INFORMATION, AND EDUCATION

They can act on those choices through high-quality services, information, and education.

RIGHT TO EQUALITY & NON-DISCRIMINATION

They have access to those services free from discrimination, coercion, and violence.

FP2020 RIGHTS AND EMPOWERMENT PRINCIPLES

These 10 principles build upon human rights principles and are critical to growing sustainable, equitable, and effective family planning programs with lasting impact.

AGENCY AND AUTONOMY

Individuals must be able to choose a contraceptive method voluntarily, free of discrimination, coercion, or violence. *Core Indicator 16*

EMPOWERMENT

Individuals are empowered as principal actors and agents to make decisions about their reproductive lives. *Core Indicator 16*

Several FP2020 Core Indicators measure dimensions of rights-based family planning:

- ***Core Indicator 9:*** *Method Mix*
- ***Core Indicator 10:*** *Stock-outs*
- ***Core Indicator 11:*** *Method Availability*
- ***Core Indicator 14:*** *Method Information Index*
- ***Core Indicator 15:*** *Counseling*
- ***Core Indicator 16:*** *Decision Making*
- ***Core Indicator 18:*** *Discontinuation & Method Switching*

For Core Indicator analyses and Estimate Tables, please see the Measurement Section of the report (pages 89-126).

ACCEPTABILITY

Healthcare facilities, trained providers, and contraceptive methods are respectful of medical ethics and individual preferences, are sensitive to gender and life-cycle requirements and respect confidentiality. *Core Indicator 18*

ACCESSIBILITY

Healthcare facilities, trained providers, and contraceptive methods are accessible—without discrimination, and without physical, economic, socio-cultural, or informational barriers.

AVAILABILITY

Healthcare facilities, trained providers, and contraceptive methods are available to ensure that individuals can exercise full choice from a full range of contraceptive methods. *Core Indicators 10 & 11*

QUALITY

Individuals have access to contraceptive services and information of good quality that are scientifically and medically appropriate. *Core Indicator 18*

INFORMED CHOICE

To exercise full, free, and informed decision making, individuals can choose among a full range of safe, effective, and available contraceptive methods. *Core Indicators 9, 14, 15 & 16*

EQUITY AND NON-DISCRIMINATION

Individuals have the ability to access quality, comprehensive contraceptive information and services free from discrimination, coercion, and violence.

To highlight disparities in contraceptive use, unmet need, and demand satisfied, FP2020 publishes estimates for Core Indicators 2, 3 and 4 disaggregated by age, urban/rural residence, and wealth quintile. In addition, Core Indicators 14–16 are disaggregated by wealth quintile.

See pages 167-172 of the report for disaggregated estimates.

TRANSPARENCY AND ACCOUNTABILITY

Individuals can readily access meaningful information on the design, provision, implementation, and evaluation of contraceptive services, programs, and policies, including government data.

VOICE AND PARTICIPATION

Individuals, particularly beneficiaries, have the ability to meaningfully participate in the design, provision, implementation, and evaluation of contraceptive services, programs, and policies.

Adapted from a graphic developed by Karen Hardee, Jan Kumar, Lynn Bakamjian, Kaja Jurczynska, Sandra Jordan, and Anneka Van Scoyoc under the Evidence Project for FP2020.

READ MORE

The digital report has more partner updates: **familyplanning2020.org/progress**.

PUTTING THE RIGHTS-BASED APPROACH INTO PRACTICE

As FP2020 countries design, implement, and monitor their family planning programs, a commitment to rights must remain paramount. Determining how best to do this—how to operationalize rights and measure the extent to which rights are being fulfilled—is an ongoing concern in the family planning sector. A broad range of FP2020 partners are involved in different aspects of this work, from shaping guidelines to developing and evaluating programs, measurement tools, and accountability efforts:

- In preparation for the 2017 Family Planning Summit, 35 representatives from governments, NGOs, and donors issued a **Quality of Care Call to Action** for family planning in FP2020 countries. It includes a detailed set of recommendations to improve quality of care in the context of rights-based family planning, and makes the case that rights contribute an extra dimension to quality of care that is additive.

Read the Quality of Care Call to Action at: summit2017.familyplanning2020.org/call-to-action.html.

- FP2020's CIP Resource Kit, which provides technical guidance for countries developing a family planning costed implementation plan (see page 35), is being updated to help operationalize rights-based family planning. **Rights-Sizing Family Planning: A Toolkit for Designing Programs to Respect, Protect, and Fulfill the Rights of Girls and Women** offers practical guidance on incorporating rights principles into every aspect of a country's family planning program.

- **Uganda's** costed implementation plan was drafted through a rights-based lens, and includes explicit pledges to protect and fulfill human rights in the provision of family planning services. The Ministry of Health is collaborating with UNFPA and other partners to translate the plan into action at the national, district, and local levels. In 2017 the Evidence Project completed a study in Uganda to test and validate a Rights-Based Service Delivery Index, designed to measure both the results of rights-based interventions and the extent to which a facility is in compliance with rights principles. The results will be disseminated to stakeholders by the end of 2018.

- **Afghanistan** joined the FP2020 partnership in 2016, and has embraced the rights-based approach with its first country action plan. The country's priorities include training providers on rights-based family planning services, linking family planning with women's empowerment efforts, and creating a dedicated reproductive health counseling line for young people.

- In **India**, the Community Action for Health (CAH) model uses data collection on local health services, report cards, and dialogues and hearings with health service providers and officials to ensure that the health needs and rights of the community are being fulfilled. The government is embracing CAH as a cornerstone of its National Health Mission, in partnership with the Population Foundation of India, and the program has the potential to serve as a social accountability mechanism for family planning services. National scale-up of the program began in the 2016–2017 fiscal year.

"Since the London Summit on Family Planning in 2012 there has been a call for ensuring that family planning programming be implemented in ways that respect, protect, and fulfill human rights. There is now global consensus that rights must be central in programs. **FP2020's partnership has been critical to translating human rights into tangible actions within family planning programs and measuring progress."**

—

KAREN HARDEE

Senior Associate and Project Director, The Evidence Project Population Council

Washington, DC

CHAPTER 04

ORGANIZING FOR SUCCESS WITH A COSTED IMPLEMENTATION PLAN

LEARN MORE

Visit our Costed Implementation Plan microsite at: **familyplanning2020.org/CIP**.

To transform a country's ambitious FP2020 commitments into concrete programs and policies, the costed implementation plan (CIP) is an indispensable tool.

The CIP is a multi-year roadmap for the country's family planning strategy, with measurable goals and realistic costed budgets. A well-constructed CIP takes the guesswork out of developing a family planning program: it identifies what's feasible, what goals are attainable, and what resources will be required to achieve those goals. It outlines all the steps needed to design and implement a successful program, from securing financing (domestic, partner, and donor) to setting up an effective monitoring and evaluation program.

WHY IT'S ESSENTIAL

A CIP can help governments:

- **Foster a unified country strategy for family planning:** The process of developing a CIP is participatory and consensus-driven, involving broad multi-sectoral engagement. Developing the CIP helps brings key priorities to the surface and rallies stakeholders around the government's plan.
- **Create a roadmap for implementation:** The CIP process ensures that specific objectives are defined and that all necessary activities are planned and sequenced. The roadmap approach provides a logical progression of steps toward meeting the country's family planning goals.
- **Estimate the impact of interventions:** The CIP includes estimates of the demographic, health, and economic impact of achieving family planning goals and commitments. This information can help governments gauge the return on their family planning investments, and position family planning as an investment with impacts beyond the health sector.
- **Develop a budget:** The CIP includes detailed costs associated with family planning goals, including commodity costs and program activities. With a clear understanding of costs, governments can mobilize the needed funds.
- **Secure resource commitments:** The CIP process can help secure donor and government commitments for the family planning program, identify funding gaps, and strengthen advocacy to ensure adequate funds are raised to effectively

SUB-NATIONAL CIPS

A growing number of FP2020 countries are using CIPs at the sub-national level. In countries with highly devolved political systems (such as Pakistan and Kenya) or strong federal systems (such as Nigeria), sub-national CIPs are an important tool:

- In Pakistan, three provinces (Khyber Pakhtunkhwa, Punjab, and Sindh) already have their own CIPs, and an RRM grant is supporting the development of a CIP in Balochistan.
- In Kenya, an increasing number of counties are developing their own CIPs. A recent RRM grant to the Kenya Muslim Youth Development Organization supported the development of a CIP in Wajir County.
- In Nigeria, five of the 36 states have completed and launched their own CIPs. An additional 11 state CIPs are currently in development.

implement the plan. (The Global Financing Facility, for example, uses FP2020 CIPs as critical input for preparing country Investment Cases.)
- **Monitor progress:** A CIP outlines how to measure and monitor performance, guiding any necessary course corrections.

When a country has a family planning CIP in place, the government also has a better handle on what to prioritize in the larger national health plan. Family planning can be incorporated as a cornerstone of development and a contributing element to the country's overall strategy for reproductive, maternal, newborn, child, and adolescent health.

STANDARD ELEMENTS OF THE CIP

The use of CIPs for family planning evolved out of the need to unify diverse stakeholders around a shared strategy to achieve family planning goals. Family planning CIPs were pioneered by Tanzania in 2009 and Kenya in 2011, and subsequently adopted as an essential tool by the countries of the Ouagadougou Partnership and FP2020.

FP2020 has led a global effort to develop a standardized approach to crafting CIPs, working in close collaboration with the technical partners who have shaped the field since 2009. The standardized approach presents recommended thematic areas and principles to guide overall CIP development.

All the major elements of a family planning program can be grouped into six thematic areas: **financing** (page 43)**, enabling environment** (page 49)**, social and behavior change** (page 51)**, service delivery** (page 53)**, supply chain** (page 59)**,** and **monitoring and accountability** (page 39).

CIP RESOURCE KIT 2.0

The FP2020 website hosts a wealth of resources to support countries in the process of developing a CIP. The initial FP2020 CIP Resource Kit was launched in 2015 in collaboration with multiple partners, and contains more than 20 guidance documents and tools for planning, developing, and executing a robust, actionable, and resourced family planning strategy.

A new version of the kit has been in development over the past year and will be rolled out in 2018. The CIP Resource Kit 2.0 will include a toolkit on incorporating a rights-based approach, guidance on fostering multi-sectoral coordination, and a resource tracking guide.

PERFORMANCE MONITORING TOOL

A major new component of the CIP Resource Kit 2.0 is the Performance Monitoring Tool, designed to strengthen the accountability framework through a sharper focus on monitoring the CIP. The Performance Monitoring Tool will better enable policymakers and program administrators to monitor, review, and adjust their country's family planning program over time, ensuring that implementation stays on track and goals are met.

The tool has three components:
- The **CIP Priority Map** is a one-page summary of the objectives that are key to achieving each program goal. The priority map depicted on page 37 was developed for Mali, based on the *Plan d'Action National de Planification Familiale du Mali 2014–2018*.
- The **Priority Results Achievement Chart** defines the indicators that measure progress on each objective.
- The **CIP Dashboard** tracks progress across the indicators and objectives using regularly collected data, such as service statistics and data from Logistic Management Information Systems (LMIS). The illustration on page 38 depicts a sample report from the CIP dashboard.

The new Performance Monitoring Tool was field-tested in Malawi and Nigeria over the course of 2017, and will be rolled out along with the updated CIP Resource Kit.

Performance Monitoring Tool: CIP Priority Map

The Performance Monitoring Tool is designed to aid in monitoring the execution of a costed implementation plan (CIP). The CIP Priority Map is a one-page summary of the objectives that are key to achieving each program goal. The priority map shown here was developed for Mali.

STRATEGIC VISION: INCREASE THE MODERN CONTRACEPTIVE PREVALENCE RATE FROM 9.9% IN 2013 TO 15% IN 2018 FOR WOMEN OF REPRODUCTIVE AGE

ADDED VALUE TO BENEFICIARIES

WHICH PROVIDE

WOMEN 15-49 YEARS OLD

Women age 15-49 are more knowledgeable about family planning and make free and informed choices.

Women age 15-49 have better access to affordable family planning options.

YOUTH (15 -24 YEARS OLD)

Young people are more knowledgeable about family planning and make free and informed choices.

Young people have better access to affordable family planning options.

MEN & COMMUNITY LEADERS

Men and leaders are knowledgeable about, accept, and support family planning.

ENABLING BODIES

IMPLEMENTED BY

- **GOVERNMENT** (REGIONAL AND NATIONAL LEVEL)
- **NON-GOVERNMENTAL ORGANIZATIONS (NGOS)**
- **ELECTED OFFICIALS**
- **PROVIDERS**
- **PRIVATE SECTOR**
- **TECHNICAL AND FINANCIAL PARTNERS**
- **LOCAL AUTHORITIES**
- **CIVIL SOCIETY**

STRATEGIC PRIORITIES TARGETING BENEFICIARIES

WHICH LEAD TO

DEMAND CREATION

- Increase the number of people who receive accurate information on family planning.
- Increase the number of leaders and men who accept and support family planning.
- Increase the number of youth who promote family planning.

SERVICE PROVISION

- Strengthen the capacity of family planning service providers at all levels.
- Provide adequate materials and equipment for family planning activities to facilities at different levels.
- Ensure the availability and accessibility of quality family planning products (contraceptive security).
- Improve access to family planning services in rural communities and enclaves.

ENABLING ENVIRONMENT

- Increase the number of family planning champions among institutions, civil society organizations, celebrities, and others.
- Include contraceptives in the list of medicines covered under mandatory health insurance.
- Enhance the institutional standing of the Division of Reproductive Health within the Division of Maternal and Child Health.

SUPERVISION, MONITORING, AND MANAGEMENT

Strengthen coordination at all levels of the system.

Revise the RH/FP communication plan and ensure monitoring of its execution.

Strengthen the supervision/ monitoring of contraceptive procurement and distribution.

FINANCING

Increase the portion of family planning in the budget allocation for reproductive health.

Increase sources of financing through innovative and diversified mechanisms.

Performance Monitoring Tool: CIP Dashboard

The Performance Monitoring Tool includes the CIP Dashboard, which tracks progress across indicators and objectives. The CIP Dashboard features a variety of reporting tools; this figure depicts a sample of the reports that can be generated.

CHAPTER 05

USING DATA STRATEGICALLY

Data provide a solid foundation for a country's family planning program, from setting goals and developing the CIP to monitoring performance and measuring impact. Data also provide advocates with the information they need to support governments in meeting their commitments, and are critical to ensuring accountability. Track20, FP2020, and other partners work to increase the availability, visibility, quality, and use of family planning data in FP2020 countries.

SUPPORTING DATA USE IN FP2020 COUNTRIES

Track20 works with FP2020 commitment-making countries to recruit, train, and support dedicated family planning monitoring and evaluation (M&E) officers. M&E officers are seconded to a country's Ministry of Health, and serve as point persons for family planning data. M&E officers' day-to-day activities vary according to country needs, ranging from producing subnational estimates of key family planning indicators to evaluating signals from routine and survey data to support programmatic decisions. In all countries, M&E officers liaise with country partners, encouraging the use of quality data, new methodologies, and tools for improved family planning programming and policy decision making.

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

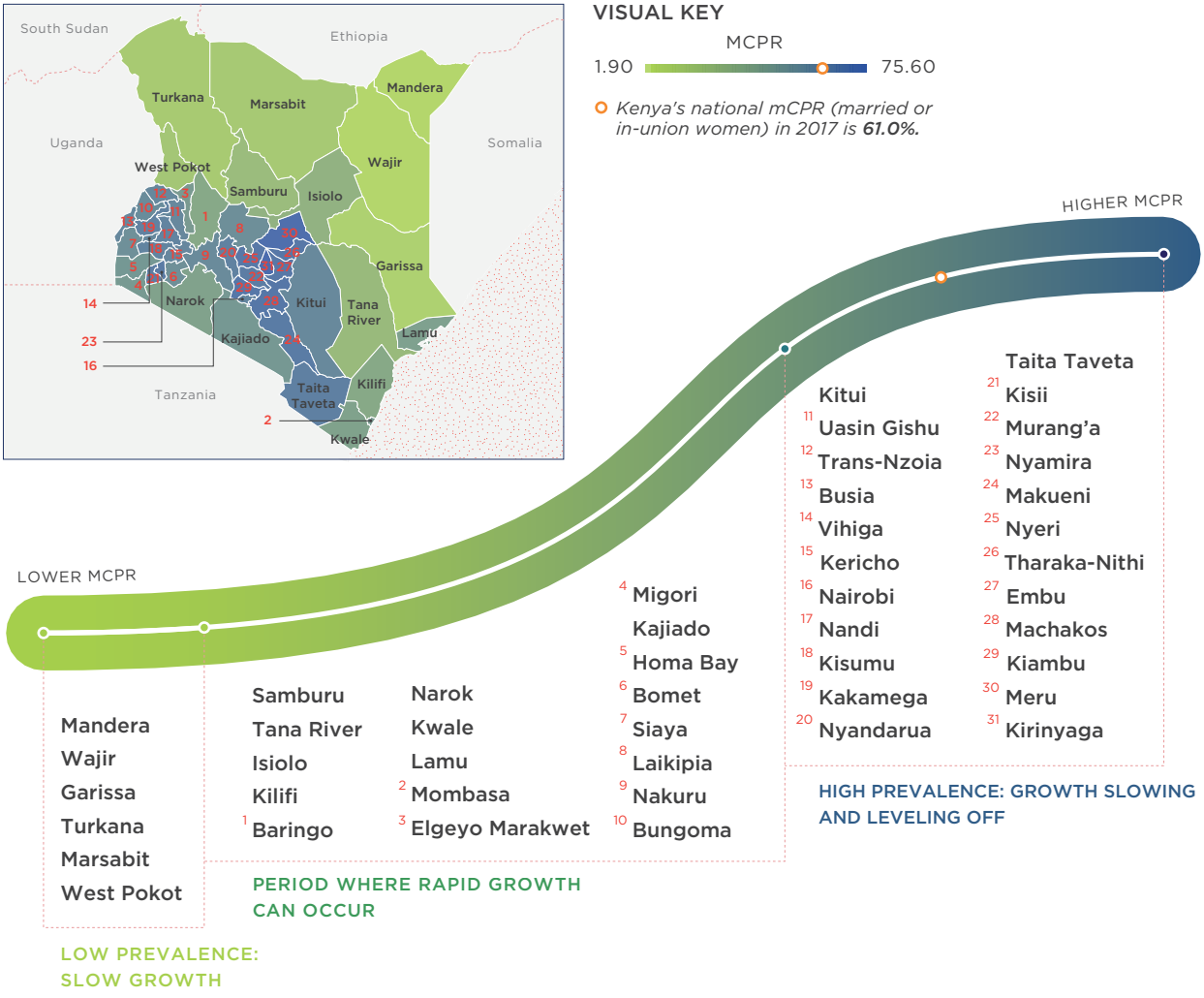
CASE STUDY: KENYA

In 2016 the Ministry of Health formed the Measurement & Knowledge Management Thematic Group to guide national and subnational data generation and monitoring of progress. Working with the in-country Track20 M&E officer, the group reviewed Kenya's family planning goals in light of available subnational data, which showed large disparities in contraceptive prevalence and growth between different regions, as seen in the S-Curve (Figure 1).

The group recognized that the majority of Kenya's population was located in counties with high rates of contraceptive use and limited potential for rapid MCPR growth. Taking this into consideration, the government decided to maintain the national goal of 58% MCPR (married women) by 2020—which it is on track to achieve—but to revise downward the goal for 2030 from 70% to 66% MCPR. County goals have also been revised accordingly, and the analysis will be shared with county health management teams for a sharpened understanding of the opportunities for growth and the resources needed.

FIGURE 1

S-curve pattern of MCPR growth in Kenya (married or in-union women)



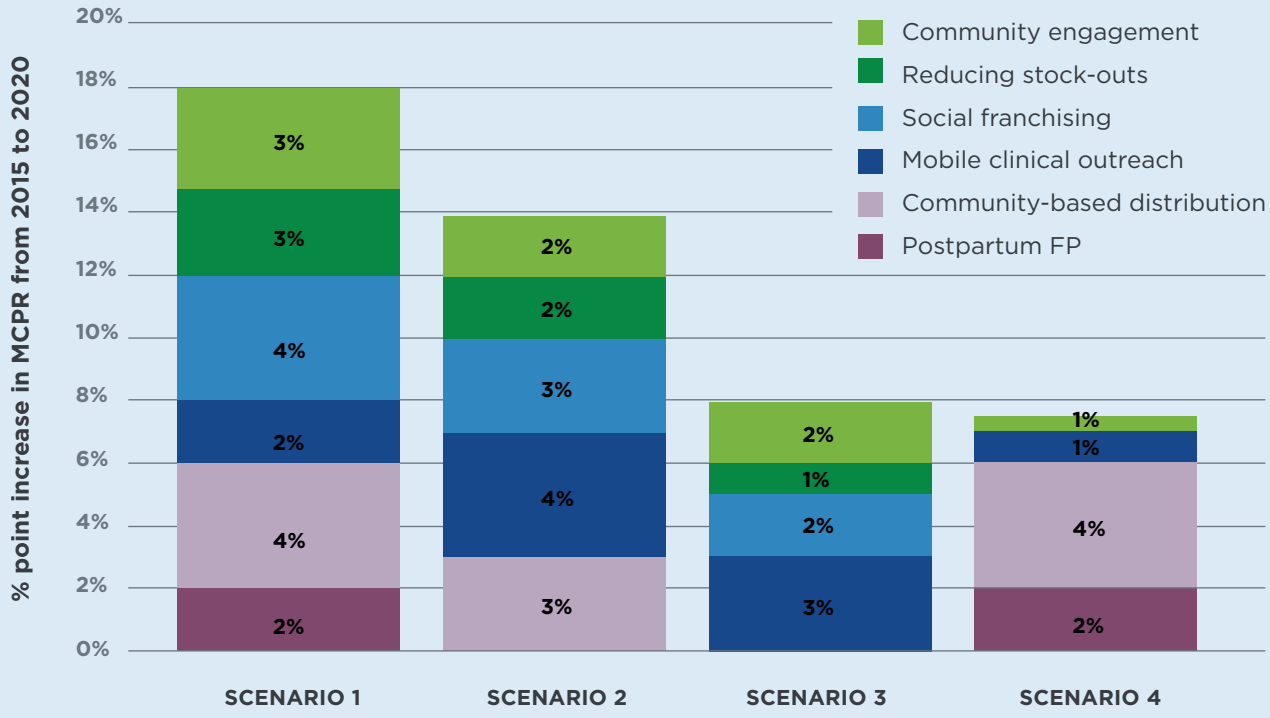
Counties are ordered from lowest to highest MCPR, top to bottom, within each category. Kenya county-level estimates of MCPR are from the 2014 Demographic and Health Survey.

This example demonstrates the importance of having timely and quality data. In March 2017, the FP2020 Performance Monitoring & Evidence Working Group met in Nairobi to learn more about how the government, the Track20 M&E officer, and other partners in Kenya are using family planning data to inform decision making. Kenyan stakeholders emphasized the importance of increasing capacity to use data at the subnational level, given the devolution of government and resource allocation to counties. Another key highlight was the piloting of FP Goals, a new program tool to help guide family planning program approaches in counties.

What Do Results Look Like?

The following is an illustrative example of an FP Goals result. The model shows the MCPR growth estimated for different scenarios, as well as the relative contribution of each intervention. Results can be used to assess a realistic MCPR goal, and support discussions on prioritization of interventions.

Expected increase in MCPR by intervention: 2015-2020



Note: *The percentages above reflect rounded numbers.*

LEARN MORE

Visit the Track20 website at: **track20.org/pages/ourwork_innovative_tools.**

TRACK20'S FP GOALS TOOL

In its efforts to support data and evidence-based decision making, Track20 developed the FP Goals tool, which combines demographic data, family planning program information, and evidence on the effectiveness of interventions to help decision-makers set realistic goals, prioritize investments, and review and interrogate their programs. The FP Goals tool has been applied in eight countries so far. For example:

- **Sierra Leone** identified three areas for significant investment—improving postpartum family planning, reducing stock-outs, and continuing the rollout of implants—and investigated the needs of unmarried and married young people.
- **Senegal** explored how best to balance supply-side investments (expanding access to services) with demand-side investments (social and behavior change interventions), in order to find the right mix for continued growth.
- **Lao PDR** assessed the trade-offs for specific strategic approaches in the country's CIP, and generated regional data to assist in the prioritization of family planning investments in each province. (See page 45 for more on the Lao PDR costed implementation plan.)

"With support from FP2020, Track20 has for the first time provided tools for us to evaluate the noise in our data, to interpret which sources of data and which methods are consistent in quality, **so that we can track and understand if our goals for family planning are being met**."

—

HELLEN SIDHA

Monitoring & Evaluation Officer, Reproductive and Maternal Health Services Unit (RMHSU)/Track20

Nairobi, Kenya

CHAPTER 06

FINANCING THE PROGRAM

Mobilizing sustainable resources for family planning is a critical area of work for the entire FP2020 community, and is of urgent concern for countries in the midst of developing and implementing their programs. In an era of heightened uncertainty and shifting donor priorities, countries and partners are exploring new financing models to support existing programs and underwrite new initiatives.

The long-term development trend is toward self-sufficiency, and a number of FP2020 countries are leading the way with larger financial commitments and innovative approaches to funding. Several countries are investigating possibilities for greater private sector involvement in program funding, commodity sourcing, and delivery channels. The World Bank's Global Financing Facility (GFF) is a new development model that is designed to support the transition to long-term sustainable domestic financing for the Global Strategy for Women's, Children's and Adolescents' Health. The GFF is tightly linked with countries' own International Development Association (IDA) credits, with additional funding from the GFF Trust Fund becoming available if countries choose to use IDA to invest in reproductive, maternal, newborn, child, and adolescent health (RMNCAH).

In an era of heightened uncertainty and shifting donor priorities, **countries and partners are exploring new financing models to support existing programs and underwrite new initiatives.**

- **India** announced at the Summit that it was committed to increasing its total allocation for family planning over the 2012–2020 period from US$2 billion to more than US$3 billion. The country will continue the implementation of costed plans for RMNCH+A,[b] including family planning, at national and sub-national levels.

- All nine countries of the **Ouagadougou Partnership** are committed to increasing their budget allocations for contraceptive purchases by at least 10% per year. The countries are also committed to building an inclusive approach to resource mobilization involving regional and local authorities, to ensure their accountability for financing the health of their populations.

- As a GFF frontrunner country, the **Democratic Republic of Congo** is using the GFF opportunity to address underfunded RMNCAH areas, particularly family planning and nutrition, and to strengthen its health systems, including commodity supply chains and public finance management. The government is also preparing a sustainable health financing strategy that focuses on increasing domestic

Photo by
ASMO (Afghan Social Marketing Organization)

resource mobilization, enhancing the alignment of domestic and external resources, and attracting additional and complementary funding.

- **Liberia** is a second-wave GFF country, and is investing in adolescent health interventions, maternal and neonatal health, community engagement, and health system strengthening. The GFF is also supporting the development of a health financing strategy, which will lead to a national contributory health scheme for sustainable and equitable financing of health services.

- **Nigeria** has pledged to ensure a total disbursement of US$56 million for family planning to the states through its GFF and IDA loans. The government is also collaborating with states, donors, and other stakeholders on a health insurance scheme to make household family planning expenditures reimbursable.

- **Indonesia** is drawing on the private sector to expand access to family planning services under its Universal Health Coverage scheme. The strategy is three-pronged: 1) increase the role of private sector doctors and midwives in providing family planning; 2) increase the role of private companies in providing family planning services in the workplace; and 3) improve the quality and accessibility of family planning services at private health facilities. The government is also on track to increase its total budget allocation for family planning from US$255 million in 2015 to US$458 million in 2019, for a total outlay of US$1.6 billion over the 2015–2019 period.

- **Kenya** is planning to partner with the private sector (including the for-profit sector) for a total market approach to optimizing the use of family planning funding. The total market approach will differentiate population segments according to ability to pay and identify which market players are best placed to reach each segment. Kenya is also committed to ensuring that all 47 counties have a family planning budget line by 2020.

- **Guinea** is enlisting the support of its mining industry to help fund the country's family planning program. Based on the national family planning strategy and a gap analysis identifying the resources needed, the Ministry of Health is asking each mining company to help cover the cost of contraceptive commodities and services in the districts where it operates.

A number of countries made commitments at the Summit to expand their domestic budget allocations for family planning (see page 77). The World Bank hosted a Summit roundtable that was attended by eight finance ministers from FP2020 countries, all of whom offered strong arguments for the economic value of investing in family planning.

CASE STUDY: LAO PDR

Lao PDR's approach to family planning is captured by the title of its First National Conference on Family Planning, held in May 2017: "Investing in Family Planning for Economic Prosperity."

Family planning is recognized as a reproductive right and central to the health and well-being of women and their children. But it's also seen as vital to building a skilled workforce that can sustain the country long-term.

Lao PDR joined the FP2020 initiative in 2016, and quickly set to work developing a costed implementation plan. The CIP, which was developed with support from the RRM

Photo by Jonathan Torgovnik
Getty Images Reportage

and with the technical assistance of Track20, is distinctive for its use of extensive modeling to identify the most cost-effective interventions under various scenarios. The final CIP outlines what is required to help Laos achieve its family planning goals and, along the way, graduate from Least Developed Country status. The government will need to invest US$15 million over four years across 18 provinces, with a focus on expanding the range of available methods to include long-acting reversible contraception, increasing the number of midwives able to provide such contraception, improving capacity at health centers, and developing campaigns to reach young people.

INVOLVING THE PRIVATE SECTOR

As pharmaceutical companies and manufacturers of contraceptives, the private sector has always been central to family planning. But there is a growing movement toward a new kind of engagement, as corporations choose to invest in the health of their employees and contribute to broader health initiatives that benefit the entire community.

Forging new partnerships with private sector partners was one of the themes of the Summit, with the spotlight on companies from outside the traditionally engaged health and pharmaceutical industries. These commitments illustrate the different ways in which private sector partners can use their networks, assets, and expertise to reach millions of women and girls:

WORKPLACE HEALTH PROGRAMS

Lindex, the Swedish fashion chain with 480 stores throughout 17 markets, has launched a three-year program worth €430,000 to provide technical, financial, and health training, including family planning, to 83,500 workers (including more than 50,000 women) in their supply chain in Bangladesh.

Similarly, **NST**, a Philippines-based apparel supplier for global brands such as Ann Taylor, Ralph Lauren, and J. Crew, together with its subsidiaries, Hamlin and Reli-

ance Producers Cooperative, announced its commitment to reach 6,000 employees—4,500 of whom are women—with family planning information and services.

Twinings, the international tea company, is expanding its current women's health program, which includes family planning, from 6,000 to 40,000 women workers and farmers (representing 60% of their supply chain in Kenya) by 2020.

CLIENT SERVICES AND COMMUNITY BUILDING

CARD-MRI, the largest micro-finance institute in the Philippines, will use its significant micro-finance network to reach at least four million women with reproductive health and family planning information and services by 2020. Together with UNFPA, CARD-MRI will train all its doctors and nurses on modern family planning methods and deploy 17 nurses around the country to provide family planning services.

Spark Minda, a leading Indian automobile manufacturer, aims to reach approximately 3,000 women from lower socio-economic strata and rural areas in the states of Uttar Pradesh, Maharashtra, Tamil Nadu, and Uttarakhand with educational workshops on family planning, reproductive health, and menstrual hygiene.

These commitments illustrate the different ways in which **private sector partners can use their networks, assets, and expertise to reach millions of women and girls**.

MEDIA OUTREACH

The **MTV Staying Alive Foundation**, in partnership with **Viacom International Media Networks**, plans to launch groundbreaking media campaigns addressing youth sexual health—tied to the hugely popular "Shuga" television show—in Nigeria, Egypt, and India, reaching 224 million young people by 2020.

Vodafone Foundation announced US$1 million in support of the Adolescents 360 program in Tanzania, partnering with Population Services International (PSI) in collaboration with the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation. Through its mobile platform, the Vodafone Foundation will help identify where services are needed and reach over 15,000 adolescents to connect with 150 youth-identified friendly providers.

KNOWLEDGE SHARING

Deploying their global reach and expertise, **Reckitt Benckiser** and its Durex brand will share the findings and data from their 4th Global Sex Survey—the largest and most comprehensive global attitudinal survey on social and cultural sex mores, covering all ages across 41 countries—to help governments and health institutions reduce sexual violence, unwanted pregnancies, and sexually transmitted infections.

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b. The acronym RMNCH+A was specifically developed by the Government of India, and has the same meaning as the more commonly-used RMNCAH acronym.

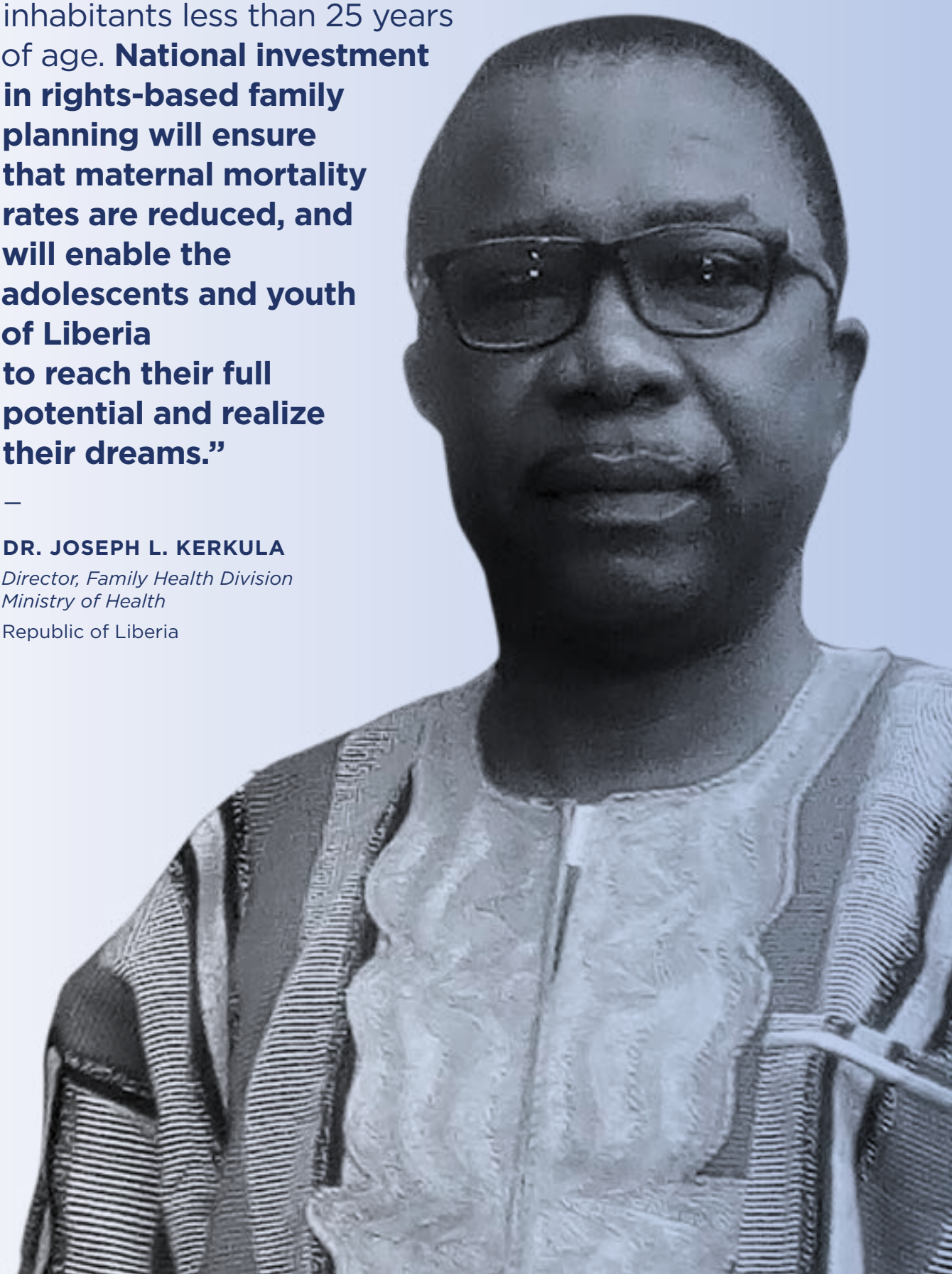
"Liberia has a youthful population, with 63% of its 4.2 million inhabitants less than 25 years of age. **National investment in rights-based family planning will ensure that maternal mortality rates are reduced, and will enable the adolescents and youth of Liberia to reach their full potential and realize their dreams."**

—

DR. JOSEPH L. KERKULA

Director, Family Health Division
Ministry of Health

Republic of Liberia



CHAPTER 07

CREATING AN ENABLING ENVIRONMENT

READ MORE
The digital report has more partner updates: **familyplanning2020.org/progress**.

Family planning programs must have political support to operate successfully. Government policies, laws, regulations, and funding priorities can either help or hinder the delivery of family planning services. Often, barriers to accessing family planning services have their roots in obsolete or conflicting policies that will need to be addressed in order to make progress on the country's FP2020 goals. Development partners have been working with advocates, implementers, and governments on this critical area of work for decades, and these essential efforts continue.

Supportive policies ensure that family planning has a prominent place on the national agenda, that adequate financial resources are allocated, that individual reproductive rights are respected and protected, that clinical guidelines are up-to-date and appropriate. Less formal but no less important is political will: the commitment of individuals in positions of authority to enable and encourage progress on family planning.

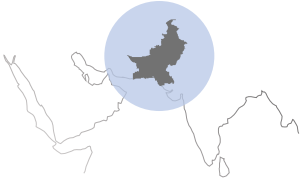
CASE STUDY: MAURITANIA

Mauritania is a member of the Ouagadougou Partnership (OP) and, until this year, was the only OP country without a law supporting access to family planning. This made it difficult for the government to deliver on its OP and FP2020 commitments, and created a conflict with the international agreements on reproductive rights that the country has signed.

That changed with the adoption earlier this year of Mauritania's first-ever reproductive health law, the culmination of a ten-year campaign by reproductive rights advocates. The new law recognizes reproductive health and family planning as universal rights guaranteed under the Mauritanian constitution. It also prohibits all forms of violence against women, including female genital mutilation.

Operationalization of the new law is proceeding apace. In September the Ministry of Health instructed all health facilities, public and private, to offer every woman the full range of contraceptive methods in order to ensure free and informed choice. Postpartum family planning has been added to the government's regulatory standards, and providers are instructed to offer it beginning with the first prenatal consultation.

CASE STUDY: PAKISTAN



When Pakistan committed to FP2020 at the 2012 London Summit, it had just embarked on a massive overhaul of its federal system. The Ministry of Health had been abolished and responsibility for health policies, financing, and programming devolved to the four provinces—all part of the shift from a centralized state to a system with significant provincial autonomy.

Five years on, the devolution process has matured and stabilized, thanks in large part to positive political will and outstanding cooperation across ministries and provinces. The original FP2020 commitment has been transformed into provincial goals, and each province has taken ownership of its FP2020 strategy. The federal Ministry of Health has been reconstituted as a coordinating body, fostering alignment and synergy across the provinces.

At the 2017 Family Planning Summit, Pakistan presented its renewed FP2020 pledge as a package commitment from the federal government and the four provinces. High-level delegations from each province attended the Summit, and the provincial chief ministers pledged to personally monitor progress on their FP2020 goals.

"Filipino women's uptake of contraceptives is stymied by FP policies and programs that either force them to use contraceptives, or deny them access because of arbitrary legal and cultural prohibitions. The truth is, Filipino women need and want a range of effective contraceptives provided for in programs that consider their realities and perspectives. **FP020 is taking an active role in making sure those realities are integrated into FP programming that enables women to make their own decisions."**

—

DR. JUNICE MELGAR

Executive Director, Likhaan Women's Health

Manila, Philippines

CHAPTER 08

CULTIVATING SOCIAL AND BEHAVIOR CHANGE

READ MORE
The digital report has more partner updates: **familyplanning2020.org/progress.**

Cultural attitudes are one of the most important factors in determining whether women and girls can exercise their right to use family planning. In some countries there is a lack of good information about contraception, and often an abundance of harmful misinformation. Many cultures place a premium on large families and frequent childbearing. Restrictions on women's rights, and notions that it is somehow wrong for women to plan their families, are serious barriers—as are beliefs that adolescents and young people should not have access to sexual and reproductive information and services.

This is why social and behavior change (SBC) is an essential element of a successful family planning program. SBC investments help to publicly open the dialogue about family planning, improve public knowledge about methods and access points, and bring family planning discussion into everyday life.

SOCIAL AND BEHAVIOR CHANGE **IN BURKINA FASO**

Burkina Faso's new costed implementation plan for 2017–2020 includes an ambitious SBC strategy, developed after a detailed analysis of the factors that prevent women and girls from using contraceptives. These include misperceptions about contraceptive side effects, opposition from male partners, women's limited decision-making power, and the opinion of many husbands and parents that contraception encourages promiscuity.

Working with Track20's FP Goals program (see page 41), the government explored the potential impact of greater investments in SBC. The new costed implementation plan aims to achieve a MCPR for married women of 32% by 2020 (up from 23.3% in 2016), and allocates almost one-fourth of the total budget to SBC activities. The planned SBC activities were chosen because of their demonstrated effectiveness in Burkina Faso and the West African region:

- National Family Planning Weeks
- Mass media campaigns targeted at specific audiences
- Promotions linked with major national events, such as National Farmers Day, the Tour du Faso, and International Women's Day
- Information campaigns for women that are segmented according to age, place of residence, and socio-professional category
- Comprehensive sex education in school, including information on family planning
- Tailored messages for adolescents and youth that are delivered through appropriate channels
- "Schools for Husbands" to inform men about contraception and enlist them as supporters
- Mobilization of religious and traditional leaders to advocate within communities for family planning

Photo by Arvind Jodha
UNFPA
Photoshare

An appropriate SBC strategy:

- Includes a focus on reaching new, underserved, or marginalized populations while continuing to meet the needs of existing users.
- Addresses the barriers that impede access for key populations (women, adolescents, young people, the poor, those living in rural and remote areas, and displaced persons).
- Employs interventions that are appropriate and effective for specific audiences.
- Promotes supportive community norms.

A country's SBC strategy should also be informed by a careful understanding of the values and factors affecting contraceptive use, along with a realistic assessment of the potential impact of SBC investments. Track20 has developed a Maximum Contraceptive Prevalence "Demand Curve" to help countries examine the possibilities and identify the amount of resources to invest (page 98).

CHAPTER 09

DELIVERING HIGH-QUALITY, RIGHTS-BASED SERVICES

READ MORE
The digital report has more partner updates: **familyplanning2020.org/progress**.

The heart of any family planning program is service delivery: providing contraceptive information, services, and supplies to the women and girls who need and want them.

A high-quality rights-based family planning program:

- Implements a **client-centered approach to care**, treating clients with dignity and respect and ensuring their privacy, confidentiality, and consent.

For more on the client-centered approach, read the Quality of Care Call to Action at: summit2017.familyplanning2020.org/call-to-action.html.

- Offers a **full range of contraceptive methods**, including emergency, short-acting, long-acting, reversible, and permanent methods.
- Provides clients with **information and counseling** and supports **method switching** if desired.
- Expands access to family planning through a **variety of service delivery platforms** beyond private and public sector facilities. These include community distribution channels, mobile outreach, drug shops, and pharmacies.
- Addresses **health worker training** needs and shortages, **capacity building**, and **quality of care** at facility and community levels.
- Promotes **health systems strengthening**, including health information systems, governance, and leadership.

WHO UPDATE: PROGESTOGEN-ONLY INJECTABLES

In March 2017, the World Health Organization issued an updated guidance statement on the use of progestogen-only injectables (DMPA and NET-EN). For women at high risk of HIV, the recommendations for use of progestogen-only injectables changed from category 1 (no restrictions on use) to category 2 (the advantages of using the contraceptive method outweigh the theoretical or proven risks).

WHO issued the new guidance in response to evidence of a possible increased risk of acquiring HIV among progestogen-only injectable users. Uncertainty exists about whether this is due to methodological issues with the evidence or a real biological effect. WHO will continue to monitor research evidence on hormonal contraception and HIV risk in order to inform policies and programs.

WHO advises that women should not be denied the use of progestogen-only injectables because of concerns about the possible increased risk. Women considering progestogen-only injectables should, however, be advised about this, about the uncertainty over a causal relationship, and about how to minimize their risk of acquiring HIV.

Read the WHO guidance at: who.int/reproductivehealth/publications/family_planning/HC-and-HIV-2017/en/.

Photo by Andrew Esiebo
BIll & Melinda Gates Foundation

EXPANDING METHOD CHOICE

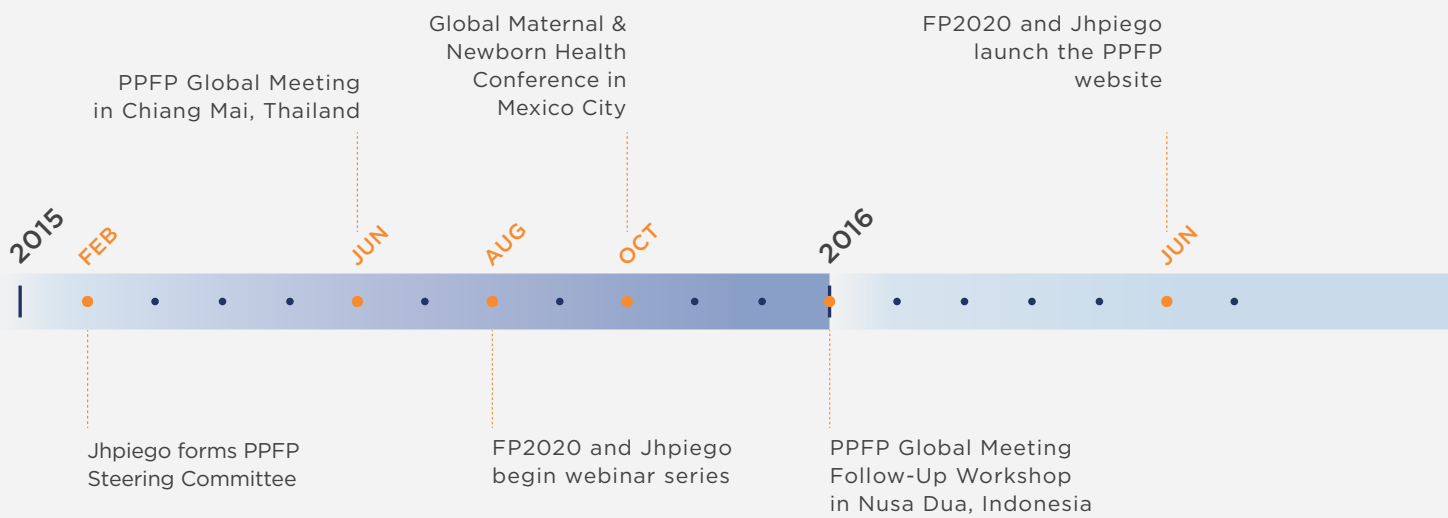
When women and girls have access to a full range of contraceptives, they are more likely to find a method that meets their needs and preferences. Expanding method choice was a key theme at the Summit: more than two dozen FP2020 countries announced plans to expand the range of contraceptives included in their family planning programs, with the goal of ensuring that a comprehensive mix of methods is available to meet the needs of women and girls throughout their reproductive lives.

Innovative public-private partnerships can expand method choice by increasing the range of high-quality contraceptives that are available and affordable, including among hard-to-reach and vulnerable populations. In 2013 a group of FP2020 partners collaborated to make implants from Bayer HealthCare and MSD available at half-price in the world's poorest countries. Shanghai Dahua, the manufacturer of Levoplant, announced at the 2017 Summit that it would offer its product at a similar price point.

GLOBAL GOOD: DMPA SubQ Collaboration

Pfizer Inc. and a consortium of donors have launched a public-private collaboration to broaden access to Sayana Press (DMPA SubQ), Pfizer's innovative injectable contraceptive. Sayana Press contains a reformulation of depo medroxyprogesterone acetate that allows it to be administered subcutaneously (subQ). The product's design means that community health workers, pharmacists, and even women themselves can be trained to administer it (where approved by national health authorities). Sayana Press is currently being introduced, scaled-up, or piloted in more than 15 FP2020 countries, with Pfizer continuing to support additional country registrations.

Collaborating to Expand Access to Postpartum and Post-Abortion Family Planning



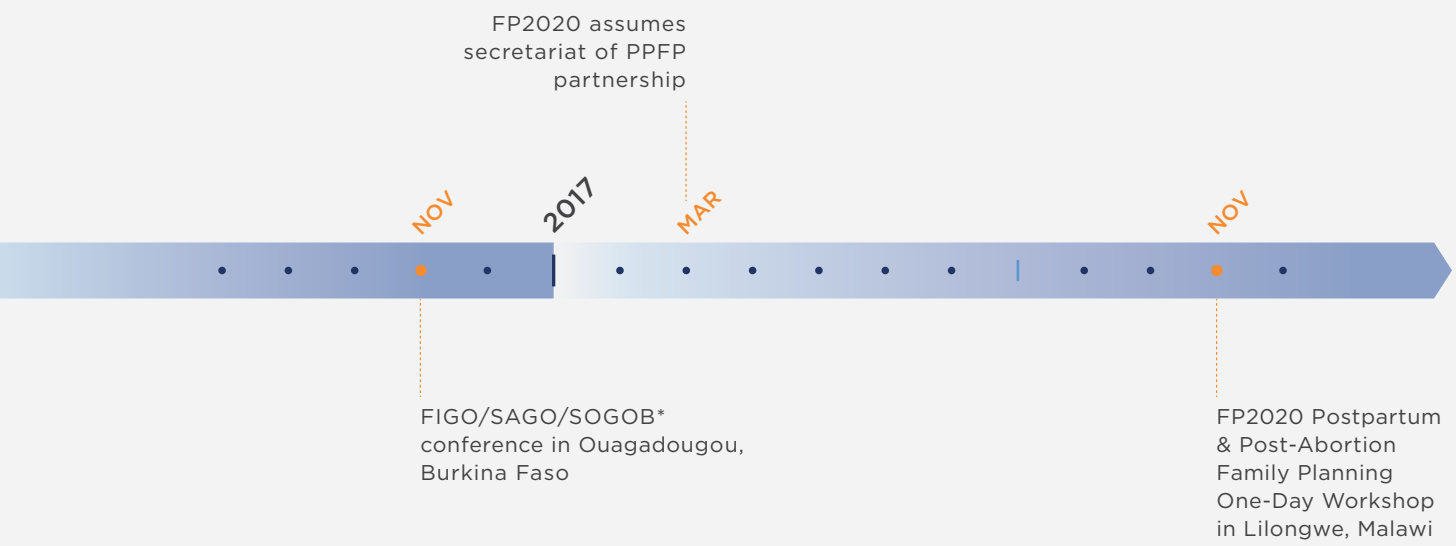
TASK-SHIFTING

In settings where doctors and nurses are in short supply, task-shifting is an important strategy for expanding service delivery. Task-shifting (also called task-sharing) is the process of delegating tasks to less-specialized health workers. Community health workers, for example, can be trained to provide injectable contraceptives and even implants. Task-shifting makes good use of the existing healthcare workforce, lowers costs, and increases the availability of family planning services. WHO recommendations on task-shifting to improve access to contraceptive methods were issued in 2013.[1]

ECOWAS RESOLUTION

In June 2017, the 18th Assembly of Health Ministers of the Economic Community of West African States (ECOWAS) adopted a resolution to promote good practices in task-shifting in family planning and reproductive health programs. The resolution calls on ECOWAS member states to mainstream the principle of task-shifting into their national plans for health human resources, integrate community health workers into their national health systems, and scale-up task-shifting as a means of building health system capacity.

All nine countries of the Ouagadougou Partnership approved the resolution, and task-shifting was included in OP's renewed regional commitment to FP2020 announced in concert with the Summit. The OP countries pledged to "implement and/or scale up promising strategies for task-shifting for long-term and permanent methods, injectables, introduction of contraceptive pills, etc., with a view to strengthen community-based Family Planning services delivery through a full range of modern contraceptive methods."



*Joint Conference of the International Federation of Gynecology and Obstetrics (FIGO), the African Society of Gynecology & Obstetrics (SAGO), and the Society of Gynecology & Obstetrics of Burkina Faso (SOGOB)

POSTPARTUM AND POST-ABORTION FAMILY PLANNING

Postpartum and post-abortion family planning (PPFP/PAFP) is the prevention of unintended pregnancy during the first 12 months following childbirth or abortion (spontaneous or induced). Pregnancies that are spaced too close together don't give a woman's body enough time to recover, and raise the risk of labor complications, premature birth, low birth weight, and infant and maternal mortality.[2] Rapid repeat pregnancies are especially risky for young adolescent girls.[3]

Many postpartum women and girls don't want to become pregnant again soon, yet the use of contraception in this period is low. Studies suggest that more than 60% of postpartum women and girls in 21 FP2020 countries are not using a family planning method despite reporting that they do not want to have another pregnancy in the next two years.[4]

EXPANDING ACCESS TO PPFP/PAFP

WHO issued the pivotal fifth edition of the Medical Eligibility Criteria for Contraceptive Use (MEC) in 2015. This edition of the MEC changed the guidance on the use of hormonal contraceptives, recommending that these options be considered suitable for postpartum women who are breastfeeding.

The revised WHO guidance opened the door for a new approach to postpartum family planning in countries with a proven gap for this service. Jhpiego and FP2020 co-hosted the PPFP Global Meeting in June 2015 in Chiang Mai, Thailand, where 16 FP2020 countries developed action plans to accelerate the implementation of PPFP within their family planning programs. The meeting inspired strong interest from other countries and growing integration with the maternal and child health community. In November 2016, 8 more FP2020 countries (all from the Ouagadougou Partnership) announced their intention to incorporate PPFP/PAFP priorities into their existing action plans.

When women and girls have access to a full range of contraceptives, **they are more likely to find a method that meets their needs and preferences.**

THE NEXT PHASE

FP2020 assumed the secretariat of the PPFP/PAFP partnership in 2017. A key focus going forward will be on building PPFP/PAFP support, advocacy, and tracking into our existing country engagement structure. Where an unmet service need for PPFP/PAFP exists, our approach will be to ensure that it is integrated into the continuum of care. FP2020 will also work to improve coordination among the global PPFP partners with regard to resourcing PPFP/PAFP needs in priority countries:

- The secretariat will routinely convene the global PPFP/PAFP steering committee to coordinate PPFP/PAFP efforts and identify opportunities to advance the global PPFP agenda.
- Each FP2020 focal point workshop will be followed by a day devoted to PPFP/PAFP, beginning with the Anglophone Africa Regional Focal Point Workshop in Malawi in November 2017.
- A new PPFP/PAFP webinar series will be launched.
- A portion of RRM funds will be earmarked for PPFP/PAFP projects.

LEARN MORE

Visit our PPFP/PAFP microsite at: **familyplanning2020.org/ppfp**.

"**FP2020 is a strong advocate at the highest level globally and in countries.** We believe that FP2020's continued leadership in this arena can pave the way for innovative partnerships and programming for postpartum and post-abortion family planning in DRC and elsewhere in Africa to reduce maternal and newborn deaths."

—

VIRGILE KIKAYA

Country Director, Jhpiego

Kinshasa,
Democratic Republic of Congo

CHAPTER 10

STRENGTHENING THE SUPPLY CHAIN

READ MORE
The digital report has more partner updates: **familyplanning2020.org/progress**.

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

Supply chain strengthening is a core area of work for most FP2020 countries. It was a major theme at the Summit, with 32 FP2020 partners announcing commitments to invest in logistics systems, procurement, inventory management, supply chain design, commodity security, and last mile delivery:

- **Somalia** committed to ensuring the continuous availability of quality family planning commodities at all levels of the pipeline, with the goal of decreasing stock-outs by 30% by 2020.
- **Togo** committed to reducing contraceptive stock-outs at service delivery points by 50% between 2017 and 2022.
- **Zimbabwe** committed to strengthening its supply chain management system and ensuring that 98% of its service delivery points have at least three modern methods of contraceptives available on the day of assessment.

The Summit also featured the announcement of three global goods:

GLOBAL GOOD: Global Visibility Analytics Network (VAN)

Delivering contraceptives to millions of users requires complex family planning supply chains that operate efficiently and effectively. The Bill & Melinda Gates Foundation and DFID (through its core funding commitment to the Reproductive Health Supplies Coalition) are contributing seed money to design and pilot a global Visibility Analytics Network (VAN) for reproductive health commodities. The global VAN will enable countries and partners to collaborate virtually on forecasted inventory needs and track progress against those forecasts. The Reproductive Health Supplies Coalition has agreed to host the global VAN and manage its implementation, while USAID and UNFPA are providing essential human resources to design, test, and use the platform.

GLOBAL GOOD: In-country VANs

In-country VANs are the local counterparts to the global VAN, enabling country program managers to forecast and track inventory needs. A number of FP2020 countries are taking the first steps toward developing their own VANs, which will result in real-time supply chain tracking and help keep stock on the shelves in sustainable, efficient ways. When linked together, the global VAN and country VANS will provide end-to-end visibility for the entire supply chain, from product source to use.

Photo by Emily Carter
PSI Photoshare

GLOBAL GOOD: Adoption of Global Data Standards

The adoption of global standards for product identification and for the capture and exchange of supply chain data is a key enabler of the global and in-country VANs. Data standards also help to ensure patient safety (through product traceability) and lower supply chain costs (through driving efficiencies). USAID and UNFPA have worked over the past year with contraceptive manufacturers to develop a roadmap and timeline for the adoption of GS1 standards (the leading standards in the health-care industry) in labeling contraceptive products.

CHAPTER 11

BUILDING EFFECTIVE PROGRAMS WITH HIGH IMPACT PRACTICES

LEARN MORE

Visit the High Impact Practices website at: **fphighimpactpractices.org.**

With finite resources to invest in family planning programming, FP2020 countries need to be able to draw on proven interventions with the broadest reach and the greatest impact. High Impact Practices (HIPs) are a set of evidence-based family planning interventions that have been vetted by experts and documented in easy-to-use briefs. Endorsed by more than 25 organizations, HIPs reflect consensus around our current understanding of what works in family planning.

The HIP initiative was launched in 2010 and is now facilitated by five core partners: USAID, UNFPA, WHO, IPPF, and FP2020. The HIP Partnership, which includes endorsing organizations as well as the core partners, plays a vital role in developing, reviewing, disseminating, and implementing the HIPs. The HIPs are also supported by a Technical Advisory Group (TAG), made up of experts in family planning

HIGH IMPACT PRACTICES **IN NEPAL**

One month after Nepal joined the FP2020 partnership in 2015, the country was struck by a devastating earthquake. The past two and half years have been challenging, but Nepal remains committed to meeting its FP2020 goals. This year the government renewed its FP2020 commitment with a revitalized pledge that builds on the original commitment and incorporates lessons learned from the earthquake disaster.

For maximum effectiveness, Nepal is making good use of HIPs (bolded below) throughout its family planning strategy:

ENABLING ENVIRONMENT: Nepal's **policy** initiatives include advocacy for family planning at all levels of government, improvements to the regulatory framework to promote public-private partnerships, and the formulation of policies to eliminate barriers to contraceptive use. The government is **financing commodities and services** through increased domestic allocation and diversification of external development partners. **Supply chain management** is being strengthened with the introduction of an electronic Logistics Management Information System (eLMIS).

SERVICE DELIVERY: Nepal's **community health workers** provide contraceptive supplies, information, and referrals. Nepal also plans to revive a private providers' network to enable **social marketing** of contraceptive services. **Mobile outreach services** include family planning camps and satellite clinics. The government is developing an integrated care strategy that includes **family planning and immunization integration**. Progress is being made on ensuring that **post-abortion family planning** is regularly offered.

SOCIAL AND BEHAVIOR CHANGE: Nepal is committed to employing **mass media** to reach youth, ethnic minorities, and marginalized and disadvantaged groups with family planning information.

HIP ENHANCEMENTS: Nepal's youth strategy includes training and certifying service providers on **adolescent-friendly contraceptive services**.

Photo by
WINGS Guatemala

research and implementation, policy makers, and representatives from donor agencies. The TAG provides an impartial review of evidence to determine which practices meet the criteria to be a HIP.

A total of 17 HIPs have been documented to date, organized into three categories:

- **Enabling Environment**
- **Service Delivery**
- **Social and Behavior Change**

In addition, the HIPs provide evidence and implementation tips on **HIP Enhancements** (technologies or practices that are not typically standalone interventions but are implemented in conjunction with HIPs) and **Evidence Summaries** (practices that do not yet meet the criteria of a HIP). All of the HIP materials can be found on the High Impact Practices website.

The practices identified in the HIP briefs are not new; many have been implemented for decades. FP2020 works with countries to identify HIPs currently in use and explore additional opportunities for HIP implementation.

CHAPTER 12

REACHING YOUNG PEOPLE

LEARN MORE

Visit our Adolescents, Youth, and Family Planning microsite at: **familyplanning2020.org/ayfp**.

Reaching adolescents and youth with the contraceptive information and services they need is a top FP2020 priority. As today's girls grow into tomorrow's women, it's essential that they be able to take charge of their own reproductive lives and make their own decisions about whether and when to have children. FP2020 is working to advance the use of evidence to develop and implement adolescent-friendly services, and is committed to strengthening partnerships between young people and decision makers to shape more effective programs, policies, and advocacy.

Nearly every country commitment at the Summit included a focus on meeting the needs of adolescents and youth. And the commitments are clearer, more actionable, and more trackable than ever before:

- **Ethiopia** committed to reducing the adolescent pregnancy rate from 12% to 3%; reducing unmet need for family planning among women aged 15–19 from 20% to 10% and among women aged 20–24 from 18% to 10%; and increasing the MCPR among women aged 15–19 from 32% to 40% and among women aged 20–24 from 38% to 43%.
- **Mozambique** committed to increasing the MCPR for all adolescents aged 15–19 from 14.1% to 19.3% by 2020, and for unmarried sexually active adolescents from 26.7% (as of 2011) to 50% by 2020.
- **Malawi** committed to reducing teenage pregnancies by 5% per year until 2030; the government also committed to implementing the latest WHO guidelines on youth contraceptives and to aligning national policies so as to allow greater access to family planning commodities by 2030.

A NEVER-BEFORE **OPPORTUNITY**

With the largest generation of young people in history entering their reproductive years, the time is now to strengthen investment and action on adolescent contraception. Experts in adolescent sexual and reproductive health and rights have issued a call to the family planning sector to take five key steps:

- Move from a one-size-fits-all approach to one that is tailored to the needs of different groups of adolescents.
- Offer adolescents the full range of contraceptive choices—not just "condoms only."
- Move away from separate reproductive health services for adolescents, and instead make existing health services more adolescent-friendly for counseling, information, and contraception.
- Work more actively with pharmacies and shops to expand contraceptive access and uptake, as the current focus on public health facilities alone omits the places where many adolescents obtain their contraceptives.
- Move from one-off in-service training for a handful of providers to a package of actions to ensure that all levels of health workers, including support staff, respond to adolescent clients effectively and with sensitivity.

Chandra-Mouli et al. Reproductive Health (2017) 14:85 DOI 10.1186/s12978-017-0347-9

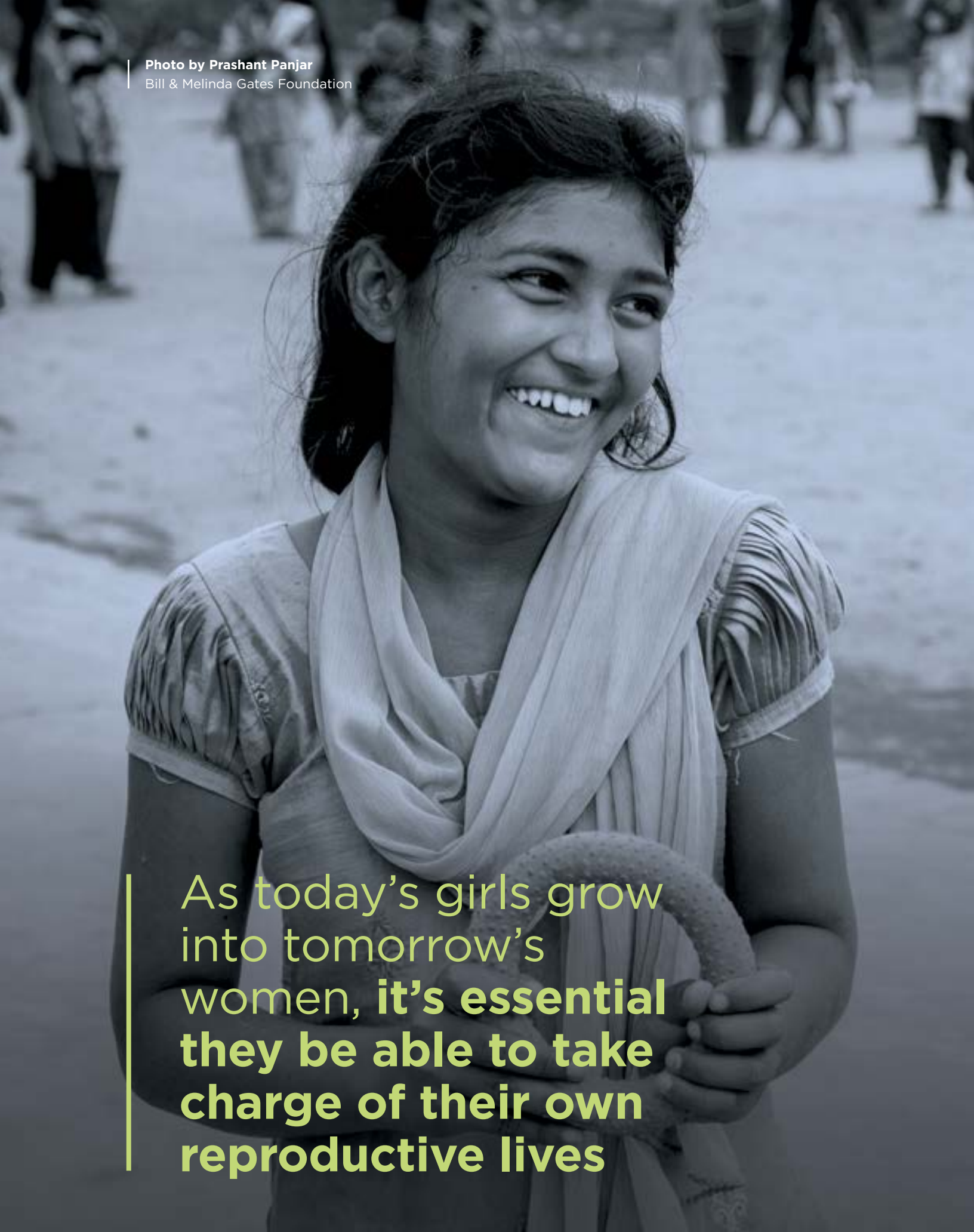


Photo by Prashant Panjar
Bill & Melinda Gates Foundation

As today's girls grow into tomorrow's women, **it's essential they be able to take charge of their own reproductive lives**

The Summit also featured the announcement of three Global Goods to strengthen the family planning sector's ability to meet the needs of young people:

GLOBAL GOOD: Youth Accountability Framework

Young people are key partners and stakeholders in family planning programs, and they have a critical role to play in holding governments and donors to account for their commitments. The Summit's Youth Advisory Group—comprised of 15 youth representatives from FP2020 countries—developed an accountability framework to mobilize young people at the country level to advocate for the full implementation of the commitments made by their governments.

↖ **Learn more about the Youth Accountability Framework at: summit2017.familyplanning2020.org/global-goods.html.**

GLOBAL GOOD: Global Adolescent Data Statement

As governments and the global community increase their response to adolescent needs, we'll require accurate data to inform policies and programs, measure progress, and ensure accountability at the country and global levels. Yet there are critical gaps in how data is gathered and reported that all too often leave adolescents invisible.[5] The Global Adolescent Data Statement is a global pledge to collect, use, and disseminate age- and sex-disaggregated data.

↖ **Learn more about the data gap and read the Global Adolescent Data Statement at: summit2017.familyplanning2020.org/adolescent-data-statement.**

GLOBAL GOOD: Partnership to Strengthen Country Capacity

To deliver on their commitments to prioritize adolescents, FP2020 countries need the technical capacity to support data-driven, actionable plans and evidence-based, scalable programs. A range of public and private donors are forming a new partnership that will amplify their investments and strengthen technical capacity across the adolescent and youth SRH programming continuum.

YOUTH-LED COMMITMENTS

On International Youth Day in 2017, the FP2020 partnership welcomed the first-ever commitments from youth-led organizations:

- Alliance des Jeunes Ambassadeurs pour la Santé de la Reproduction et la Planification Familiale en Afrique de l'Ouest Francophone
- International Youth Alliance for Family Planning
- Organization of Africa Youth-Kenya
- Tanzania Youth and Adolescent Reproductive Health Coalition (TAYARH)
- Uganda Youth and Adolescents Health Forum (UYAHF)

These commitments outline the tangible steps young people are taking to bring rights-based family planning to communities around the world. They are also an expression of young people's desire to be held accountable. Young people increasingly recognize that they too are part of the FP2020 partnership, and are eager to contribute to reaching their countries' FP2020 goals.

ADVANCING EVIDENCE

FP2020 encourages the utilization of evidence to inform the community's work on adolescents and youth. Focal point workshops include expert sessions and consultations to further the understanding of this evidence, resulting in action plans with a more robust technical focus on youth issues.

FP2020 has also launched a new web resource on Adolescents, Youth, and Family Planning. The website highlights the importance of engaging directly with young people and provides a wealth of resources on the best ways of reaching adolescents with programs and policies that meet their needs.

"Partnering with young people on family planning is important because it's about the young people: the choices they make, the decisions about their health and their right to information. FP2020 has helped me and is still helping my organization (UYAFPAH) to build our partnerships by connecting us with FP2020 focal points in Uganda and through networking sessions at FP2020 events such as the recently concluded London Summit, among others. "

—

JOAN AMANDA BANURA

Team Leader, Uganda Youth Alliance for Family Planning & Adolescent Health

-

Adolescent Health Country Coordinator, International Youth Alliance on Family Planning

Kampala, Uganda

CHAPTER 13

HARNESSING THE FUTURE

Countries that invest in family planning are laying the groundwork for sustainable development and a healthier, more prosperous future. Rights-based family planning is essential to achieving the Sustainable Development Goals, which envision a world where women and girls are empowered to shape their own lives; where families are healthier and children flourish; where an educated labor force supports a vibrant modern economy; and where prosperity and stability serve as antidotes to extremism.

The FP2020 goal of enabling 120 million additional women and girls to use contraceptives is a critical global milestone on the path to meeting Sustainable Development Goals 3 and 5, which call for universal access to sexual and reproductive health and rights and gender equality. But FP2020 progress also contributes to the entire Sustainable Development Goal agenda. Rights-based family planning is a powerful intervention with ripple effects across the whole of society. When women are able to use modern contraception, their quality of life improves and their families and communities prosper. When countries ensure that rights-based family planning is available to all, the result is a cascade of benefits across multiple sectors.

THE DEMOGRAPHIC DIVIDEND

For many countries, the long-term prospects for a more prosperous future are linked with the demographic transition: the shift from high rates of mortality and fertility to low rates. Most FP2020 countries are in the early stages of the transition. Mortality rates have fallen significantly—especially infant mortality—but fertility rates are still high. The result is rapid population growth and an enormous youth bulge.

This rising generation of young people represents a tremendous opportunity. If they choose to have fewer children than their parents and grandparents did, that will unlock the possibility of a demographic dividend: the burst of economic growth

AFRICAN UNION: YEAR OF THE DEMOGRAPHIC DIVIDEND

In view of the demographic dividend's pivotal importance to the future of the continent, the African Union dedicated 2017 to the theme. In January the AU adopted the "Roadmap to Harness the Demographic Dividend through Investments in Youth," developed in collaboration with UNFPA and other partners. The Roadmap is built around four thematic pillars, with key actions and deliverables defined for each:

- **Employment and entrepreneurship**
- **Education and skills development**
- **Health and wellbeing**
- **Rights, governance, and youth empowerment**

African member states have subsequently begun to prepare their own national roadmaps, outlining the investments in youth they will undertake to realize the demographic dividend. FP2020 countries that have launched demographic dividend roadmaps include Kenya, Nigeria, Tanzania, and Uganda.

that can happen when the ratio of working adults to dependent children increases. With fewer dependents to support, a country has a window of opportunity for rapid economic growth if the right investments in health, education, and jobs are made.

But in order for this to happen, women and girls need to be able to use contraception. Girls need access to education, freedom from early and forced marriage, and an equal chance in life. As they reach adulthood they need to be able to decide for themselves whether, when, and how many children they want, and to participate in the paid labor force if they choose. They need full, unfettered access to family planning and other sexual and reproductive health services.

This is why rights-based family planning is essential. It's the fundamental building block—the basic first step—that positions countries to reap the demographic dividend while respecting, protecting, and fulfilling the rights of their citizens.

Photo by DS Panwar
Photoshare

SPOTLIGHT

FAMILY PLANNING IN THE SAHEL AND LAKE CHAD BASIN

In the Sahel and Lake Chad Basin, demographic pressure, climate change, environmental degradation, poverty, inequality, and violent extremism intersect to create a burgeoning crisis. Millions face food insecurity and there are increasing numbers of displaced persons. Solving these challenges will require a holistic approach that addresses root causes and includes a strong focus on empowering women and investing in young people.

The Sahel Women's Empowerment and Demographic Dividend (SWEDD) Project, a joint initiative from the World Bank and UNFPA, is collaborating with the governments of Burkina Faso, Chad, Côte d'Ivoire, Mali, Mauritania, and Niger to reduce gender inequality in the Sahel, reframe family planning as an essential investment, and accelerate the demographic transition.

All of the SWEDD countries and Lake Chad countries are also FP2020 commitment-making countries:

Burkina Faso is committed to repositioning family planning as a major strategy for economic and social development. The country has already registered a significant increase in the modern contraceptive prevalence rate (from 15.7% for all women in 2012 to 22.4% in 2017), and the government is working with partners to boost the supply of quality services and the public demand for family planning. Burkina Faso's new CIP for 2017–2020 has a strong focus on SBC strategies (see page 51) to tackle the social norms that impede the use of contraceptives. Approximately 28% of the total budget is devoted to adolescents and young people. The government of Burkina Faso assumed a seat on the FP2020 Reference Group in 2017.

Cameroon began developing its national demographic dividend roadmap in 2017. With support from UNFPA, the country launched a highly consultative process that brought together youth-led groups, civil society organizations, government ministries, statistical institutions, and representatives from UN agencies and the World Bank. The Youth Leadership Forum on the Demographic Dividend contributed recommendations on issues directly affecting young people, while Women for a Change Cameroon mobilized CSOs working in areas related to the four pillars of the AU road map. Once Cameroon's roadmap is finalized, the government will institute an inclusive technical and coordination mechanism for follow-up and implementation.

Chad joined the FP2020 partnership in 2017, with a commitment organized around reaching adolescents and youth with rights-based family planning (see page 21). Chad is developing an ambitious framework to hasten the demographic transition, and in 2017 played host to two important regional conferences. At the PanAfrican Youth Forum, held in late June 2017 in N'Djamena, hundreds of young people from countries in the region gathered to define their role in planning for the demographic dividend. A month later the Regional Symposium on "Islam, Demographic Dividend and Family Welfare" brought together 1,200 delegates from 20 countries to discuss women's health empowerment, youth engagement, and the positive contribution Muslim leaders can make.

Côte d'Ivoire updated its FP2020 commitment this year with a sharpened focus on increasing the MCPR for all women, reducing unmet need for contraception, and decreasing the maternal mortality ratio. Côte d'Ivoire also aims to achieve 100%

Photo by
VOA News

availability of contraception in public and private health facilities by 2020. The government is committed to increasing its domestic budget allocation for family planning by 10% each year until 2020, integrating contraception into the minimum service package provided by community health workers, ensuring the availability of adolescent and youth-friendly contraceptive services, and strengthening the supply chain for commodities.

When **Mali** joined the FP2020 partnership in 2015, it pledged to achieve a modern contraceptive prevalence rate of 15% by 2018. The country is on track to meet that goal and even exceed it, and so the government has followed up with a more ambitious pledge. Mali's updated FP2020 commitment, announced at the Summit, calls for achieving a modern contraceptive prevalence rate of 20% by 2020. Mali is also committed to strengthening the institutional framework for family planning; addressing access for adolescents, young people, and rural and vulnerable populations; and making a greater domestic investment in the purchase of contraceptives.

Mauritania recognizes the importance of family planning as a strategy to improve health and alleviate poverty. With the adoption of its new law guaranteeing the right to reproductive health and family planning (page 49), the country is now better positioned to follow through on its family planning objectives. Mauritania's renewed FP2020 commitment focuses on introducing new methods and postpartum family planning; providing contraception to women, adolescents, and young marrieds in 100% of targeted health facilities; and strengthening an integrated supply chain.

The government of **Niger** is keenly aware of the potential benefits of a demographic dividend, and is committed to family planning as the cornerstone of its national economic and social development plan. In its renewed FP2020 commitment of 2017, Niger committed to expanding service delivery options through task-shifting, increasing its domestic budget allocation for contraceptive commodities by 10% each year until 2020, and dedicating at least 15% of the national family planning budget to interventions targeting adolescents and youth.

Nigeria launched its national roadmap for the demographic dividend in July 2017, with the goal of achieving a healthy population and sustainable development. The roadmap calls for a youth-centered approach, with programs to improve health and access to family planning, enhance the potential of young people to contribute to the economy, create a social safety net, and promote good governance and the rule of law. Nigeria's renewed FP2020 commitment also includes a youth focus, with a pledge to provide youth-friendly services in health facilities and age-appropriate SRH information through the Family Life Health Education Curriculum.

02 | FP2020 & GLOBAL PARTNERS

CHAPTER 01

THE FAMILY PLANNING SUMMIT FOR SAFER HEALTHIER AND EMPOWERED FUTURES

LEARN MORE

Visit the Summit website at: **summit2017.familyplanning2020.org**.

The Family Planning Summit for Safer, Healthier and Empowered Futures convened in London on July 11, 2017, the fifth anniversary of the 2012 London Summit that launched FP2020. Co-hosted by the UK Government, UNFPA, and the Bill & Melinda Gates Foundation, in close partnership with the FP2020 Secretariat, the Summit was a moment of solidarity, celebration, and renewal for the entire FP2020 community. In parallel with the Summit in London, more than 3,000 people gathered at 34 satellite events in Afghanistan, Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, India, Indonesia, Iran, Kenya, Liberia, Madagascar, Malawi, Myanmar, Nepal, Nigeria, Pakistan, Sierra Leone, Tanzania, Thailand, and Uganda.

The Summit was organized around six major themes:

- **Adolescents and Youth**
- **Humanitarian Settings**
- **Contraceptive Method Choice**
- **Supply Chain Strengthening**
- **Financing Solutions**
- **Private Sector Networks**

Each theme was the focus of intense collaboration leading up to and during the Summit, reflected in numerous commitments, consultations, calls to action, evidence briefs, technical commentaries, side events, and spotlight sessions. Eleven Global Goods were announced (see box), each linked to one of the major Summit themes.

Page 71 Photo by Robyn Russell Universal Access Project, UN Foundation

GLOBAL GOODS

The Summit was the occasion for the announcement of 11 Global Goods: a diverse set of group initiatives in the reproductive health sector involving various combinations of governments, donors, organizations, and multilateral agencies. Each Global Good is of vital importance to the family planning community and was highlighted at the Summit. The Global Goods are featured throughout this report:

Youth Accountability Framework – page 65

Global Adolescent Data Statement – page 65

Partnership to Strengthen Country Capacity – page 65

Minimum Initial Service Package (MISP) – page 75

Global Roadmap for Improving Data, Monitoring, and Accountability for Family Planning and Sexual and Reproductive Health in Crises – page 75

DMPA SubQ Collaboration – page 55

Global Visibility Analytics Network (VAN) – page 59

In-country VANs – page 59

Adoption of Global Data Standards (GS1) – page 60

Bridge Funding Mechanism for UNFPA Supplies – page 75

Pathways to Sustainable Domestic Financing for Family Planning/SRHR – page 76

A total of 74 commitment makers stepped forward with new and renewed pledges, including 25 new partners making FP2020 commitments for the first time:

- 3 new and 33 renewing FP2020 focus countries;
- 3 new and 8 renewing donor countries;
- 6 new and 3 renewing civil society organizations;
- 13 new and 3 renewing private sector partners; and
- 2 renewing foundations.

Summaries of all the commitments are available on the Summit website, along with related calls to action, publications developed for the Summit, and coverage of events.

These outcomes and commitments are just the beginning. The Summit served as a nexus for critical conversations about how to strengthen the framework for family planning, accelerate progress on FP2020 goals, and create a brighter future for every woman and girl. The results will help carry the family planning community forward for decades.

HUMANITARIAN SETTINGS

An important goal of the Summit was to mobilize global attention to the family planning needs of crisis-affected women and girls. More than 32 million women and girls of reproductive age worldwide are in dire need of humanitarian aid. Millions have been forced from their homes by violence and persecution; millions more are fleeing natural disasters, drought, and famine. For women and girls living in refugee camps and crisis zones, modern contraception is an essential lifesaving intervention.

Access to contraception is often overlooked as an emergency relief priority but, in fact, the need for family planning services and supplies becomes more acute in emergency settings. Women and girls affected by armed conflict and natural disasters are at increased risk of sexual violence and unintended pregnancy. Childbirth is fraught with danger: the rate of maternal death and injury in crisis zones is almost double the world average. Making voluntary contraception available in these settings isn't an option; it's a requirement.

With millions of women and girls living in crisis settings, FP2020 commitments and rights-based principles cannot be fulfilled without deliberate efforts to reach these vulnerable populations. Twenty-one FP2020 partners made commitments at the Summit to deliver lifesaving family planning services to women and girls in humanitarian settings and other hardest-to-reach populations, and three Global Goods were announced:

Photo by
Jonathan Torgovnik
Getty Images
Reportage

GLOBAL GOOD: Minimum Initial Service Package (MISP)

The Minimum Initial Service Package (MISP) is the international standard for reproductive health care in crisis settings, developed and vetted over the past two decades by the global humanitarian community. The MISP defines a set of lifesaving priority activities that are to be implemented at the onset of every humanitarian crisis, with the goal of ensuring effective coordination and leadership in responding to crisis, preventing and managing the consequences of sexual violence, reducing HIV transmission, preventing excess maternal and newborn morbidity and mortality, and planning for comprehensive sexual and reproductive health care as the situation permits. UNFPA is the custodian of the Reproductive Health kits that are an essential element of the MISP, and ensures that the kits are available to all actors in various humanitarian settings around the world.

An updated version of the MISP, with a new specific objective on the prevention of unintended pregnancies, was announced at the Summit. The revised MISP was launched at the 17th Inter-Agency Working Group for Reproductive Health in Crises (IAWG) annual meeting in Athens, Greece, in November 2017.

↖ **Learn more about the Minimum Initial Service Package at: iawg.net/minimum-initial-service-package.**

GLOBAL GOOD: Global Roadmap for Improving Data, Monitoring, and Accountability for Family Planning and Sexual and Reproductive Health in Crises

The global community needs to improve our ability to deliver for women and girls in crises, and we need to be held accountable. The Global Roadmap for Improving Data, Monitoring, and Accountability for Family Planning and Sexual and Reproductive Health in Crises will address the lack of information that lies behind the failure to reach these most vulnerable women. This game-changing initiative means that, by 2019, we will have more evidence on what methods work in these contexts, and we will be able to gather vital data to enable better outcomes for women and girls.

The roadmap outlines an inclusive process to develop a global data, monitoring, and accountability framework by 2019, and to support the implementation of that framework once developed. The process will include consultation across the humanitarian and development sectors, review of existing data and mechanisms, development of tools and methodologies to use in humanitarian settings, selection of a set of core indicators, and agreement on reporting mechanisms.

↖ **Learn more about the Global Roadmap at: summit2017.familyplanning2020.org/humanitarian-accountability-roadmap.**

DONOR FINANCING INITIATIVES

The Summit featured the announcement of two new donor-led initiatives to address persistent financing challenges in the family planning sector:

GLOBAL GOOD: Bridge Funding Mechanism for UNFPA Supplies

As the world's largest provider of donated contraceptives, UNFPA Supplies is committed to providing countries with the family planning commodities they need as efficiently as possible. However, in line with UN rules, UNFPA Supplies can only procure family planning supplies with cash on hand—yet the timing of donors' funding disbursements and countries' requests for commodities does not always match up. This means that contraceptive orders cannot be placed until donor funding arrives, which results in delayed orders, higher prices and, at worst, shortages and stock-outs at the community level.

That's why UNFPA Supplies is working with the Bill & Melinda Gates Foundation and DFID to develop a Bridge Funding Mechanism. The proposed Bridge Funding Mechanism would provide a revolving pool of financing of up to US$80 million that

UNFPA Supplies can use to place commodity orders to meet country needs. The pool would be replenished when committed donor funding is disbursed later in the year.

The Bridge Funding Mechanism is expected to speed up the procurement process, lower the cost of commodities, and ultimately reduce up to 50% of UNFPA-related commodity stock-outs—delivering better results for countries, donors, and the women and families they serve.

GLOBAL GOOD: Pathways to Sustainable Domestic Financing for Family Planning/SRHR

DFID, Global Affairs Canada, and the Bill & Melinda Gates Foundation will collectively invest US$90 million in mechanisms that enable sustainable domestic financing for family planning. DFID and Global Affairs Canada will invest through the Global Financing Facility to accelerate efforts to achieve sexual and reproductive health outcomes including family planning. The Bill & Melinda Gates Foundation, also an investor in the GFF, will contribute additional, complementary financing to support technical assistance in countries to expand the impact of the DFID and Global Affairs Canada investments.

Photos, left to to right:

Priti Patel, Secretary of State for International Development, Government of the United Kingdom
-
Dr. Natalia Kanem, Executive Director, United Nations Population Fund
-
Bottom photo: see endnote 19 on page 126 for full list of names
-
Photos by Michael Kemp
Bill & Melinda Gates Foundation

FINANCIAL COMMITMENTS

A total of 43 partners announced specific, quantifiable financial commitments at the Summit, including 17 FP2020 countries, 14 donors, 7 civil society organizations, and 5 private sector partners. The FP2020 Secretariat and partners have since worked with governments, FP2020 focal points, and in-country partners to better understand and contextualize these commitments.

FP2020 COUNTRIES: Mobilizing domestic resources for family planning is vital to the long-term sustainability of family planning services, and 17 FP2020 countries made domestic financing commitments at the Summit. These pledges total approximately US$3.8 billion, and mark a growing commitment by countries to fund their own programs. For example:

- **Senegal** committed to increasing their domestic budget allocation for the purchase of contraceptives from 300 million to 500 million West African CFA francs by 2020.
- **Bangladesh** committed to mobilizing US$615 million from its development budget for the family planning program implemented by the Directorate General of Family Planning as part of its 4th Health, Population and Nutrition Sector Program (2017–2021). This is a 67% increase from the allocation for family planning in the 3rd Program (2012–2016).
- **Indonesia** increased its total budget allocation for family planning to US$1.6 billion over the 2015–2019 period. This includes an almost two-fold increase in budget allocation from US$255 million in 2015 to US$458 million in 2019. Additional funding assistance for health programs, including family planning, will be provided to local governments in the amount of US$1.7 billion per year. Indonesia has also committed to maintaining a steady increase in its Family Planning Operational Fund between 2018 and 2020, from US$136 million to US$174 million.

Most of the domestic funding pledged at the Summit (96%) comes from three countries: Bangladesh, India, and Indonesia. There continue to be overall challenges in the tracking of domestic expenditures on family planning (see, for example, the discussion on page 112), but efforts are underway by UNFPA, WHO, and others to have validated numbers available in 2018. That will enable greater transparency and accountability as countries' domestic financing commitments are fulfilled.

DONORS: A total of US$2.6 billion was pledged by 14 donors at the Summit, including commitments by four first-time commitment makers: Canada, Belgium, Finland, and Iceland. Increased financial commitments were also announced by Australia, Denmark, the European Commission, Luxembourg, Netherlands, Norway, Sweden, and the United Kingdom, as well as by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation. At this stage, it is estimated that around US$1.25 billion of this constitutes "new funding" that has been pledged in addition to existing baseline spending. This equates to approximately US$400 million per year through 2020.

CIVIL SOCIETY ORGANIZATIONS: Five CSOs announced financial commitments totaling approximately US$64 million, with US$6 million of this coming from a new commitment maker, Comic Relief, which is not donor-funded.

PRIVATE SECTOR PARTNERS: Seven new partners from the private sector made financial commitments totaling almost US$19 million, with investments in workplace health programs, media outreach, and client and community services.

"I am convinced change is possible. Over the last decades, we have made tremendous progress related to sexual and reproductive health. We should be proud of this progress. [But] there are still too many places in the world where we need to invest, and often don't even know them. **If we bring these ideas together—that we all should be feminists, that we all should pledge financial means, and that we should use technology to make sure that it gets to the places where it's necessary—besides being a feminist, I will also be an optimist**."

—

MINISTER ALEXANDER DE CROO

Remarks made at the Family Planning Summit on July 11, 2017 in London

Deputy Prime Minister and Minister of Development Cooperation, Digital Agenda, Telecommunications and Postal Services

Kingdom of Belgium

CHAPTER 02

MOBILIZING RESOURCES

The global funding landscape for family planning is in a state of flux. The Mexico City Policy, reduced funding to UNFPA, and policy changes in the US have created an uncertain environment for family planning programs around the world. Many partners are scaling back their programs in response to the loss of US funding; donors and countries are shifting to accommodate the situation by reprioritizing and reallocating their resources. The question of who funds what, and how reliable that funding is, remains unsettled.

The annual analysis from the Kaiser Family Foundation indicates that bilateral funding for family planning declined in 2016 for the second year in a row, essentially retreating to 2013 levels. At the same time, the Summit generated a groundswell of new funding commitments from donor governments (page 77), which KFF intends to track going forward. The extent to which new commitments are able to offset funding reductions from other quarters will become clearer next year.

The digital version of this report includes additional analysis of European donor trends from Countdown 2030 Europe.

READ MORE
The digital report has more on this topic: **familyplanning2020.org/progress**.

DONOR GOVERNMENT FUNDING FOR FAMILY PLANNING IN 2016: KAISER FAMILY FOUNDATION ANALYSIS

OVERVIEW

Donor government funding for bilateral family planning decreased in 2016 compared to the prior year (see Figure 2).[c] This marked the second year of declines in a row, after an initial increase following the London Summit in 2012. These decreases are largely due to currency fluctuations and the timing of donor disbursements. Still, after accounting for these factors, funding has declined to 2013 levels.

These findings are based on analysis of data from 30 governments which were members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) in 2016 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; data for the remaining donors were obtained from the OECD Creditor Reporting System (CRS). Key findings from 2016 are as follows:

BILATERAL FUNDING:

- After the 2012 London Summit on Family Planning, bilateral funding from donor governments began to rise, reaching a peak in 2014. Since then, funding has declined to 2013 levels, even after accounting for currency fluctuations and timing of donor disbursements.
- In 2016, donor governments provided US$1.19 billion in bilateral funding compared to US$1.34 billion in 2015 (a decrease of more than US$150 million or 12%, as measured in current terms).
- Funding increased from five donors (Australia, Denmark, Germany, the Netherlands, and Sweden), remained flat for one (Canada), and decreased for four (France, Norway, the UK, and the US).
- The decline in funding from the US (from US$638.0 million in 2015 to US$532.7 million in 2016) appears to reflect the timing of disbursements, as overall funding commitments by the US have remained flat for several years.[d]
- Even with the decrease in funding by the US, it remained the largest bilateral donor to family planning in 2016, accounting for 45% of total bilateral funding.

FIGURE 2

Donor government bilateral disbursements for family planning, 2012–2016*

In millions, USD

COUNTRY	2012	2013	2014	2015	2016	NOTES
Australia	$43.2	$39.5	$26.6	$12.4	$14.9	Australia identified AU$18.4 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, RH, maternal health, and other sectors) and a percentage of the donor's core contributions to several multilateral organizations (e.g., UNFPA). For this analysis, Australian bilateral FP funding did not include core contributions to multilateral institutions. However, it was not possible to identify and adjust for funding to other non-FP-specific activities in most cases. Data for 2016 are preliminary.
Canada	$41.5	$45.6	$48.3	$43.0	$43.8	Bilateral funding is for family planning and reproductive health components of combined projects/activities in FY16–17; family planning-specific activities cannot be further disaggregated. 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	Bilateral funding is for family planning-specific activities in 2016.
France	$49.6	$37.2	$69.8	$68.6	$39.9	Bilateral funding is new commitment data for a mix of family planning, reproductive health, and maternal & child health activities in 2012–2016; family planning-specific activities cannot be further disaggregated.
Germany	$47.6	$38.2	$31.3	$34.0	$37.8	Bilateral funding is for family planning-specific activities.
Netherlands	$105.4	$153.7	$163.6	$165.8	$183.1	The Netherlands budget provided a total of US$469.5 million in 2016 for "Sexual and Reproductive Health & Rights, including HIV/AIDS," of which an estimated US$179.3 million was disbursed for family planning and reproductive health activities (not including HIV); family planning-specific activities cannot be further disaggregated.
Norway	$3.3	$20.4	$20.8	$8.1	$5.7	Bilateral funding is for family planning-specific activities, narrowly defined under the corresponding DAC subsector 13030. Overall bilateral and multilateral Norwegian support to Sexual and Reproductive Health and Rights (SRHR) including family planning was NOK1.186 billion ($142 million) in 2016
Sweden	$41.2	$50.4	$70.2	$66.0	$92.5	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	$203.4	In the financial year 2016/17, the UK spending on family planning was £171.23 million. This is a provisional estimate, using the FP2020-agreed methodology, which includes funding from non-FP-specific activities (e.g., HIV, RH, maternal health, and other sectors) and a percentage of the donor's core contributions to several multilateral organizations. For this analysis, UK bilateral FP funding of £155.4 million was calculated by removing unrestricted core contributions to multilateral organizations. However, it was not possible to identify and adjust for funding for other non-FP-specific activities in most cases. The nominal US$ decrease from 2014 to 2016 significantly exchange rate-related. Bilateral funding is for combined family planning and reproductive health, consistent with the agreed-upon methodology. A final estimate will be available after DFID publishes its annual report for 2016/17 in 2018.
US	$485.0	$585.0	$636.6	$638.0	$532.7	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	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 2016 are the 2015 totals, the most recent year available; 2015 presents 2014 totals; etc.).
TOTAL	$1,093.6	$1,325.0	$1,432.7	$1,344.0	$1,187.8	

* 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 (RH), maternal health, and other areas, as well as a percentage of a donor's core contributions to several multilateral organizations, including UNFPA, the World Bank, WHO, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Among the donors profiled, Australia and the UK reported FP funding using this revised methodology.

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

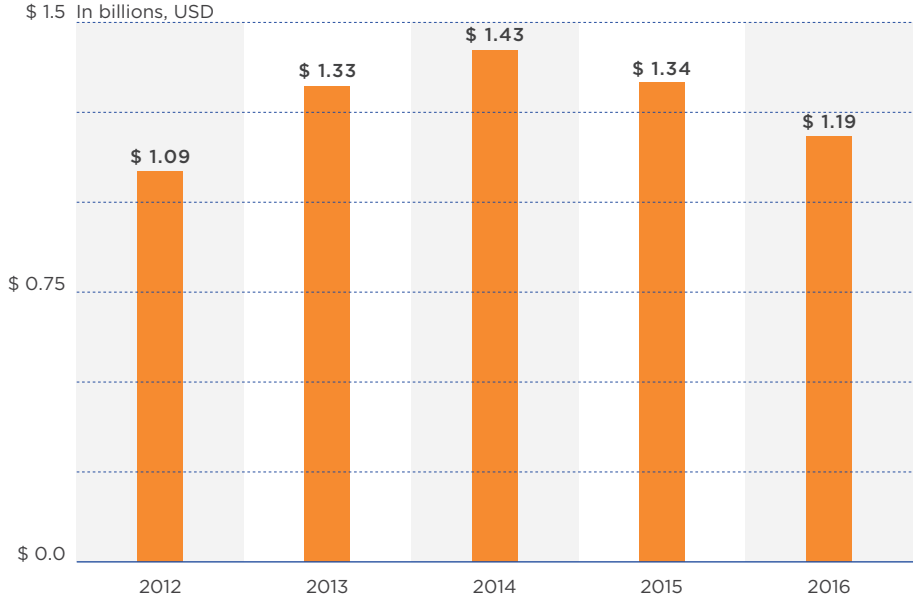
The UK was the second largest donor (US$203.4 million, 17%), followed by the Netherlands (US$183.1 million, 15%), Sweden (US$92.5 million, 8%), and Canada (US$43.8 million, 4%).

DONOR CONTRIBUTIONS TO UNFPA:

- In addition to bilateral disbursements for family planning—which include non-core contributions to UNFPA for family planning projects as specified by the donor—donors also contribute to UNFPA's core resources, which are meant to be used for both programmatic activities (family planning, population and development, HIV/AIDS, gender, and sexual and reproductive health and rights) and operational support.
- In 2016, donor government core contributions totaled US$347.0 million, compared to US$392.6 million in 2015 (a decline of US$45.6 million or 12%). Among the donors profiled, two increased funding (Germany and Sweden), four remained flat (Canada, France, Netherlands, and the US), and four declined (Australia, Denmark, Norway and the UK).[e] When measured in currency of origin, UK contributions remained flat.
- Sweden provided the largest core contribution to UNFPA in 2016 (US$59.0 million), followed by Norway (US$46.8 million), the Netherlands (US$39.1 million), and the US (US$30.7).
- In 2016, UNFPA reports that it spent an estimated US$319 million (or 40% of its resources) on family planning. Of this, an estimated US$76 million came from

FIGURE 3

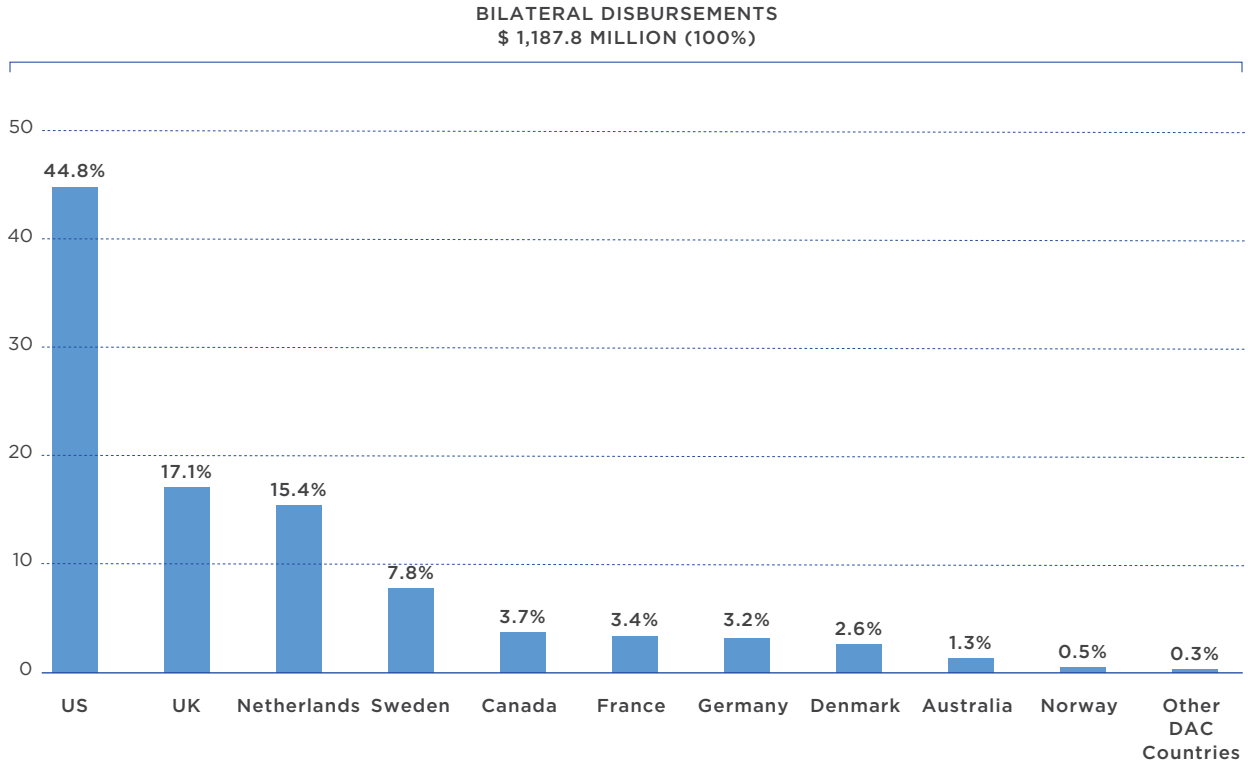
International bilateral family planning assistance from donor governments: disbursements, 2012-2016



Figures based on Kaiser Family Foundation analysis of donor government funding for family planning.

FIGURE 4

International family planning assistance: donor governments as a share of bilateral disbursements, 2016



Figures based on KFF analysis of donor government funding for family planning. Percentages do not exactly sum to 100.0% due to rounding.

core resources (resources meant to be used by UNFPA for both programmatic activities and operational support) and an estimated US$243 million came from non-core resources (resources earmarked for specific programmatic activities).[6]

METHODOLOGICAL NOTE

The financial data presented in this analysis represent "disbursements" which are defined as the actual release of funds to, or the purchase of goods or services for, a recipient. They were obtained through direct communication with donor governments, analysis of raw primary data, and the OECD CRS. UNFPA core contributions were obtained from Executive Board documents. Constant US$ amounts were calculated using the OECD's "Deflators for Resource Flows from DAC Donors" and adjusting non-US$ funding amounts accordingly. In order to take into account the global rise in the US dollar, 2014 was used as the base year.

In some cases it is difficult to disaggregate bilateral family planning funding from broader reproductive and maternal health totals, and the two are sometimes represented as integrated totals (Canada, France, the Netherlands, Sweden, and the US do not disaggregate family planning funding from broader reproductive and/or

maternal health totals). In addition, family planning-related activities funded in the context of other official development assistance sectors (e.g., education, civil society) have remained largely unidentified. For purposes of this analysis, we worked closely with the largest donors to family planning to identify such cross-sectoral family planning-specific funding where possible (see Figure 2 notes). Going forward, it will be increasingly important to efforts to track donor government support for family planning to have such funding identified within other activity categories by primary financial systems.

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

ESTIMATING EXPENDITURES

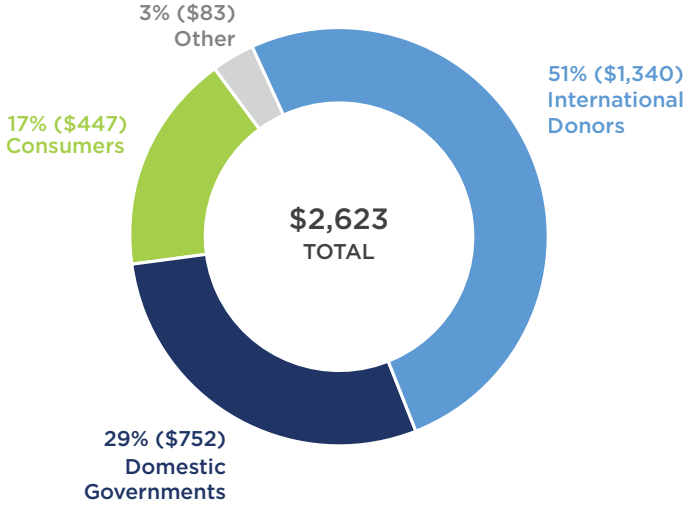
Family planning expenditures are not comprehensively tracked by current information systems. However, some information is available which we can use to estimate expenditures in the FP2020 focus countries. In addition to the bilateral donor disbursements discussed above, expenditures are also made from domestic government budgets and by non-governmental organizations (NGOs), corporations, and consumers. Estimates of domestic government expenditures are available from the FP Resource Flows Project implemented by UNPFA and the Netherlands Interdisciplinary Demographic Institute (NIDI), which uses national consultants to collect information from various government offices on domestic government expenditures as well as NGOs and corporations.

Another source of expenditure is out-of-pocket payments (OOP) by consumers who purchase family planning services from private sector providers. The number of users relying on the private sector can be estimated from the total number of modern method users presented in this report together with DHS data on method

FIGURE 5

Distribution of family planning expenditures in 69 FP2020 countries by source of funds, 2015

In millions, USD



The International Family Planning Expenditure Tracking Expert Advisory Group developed estimates of family planning expenditures in FP2020 countries, drawing on data from KFF, UNFPA/NIDI, DHS, PMA2020 and Track20. Dollar amounts do not add up exactly to the total value due to rounding.

mix and the proportion of users of each method who rely on the private sector. Information on the amount paid by each consumer is available for 14 countries from DHS and PMA2020 surveys and PSI studies on the prices charged by social marketing programs. These 14 countries represent about three-quarters of all modern method users. Countries without surveys are based on proxy countries from the 14 for which we do have data.

The results indicate that total family planning expenditures in 2015 in the 69 FP2020 countries stood at approximately US$2.7 billion. About half of the resources came from international donors, just under one-third were from domestic government expenditures, and most of the remaining were out-of-pocket payments by consumers. This is equivalent to about US$9 per modern method user.

The new estimate of OOP spending is considerably lower than last year's, largely due to new information from PMA2020 facility surveys in nine countries and the addition of a new data source, PSI FPWatch market studies, in five countries. These studies provide more up-to-date data, especially for the short term methods (condoms, injectables, and pills) that represent almost three-quarters of OOP payments. The methodology for estimating international donor expenditures has been revised since last year, and is now aligned with the Kaiser Family Foundation's analysis.

The estimates of domestic government and OOP expenditures are not yet refined enough to detect trends over time, but we should see significant increases in the coming years if recent pledges are fulfilled. Additional details are available in the Track20 report "Family Planning Expenditures in 69 Low- and Middle-Income Countries in 2015."

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c. 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.

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

e. Denmark's ostensible decrease in UNFPA core funding, recorded in UNFPA financial statements, is largely attributable to earlier advance payments. On this basis, Danish national accounts indicate an increase from DKK140 million to DKK194 million for the time period.

Photo by
Ashish Bajracharya
Population Council
Photoshare

CHAPTER 03

FP2020 IN THE GLOBAL HEALTH ARCHITECTURE

FP2020 is aligned with the *Every Woman Every Child* Global Strategy for Women's, Children's and Adolescents' Health. Launched during the United Nations Millennium Development Goals Summit in 2010 and renewed with the launch of the Sustainable Development Goals in 2015, *Every Woman Every Child* (EWEC) is an unprecedented global movement to address the major health challenges facing women, children, and adolescents around the world. The Global Strategy presents a roadmap to ending all preventable deaths of women, children, and adolescents within a generation.

FP2020 is an *Every Woman Every Child* partner, and a commitment to FP2020 is counted as a commitment to *Every Woman Every Child*. A significant portion of all EWEC commitments are through FP2020: from July 2012 through July 2017, a total of 124 partners made FP2020/EWEC commitments, including 55 governments, 38 civil society organizations, 9 foundations, 4 multilateral institutions, and 11 private sector partners. FP2020 commitments to extend the lifesaving benefits of modern contraception play a vital role in contributing to improved outcomes for women's, children's, and adolescents' health and wellbeing.

FP2020 also coordinates with other global and regional initiatives in the reproductive health sector:

- FP2020 maintains strong relationships with the World Bank, collaborating with the Global Financing Facility Secretariat and contributing to the Bank's adolescent health strategy. In 2017 FP2020 broadened its partnership with the Bank to include the Sahel Women's Empowerment and Demographic Dividend Project (SWEDD), a joint project from the World Bank and UNFPA.
- FP2020 coordinates with the Ouagadougou Partnership, with monthly calls between the FP2020 Secretariat and the OP Coordination Unit to align the work across the nine OP countries in Francophone Africa and in the region.
- FP2020 participates in World Health Organization initiatives, including the Implementing Best Practices (IBP) initiative, HRP (the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction), the Technical Working Group on SRHR in Humanitarian Settings, and the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents.
- FP2020 partners with K4Health on Family Planning Voices (#FPVoices), a highly successful global storytelling project that shares personal stories from people who are passionate about family planning.
- FP2020 serves as a core convener of the HIP Partnership, together with USAID, UNFPA, WHO, and IPPF.
- FP2020 collaborates with the International Youth Alliance for Family Planning (IYAFP) and other youth networks to strengthen youth participation in family planning and improve the broader sexual and reproductive health community's understanding of youth friendly services.
- FP2020 also coordinates with the Reproductive Health Supplies Coalition (RHSC), the Partnership for Maternal, Newborn & Child Health (PMNCH), the Inter-Agency Working Group for Reproductive Health in Crises (IAWG), the Interagency Gender Working Group (IGWG), Women Deliver, and SheDecides.

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Photoshare

CHAPTER 04

REFERENCE GROUP

The FP2020 Reference Group provides overall strategic direction for the partnership. With members representing a broad cross-section of FP2020 partners, the Reference Group serves as an advocacy and accountability mechanism to ensure that we reach our goal of delivering rights-based family planning to 120 million additional women and girls.

One of the greatest strengths of the Reference Group is its diversity. The composition of the group has evolved and expanded over the course of the initiative to ensure that a variety of viewpoints are represented. Last year a new youth seat was created; this year the total number of seats was increased from 18 to 23 to strengthen representation from the Global South and include leaders from the faith and feminist communities.

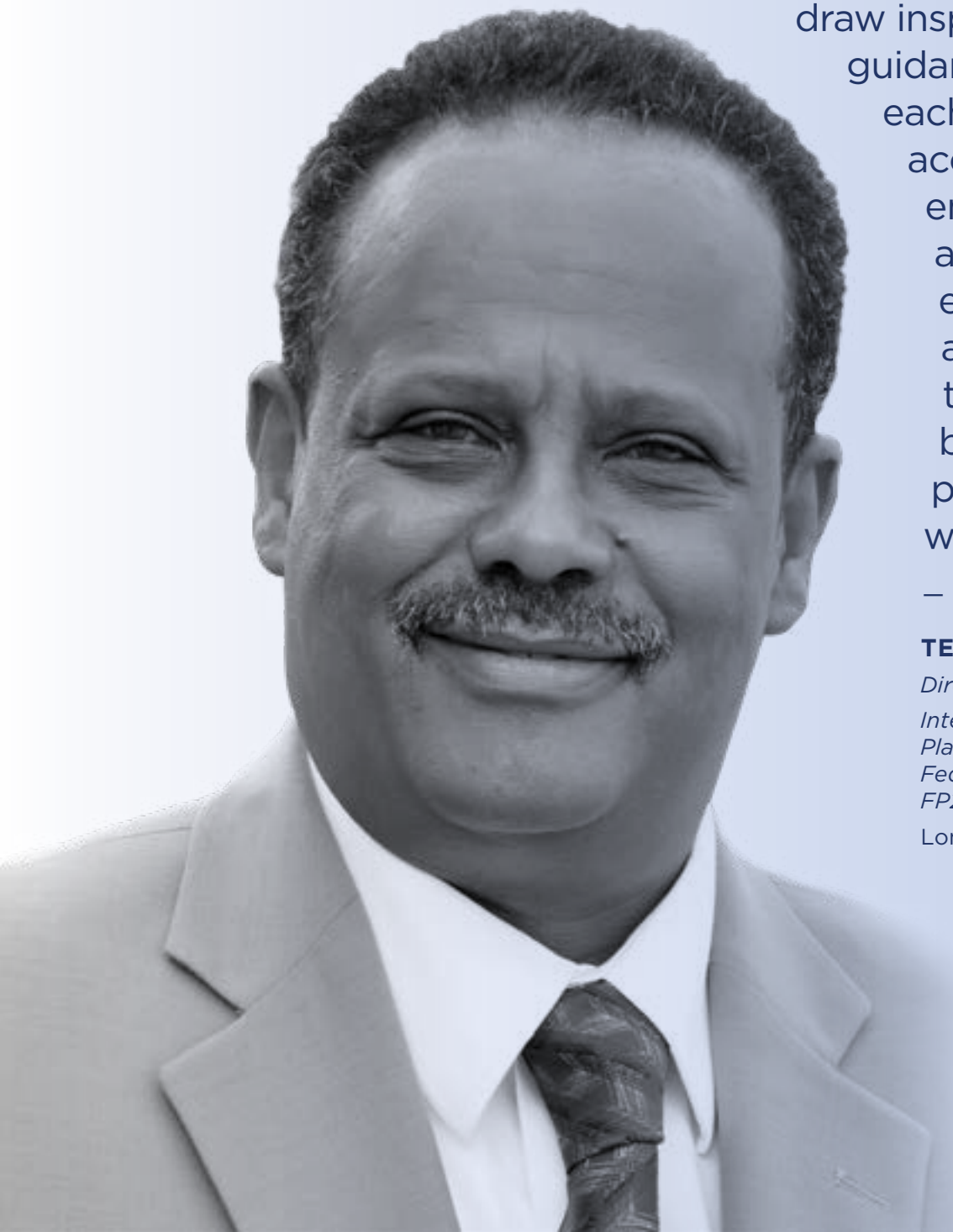
The current membership now includes seven Ministers of Health from FP2020 countries—Burkina Faso, DR Congo, India, Myanmar, Nigeria, the Philippines, and Uganda—who provide important regional perspectives. Young people, faith groups, and women's organizations are represented, along with the research community

Photo by Gabriel Adeyemo
UNFPA

and family planning service providers. This breadth of vision enables the Reference Group to maintain a global perspective on the FP2020 movement while also registering and responding to the specific needs of countries and constituencies.

The structure of the Reference Group also facilitates partnerships across the global health architecture. With the World Bank, the World Health Organization, UNFPA, and the largest family planning donors and foundations all represented, the opportunities for effective cross-institutional collaboration and alignment are enhanced.

As global advocates for family planning, the Reference Group works to ensure that family planning remains a high priority on the global agenda and that FP2020 is integrated into the broader development architecture. Within their own countries and institutions, Reference Group members are a powerful force for meaningful change and an expansion of rights-based programming.



"**The FP2020 Reference Group amplifies our commitment to enable women and girls to control their own future. It gathers together some of the most determined people fighting to realize the vision set forth by the FP2020 partnership.** We draw inspiration and guidance, and hold each other accountable to ensure women and girls everywhere are able to access the rights-based family planning they want and need."

—

TEWODROS MELESSE

Director-General,

International Planned Parenthood Federation, FP2020 Reference Group

London, UK

03

FP2020 MEASUREMENT

INTRODUCTION

MEASURING PROGRESS

LEARN MORE

Visit our Data and Measurement Hub at: **familyplanning2020.org/measurement-hub**.

As a time-bound initiative with an ambitious goal, FP2020 is committed to measuring progress since the 2012 London Summit. FP2020's measurement and learning agenda and the efforts of FP2020 partners to annually measure progress are transforming the monitoring of family planning data. FP2020 aims to improve the infrastructure and capacity for generating more frequent, high quality data for decision making.

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 monitoring progress, to the global-level efforts to align indicators and measures across surveys. The results of these efforts are FP2020's annual comparable estimates on different dimensions of family planning across the 69 focus countries: the 18 FP2020 Core Indicators.

The FP2020 Core Indicators were selected by the FP2020 Performance Monitoring & Evidence (PME) Working Group as critical for helping family planning stakeholders assess progress and the impact of FP2020 efforts. With training and technical support from Track20, commitment-making countries produce comparable estimates for the Core Indicators through a network of country-based Monitoring and Evaluation (M&E) officers housed in government institutions. In annual data consensus workshops, country experts review their Core Indicators and other pertinent national and subnational data to shed light on where gains are being made, where efforts should be reinforced, where investments will have the most impact, and where more data and information are needed. Once estimates have been produced, Track20 and the FP2020 Secretariat's Data & Performance Management team analyze the Core Indicator data and draft the Measurement section of the FP2020 Progress Report, with feedback and input from the FP2020 PME Working Group.

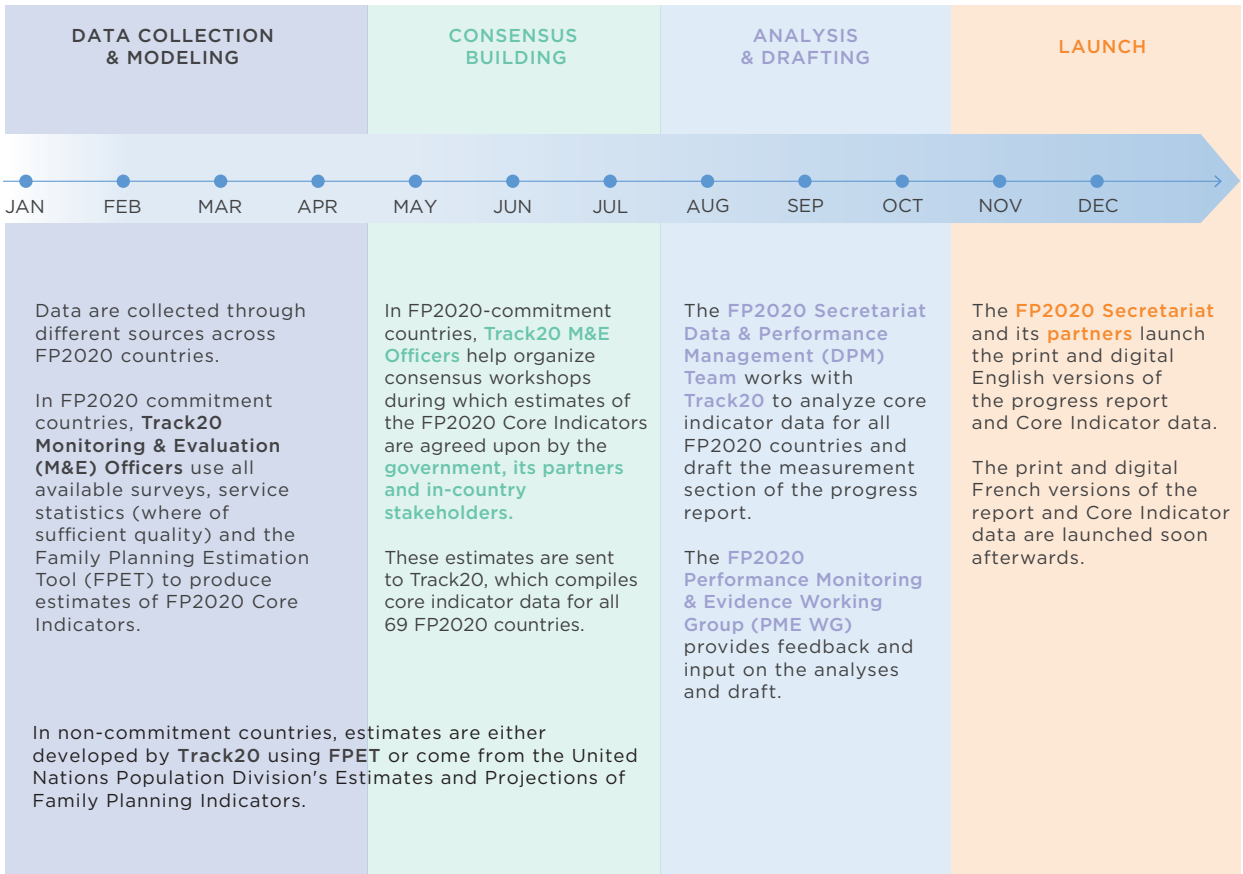
Page 89 Photo by Jessica Alderman
Photoshare

CORE INDICATOR 18
CONTRACEPTIVE DISCONTINUATION & METHOD SWITCHING

This year FP2020 added an indicator to its suite of core indicators. Core Indicator 18 measures rates of contraceptive discontinuation (18a) and contraceptive method switching (18b). The addition of this indicator marks the culmination of FP2020's efforts over the past few years to highlight the importance of measuring and better understanding how often and why women stop using contraceptives, or switch from one method to another. This understanding is critical to addressing discontinuation—particularly for women who discontinue despite being in need of contraception—and enabling women to switch to more suitable methods if they choose.

FIGURE 6

FP2020 annual measurement and reporting process



The process of annually producing, reviewing, 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. The FP2020 PME Working Group is at the forefront of these efforts, helping to harmonize measurement of key indicators among partners, surveys, and platforms. This includes reporting all-women estimates of modern contraceptive prevalence, adopting the RHSC's universal stock-outs indicator, and working toward improved estimates of donor and domestic government expenditures on family planning.

Our aim is that the FP2020 Core Indicators and data in this report will spark productive conversations about what needs to 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 for Women's, Children's and Adolescents' Health, and ultimately the Sustainable Development Goals.

For country-specific data, please visit: **family planning2020.org/countries or track20.org/pages/countries.**

CORE INDICATORS

The FP2020 Core Indicators cover various aspects of family planning, and the selected indicators are based on a results framework that aims 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 the basis for holistic monitoring of family planning progress to ensure that individuals' needs are met and rights are respected.

Additional information on the methodologies used to produce estimates for the FP2020 Core Indicators is provided at the end of the Measurement Section, as well as on the FP2020 and Track20 websites. Subsequent chapters of this section present analyses of the Core Indicators, drawing on the latest estimates. The final section of the report features tables with estimates for the 18 Core Indicators. These estimates are also available and downloadable online, in the digital version of the progress report.

FIGURE 7

FP2020 Core Indicators

VISUAL KEY

- Estimates derived through modeling
- Estimates based on surveys and routine data

ADDITIONAL USERS

Analysis: pages 95-99
Estimates: pages 131-132

1

MODERN CONTRACEPTIVE PREVALENCE RATE (MCPR)

Analysis: pages 95-99
Estimates: pages 133-134

2

UNMET NEED

Analysis: pages 100-102
Estimates: pages 135-136

3

DEMAND SATISFIED

Analysis: pages 100-102
Estimates: pages 137-138

4

UNINTENDED PREGNANCIES

Analysis: pages 103-104
Estimates: pages 139-140

5

UNINTENDED PREGNANCIES AVERTED

Analysis: pages 103-104
Estimates: pages 141-142

6

UNSAFE ABORTIONS AVERTED

Analysis: pages 103-104
Estimates: pages 143-144

7

MATERNAL DEATHS AVERTED

Analysis: pages 103-104
Estimates: pages 145-146

8

METHOD MIX

Analysis: pages 105-108
Estimates: pages 147-150

9

STOCK-OUTS

Analysis: pages 109-11
Estimates: pages 151-152

10

METHOD AVAILABILITY

Analysis: pages 109-111
Estimates: page 153

11

DOMESTIC GOVERNMENT FAMILY PLANNING EXPENDITURES

Estimates not reported this year. See page 112 for more information.

12

COUPLE-YEARS PROTECTION (CYPs)

Analysis: page 113
Estimates: page 154

13

METHOD INFORMATION INDEX

Analysis: pages 114-117
Estimates: pages 155-156

14

FAMILY PLANNING COUNSELING

Analysis: pages 114-117
Estimates: page 157

15

FAMILY PLANNING DECISION MAKING

Analysis: pages 114-117
Estimates: page 158

16

ADOLESCENT BIRTH RATE (ABR)

Analysis: page 118
Estimates: pages 159-160

17

DISCONTINUATION & METHOD SWITCHING

Analysis: pages 119-121
Estimates: pages 161-164

18

INDICATORS 1-2
ADDITIONAL USERS AND MCPR

INDICATOR **NO. 1**

Number of additional users of modern methods of contraception
The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to 2012

INDICATOR **NO. 2**

Modern contraceptive prevalence rate (MCPR)
The percentage of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time

Core Indicator 1, the number of additional users of modern methods of contraception, is the most direct measure of progress toward achieving the goal of adding 120 million additional users by the year 2020. Additional users are calculated by comparing the total number of users of modern contraception across the 69 FP2020 focus countries in any given year with the number of users there were in 2012, at the outset of FP2020. The total number of users of modern contraception is calculated using **Core Indicator 2, the prevalence of use of modern methods of contraception among all women**, and the total women of reproductive age in each country, estimates of which are available from the United Nations Population Division.

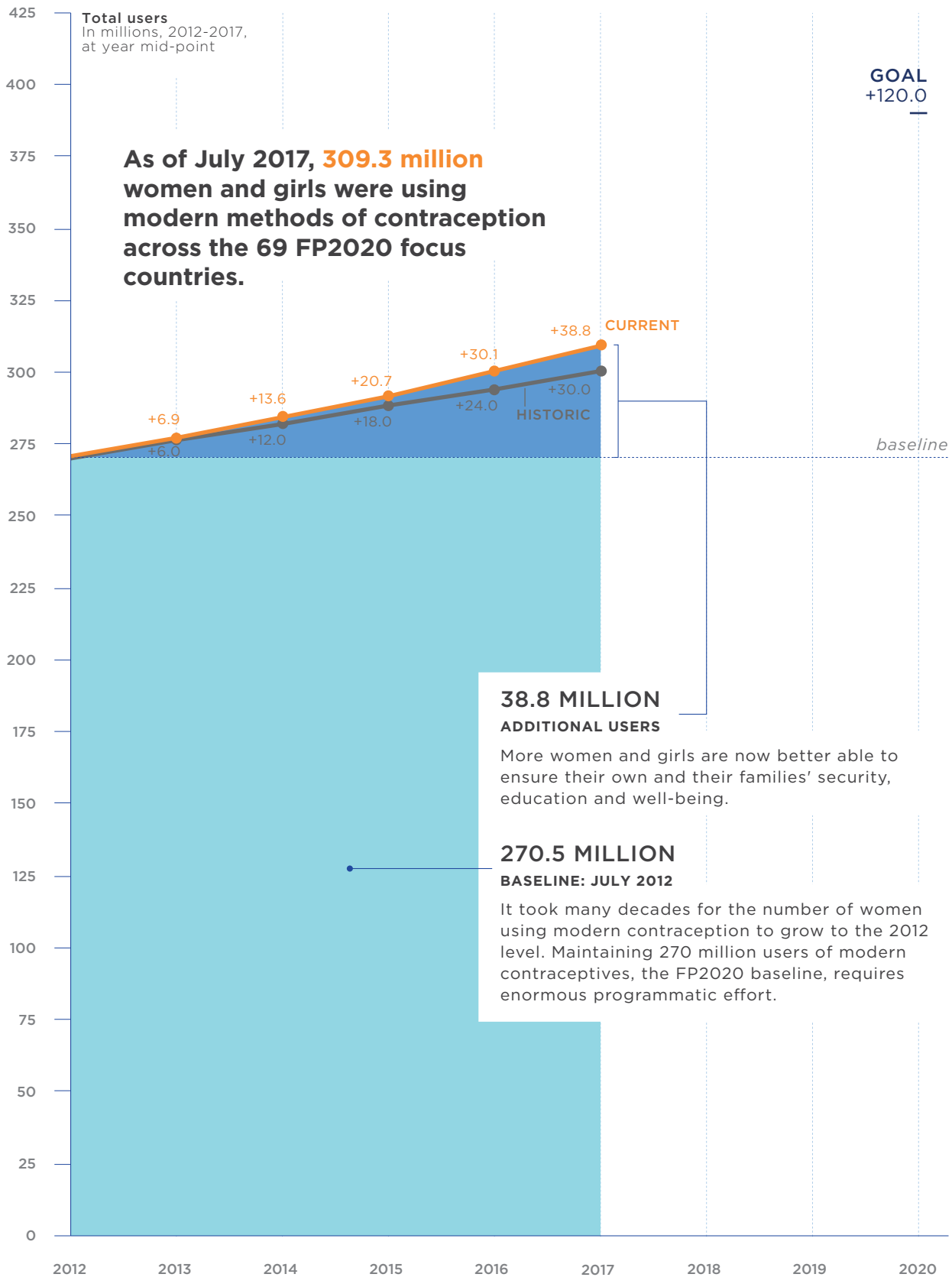
At the 2017 Family Planning Summit, policymakers, countries, donors, civil society, and private sector partners renewed their commitment to reaching more women and girls, and data show that there are many signs of progress even in the face of challenges and uncertainty. As of July 2017, the total number of women and girls using a modern method of contraception in the world's 69 poorest countries had grown to more than 309 million, 38.8 million more than were using contraception in 2012 (see figure on next page).

The population of women of reproductive age in the 69 FP2020 countries is growing by 15 million each year, and today there are an estimated 909 million women age 15–49 in FP2020 countries. This is 74 million more than there were in 2012. The growth in additional users of modern methods of contraception to 38.8 million is approximately 30% greater than the historic trend, and is a sign that health systems are stepping up to the task of meeting the contraceptive needs of an ever-growing number of women and girls.

Closer examination of Core Indicator 1 shows that more than half of the 38.8 million additional users of contraception are in Asia (21.9 million). Asia includes four of the five most populous FP2020 countries: India, Indonesia, Pakistan, and Bangladesh. Because of their size, progress in Asian countries has a large influence on progress toward the FP2020 goal of 120 million additional users. Yet despite the large increase in the number of women using contraception in Asia (today there are 246 million users of modern contraception in the FP2020 countries of Asia), the modern contraceptive prevalence rate (MCPR) across regions of Asia is growing between 0.2 to 0.4 percentage points per year (see Figure 10). In 2017, 38% of all women of reproductive age in Asia were using a modern method.

In contrast, the pace of MCPR growth in Africa over the last several years has been much faster. As

Total and additional users of modern contraception, 2012-2017



of July 2017, there were 16 million additional women using a modern method of contraception in the FP2020 countries of Africa as compared to 2012. Since 2012, MCPR among all women has grown from 19.5% to 23.4% in the region, with the fastest growth occurring in Eastern and Southern Africa (1.2 percentage point increase per year), followed by Western Africa (0.8 percentage point increase per year).

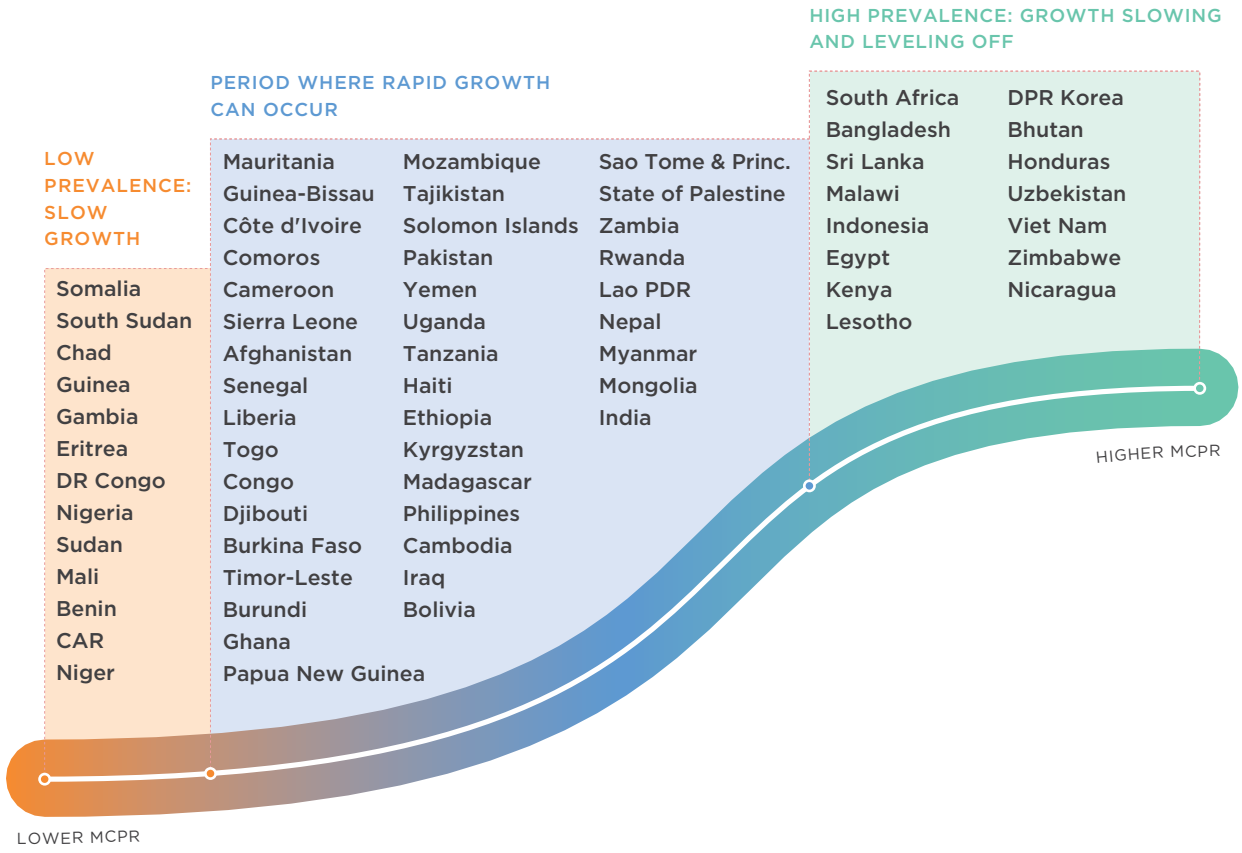
The S-Curve pattern of MCPR growth, described in depth in last year's report, remains an important tool that helps countries assess their trends and opportunities for growth both at national and subnational levels (see Figure 8). Countries are increasingly using data to assess and adjust their family planning programs, and there are now 12 countries within reach of achieving the goals for MCPR growth they established as part of their FP2020 commitments.

High prevalence countries, such as several in Asia, are exploring opportunities to expand method choice, increase postpartum family planning, reduce inequity, and ensure 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.

Countries with moderate prevalence are attempting to capitalize on the opportunity for rapid MCPR

FIGURE 8

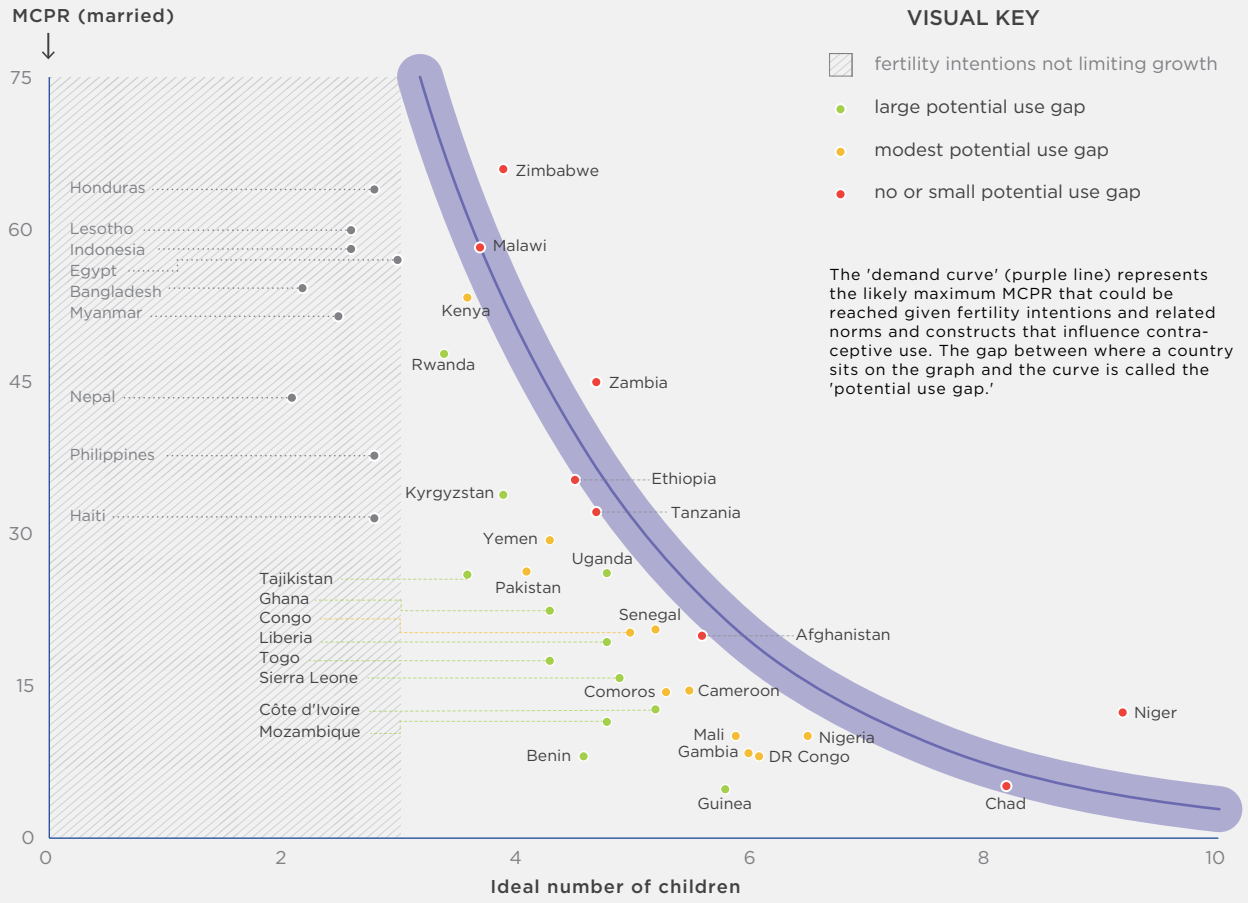
S-curve pattern of MCPR growth (married or in-union women)



Countries are ordered from lowest to highest MCPR, top to bottom, within each category.

FIGURE 9

Finding the balance between supply and demand investments: the maximum contraceptive prevalence demand curve



MCPR (married or in-union women) and ideal number of children are from the most recent DHS survey for each country for which data are available (only includes data since 2011).

Many countries struggle to achieve the right balance of investments between expanding family planning services and undertaking social and behavior change (SBC) activities. If countries allocate too few resources to SBC, then investments to improve family planning services may fall short of their potential impact. If there is not enough support for expanded services, then countries may not be able to meet demand.

Track20 has developed the Maximum Contraceptive Prevalence "Demand Curve" and associated analyses to help countries assess this balance. The "demand curve" (purple line) represents the likely maximum MCPR that could be reached given fertility intentions and related norms and constructs that influence contraceptive use. The curve is based on a historic relationship between MCPR and the mean ideal number of children, an indicator that represents a broad range of social and cultural norms that influence the motivation to use, or not use, contraception. The gap between where a country sits on the graph and the curve is called the "potential use gap," and can be interpreted as follows:

- In countries such as Tanzania and Chad, where the gap is small or modest (indicated by a red or orange dot on the graphic), investments in SBC likely need to be prioritized, and there is limited potential for growth in MCPR from a narrow focus on investments in expanded service delivery.
- Countries where this gap is large, such as Benin and Mozambique (indicated by a green dot on the graphic), are more likely to see substantial increases in MCPR from investments to improve and expand family planning service delivery. Demand in these countries is less likely to be a constraint.
- Finally, this concept is not considered applicable in countries such as Bangladesh where the mean ideal number of children is low (indicated by a grey dot on the graphic).

Regardless of a country's position in the graphic, additional analysis is likely to be helpful in understanding barriers to uptake. While this graphic shows the national picture in each country, there is often very large subnational variation across states or regions.

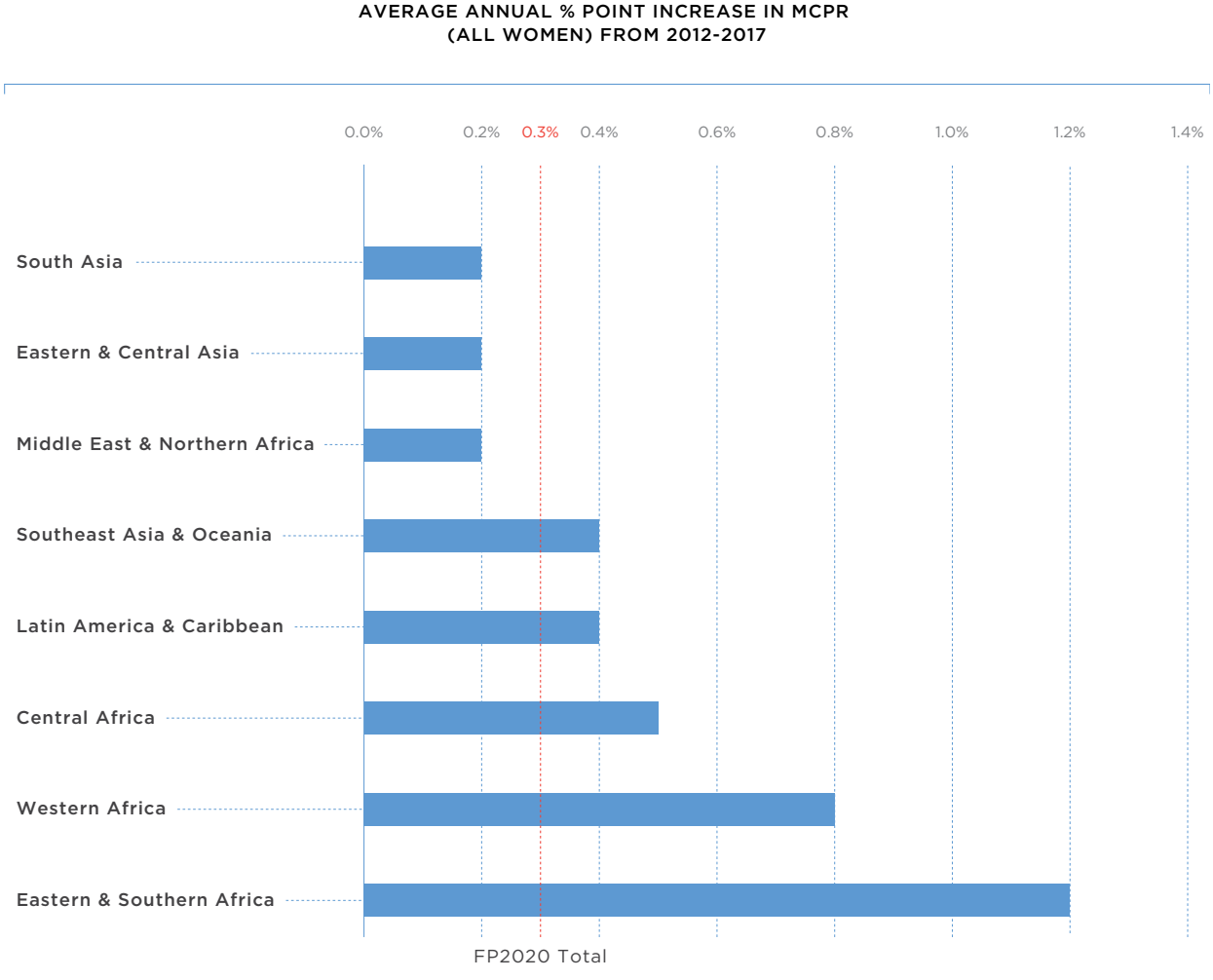
↖ **Subnational demand curves are available for most FP2020 countries under the "Additional Analysis" tab on each country page of the FP2020 and Track20 websites: family planning2020.org/countries and track20.org/pages/countries.**

growth and are focusing their FP2020 efforts on service delivery and supply chain improvements. They are also striving to reach underserved and marginalized populations through mobile outreach services and ensure that existing contraceptive services reach adolescents and youth. Across all FP2020 countries, analysis of MCPR by wealth quintile suggest that these efforts are having an impact. Among the 19 countries with two comparable surveys with wealth quintile data since the launch of FP2020, 17 have seen an increase in MCPR among the lowest wealth quintile—and in 14 countries that increase has been faster than the national average.

Low prevalence countries, principally in Western and Central Africa, face different challenges in expanding the availability and use of contraceptives. Efforts in these countries can be most effectively focused on building political support for family planning, promoting supportive social norms around family planning and stimulating demand for services, and establishing the basic infrastructure and providers to deliver quality services.

FIGURE 10

Annual MCPR growth by region



INDICATORS 3-4
UNMET NEED AND DEMAND SATISFIED

INDICATOR **NO. 3**

Percentage of women with an unmet need for modern contraception
The percentage of fecund women of reproductive age who want no more children or to postpone having the next child, but are not using a contraceptive method, plus women who are currently using a traditional method of family planning. Women using a traditional method are assumed to have an unmet need for modern contraception

INDICATOR **NO. 4**

Percentage of women whose demand is satisfied with a modern method of contraception
The percentage of women (or their partners) who desire either to have no additional children or to postpone the next child and who are currently using a modern contraceptive method. Women using a traditional method are assumed to have an unmet need for modern contraception

Across the FP2020 countries, we estimate that just over one in five married or in-union women of reproductive age have an unmet need for modern methods of contraception in 2017.[f]

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

Core Indicator 3, unmet need for modern contraception, captures women who are not using modern contraception, are at risk of becoming pregnant, and say that they do not want to have a child soon or that they do not want to have any more children.[h] It includes women currently not using a method as well as those using traditional methods, who are considered to have an unmet need for a more effective modern method. There are many potential reasons why a woman who does not want to become pregnant would not use modern contraception. These include limited geographic access to contraception as well as a wide range of other issues, such as perceived health side effects or social disapproval. This is why unmet need should not be interpreted as a direct measure of lack of access. Understanding the barriers to use within each country's context is important to ensure that programs are able to address the needs of women across different settings and situations.

In 2017, 21.7% of married or in-union women of reproductive age across the FP2020 focus countries had an unmet need for modern methods of contraception. At the aggregate level, little change has been seen on this indicator since 2012 (a decline of less than half a percentage point); nevertheless, the overall picture hides many different changes that are happening across countries and regions. Similar to the S-Curve for changes in MCPR, we know that unmet

need also changes in predictable ways as countries transition from low to high contraceptive use. The pattern generally follows an upside-down U shape, in which unmet need tends to rise first in countries with low levels of contraceptive use and unmet need: this is a sign of the changing desires of women to space and limit pregnancies. Eventually unmet need declines—the other side of the upside-down U—with improvements in contraceptive service delivery. Understanding this pattern can help countries interpret their level of unmet need and the changes that appear in the data.

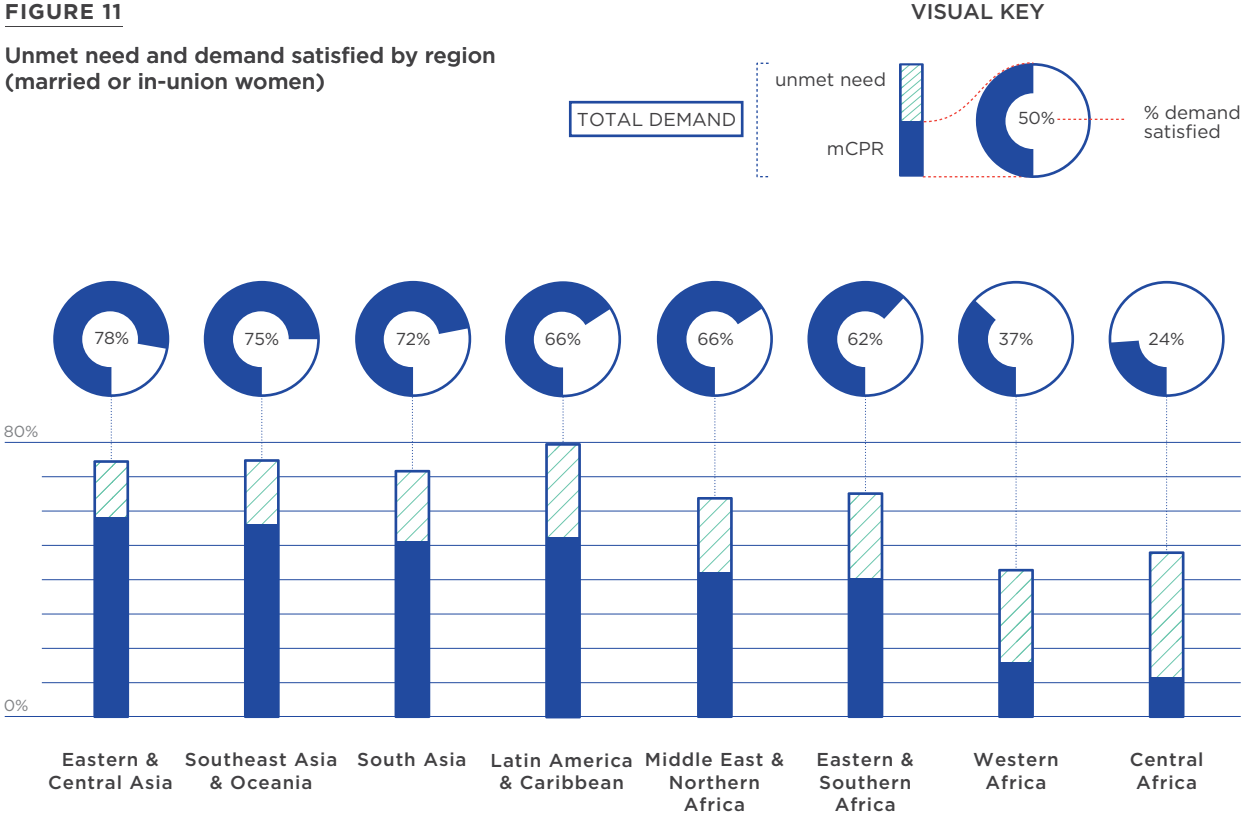
In places with low contraceptive use and high fertility desires, unmet need tends to be low. As these dynamics change and contraceptive use begins to rise, unmet need also increases, since the demand for contraception initially outpaces a country's ability to expand contraceptive services to meet this increased demand. This can be seen in Western Africa, where unmet need has increased slightly from 2012 (25.9% to 26.9%).

For countries in the middle of the S-Curve, where more rapid increases in MCPR can be seen, we start to see declines in unmet need. This can be seen in Eastern and Southern Africa, where unmet need for modern methods has dropped by more than 3 percentage points since 2012—by far the largest change in any region of FP2020 countries. Many countries in this region have also been experiencing rapid increases in MCPR, suggesting that this growth contributed at least in part to reductions in unmet need.

Finally, just as increases in MCPR begin to slow and eventually plateau, declines in unmet need slow. This can be seen in South Asia, which is home to a large percentage of the women of reproductive age living in the 69 FP2020 focus countries. Unmet need in South Asia has remained largely unchanged, moving from

FIGURE 11

Unmet need and demand satisfied by region (married or in-union women)



For a breakdown of FP2020 focus countries included in each region, please see Appendix 4.

Photo by Sam Phelps
Bill & Melinda Gates Foundation

20.8% in 2012 to 20.4% in 2017. For many countries in this region, unmet need is already low and further declines may be limited. We would never expect unmet need to reach 0; for comparison, in Europe unmet need for modern methods was 17.7% in 2017.[7]

Core Indicator 4, demand satisfied with a modern contraceptive method, is constructed based on MCPR and unmet need for modern methods, with total demand assumed to encompass current 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.[8] In a country where unmet need is low because fertility desires remain high, overall demand for contraception will be lower—meaning a smaller number of users (i.e., a lower MCPR) can result in a relatively high proportion of demand satisfied.

Levels of demand satisfied are shown in Figure 11, with regions ordered from the highest to lowest levels of demand satisfied shown in the circle above each bar. This measure is shown together with the MCPR and unmet need in each region to illustrate how the three indicators are related (data shown here for married and in-union women). It can be seen that overall demand (the height of the bar) is comprised of the combination of MCPR and unmet need, and is low in both Western and Central Africa as compared to the other regions. Demand satisfied with a modern method is the portion of the bar filled by MCPR, and is lowest in Central Africa, where there is slightly higher demand than West Africa but less contraceptive use.

Several countries in West Africa have expanded access to a range of contraceptive choices and are beginning to see accelerated growth in the use of modern contraceptives. In Niger, the modern contraceptive prevalence rate has grown from 12% to 15% since 2012 among all women of reproductive age. At the same time unmet need has increased from 18% to 20%. In countries like Niger, where contraceptive use has historically been very low and fertility is high, an increase in unmet need is actually a sign of progress as it may indicate an increase in the percentage of women who desire to space or limit pregnancies. Niger's growth in both MCPR and unmet need is a signal of opportunity for further investment in family planning information and services, and Niger would benefit from increased investment in SBC programs. The country's efforts over the last few years have dramatically increased access points for family planning services, so a comparative effort to increase demand is the next step in building on their success.

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f. FP2020 is currently modeling unmet need for married women for the 69 FP2020 focus countries, and aims in future years to move to modeling unmet need for all women. This estimate differs from Adding It Up, which measures unmet need for all developing countries for married women and unmarried sexually active women.

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

h. Women who are currently pregnant or postpartum amenorrheic whose pregnancy/last births were wanted at the time they occurred are not considered 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.

INDICATORS 5-8
IMPACTS OF MODERN CONTRACEPTIVE USE

INDICATOR **NO. 5**	**Number of unintended pregnancies** The number of pregnancies that occurred at a time when women (and their partners) either did not want additional children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies, including current pregnancies
INDICATOR **NO. 6**	**Number of unintended pregnancies averted due to modern contraceptive use** The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period
INDICATOR **NO. 7**	**Number of unsafe abortions averted due to modern contraceptive use** The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period
INDICATOR **NO. 8**	**Number of maternal deaths averted due to modern contraceptive use** The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period

From the midpoint of July 2016 through the midpoint of July 2017, modern contraceptive use by 309 million women across the 69 FP2020 focus countries averted an estimated 84 million unintended pregnancies, 26 million unsafe abortions, and 125,000 maternal deaths

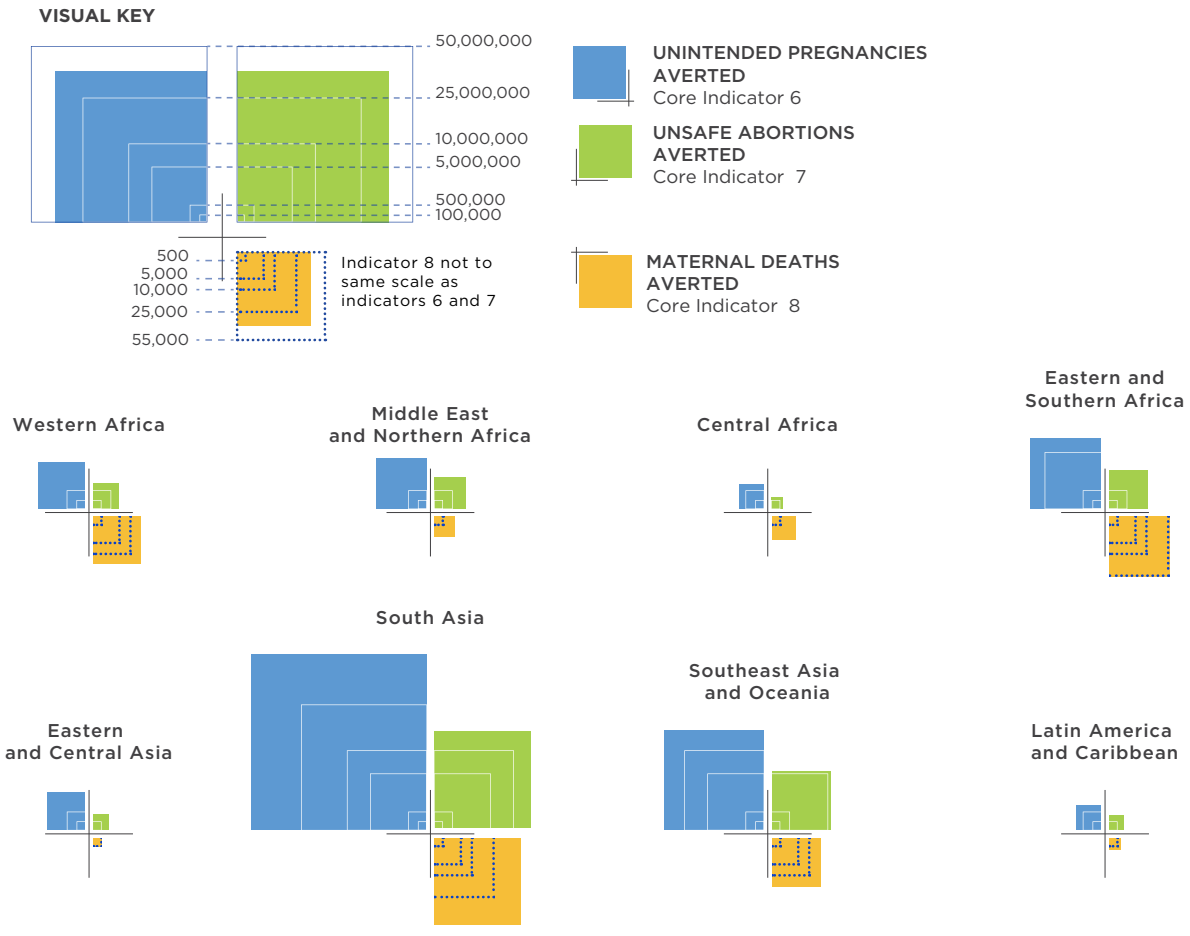
Core Indicators 5 to 8 tell us about the impact of modern contraceptive use and the consequences of non-use. This set of indicators provides powerful information about why family planning is so important, and helps us to contextualize the impact that contraceptive use is having on the lives of women. By choosing to use modern contraceptives, women are less likely to experience unintended pregnancies, unsafe abortions, and, ultimately, maternal deaths from complications during delivery or from unsafe abortions.

As a result of the more than 309 million women using modern contraception, 84 million unintended pregnancies were prevented from the midpoint of 2016 to the midpoint of 2017 compared to the number that would occur if no modern contraceptives were used. Preventing these unintended pregnancies has in turn averted 26 million unsafe abortions and 125,000 maternal deaths. These numbers represent the total annual impact of the more than 309 million women using modern contraception across FP2020 countries—not just the impact from the 38.8 million additional users of modern contraception in 2017. Figure 12 shows the distribution of these impacts by region, with the largest number of pregnancies, unsafe abortions, and maternal deaths averted in South Asia due to the large number of women using contraception. As contraceptive use grows across the other regions, so too will the impacts.

FIGURE 12

Regional impact of modern contraceptive use

Impact varies between regions because of the number of women using modern contraception, as well as differences in method mix, rates of safe and unsafe abortion, and maternal mortality rates.



For a breakdown of FP2020 focus countries included in each region, please see Appendix 4.

It is important to recognize that even in 2012, contraceptive use was having a large impact: in that year, it is estimated that modern contraceptive use across the 69 focus countries averted 74 million unintended pregnancies. This means that in 2017, efforts to reach additional users and improve access to a range of methods have resulted in 10 million more unintended pregnancies averted annually than just 5 years ago.

Despite the large impact that modern contraceptive use has on reducing unintended pregnancies, unsafe abortions, and maternal mortality, an estimated 42.5 million women across FP2020 countries still experienced an unintended pregnancy from July 2016 to July 2017 (as shown in the Core Indicator 5 Estimate Table). Most of these unintended pregnancies occurred among women who reported not wanting to get pregnant but who were not using modern contraception, while some occurred among women who were using a modern method but experienced a contraceptive failure.

INDICATOR 9
MODERN CONTRACEPTIVE METHOD MIX

INDICATOR
NO. 9

Percentage of women using each modern method of contraception
The percentage of total family planning users using each modern method of contraception

Core Indicator 9, modern contraceptive method mix, presents the distribution of modern contraceptive users by the method they use, based on the most recent survey data available.

Contraceptive method mix is a complex indicator, as the choice of a contraceptive method reflects individual preferences, societal and cultural norms, and local and regional issues affecting contraceptive availability and accessibility, including policies, cost, infrastructure, and provider training. This indicator provides insight into and context for Core Indicator 2, MCPR, detailing the composition of contraceptive use in each of the 69 FP2020 countries. Contraceptive method mix highlights which methods are driving contraceptive use as well as which methods are potentially underutilized, indicating where there may be issues of acceptability or accessibility of particular methods, or opportunities to expand access to a wider range of methods.

While there is no "right" method mix or "ideal" method, there is broad consensus that providing access to a wide variety of methods is essential to providing quality of care and ensuring full choice in family planning from a rights-based framework.[9] A diverse mix of methods on offer provides women with greater choice as well as access to longer acting and more effective methods of contraception, reducing the risk of unintended pregnancy and subsequent negative outcomes. Availability of a range of options makes it more likely that women can choose a contraceptive method that best suits their needs and preferences, increasing consistent use and reducing discontinuation.[10 11]

Modern contraceptive method mix varies greatly across the 69 FP2020 focus countries. Figure 13 shows the most commonly used modern method in each country (defined as the single method that makes up the largest proportion of the method mix). Injectables are the most common method in use in 28 countries, followed by pills in 16 countries, condoms in 9 countries, and IUDs in 8 countries. Female sterilization is the most common method in use is 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. This kind of method skew (where one method dominates, making up 60% or more of the method) seen in India with female sterilization and in Ethiopia, where 63% of modern contraceptive users rely on injectables, can be indicative of individual preferences and socio-cultural norms promoting or discouraging particular methods. Skew toward a particular method may also be strongly driven by the healthcare system, contraceptive availability, and how and where women access contraceptives. Limited health infrastructure or a shortage of healthcare providers may prompt women to obtain methods from 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.

More important than the most common method in use is an examination of the number of methods available and in use in each country. Analysis in developing countries has shown that when more contraceptive methods are offered, a larger proportion of women choose to use a modern method[12] and contraceptive discontinuation rates are lower, both contributing to national growth in MCPR.[13] Based on method mix data for the 69 FP2020 countries, 39% (or 27 countries) have 5 or more modern methods in use, measured as at least 5% of users using each method.[i] Among these, three

countries have 6 methods in use: Bhutan, Cambodia, and Kenya. In these countries, female sterilization, IUDs, injections, pills, and condoms (listed in order of effectiveness) all contribute at least 5% of the method mix. In Cambodia and Kenya, implants contribute at least 5% of the method mix. Of note, Bhutan is one of only two countries (the other being Nepal) where male sterilization comprises more than 5% of the method mix, making up nearly 20% of use in Bhutan and 10% in Nepal. Pills and injectables are among the methods in use among all countries with 5 or more methods in use, while male condoms are in use in all but one country (Timor-Leste). Female sterilization is in use in nearly all those with 5 or more methods in use (except Benin, Ghana, and Senegal). Among those countries with 5 or more methods in use, implants make up at least 5% of modern use in all the African countries while IUDs make up at least 5% of modern use in all Asian and LAC countries, with some overlap. At the other end, two countries are categorized as having only one method in use: Uzebekistan and DPR Korea, where more than 80% of modern users are using IUDs. Four countries—Niger, CAR, Sudan, and Djibouti—are categorized as just having two methods in use, with the majority of modern users relying on short-term methods (pills, injectables, or condoms) for contraception.

While data on method mix alone cannot be used to assess availability of methods, it can be used in conjunction with other indicators, such as Indicator 11 (measuring the proportion of facilities offering at least 3 or 5 modern methods) and Indicator 10 (measuring method-specific stock-out levels), to help understand method use and potential barriers limiting women from accessing a full range of modern methods.

Shifts in method mix and method prevalence over time can provide evidence of changing norms and preferences, improvements or declines in the health-care system, shifts in policy, and changes in access to various contraceptive methods. Analysis of changes in method prevalence and method mix since the inception of FP2020[i] suggests that previously observed growth trends in the prevalence of implants and injectables have continued. The prevalence of injectables and implants each grew in 17 of 25 countries with sufficient data for analysis. The fastest growth in implants was seen in Malawi, where implant prevalence grew 7.9 percentage points among all women between 2010 and 2015, contributing to a large increase in MCPR. While increases in injectables generally continued to support their dominance in the method mix—or method skew in some countries—the growth in implants is increasing the diversity of the method mix in many countries.

i. 5% of users was used as a cutoff, rather than any users (>0%), so as to indicate wider uptake of a method. Lactational Amenorrhea Method (LAM) is excluded from this analysis to focus on methods that require a service or commodity. The following methods were included: female sterilization, male sterilization, IUDs, implants, injectables, pills, male condoms, female condoms, diaphragm, foam or jelly, standard days method, and emergency contraception.

j. Countries with sufficient data for analysis included: Bangladesh, Burundi, Cambodia, Cameroon, Chad, Egypt, Ethiopia, Ghana, Guinea-Bissau, India, Kenya, Kyrgyzstan, Lesotho, Malawi, Mauritania, Rwanda, Sao Tome & Principe, Senegal, South Africa, State of Palestine, Sudan, Tanzania, Timor-Leste, Uganda, and Zimbabwe.

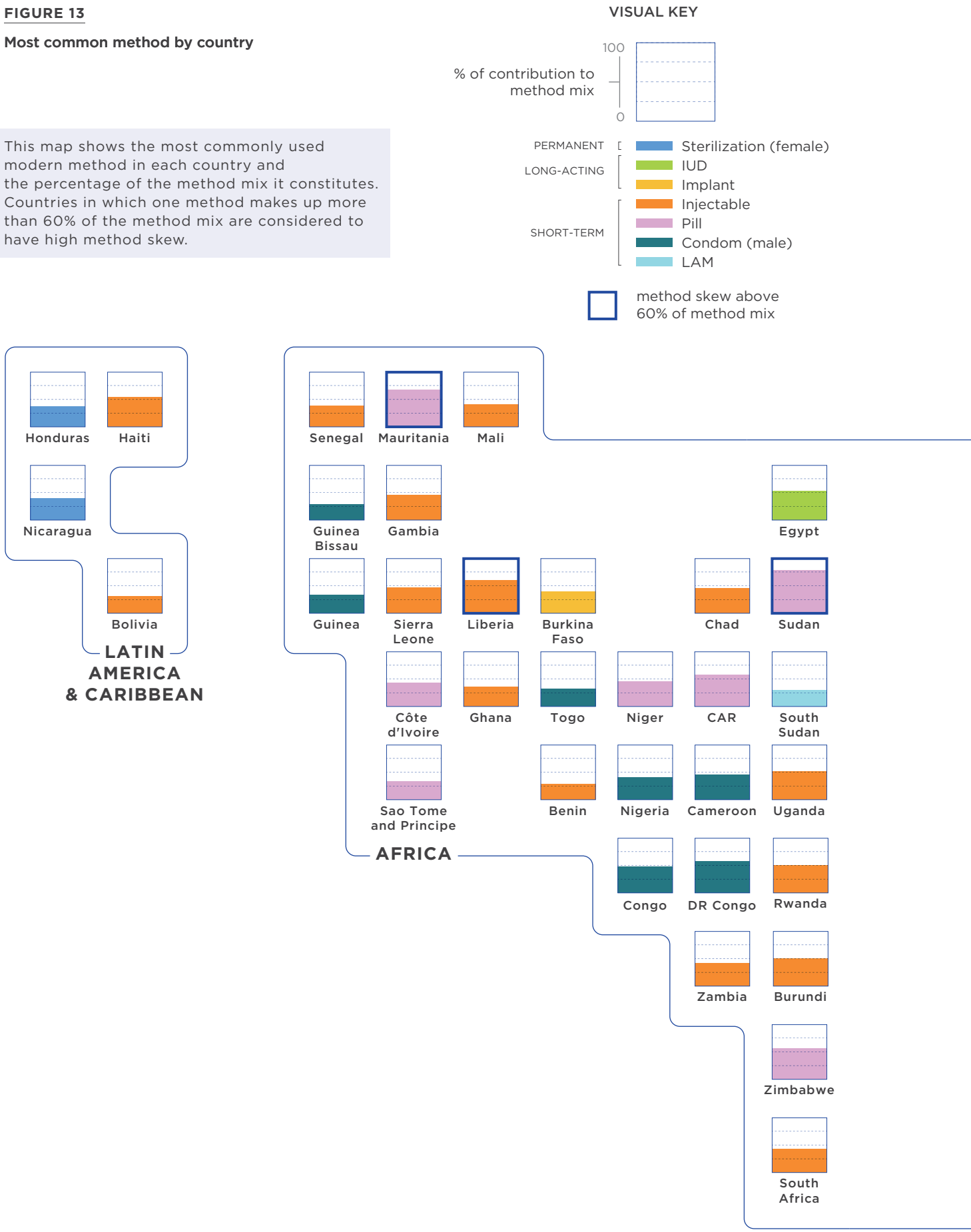
COUNTRY DATA USE

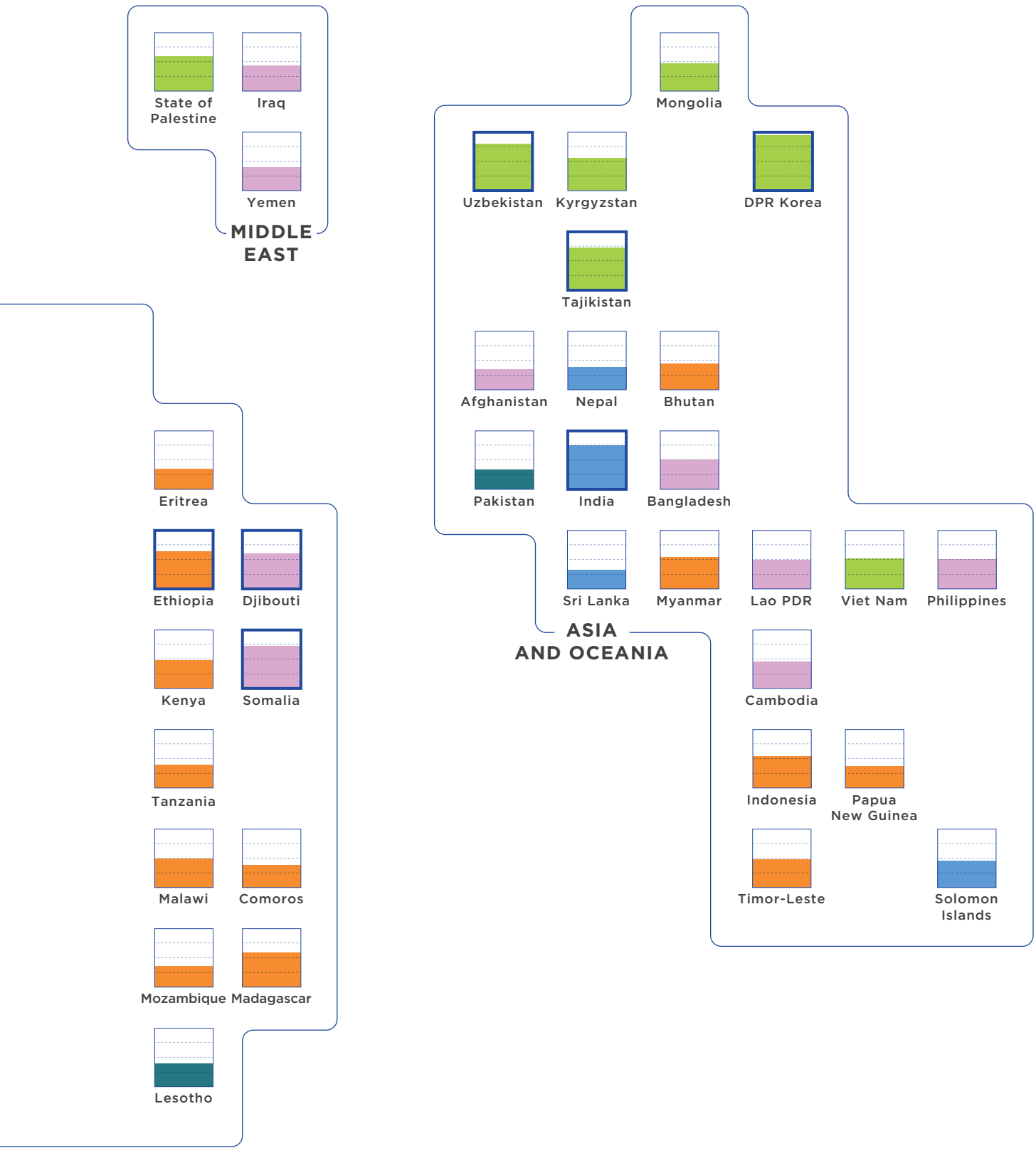
India is using data on their contraceptive method mix and changing demographics to identify strategies for expanding method choice through the public sector. For several decades, women in India have primarily relied on female sterilization after having their desired number of children. The Government of India is in the process of introducing a range of new methods through the public sector to increase the contraceptive options available to women and couples. Recent data from the NFHS-4 survey reveal an increase in the age at marriage and may indicate changing social norms around marriage and early childbearing. The rapidly changing social norms suggest an opportunity for the government's expansion of method choice to reach the next generation of women in India.

FIGURE 13

Most common method by country

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.




State of Palestine
Iraq
Yemen
MIDDLE EAST
Mongolia
Uzbekistan
Kyrgyzstan
DPR Korea
Tajikistan
Afghanistan
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Bhutan
Pakistan
India
Bangladesh
Sri Lanka
Myanmar
Lao PDR
Viet Nam
Philippines
ASIA AND OCEANIA
Cambodia
Indonesia
Papua New Guinea
Timor-Leste
Solomon Islands
Eritrea
Ethiopia
Djibouti
Kenya
Somalia
Tanzania
Malawi
Comoros
Mozambique
Madagascar
Lesotho

INDICATORS 10-11 CONTRACEPTIVE STOCK-OUTS AND AVAILABILITY

INDICATOR **NO. 10**

Percentage of facilities stocked out, by method offered, on the day of assessment
Percentage of facilities experiencing stock-outs of specific methods of contraceptive offered, on the day of assessment

INDICATOR **NO. 11A**

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

INDICATOR **NO. 11B**

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

Stock-outs refer to the temporary unavailability of contraceptive commodities (or supplies) at a health facility or store where the method or services are offered, and in the case of sterilization it refers to the temporary unavailability of supplies and/or trained staff at a health facility where the service is supposed to be available according to national health system guidelines. FP2020 indicators reflect the availability of contraceptives at the facility at a point in time (the day of a facility survey), and measure stock-outs by method as well as stock-outs for a range of methods. The availability of comparable data across countries on contraceptive stock-outs continues to improve, and depends largely on facility surveys conducted by UNFPA. This year 27 of the 69 countries had data on **Core Indicator 10, stock-outs by method**, while 30 countries had data on stock-outs of any method.

The data show that stock-outs vary considerably both by level and by type of method. Figure 14 shows by country the percentage of facilities stocked out by method offered. The levels of of stock-outs range widely, from lows of 0% for condoms in some countries, to the other extreme of 94% of facilities in one country experiencing implant stock-outs. In general, stock-outs are lower for the most commonly used methods in countries (highlighted in Figure 14). In East Africa, for example, where injections are the most common method, stock-out levels are a relatively low 9.8%, with only one country—Sudan—experiencing high double-digit stock-outs in 2017. These data suggest that many countries are successfully monitoring key commodities within supply chains to deliver the most commonly used products to clients.

FIGURE 14

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

See Core Indicator 10 Estimate Table for data sources. See Core Indicator 9 Estimate Table for method mix by country.

If we look at the three most commonly dispensed methods at the primary level (condoms, pills, and injectables), nine countries had stock-outs of less than 10%, and five of these had stock-out levels of less than 5%, including Zimbabwe, Sao Tome and Principe, Rwanda, Nepal, and Burkina Faso. If we include long-acting methods (IUDs and implants), six countries had stock-outs of less than 10%. Learning more about these countries' supply chains can help FP2020 partners working in commodity security identify the common elements in governance, logistics systems, and funding stability that explain the success of these diverse countries.

The Asia region has more limited data, but generally shows lower levels of stock-outs for short term methods such as pills, injectables, and emergency contraception. This region has average stock-out levels that are marginally higher than levels in West Africa, at 33% and 32% respectively.

Stock-out data is currently not available through the routine Logistics Management Information Systems (LMIS) used by the public sector in most countries to manage supply chains for essential medicines and health system supplies. This is expected to change in 2018, when it is anticipated that data from large supply chain partners and projects will be made publicly available. The availability of this data in some countries may begin to change the way that countries are able to monitor supply chains and prevent stock-outs.

Core Indicators 11a and 11b measure method availability at primary and secondary/tertiary facilities respectively. There has been a substantial increase in the number of countries reporting availability of three or five methods in stock on the day of survey. Data are available for 22 countries in 2017—as compared to just 8 in 2016—with the increase due entirely to changes in the questionnaire used by UNFPA in its facility surveys.[k] In most countries, secondary and tertiary level facilities show greater availability of a wider range of contraceptive methods than primary facilities. There were 9 countries in which fewer than 75% of primary facilities had at least 3 modern methods in stock on the day of the survey. In contrast, there were only 3 countries in which fewer than 75% of secondary or tertiary facilities had 5 or more modern methods in stock on the day of the survey. In several countries the range of methods available was low at both levels, including the Democratic Republic of Congo, in which only 39% of primary facilities and 20% of secondary facilities had 3 or 5 methods available respectively. These data do not indicate stock-outs for specific methods, but do suggest the need for further examination of the limitations that are constraining the range of contraceptive choices at various levels of the health care system.

k. UNFPA facility surveys have now adopted these indicators as part of their alignment with global partners around Universal Stock-out Indicators recommended by the Reproductive Health Supplies Coalition.

COUNTRY DATA USE

In most countries data on stock-outs are the responsibility of logistics systems managers, not the family planning program, and the purpose of monitoring stock-outs is principally for inventory management rather than program management.

In Ethiopia, for example, family planning program managers from the Federal Ministry of Health (FMOH) do not have visibility into real-time data on stock-outs. This is the responsibility of the Pharmaceuticals Fund and Supply Agency (PFSA) and is maintained independently of Health Management Information System (HMIS) data. HMIS reports do capture stock-outs of a tracer commodity (Depo-Provera), but with method mix targeted for expansion, the tracer is increasingly insufficient for management. In this year's data consensus workshop, survey data from UNFPA Supplies pointed to higher than expected levels of method-specific stock-outs, and program managers discussed their lack of access to commodity stock-out data. As a result, the FMOH agreed to begin getting stock-out data routinely from PFSA.

In Zimbabwe, high contraceptive prevalence rates create a disincentive to review facility level stock-outs. As in Ethiopia, the logistics management of family planning commodities is not within the purview of the family planning program. Survey data shared at this year's data consensus meeting showed higher than expected levels of stock-outs for long-acting methods compared with LMIS data. Discussion of the reasons focused on whether facilities that do not yet have trained providers should be counted as "stocked out" of long-acting methods; the consensus was that this is inefficient.

INDICATOR 12
DOMESTIC GOVERNMENT EXPENDITURES ON FAMILY PLANNING

INDICATOR
NO. 12

Annual expenditure on family planning from government domestic budget
Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government

At the time of the London Summit in July 2012, it was estimated that US$14.3 billion would be required through 2020 to meet family planning needs. The funds for accelerating family planning progress in the 69 FP2020 focus countries are expected to come from international donors, national governments, NGOs, and individuals who pay for their services in the private sector. Mobilizing domestic resources for family planning is an important aspect of the long-term sustainability of family planning services, and many governments have made commitments to increase domestic expenditures on family planning. Most domestic governments, at a minimum, pay for the health facilities and personnel that deliver family planning services through public channels. Some governments also pay for commodities, training, research, and promotion, while others rely on donors to support these activities. Several efforts are underway to track family planning expenditures, but the task is complicated by the nature of government expenditures.

Domestic government spending on family planning commodities can be tracked most easily since these expenditures usually have a specific line item in the government budget. Some other activities, such as training and research, may be integrated with other reproductive health activities and the specific family planning components may be difficult to separate out. The most difficult part is determining the amount of health system spending (personnel, facilities, transport, logistics) that should be allocated to family planning. It may also be difficult to capture government expenditures by provincial or state governments, which are increasingly important in some countries.

The World Health Organization collects data on health expenditures through its System of Health Accounts (SHA). This system is meant to capture all health expenditures and, therefore, can properly allocate shared expenses to specific services. To date, family planning expenditure information is available from 12 countries for various years from 2011 to 2014. It shows aggregate annual government expenditures of about US$45 million. As the system expands, information on more countries may become available.

A second source of information on domestic government expenditures is the UNFPA-NIDI Resource Flows Project, which works through local UNFPA offices and consultants to collect information on family planning expenditures from governments and NGOs. In 2016, this effort included 28 FP2020 countries and reported aggregate government spending on family planning of US$570 million in 2015. This effort relies on responses from individual governmental organizations and the response rate varies by country. This approach is better at capturing activities clearly designated as family planning and may under-estimate shared expenses. In 2017 UNFPA-NIDI will add a validation component that will include national review of the final estimates, which should improve the quality of the estimates and their utility in tracking resource mobilization. As the methodology for collecting domestic expenditures improves and becomes standardized across countries, we also hope to be able to report on trends over time in government expenditures on family planning.

INDICATOR 13
COUPLE-YEARS OF PROTECTION

INDICATOR
NO. 13

Couple-Years of Protection (CYP)
The estimated protection provided by family planning services during a one year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method

Core Indicator 13, couple-years of protection, is the only core indicator to come directly from routine data systems. Countries collect information from the public sector (and in some cases the private sector) about the number of services and products provided to clients. This information is vital for monitoring health system performance, forecasting inventory stocks to ensure adequate supplies are available, and tracking trends and progress over time.

Routine information collected by health providers on their client visits, such as the number of services and products provided to clients, are converted into couple-years of protection (CYPs) to allow for comparison of the pregnancy prevention delivered through the provision of different contraceptive methods. This is needed because providing one IUD and one condom generate very different levels of protection against pregnancy for the clients receiving them. The CYP measure adjusts for these differences and shows the total years of protection that will result from the services provided or products distributed/sold in each year.

The CYP estimates presented in this report are based on data from countries' routine information systems and were reviewed by countries at their annual data consensus workshops after various quality assessments. Since countries need to have robust health information systems to report on CYPs, the indicator also serves as a proxy for the importance of investing in Health Management Information Systems and using routine data in countries. Each year since 2012, an increasing number of countries have been able to use their service statistics to report on CYPs.

CYP data and particularly trends from year to year should not be interpreted without additional information, as there are often factors that may explain large variations between years. In Ethiopia, for example, CYPs are based on commodities distributed to facilities. In 2012 and 2013 Ethiopia embarked on an effort to improve method choice, particularly for long acting reversible contraceptives in the public sector. The high numbers of CYPs for these years are due to the fact that large volumes of implants - which have a relatively high conversion factor (i.e. number of CYPs per implant) - were distributed to facilities for use in subsequent years.

COUNTRY DATA USE

While there are limitations to what a CYP estimate can tell us about users of family planning, trends in routine service statistics data can be used to inform estimates of current MCPR. In Mozambique, for example, data from routine information systems from 2012 to 2015 suggested an upward trend in services being provided to clients. The last nationally representative survey for Mozambique was conducted in 2011, and without information from routine data systems, estimates of MCPR would have continued on the path of slow growth that Mozambique had been following. The service statistics from Mozambique suggested a more rapid growth in contraceptive services, and these data were used to inform Mozambique's FP2020 MCPR estimates. Later, a nationally representative survey, the Mozambique AIDS Indicator Survey, confirmed the rapid growth in contraceptive use that had been suggested by service statistics. Without these data Mozambique would have had little information to help explain its progress, and today we know that Mozambique is among the fastest growing countries in terms of expanded contraceptive use.

INDICATORS 14-16
MEASURING RIGHTS: COUNSELING, INFORMED CHOICE AND DECISION MAKING

INDICATOR **NO. 14**

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

INDICATOR **NO. 15**

Percentage of women who were provided with information on family planning during recent contact with a health service provider
The percentage of women who were provided information on family planning within the last 12 months through contact with a health service provider or field worker

INDICATOR **NO. 16**

Percentage of women who decided to use family planning alone or jointly with their husbands/partners
The percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner

Rights-based family planning is an approach to developing and implementing programs that aims to fulfill the rights of all individuals to choose whether, when, and how many children to have; to act on those choices through high-quality sexual and reproductive health services, information, and education; and to access those services free from discrimination, coercion, and violence. FP2020 partners are working across countries to translate rights principles into practical programs and measurable indicators. The data collection for these efforts includes facility audits, provider interviews, client observation, and client exit interviews. The knowledge gained will inform future measurement and monitoring of rights and quality at the facility, provider, and client-level.

FP2020 relies on household survey data for Core Indicators 14, 15, and 16, which measure informed choice, quality of care, and empowerment, all of which are important aspects of rights-based family planning. Measurement limitations are primarily due to what data are available from household surveys and comparable across countries.

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

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

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

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

Research has shown that improved quality of care, one aspect of rights-based family planning, results in declines in contraceptive discontinuation and increases in contraceptive use. Proper counseling provides women and girls with medically accurate information about their bodies and contraceptive options, enables them to explore and choose among a range of methods as their sexual and reproductive health needs evolve over time, and helps them understand potential side effects.

MII values in 2017 span a wide range, from 13% of contraceptive users in Pakistan to 71% of contraceptive users in Zambia responding "yes" to all three questions. Looking at the individual components (Figure 15), a greater percentage of women report receiving information on other methods (average across countries of 63%) than report being informed about side effects (52%) or how to handle them (52%). Users of implants and IUDs tend to receive more information regarding their methods. Long term trends available from the DHS show that most countries with multiple surveys show an improvement over time in counseling. Comparing the two most recent surveys, however, reveals that very few countries have made recent progress in the MII measures of providing counseling and information to women adopting a contraceptive method.[14] These findings show that there is room for improvement in counseling across the 69 FP2020 focus countries.

Core Indicator 14 measures the information and counseling received by women who have adopted a method. **Core Indicator 15 measures the proportion of women who received any kind of family planning information in the last 12 months, either from a health worker in a facility or in the field** (among both those using and not using contraception). The percentages vary across countries with available data, from 6% in Guinea to 52% in Liberia. These numbers must be interpreted in context, as not all women want or need family planning information, and information may be provided by other channels, including media, schools, and social networks. But in half of the countries with data for this indicator (16 out of 32), at least 75% of women reported not receiving information on family planning in the last year in their contact with health providers. This indicator signals that many countries will need to expand family planning information, education, and communications efforts if they hope to enable more women and girls to make informed contraceptive choices by 2020.

Core Indicator 16 measures the percentage of women using family planning who made family planning decisions either by themselves or jointly with their husbands or partners. Across countries that have had surveys since 2012, the indicator shows a high level of women's participation in contraceptive decision making, ranging from 71% in Comoros to 98% in Egypt and Rwanda. It is important to note that in 15 of 35 countries with data, at least 1 in 10 female users reported that they were not involved in such important choices as whether and when to use contraceptives and what method to use. These data suggest that in many countries work remains to be done to ensure that all women and girls can make contraceptive decisions voluntarily and free from discrimination, coercion, or violence.

The results from Indicator 16, however, paint an incomplete picture of empowerment. Given that the indicator scores are high and vary little across countries and years, the indicator is likely not capturing many of the challenges that women face in deciding to use contraceptives. Furthermore, Indicator 16 only measures the decision-making power of women who are currently using a method, and gives no insight into the experiences of women who are not using a method or how that decision was made. Research on reasons for non-use of family planning among women with unmet need indicates that opposition by partners or others is a challenge for women, along with more commonly cited reasons: fear of side effects, infrequent sex, and amenorrhea or breastfeeding.[15] Survey changes in the next DHS questionnaire mean that in the future this question will be asked of women not using contraceptives, as is already done by PMA2020. These data will likely serve the longer-term SDG measurement effort as well, as SDG indicator 5.6.1 is "the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care."

While Core Indicators 14, 15, and 16 are limited in what they each reveal, they can paint a fuller picture

FIGURE 15

Method Information Index (Core Indicator 14)

This index measures the extent to which women were given specific information when they received family planning services.

See Core Indicator 14 Estimate Table for Method Information Index values disaggregated by method and for data sources.

Photo by Prasanta Biswas
Photoshare

when examined alongside each other. In Chad, for example, one of FP2020's newest commitment makers, where contraceptive prevalence is very low, substantial efforts are needed to integrate rights and quality of care into family planning. Only 14% of women have received information on family planning in their recent contact with health providers, and among the small percentage of women using family planning, only 38% reported that they had been informed about side effects and alternatives to their current method. A relatively large percentage of contraceptive users also reported that they had not made the decision to use contraceptives alone or with their partners (18%). In its new FP2020 commitment and in response to data from the recently completed DHS, Chad has identified actions the country needs to take to improve rights within its family planning program.

As FP2020 partners and focus countries learn from efforts to operationalize and measure rights and empowerment principles at the service delivery point, these lessons will need to be shared widely in the public and private sector. These efforts are critical to sustaining and expanding contraceptive use while respecting, protecting, and fulfilling the rights of all contraceptive users.

INDICATOR 17
ADOLESCENT BIRTH RATE

INDICATOR
NO. 17

Adolescent birth rate
The number of births to adolescent females aged 15–19 occurring during a given reference period per 1,000 adolescent females

The 2017 Family Planning Summit brought together countries, donors, and civil society to shine a spotlight on young people and provide them the tools they need to thrive. Dozens of new and revitalized commitments at the Summit focused on delivering tailored, rights-based, voluntary family planning programs and services to adolescents and youth in FP2020 countries.

Core Indicator 17, the adolescent birth rate (ABR), is a measure of the rate at which adolescent females are bearing children, and is expressed as the number of births per 1,000 adolescents aged 15 to 19 years. This indicator was monitored as part of the ICPD Program of Action, the Millennium Development Goals, and now the Sustainable Development Goals; it is the only FP2020 indicator focused solely on adolescents. Age disaggregated data, including for the 15–19 age group, is available for several indicators in the estimate tables for this report.

Among the 49 FP2020 focus countries with sufficient recent data to produce estimates, the adolescent birth rate ranged widely: from 38 per 1,000 in Indonesia to 179 per 1,000 in Chad. In general, the highest rates are seen in Western Africa, a reflection of the high rates of child marriage and low levels of contraceptive use in that region. High adolescent birth rates may also be attributed to social stigma, provider bias, and policies that limit young people's access to contraceptives. Over time, improvements in adolescents' sexual and reproductive health—including comprehensive sexuality education, adolescent-friendly contraceptive information and services, and reduced rates of child marriage—should result in fewer pregnancies among adolescents. But because the adolescent birth rate relies on several years of an interviewed woman's birth history, it may not change as rapidly as contraceptive behaviors.

Analysis of adolescent birth rates across 30 countries with sufficient data[I] suggests a downward trend, with 19 of the 30 countries showing a decline in the adolescent birth rate between the previous estimates and the current survey. In most of these countries, however, the decline was marginal, and only 8 countries exhibited a decline of 10 adolescent births per 1,000 or greater: Congo, Indonesia, Kenya, Malawi, Mali, Nepal, Niger, and Sierra Leone. With the exception of Congo, which is not an FP2020 commitment-making country, each of these countries made specific adolescent-focused commitments at the Summit and are among the many countries working to improve the health and wellbeing of adolescents. Of these countries, however, only Malawi and Sierra Leone have seen substantial increases in contraceptive use among the 15 to 19 year old age group.

Improving the sexual and reproductive health of adolescents is a priority across many countries, but the data above illustrate some of the challenges in tracking progress with current indicators. In part this is because the adolescent birth rate measures births rather than pregnancies. Birth rates can decline for several reasons, including a decline in the proportion of adolescents who are sexually active, an increase in the proportion of adolescents using contraception, or an increase in the proportion of adolescents terminating pregnancies through abortion. This suggests that relying solely on tracking adolescent birth rates is insufficient for informing country-specific interventions, policies, and resource allocations for adolescent sexual and reproductive health.[16]

We need additional data to inform effective policies and programs for adolescents, but there are important data gaps in data collection, reporting, and understanding that limit our ability to monitor progress.[17] The Summit focused attention on these data gaps (see page 65), and overcoming the challenges will require the collective efforts of country governments, donors, data collection agencies, health providers, and civil society organizations.

I. 30 countries have had a survey reporting ABR since 2013 and have an earlier estimate of ABR from a comparable survey in an earlier year. PMA2020 surveys were not compared to one another due to the short duration of time between surveys.

INDICATOR 18
CONTRACEPTIVE DISCONTINUATION AND METHOD SWITCHING

INDICATOR **NO. 18A**

Contraceptive discontinuation rate
Among women of reproductive age who began an episode of contraceptive use 3–62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use, reported by whether the woman discontinued while in need of contraception, discontinued because she is not in need of contraception, and the total all-reasons discontinuation rate, according to specific method

INDICATOR **NO. 18B**

Contraceptive method switching
Among women of reproductive age who began an episode of contraceptive use 3–62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use, and use of a different method begins after no more than one month of non-contraceptive use

Over the past few years FP2020 has highlighted the importance of better understanding reasons for contraceptive discontinuation, which presents a challenge to achieving FP2020 goals. Following the publication of a report on discontinuation in 2015 and the inclusion of a special section on discontinuation in the 2016 FP2020 Progress Report, this year FP2020 added this indicator to its suite of Core Indicators.

Core Indicator 18 measures rates of contraceptive discontinuation (18a) and contraceptive method switching (18b) for each method. By measuring the rates at which women stop using methods, as well as the rates at which they switch from one method to another, Core Indicator 18 provides a fuller picture of the dynamics or churn of contraceptive use as women begin using a method, stop for a variety of reasons (most frequently because they want to become pregnant), start using a method again, or switch to a preferred or more effective method. Information on discontinuation complements existing measures of contraceptive prevalence, method mix, method availability, informed choice, and decision-making.

Learn more about discontinuation at: familyplanning2020.org/discontinuation.

Core Indicator 18a estimates the total discontinuation rate for each method and disaggregates this estimate into two separate rates: 1) discontinuation while a woman is in need of contraception and 2) discontinuation because a woman is not in need of contraception. These two rates reflect a range of reasons for discontinuation. Reasons for discontinuation while a woman is in need include: method failure, health concerns or side effects, wanting a more effective method, inconvenience of using a method, lack of access to a method or a method being too far, cost of a method, opposition from a husband, and other context-specific reasons. Reasons for discontinuation because a woman is not in need include: wanting to become pregnant, infrequent sex or husband's absence, marital dissolution/separation, difficulty in getting pregnant/menopause.

These two broad categories of reasons for discontinuation are based on an important distinction for measuring and addressing the phenomenon: discontinuation while in need of contraception suggests

that women are at risk of unintended pregnancy, while discontinuation when there is no need for contraception does not carry this risk. Understanding the rates of both types of discontinuation—in addition to the total rate of discontinuation—is critical for developing responses. Though Core Indicator 18a sheds light on the rate and reasons for discontinuation of different methods, it does not provide the full picture of what happens when women stop using contraception. For this we need a complementary indicator which measures the rate at which women switch from one method to another.

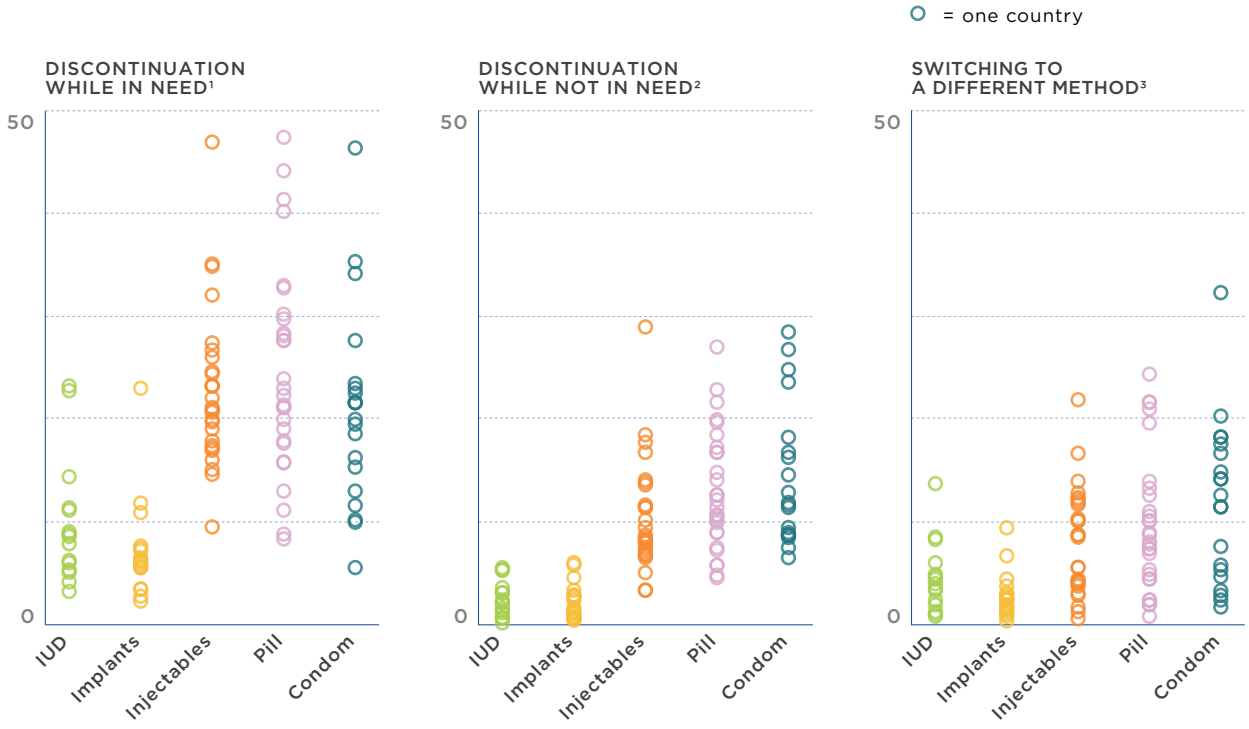
Core Indicator 18b estimates the rate at which women stop using one method and begin using another method. This indicator covers two scenarios in which a) a woman stops using one method and immediately begins using another method, or b) a woman stops using one method because she wants a more effective method and begins using a different method after a short period of time (no more than one month). The rate of method switching is reported separately from the rate of discontinuation because method switching is not exclusive of other reasons for discontinuation. For example, if a woman stops using a method because of health concerns or side effects and immediately begins using a different method, this would be counted as one episode of discontinuation and one episode of method switching. By reporting method switching as a different indicator (18b), we avoid double counting in estimates for discontinuation (18a).

Core Indicators 18a and 18b highlight patterns of discontinuation and switching for different methods and can signal potential issues with the provision or

FIGURE 16

Rates of contraceptive discontinuation and method switching

This graph shows the distribution of contraceptive discontinuation and method switching rates for 28 countries with survey data since 2012. In general, rates of discontinuation while in need and while not in need are higher for short-term methods, including injectables, pills and condoms.



[1] Reasons for discontinuation while a woman is in need include: method failure, health concerns or side effects, wanting a more effective method, inconvenience of using a method, lack of access to a method or a method being too far, cost of a method, opposition from a husband, and other context-specific reasons. [2] Reasons for discontinuation because a woman is not in need include: wanting to become pregnant, infrequent sex or husband's absence, marital dissolution/separation, difficulty in getting pregnant/menopause. [3] Switching is not exclusive of other reasons for discontinuation. See Core Indicator 18 Estimate Table for complete indicator definition.

use of certain methods (such as lack of counseling, inconsistent method availability, or physical barriers to access). For example, Figure 16 shows that discontinuation rates are consistently higher for short-term methods, including injectables and pills, which have rates as high as 60% and 70% in some countries. Analysis of 28 countries with survey data since 2012 shows average rates of discontinuation 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 could be related to side effects, among other possible reasons.

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 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 the best option from a range of available methods. Conversely, very low rates of method switching could suggest that women are not able to act on their preferences or that method availability is limited.

In order to understand and effectively address discontinuation, more in-depth analysis is needed on a country and method-specific basis to determine the root causes of this churn in use, whether interventions are needed, and what interventions will have the greatest impact. Core Indicator 18 is a first step toward such an analysis but is insufficient by itself; it must be situated within the broader dynamics of contraceptive use. Discontinuation rates are static, point-in-time estimates, while contraceptive use changes over time as women start, continue, stop, and/or switch methods for different reasons. Additional investments in client-specific longitudinal data collection, monitoring and evaluation can yield better information about discontinuation and the dynamics of contraceptive use—information that can be used to develop and improve programmatic interventions to address discontinuation.

METHODOLOGY

BEHIND THE DATA

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

TIME PERIODS COVERED IN THIS REPORT

The estimates presented in this report measure annual progress, and for Indicators 1–8, represent the value as of the mid-point of each year (e.g., the 2017 estimates for Indicators 1 and 2 show additional users and MCPR as of July 2017). The baseline year of 2012 is presented as the mid-point of 2012, or July 2012, when the London Summit took place. This 2017 Progress Report marks year five of the FP2020 initiative.

FAMILY PLANNING ESTIMATION TOOL (FPET)

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

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

THE ROLLING BASELINE AND RE-ESTIMATING THE ENTIRE TREND

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

The second component is the use of a "rolling" baseline, meaning we recalculate annual estimates (starting with 2012) on an ongoing basis as new data become available. Continuously incorporating new data improves our ability to monitor progress, so that by 2020 our estimates for all years (2012 to 2020) will represent the most comprehensive and accurate data available. Calculations of the number of additional users depend on MCPR and the population of women of reproductive age (WRA). There is often a lag time of a year, and sometimes longer, before the surveys

CHANGE TO RATE MODEL

Estimates for previous years were based on the 'level' model which estimates historical trends by fitting curves to data on the level of MCPR. This approach smooths fluctuations from survey to survey and identifies the long-term trend, but it is relatively insensitive to short-term changes. Since we want to know whether trends have changed for the better since the start of FP2020, the 'level' model may under-estimate true progress.

This year we changed to a 'rate' model, which fits trend curves to rates of change in MCPR rather than levels of MCPR. While this approach risks giving too much weight to spurious changes, it should be better at identifying recent changes that are the result of real progress. The effect of this change on current year estimates is small, but projections to 2020 should be more sensitive to recent progress.

used to calculate MCPR are released. In addition, updated population estimates (including WRA) often include retrospective modifications of past estimates based on newly released census data and other sources.

Consequently, as new data become available, they affect not only current year estimates but those calculated in previous years as well. The advantage of using rolling estimates is seen by comparing the estimate of the number of users of modern contraception that was calculated for the London Summit on Family Planning in 2012 (258 million) to the updated estimate for 2012 that we use now (271 million).

Our revised baseline calculation incorporates new surveys that give us a better sense of the current MCPR in a country as well as what the MCPR was in 2012. These MCPR estimates are combined with UN Population Division population estimates to produce estimates of the number of users of modern contraceptives for the current year and for previous years. As a result, we now consider the total number of contraceptive users in 2012 to be 13 million more than originally estimated in 2012. Were we to use the old estimate for 2012, this discrepancy could be misconstrued as 13 million additional users on top of the actual 38.8 million additional users.

Not only is our 2012 estimate updated, but so are our 2013–2016 estimates. This means that the number of additional users that we estimated for these years in our last report has also been re-estimated. Because of these changes, it is important not to compare numbers in this report to numbers in previous reports. Instead, this report publishes the entire 2012 to 2017 trend based on the most recent data, enabling comparison of changes over time.

Similarly, next year the 2018 Progress Report will feature recalculated estimates for the entire 2012–2018 period. These estimates will incorporate new survey data, as well as revised population estimates from the UN Population Division, which were published in June 2017 but could not be incorporated into this year's estimates due to FP2020's annual measurement and reporting timeline (see Figure 6: FP2020 annual measurement and reporting process).

More information on the methodology for the rolling baseline can be found on the Track20 website.[18]

DATA RECENCY

New data from surveys and service statistics become available over the course of the year, and 18 countries have new data available since last year's report. Due to variations in data sources, the strength and "recency" (how old the data are) of the estimates differ from indicator to indicator and country to country. The most recent data for each country ranges from 2002 to 2017 and is classified accordingly in the estimate tables: "old" (before 2012), "recent" (2012–2015.5) and "new" (2016 to the present).

USING SERVICE STATISTICS TO IMPROVE ESTIMATES

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

- consistent levels of reporting over time (with at least 60% of facilities reporting data), so that changes in the volume of service statistics do not represent more facilities reporting, rather than an increase in services delivered;
- at least three years of consistent data, with at least one year overlapping with a survey so that the model can calibrate the two trends; and
- at least one year of service statistics reported after the most recent survey; if a survey is the most recent data point, the survey will be used to inform the MCPR trend.

In 2017, MCPR estimates were informed by service statistics for 13 countries.

FP2020 USES MULTIPLE DATA SOURCES

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

DHS

214 surveys

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

NATIONAL & OTHER

206 surveys

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

MICS

85 surveys

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

PMA2020

26 surveys

Performance Monitoring and Accountability 2020 (PMA2020), supported by the Bill & Melinda Gates Foundation, began in 2013 and carries out mobile-based household and facility surveys in 11 countries.

SERVICE STATISTICS

84 data points

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

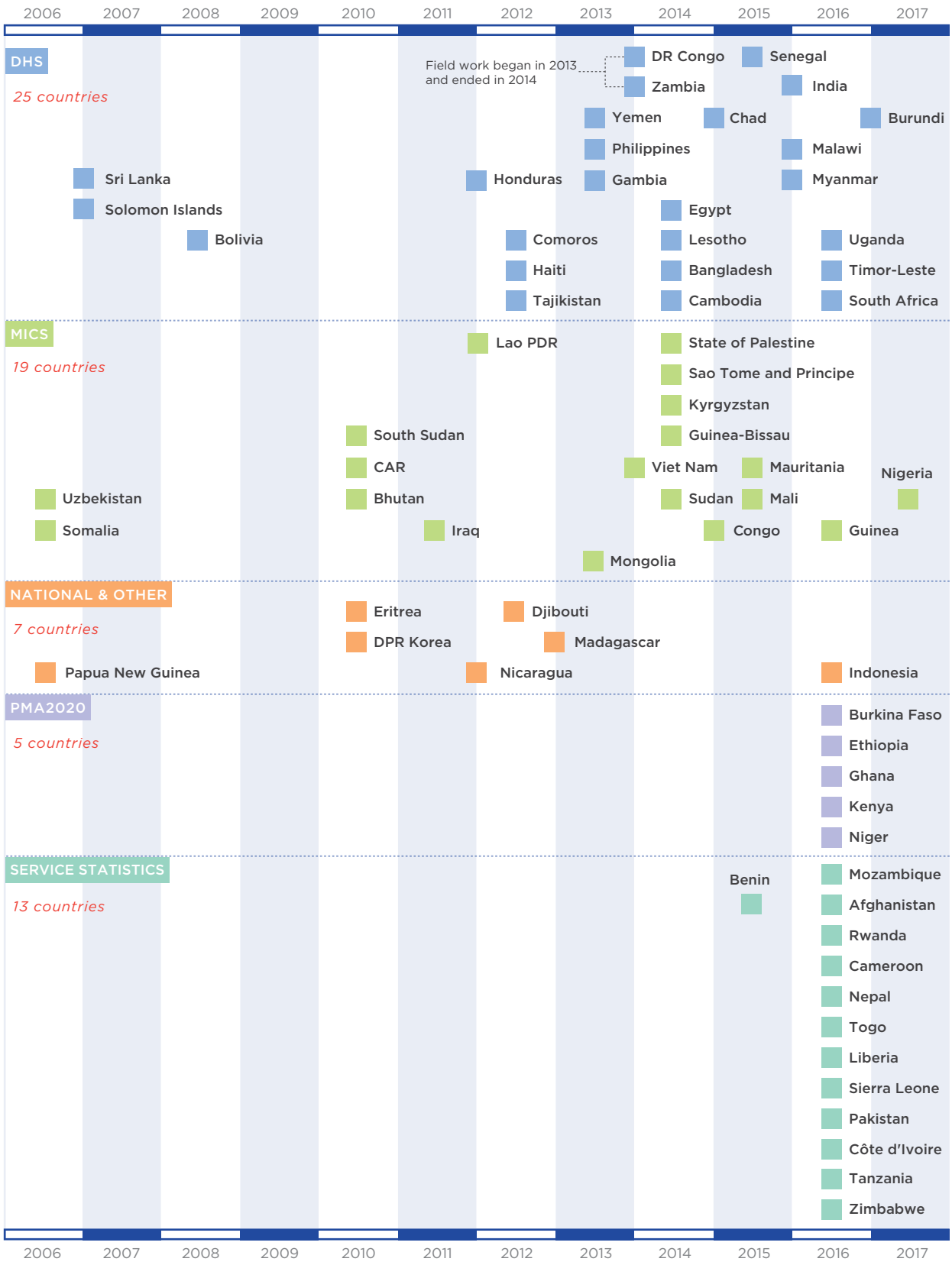
FAMILY PLANNING ESTIMATION TOOL (FPET)

A statistical model that produces estimates of MCPR, unmet need, and demand satisfied based on historic survey data, service statistics, and regional and global patterns of change. The model uses all available data to produce the best estimate of these indicators in each country.

FP2020 estimates indicators 2,3, and 4

DATA RECENCY

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



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19. Photo taken at the 2017 Family Planning Summit on July 11th. From left to right:
- Edouard Keita, Ouagadougou Partnership Young Ambassador, Mali
- Margaret Bolaji, FP2020 Reference Group, Nigerian Urban Reproductive Health Initiative
- Pauline Anyona, Organization of African Youth, Kenya
- Qaisar Ahmed, Y-PEER Pakistan, Pakistan
- (kneeling) Isidore Djifa Kuessan, IPPF (AIBEF), Togo
- Melinda Gates, Bill & Melinda Gates Foundaiton
- Amanda Banura, IYAFP, Uganda
- (behind) Franklin Anand, Restless Development and Women Deliver Young Leader, India
- Patrick Mwesigye, Uganda Youth and Adolescents Forum, Uganda
- Halima Lila, TAYARH and RHSC Youth Caucus, Tanzania
- Jona Claire Turalde, University of the Philippines Diliman and SheDecides, Philippines.

ESTIMATE TABLES

INTRODUCTION

ESTIMATE TABLES

The digital report contains the full data set for all indicators: **familyplanning2020.org/progress.**

FP2020's 18 Core Indicators are the foundation of our measurement agenda and strive to capture different dimensions of family planning, including availability, quality, equity, informed choice, use, and empowerment. Together they present a varied family planning landscape, across and within the 69 FP2020 focus countries. Though these indicators are reported in a standardized way across the focus countries, it is important to understand nuances between the indicators and the way they are presented in this report.

Some indicators are reported for all women (number of additional users and MCPR), while others are currently reported for married or in-union women (unmet need and demand satisfied), with the ultimate aim of reporting these indicators for all women as we develop a sound methodology for doing so. Some indicators are derived annually from modeling (Indicators 1–8), while others are based on the most recent survey (Indicators 9–11 and 14–18). In addition, we present some indicators disaggregated by age, urban/rural residence, and wealth quintile, to highlight disparities in contraceptive use, unmet need, and demand satisfied. The disaggregated data, however, are only available from the most recent surveys for married women, and so may not match with the annual modeled estimates for these indicators.

The full data set for all indicators is available online in the digital version of the Progress Report. This data is also available on the FP2020 and Track20 websites, which have country-specific pages with information and downloadable data on each of the 69 FP2020 focus countries.

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Cover Asia Press Photoshare

GRAPHIC **DATA RECENCY** KEY

OLD	RECENT	NEW
•	●	●
Before 2012	2012 - 2015.5	2016 - Present

Note:
Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

Photo by
WINGS Guatemala

INDICATOR NO. 1

Number of additional users of modern methods of contraception

DEFINITION	The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to 2012.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara).
SOURCE	UN Population Division (for number of women of reproductive age); Family Planning Estimation Tool (FPET) for mCPR, using all available household surveys such as DHS, PMA2020, MICS, RHS and comparable national sources, including service statistics where possible.

RECENCY KEY

OLD ● Before 2012

RECENT ● 2012-2015.5

NEW ● 2016-Present

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
○ ○ ●	Afghanistan	-	65,000	150,000	238,000	313,000	406,000
○ ● ○	Bangladesh	-	592,000	981,000	1,408,000	1,846,000	2,308,000
○ ○ ●	Benin	-	35,000	79,000	119,000	151,000	185,000
● ○ ○	Bhutan	-	3,000	6,000	9,000	12,000	14,000
● ○ ○	Bolivia	-	33,000	66,000	98,000	130,000	160,000
○ ○ ●	Burkina Faso	-	64,000	136,000	219,000	326,000	400,000
○ ○ ●	Burundi	-	12,000	15,000	14,000	16,000	44,000
○ ● ○	Cambodia	-	49,000	91,000	141,000	190,000	237,000
○ ○ ●	Cameroon	-	72,000	148,000	260,000	311,000	405,000
● ○ ○	CAR	-	9,000	19,000	30,000	42,000	55,000
○ ● ○	Chad	-	13,000	29,000	41,000	52,000	64,000
○ ● ○	Comoros	-	1,000	2,000	4,000	6,000	7,000
○ ● ○	Congo	-	7,000	16,000	34,000	53,000	75,000
○ ○ ●	Côte d'Ivoire	-	49,000	-	99,000	283,000	371,000
○ ● ○	Djibouti	-	2,000	4,000	6,000	9,000	12,000
● ○ ○	DPR Korea	-	21,000	41,000	49,000	46,000	37,000
○ ● ○	DR Congo	-	82,000	208,000	381,000	542,000	733,000
○ ● ○	Egypt	-	77,000	198,000	404,000	609,000	840,000
● ○ ○	Eritrea	-	4,000	8,000	13,000	19,000	25,000
○ ○ ●	Ethiopia	-	484,000	982,000	1,424,000	1,762,000	2,221,000
○ ● ○	Gambia	-	-	1,000	3,000	5,000	8,000
○ ○ ●	Ghana	-	64,000	136,000	303,000	355,000	429,000
○ ○ ●	Guinea	-	18,000	47,000	77,000	108,000	137,000
○ ● ○	Guinea-Bissau	-	7,000	15,000	24,000	32,000	40,000
○ ● ○	Haiti	-	27,000	52,000	79,000	105,000	133,000

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
● ○ ○	Honduras	-	27,000	54,000	78,000	102,000	125,000
○ ● ○	India	-	1,534,000	2,680,000	3,599,000	6,163,000	9,184,000
○ ○ ●	Indonesia	-	444,000	635,000	721,000	1,686,000	2,094,000
● ○ ○	Iraq	-	108,000	221,000	331,000	431,000	536,000
○ ○ ●	Kenya	-	291,000	599,000	983,000	1,347,000	1,575,000
○ ● ○	Kyrgyzstan	-	9,000	23,000	33,000	42,000	51,000
● ○ ○	Lao PDR	-	28,000	54,000	80,000	105,000	130,000
○ ● ○	Lesotho	-	16,000	31,000	41,000	49,000	57,000
○ ○ ●	Liberia	-	19,000	33,000	60,000	89,000	107,000
○ ● ○	Madagascar	-	115,000	227,000	343,000	459,000	574,000
○ ● ○	Malawi	-	131,000	267,000	388,000	498,000	602,000
○ ● ○	Mali	-	34,000	78,000	124,000	162,000	202,000
○ ● ○	Mauritania	-	6,000	14,000	21,000	29,000	36,000
○ ● ○	Mongolia	-	2,000	6,000	11,000	15,000	17,000
○ ○ ●	Mozambique	-	199,000	454,000	724,000	946,000	1,101,000
○ ● ○	Myanmar	-	147,000	298,000	445,000	600,000	749,000
○ ○ ●	Nepal	-	121,000	242,000	373,000	503,000	628,000
● ○ ○	Nicaragua	-	14,000	27,000	39,000	52,000	64,000
○ ○ ●	Niger	-	31,000	61,000	103,000	132,000	180,000
○ ○ ●	Nigeria	-	31,000	520,000	1,130,000	1,715,000	1,889,000
○ ○ ●	Pakistan	-	543,000	1,193,000	1,760,000	2,337,000	2,921,000
● ○ ○	Papua New Guinea	-	15,000	28,000	43,000	55,000	70,000
○ ● ○	Philippines	-	254,000	500,000	717,000	943,000	1,151,000
○ ○ ●	Rwanda	-	34,000	66,000	79,000	121,000	175,000
○ ● ○	Sao Tome & Princ.	-	-	1,000	2,000	3,000	4,000
○ ● ○	Senegal	-	55,000	116,000	163,000	200,000	239,000
○ ○ ●	Sierra Leone	-	40,000	71,000	103,000	148,000	178,000
● ○ ○	Solomon Islands	-	1,000	2,000	3,000	4,000	5,000
● ○ ○	Somalia	-	2,000	5,000	7,000	11,000	14,000
○ ○ ●	South Africa*	-	16,000	6,000	17,000	33,000	142,000
● ○ ○	South Sudan	-	4,000	10,000	15,000	21,000	28,000
● ○ ○	Sri Lanka	-	21,000	39,000	66,000	87,000	115,000
○ ● ○	State of Palestine	-	11,000	23,000	33,000	44,000	55,000
○ ● ○	Sudan	-	57,000	120,000	194,000	272,000	354,000
○ ● ○	Tajikistan	-	13,000	29,000	48,000	64,000	83,000
○ ○ ●	Tanzania	-	172,000	354,000	559,000	828,000	1,071,000
○ ○ ●	Timor-Leste	-	1,000	2,000	4,000	6,000	8,000
○ ○ ●	Togo	-	23,000	62,000	114,000	148,000	169,000
○ ○ ●	Uganda	-	135,000	272,000	439,000	696,000	904,000
● ○ ○	Uzbekistan	-	52,000	99,000	139,000	171,000	211,000
○ ● ○	Viet Nam	-	118,000	186,000	358,000	516,000	637,000
○ ● ○	Yemen	-	71,000	147,000	230,000	314,000	407,000
○ ● ○	Zambia	-	79,000	156,000	228,000	304,000	381,000
○ ○ ●	Zimbabwe	-	96,000	198,000	291,000	366,000	428,000
	TOTAL	**-**	**6,920,000**	**13,660,000**	**20,730,000**	**30,140,000**	**38,880,000**

*Not included in totals

INDICATOR NO. 2

Modern contraceptive prevalence rate, MCPR (all women)

DEFINITION	The percentage of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara).
SOURCE	Family Planning Estimation Tool (FPET), using all available household surveys such as DHS, PMA2020, MICS, RHS and comparable national sources including service statistics where possible.

RECENCY KEY

OLD ● Before 2012 — RECENT ● 2012-2015.5 — NEW ● 2016-Present

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
○ ○ ●	Afghanistan	11.1	11.6	12.3	13.0	13.4	14.1
○ ● ○	Bangladesh	43.0	43.7	44.0	44.3	44.7	45.1
○ ○ ●	Benin	10.5	11.6	13.0	14.1	14.9	15.7
● ○ ○	Bhutan	44.5	45.2	45.7	46.3	46.8	47.2
● ○ ○	Bolivia	27.5	28.2	28.9	29.5	30.1	30.6
○ ○ ●	Burkina Faso	15.7	16.8	18.1	19.5	21.4	22.4
○ ○ ●	Burundi	17.1	17.1	16.8	16.2	15.9	16.4
○ ● ○	Cambodia	25.6	26.4	27.0	27.8	28.6	29.3
○ ○ ●	Cameroon	17.0	17.9	18.8	20.2	20.6	21.6
● ○ ○	CAR	10.9	11.5	12.0	12.6	13.2	13.9
○ ● ○	Chad	2.7	3.0	3.4	3.7	3.9	4.1
○ ● ○	Comoros	10.3	10.7	11.3	11.8	12.4	12.9
○ ● ○	Congo	22.7	23.0	23.3	24.4	25.5	26.7
○ ○ ●	Côte d'Ivoire	14.6	15.1	15.2	16.8	19.6	20.6
○ ● ○	Djibouti	15.3	16.0	16.9	17.6	18.5	19.3
● ○ ○	DPR Korea	42.8	43.0	43.1	43.2	43.3	43.4
○ ● ○	DR Congo	7.9	8.1	8.5	9.1	9.7	10.3
○ ● ○	Egypt	41.6	41.4	41.3	41.6	42.0	42.3
● ○ ○	Eritrea	5.1	5.4	5.6	5.9	6.2	6.5
○ ○ ●	Ethiopia	19.9	21.4	22.7	23.8	24.3	25.3
○ ● ○	Gambia	7.2	6.9	7.1	7.3	7.6	7.8
○ ○ ●	Ghana	18.1	18.7	19.4	21.4	21.7	22.3
○ ○ ●	Guinea	7.6	8.1	8.8	9.6	10.3	11.0
○ ● ○	Guinea-Bissau	23.7	24.8	26.0	27.2	28.3	29.4
○ ● ○	Haiti	21.6	22.2	22.7	23.3	23.8	24.4
● ○ ○	Honduras	43.0	43.3	43.5	43.7	43.8	43.9

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
○ ● ○	India	39.2	39.2	39.0	38.8	39.1	39.6
○ ○ ●	Indonesia	44.6	44.8	44.7	44.4	45.5	45.7
• ○ ○	Iraq	24.8	25.2	25.6	26.1	26.4	26.8
○ ○ ●	Kenya	36.5	38.3	40.1	42.3	44.2	44.8
○ ● ○	Kyrgyzstan	25.1	25.7	26.5	27.1	27.7	28.1
• ○ ○	Lao PDR	32.8	33.8	34.6	35.4	36.1	36.8
○ ● ○	Lesotho	43.2	45.5	47.4	48.3	49.0	49.6
○ ○ ●	Liberia	18.1	19.6	20.4	22.4	24.5	25.3
○ ● ○	Madagascar	27.1	28.4	29.4	30.5	31.4	32.3
○ ● ○	Malawi	38.0	40.1	42.2	43.8	44.9	45.7
○ ● ○	Mali	9.5	10.2	11.1	11.9	12.5	13.1
○ ● ○	Mauritania	7.0	7.6	8.1	8.7	9.2	9.7
○ ● ○	Mongolia	38.7	38.9	39.3	39.8	40.2	40.5
○ ○ ●	Mozambique	16.5	19.4	23.0	26.7	29.3	30.8
○ ● ○	Myanmar	28.0	28.8	29.6	30.3	31.0	31.7
○ ○ ●	Nepal	35.1	35.8	36.6	37.5	38.3	39.1
• ○ ○	Nicaragua	51.5	51.6	51.7	51.8	51.9	52.0
○ ○ ●	Niger	10.8	11.3	11.6	12.3	12.5	13.1
○ ○ ●	Nigeria	11.9	11.7	12.6	13.7	14.7	14.7
○ ○ ●	Pakistan	17.0	17.8	18.8	19.6	20.4	21.2
• ○ ○	Papua New Guinea	18.2	18.5	18.8	19.1	19.3	19.5
○ ● ○	Philippines	23.4	24.0	24.5	25.0	25.5	25.9
○ ○ ●	Rwanda	26.3	26.9	27.3	27.0	27.6	28.6
○ ● ○	Sao Tome & Princ.	32.4	33.9	35.2	36.1	36.7	37.4
○ ● ○	Senegal	11.0	12.3	13.7	14.6	15.1	15.7
○ ○ ●	Sierra Leone	17.3	19.6	21.0	22.5	24.7	25.9
• ○ ○	Solomon Islands	19.8	20.1	20.4	20.7	20.9	21.1
• ○ ○	Somalia	1.1	1.2	1.2	1.3	1.4	1.5
○ ○ ●	South Africa*	47.7	47.3	46.8	46.5	46.2	46.7
• ○ ○	South Sudan	1.8	1.9	2.1	2.2	2.3	2.4
• ○ ○	Sri Lanka	53.5	54.0	54.4	54.9	55.2	55.7
○ ● ○	State of Palestine	22.4	22.8	23.1	23.3	23.5	23.7
○ ● ○	Sudan	9.9	10.3	10.7	11.2	11.6	12.1
○ ● ○	Tajikistan	18.3	18.6	19.0	19.5	20.0	20.6
○ ○ ●	Tanzania	24.7	25.5	26.2	27.0	28.3	29.2
○ ○ ●	Timor-Leste	13.2	13.6	14.0	14.3	14.7	15.3
○ ○ ●	Togo	16.3	17.3	19.0	21.5	22.7	23.2
○ ○ ●	Uganda	21.5	22.4	23.2	24.2	26.1	27.3
• ○ ○	Uzbekistan	45.9	46.1	46.3	46.5	46.5	46.7
○ ● ○	Viet Nam	46.6	46.9	47.1	47.7	48.3	48.7
○ ● ○	Yemen	17.2	17.8	18.4	19.1	19.8	20.5
○ ● ○	Zambia	30.5	31.7	32.7	33.5	34.3	35.0
○ ○ ●	Zimbabwe	43.6	45.1	46.6	47.8	48.5	48.7
	OVERALL (weighted average)	**32.4**	**32.6**	**32.9**	**33.1**	**33.6**	**34.0**

*Not included in totals

INDICATOR NO. 3

Percentage of women with an unmet need for modern contraception (married or in-union women)

DEFINITION	The percentage of fecund women of reproductive age who want no more children or to postpone having the next child, but are not using a contraceptive method, plus women who are currently using a traditional method of family planning. Women using a traditional method are assumed to have an unmet need for modern contraception.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara).
SOURCE	FPET, using all available household surveys such as DHS, PMA2020, MICS and RHS.

RECENCY KEY

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
○ ● ○	Afghanistan	26.2	26.0	25.6	25.3	25.2	25.1
○ ● ○	Bangladesh	20.6	19.8	19.7	19.6	19.4	19.2
○ ● ○	Benin	37.1	36.9	36.7	36.3	36.0	35.7
• ○ ○	Bhutan	14.3	14.0	13.5	13.3	12.9	12.7
• ○ ○	Bolivia	40.7	39.9	39.0	38.2	37.4	36.7
○ ○ ●	Burkina Faso	25.9	25.9	25.9	25.9	25.6	25.3
○ ○ ●	Burundi	32.1	32.3	32.6	33.0	33.4	33.0
○ ● ○	Cambodia	31.0	30.4	29.9	29.5	29.2	28.7
○ ● ○	Cameroon	33.9	34.0	34.1	34.0	34.0	33.8
• ○ ○	CAR	30.1	30.1	30.2	30.0	30.1	29.9
○ ● ○	Chad	22.1	22.1	22.1	22.3	22.5	22.8
○ ● ○	Comoros	37.0	36.8	36.6	36.4	36.2	35.9
○ ● ○	Congo	41.1	40.3	39.6	39.0	38.4	37.8
• ○ ○	Côte d'Ivoire	29.1	29.2	29.4	29.5	29.4	29.3
○ ● ○	Djibouti	31.3	31.2	30.9	30.7	30.4	30.0
• ○ ○	DPR Korea	17.2	17.0	16.9	16.8	16.6	16.4
○ ● ○	DR Congo	40.3	40.3	40.2	40.1	40.1	40.0
○ ● ○	Egypt	13.0	13.2	13.3	13.2	13.0	12.9
• ○ ○	Eritrea	30.1	30.1	30.2	30.3	30.4	30.4
○ ○ ●	Ethiopia	27.4	26.5	25.6	24.8	24.3	24.0
○ ● ○	Gambia	26.4	26.2	26.3	26.5	26.6	26.7
○ ○ ●	Ghana	37.3	36.3	35.3	34.5	34.5	34.0
○ ○ ●	Guinea	24.7	25.1	25.3	25.5	25.8	26.0
○ ● ○	Guinea-Bissau	22.4	22.6	22.8	22.9	23.0	23.2
○ ● ○	Haiti	38.7	38.0	37.4	36.7	36.2	35.5
• ○ ○	Honduras	19.8	19.5	19.3	19.0	18.9	18.6

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
○ ● ○	India	19.4	19.4	19.4	19.4	19.3	19.2
○ ○ ●	Indonesia	13.4	13.4	13.7	14.3	14.5	14.3
• ○ ○	Iraq	28.5	28.3	28.0	27.8	27.6	27.3
○ ○ ●	Kenya	24.4	22.9	21.3	19.4	17.7	17.2
○ ● ○	Kyrgyzstan	21.0	20.9	20.7	20.6	20.5	20.3
• ○ ○	Lao PDR	25.6	25.1	24.5	23.9	23.5	22.9
○ ● ○	Lesotho	22.1	20.7	19.5	18.7	18.2	17.7
○ ● ○	Liberia	33.1	32.7	32.5	32.2	31.8	31.4
○ ● ○	Madagascar	28.3	27.7	27.2	26.6	26.1	25.6
○ ● ○	Malawi	25.3	23.5	21.9	20.6	19.7	19.0
○ ● ○	Mali	26.9	26.7	26.6	26.5	26.6	26.6
○ ● ○	Mauritania	33.0	33.0	32.9	32.9	32.7	32.4
○ ● ○	Mongolia	21.1	21.0	20.8	20.5	20.2	20.1
○ ● ○	Mozambique	28.1	28.0	27.7	27.2	26.7	26.4
○ ● ○	Myanmar	19.6	19.1	18.5	18.0	17.4	17.0
○ ● ○	Nepal	29.8	29.0	28.1	27.3	26.4	25.7
• ○ ○	Nicaragua	10.6	10.4	10.3	10.3	10.2	10.1
○ ○ ●	Niger	18.7	19.2	19.6	20.0	20.5	20.8
○ ○ ●	Nigeria	22.8	22.7	23.3	24.1	24.7	25.6
○ ● ○	Pakistan	30.3	29.8	29.3	28.6	29.1	28.9
• ○ ○	Papua New Guinea	33.0	32.8	32.6	32.3	32.2	32.0
○ ● ○	Philippines	34.3	33.8	33.3	32.8	32.3	31.9
○ ● ○	Rwanda	27.1	26.3	25.5	25.4	24.8	24.1
○ ● ○	Sao Tome & Princ.	36.2	35.0	33.9	32.8	32.0	31.2
○ ● ○	Senegal	30.0	29.2	27.9	26.8	26.9	26.9
○ ● ○	Sierra Leone	27.6	27.2	27.2	27.3	27.3	27.3
• ○ ○	Solomon Islands	27.9	27.9	27.8	27.8	27.6	27.5
• ○ ○	Somalia	31.3	31.3	31.3	31.4	31.5	31.5
○ ○ ●	South Africa*	15.2	15.3	15.4	15.5	15.5	15.4
• ○ ○	South Sudan	30.2	30.3	30.3	30.4	30.4	30.5
• ○ ○	Sri Lanka	23.0	22.7	22.5	22.2	22.0	21.7
○ ● ○	State of Palestine	26.0	25.6	25.4	25.2	25.0	25.0
○ ● ○	Sudan	29.3	29.4	29.4	29.5	29.5	29.5
○ ● ○	Tajikistan	25.5	25.4	25.3	25.2	25.1	25.0
○ ● ○	Tanzania	30.1	29.6	29.2	28.7	28.4	27.9
○ ○ ●	Timor-Leste	29.3	28.9	28.5	28.1	27.7	27.5
○ ● ○	Togo	37.0	36.5	36.1	35.5	35.1	34.6
○ ○ ●	Uganda	37.3	36.7	36.0	35.4	34.1	33.2
• ○ ○	Uzbekistan	13.0	12.9	12.8	12.8	12.8	12.6
○ ● ○	Viet Nam	17.0	17.3	17.9	17.7	17.5	17.4
○ ● ○	Yemen	33.9	33.4	33.1	32.6	32.2	31.7
○ ● ○	Zambia	27.3	26.2	25.4	24.7	24.2	23.5
○ ● ○	Zimbabwe	14.0	13.3	12.6	12.1	11.7	11.5
	OVERALL (weighted average)	**22.1**	**21.9**	**21.9**	**21.8**	**21.8**	**21.7**

*Not included in totals

INDICATOR NO. 4

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

DEFINITION	The percentage of women (or their partners) who desire either to have no additional children or to postpone the next child and who are currently using a modern contraceptive method. Women using a traditional method are assumed to have an unmet need for modern contraception.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara).
SOURCE	FPET, using all available household surveys such as DHS, PMA2020, MICS and RHS.

RECENCY KEY

OLD — RECENT — NEW

Before 2012 — 2012-2015.5 — 2016-Present

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
○ ● ○	Afghanistan	38.5	39.7	41.4	43.0	44.0	45.3
○ ● ○	Bangladesh	72.2	73.3	73.6	73.9	74.2	74.5
○ ● ○	Benin	19.9	21.7	23.7	25.5	26.7	27.9
• ○ ○	Bhutan	81.0	81.6	82.2	82.7	83.2	83.6
• ○ ○	Bolivia	49.3	50.5	51.6	52.7	53.7	54.6
○ ○ ●	Burkina Faso	40.3	42.1	43.8	45.7	48.3	49.7
○ ○ ●	Burundi	45.2	45.1	44.3	43.2	42.3	43.5
○ ● ○	Cambodia	54.7	55.8	56.8	57.9	58.9	59.8
○ ● ○	Cameroon	31.0	32.0	33.0	34.7	35.1	36.3
• ○ ○	CAR	27.5	28.5	29.4	30.4	31.5	32.6
○ ● ○	Chad	11.1	12.6	14.0	14.8	15.4	15.9
○ ● ○	Comoros	28.5	29.5	30.7	31.8	32.9	34.0
○ ● ○	Congo	33.2	33.9	34.5	35.9	37.4	38.8
• ○ ○	Côte d'Ivoire	31.0	31.8	31.8	33.9	37.4	38.7
○ ● ○	Djibouti	38.0	39.2	40.6	41.8	43.2	44.6
• ○ ○	DPR Korea	78.6	78.8	79.0	79.2	79.4	79.6
○ ● ○	DR Congo	15.9	16.2	16.9	18.0	18.8	19.9
○ ● ○	Egypt	81.9	81.6	81.5	81.7	82.0	82.3
• ○ ○	Eritrea	20.5	21.3	22.0	22.8	23.6	24.3
○ ○ ●	Ethiopia	51.5	54.1	56.5	58.3	59.4	60.6
○ ● ○	Gambia	25.4	24.8	25.0	25.5	26.2	26.7
○ ○ ●	Ghana	37.2	38.6	40.1	43.0	43.4	44.4
○ ○ ●	Guinea	16.8	17.4	18.6	19.8	20.9	21.7
○ ● ○	Guinea-Bissau	36.9	37.9	38.7	39.7	40.5	41.3
○ ● ○	Haiti	44.7	45.8	46.8	47.9	48.8	49.9
• ○ ○	Honduras	76.4	76.7	77.0	77.4	77.5	77.8

RECENCY	COUNTRY	2012	2013	2014	2015	2016	2017
○ ● ○	India	73.2	73.2	73.1	73.0	73.3	73.6
○ ○ ●	Indonesia	81.9	81.9	81.4	80.6	80.3	80.6
• ○ ○	Iraq	58.6	59.2	59.8	60.4	60.9	61.5
○ ○ ●	Kenya	67.1	69.5	71.9	74.8	77.3	78.0
○ ● ○	Kyrgyzstan	62.5	63.1	64.1	64.7	65.3	65.8
• ○ ○	Lao PDR	63.7	64.8	65.9	67.0	67.8	68.8
○ ● ○	Lesotho	70.6	73.0	75.0	76.1	76.9	77.6
○ ● ○	Liberia	33.8	35.9	36.9	39.4	41.8	42.9
○ ● ○	Madagascar	54.3	55.9	57.2	58.6	59.8	61.0
○ ● ○	Malawi	65.9	68.7	71.3	73.2	74.5	75.6
○ ● ○	Mali	26.7	28.2	30.0	31.7	32.7	33.7
○ ● ○	Mauritania	26.0	27.3	28.9	30.4	31.7	32.9
○ ● ○	Mongolia	70.6	70.8	71.2	71.7	72.2	72.5
○ ● ○	Mozambique	35.4	39.3	43.7	47.8	50.6	52.2
○ ● ○	Myanmar	70.2	71.3	72.5	73.5	74.6	75.5
○ ● ○	Nepal	60.4	61.6	62.8	64.1	65.3	66.4
• ○ ○	Nicaragua	87.9	88.0	88.2	88.3	88.4	88.5
○ ○ ●	Niger	39.1	39.4	39.7	40.1	41.1	41.9
○ ○ ●	Nigeria	31.5	31.2	32.3	33.4	34.5	33.7
○ ● ○	Pakistan	46.8	48.4	49.9	51.6	52.1	53.3
• ○ ○	Papua New Guinea	44.8	45.4	46.0	46.5	46.9	47.3
○ ● ○	Philippines	52.2	53.1	54.1	54.9	55.8	56.5
○ ● ○	Rwanda	62.4	63.6	64.6	64.5	65.6	66.9
○ ● ○	Sao Tome & Princ.	52.8	54.8	56.5	57.9	58.9	60.0
○ ● ○	Senegal	33.7	36.9	40.4	43.0	43.9	44.7
○ ● ○	Sierra Leone	31.9	34.9	36.6	38.1	40.3	41.4
• ○ ○	Solomon Islands	51.3	51.7	52.1	52.5	52.8	53.2
• ○ ○	Somalia	5.7	6.1	6.5	6.9	7.3	7.7
○ ○ ●	South Africa*	78.9	78.7	78.4	78.2	78.1	78.3
• ○ ○	South Sudan	8.3	8.7	9.2	9.6	10.1	10.6
• ○ ○	Sri Lanka	70.9	71.4	71.7	72.1	72.5	72.9
○ ● ○	State of Palestine	63.3	64.0	64.5	64.8	65.2	65.5
○ ● ○	Sudan	26.7	27.4	28.2	29.0	29.8	30.7
○ ● ○	Tajikistan	51.0	51.5	52.2	52.9	53.7	54.4
○ ● ○	Tanzania	49.4	50.6	51.7	52.8	54.3	55.5
○ ○ ●	Timor-Leste	42.7	43.7	44.7	45.6	46.7	47.8
○ ● ○	Togo	31.2	32.8	35.2	38.4	40.0	40.9
○ ○ ●	Uganda	42.0	43.4	44.7	46.2	49.0	50.8
• ○ ○	Uzbekistan	83.2	83.3	83.5	83.6	83.6	83.8
○ ● ○	Viet Nam	79.6	79.2	78.6	78.9	79.1	79.3
○ ● ○	Yemen	45.5	46.7	47.8	49.0	50.3	51.5
○ ● ○	Zambia	60.6	62.5	64.0	65.1	66.2	67.2
○ ● ○	Zimbabwe	81.5	82.6	83.7	84.4	85.1	85.3
	OVERALL (weighted average)	**66.8**	**67.1**	**67.2**	**67.4**	**67.7**	**68.0**

*Not included in totals

INDICATOR NO. 5

Number of unintended pregnancies

DEFINITION	The number of pregnancies that occurred at a time when women (and their partners) either did not want additional children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies, including current pregnancies.
SCOPE	Reported annually, for all 69 FP2020 focus countries; 2012 and 2017 figures shown here, figures for intervening years available in online progress report.
SOURCE	Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY KEY

OLD ● Before 2012

RECENT ● 2012-2015.5

NEW ● 2016-Present

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2017
○ ● ○	Afghanistan	271,000	270,000
○ ● ○	Bangladesh	2,081,000	2,019,000
● ○ ○	Benin	129,000	139,000
● ○ ○	Bhutan	6,000	5,000
● ○ ○	Bolivia	314,000	318,000
● ○ ○	Burkina Faso	101,000	110,000
● ○ ○	Burundi	245,000	277,000
○ ● ○	Cambodia	190,000	191,000
● ○ ○	Cameroon	303,000	320,000
● ○ ○	CAR	57,000	59,000
○ ● ○	Chad	111,000	124,000
○ ● ○	Comoros	13,000	14,000
● ○ ○	Congo	70,000	74,000
● ○ ○	Côte d'Ivoire	349,000	381,000
● ○ ○	Djibouti	12,000	12,000
● ○ ○	DPR Korea	175,000	178,000
○ ● ○	DR Congo	1,357,000	1,508,000
○ ● ○	Egypt	944,000	960,000
● ○ ○	Eritrea	79,000	79,000
● ○ ○	Ethiopia	1,562,000	1,632,000
○ ● ○	Gambia	18,000	20,000
○ ● ○	Ghana	658,000	686,000
○ ● ○	Guinea	126,000	135,000
○ ● ○	Guinea-Bissau	21,000	22,000
○ ● ○	Haiti	249,000	247,000
● ○ ○	Honduras	153,000	152,000
● ○ ○	India	13,491,000	13,400,000
○ ● ○	Indonesia	2,690,000	2,605,000

RECENCY	COUNTRY	2012	2017
● ○ ○	Iraq	539,000	596,000
○ ● ○	Kenya	971,000	1,020,000
○ ● ○	Kyrgyzstan	14,000	13,000
● ○ ○	Lao PDR	68,000	68,000
○ ● ○	Lesotho	56,000	57,000
○ ● ○	Liberia	83,000	88,000
● ○ ○	Madagascar	171,000	190,000
○ ○ ●	Malawi	460,000	506,000
○ ● ○	Mali	175,000	190,000
● ○ ○	Mauritania	57,000	60,000
○ ● ○	Mongolia	145,000	142,000
● ○ ○	Mozambique	273,000	296,000
● ○ ○	Myanmar	570,000	548,000
○ ● ○	Nepal	187,000	183,000
● ○ ○	Nicaragua	95,000	90,000
○ ● ○	Niger	131,000	157,000
○ ● ○	Nigeria	1,028,000	1,104,000
○ ● ○	Pakistan	2,068,000	2,138,000
● ○ ○	Papua New Guinea	68,000	70,000
○ ● ○	Philippines	2,144,000	2,196,000
○ ● ○	Rwanda	231,000	232,000
○ ● ○	Sao Tome and Principe	5,000	5,000
○ ● ○	Senegal	186,000	201,000
○ ● ○	Sierra Leone	55,000	56,000
● ○ ○	Solomon Islands	5,000	5,000
● ○ ○	Somalia	257,000	284,000
● ○ ○	South Africa*	975,000	964,000
● ○ ○	South Sudan	95,000	108,000
● ○ ○	Sri Lanka	167,000	153,000
○ ● ○	State of Palestine	72,000	79,000
○ ● ○	Sudan	662,000	697,000
○ ● ○	Tajikistan	32,000	34,000
○ ● ○	Tanzania	1,079,000	1,186,000
● ○ ○	Timor-Leste	20,000	20,000
○ ● ○	Togo	125,000	133,000
○ ● ○	Uganda	1,225,000	1,365,000
● ○ ○	Uzbekistan	71,000	69,000
○ ● ○	Viet Nam	924,000	915,000
● ○ ○	Western Sahara	6,000	6,000
○ ● ○	Yemen	533,000	554,000
○ ● ○	Zambia	403,000	447,000
○ ● ○	Zimbabwe	306,000	311,000
	TOTAL	**41,570,000**	**42,540,000**

*Not included in totals

INDICATOR NO. 6

Number of unintended pregnancies averted due to modern contraceptive use

DEFINITION	The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara); 2012 and 2017 figures shown here, figures for intervening years available in online progress report.
SOURCE	Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY KEY

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2017
○ ○ ●	Afghanistan	176,000	275,000
○ ● ○	Bangladesh	4,754,000	5,346,000
○ ○ ●	Benin	55,000	96,000
• ○ ○	Bhutan	24,000	28,000
• ○ ○	Bolivia	191,000	234,000
○ ○ ●	Burkina Faso	166,000	278,000
○ ○ ●	Burundi	113,000	125,000
○ ● ○	Cambodia	276,000	339,000
○ ○ ●	Cameroon	213,000	312,000
• ○ ○	CAR	28,000	41,000
○ ● ○	Chad	19,000	37,000
○ ● ○	Comoros	4,000	6,000
○ ● ○	Congo	47,000	63,000
○ ○ ●	Côte d'Ivoire	192,000	277,000
○ ● ○	Djibouti	8,000	11,000
• ○ ○	DPR Korea	835,000	847,000
○ ● ○	DR Congo	323,000	488,000
○ ● ○	Egypt	2,542,000	2,775,000
• ○ ○	Eritrea	12,000	18,000
○ ○ ●	Ethiopia	1,217,000	1,845,000
○ ● ○	Gambia	8,000	10,000
○ ○ ●	Ghana	285,000	388,000
○ ○ ●	Guinea	44,000	74,000
○ ● ○	Guinea-Bissau	24,000	34,000
○ ● ○	Haiti	151,000	185,000
• ○ ○	Honduras	247,000	282,000
○ ● ○	India	36,536,000	39,170,000
○ ○ ●	Indonesia	8,553,000	8,880,000

RECENCY	COUNTRY	2012	2017
● ○ ○	Iraq	491,000	625,000
○ ○ ●	Kenya	1,036,000	1,472,000
○ ● ○	Kyrgyzstan	100,000	113,000
● ○ ○	Lao PDR	145,000	179,000
○ ● ○	Lesotho	55,000	70,000
○ ○ ●	Liberia	47,000	76,000
○ ● ○	Madagascar	385,000	538,000
○ ● ○	Malawi	383,000	555,000
○ ● ○	Mali	92,000	148,000
○ ● ○	Mauritania	16,000	25,000
○ ● ○	Mongolia	85,000	90,000
○ ○ ●	Mozambique	235,000	509,000
○ ● ○	Myanmar	1,096,000	1,300,000
○ ○ ●	Nepal	731,000	909,000
● ○ ○	Nicaragua	233,000	251,000
○ ○ ●	Niger	74,000	109,000
○ ○ ●	Nigeria	1,052,000	1,490,000
○ ○ ●	Pakistan	1,907,000	2,640,000
● ○ ○	Papua New Guinea	89,000	109,000
○ ● ○	Philippines	1,510,000	1,810,000
○ ○ ●	Rwanda	196,000	244,000
○ ● ○	Sao Tome and Principe	3,000	4,000
○ ● ○	Senegal	100,000	166,000
○ ○ ●	Sierra Leone	66,000	114,000
● ○ ○	Solomon Islands	7,000	9,000
● ○ ○	Somalia	6,000	9,000
○ ○ ●	South Africa*	1,786,000	1,824,000
● ○ ○	South Sudan	9,000	14,000
● ○ ○	Sri Lanka	792,000	824,000
○ ● ○	State of Palestine	62,000	77,000
○ ● ○	Sudan	219,000	305,000
○ ● ○	Tajikistan	108,000	131,000
○ ○ ●	Tanzania	760,000	1,054,000
○ ○ ●	Timor-Leste	9,000	11,000
○ ○ ●	Togo	69,000	113,000
○ ○ ●	Uganda	446,000	689,000
● ○ ○	Uzbekistan	1,038,000	1,098,000
○ ● ○	Viet Nam	3,206,000	3,376,000
○ ● ○	Yemen	249,000	347,000
○ ● ○	Zambia	269,000	370,000
○ ○ ●	Zimbabwe	415,000	525,000
	TOTAL	**74,860,000**	**84,990,000**

*Not included in totals

INDICATOR NO. 7

Number of unsafe abortions averted due to modern contraceptive use

DEFINITION	The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara); 2012 and 2017 figures shown here, figures for intervening years available in online progress report.
SOURCE	Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY KEY

OLD — Before 2012

RECENT — 2012-2015.5

NEW — 2016-Present

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2017
○ ○ ●	Afghanistan	53,000	84,000
○ ● ○	Bangladesh	1,452,000	1,633,000
○ ○ ●	Benin	17,000	30,000
• ○ ○	Bhutan	7,000	8,000
• ○ ○	Bolivia	72,000	89,000
○ ○ ●	Burkina Faso	53,000	89,000
○ ○ ●	Burundi	33,000	37,000
○ ● ○	Cambodia	96,000	117,000
○ ○ ●	Cameroon	49,000	71,000
• ○ ○	CAR	6,000	9,000
○ ● ○	Chad	4,000	8,000
○ ● ○	Comoros	1,000	1,000
○ ● ○	Congo	10,000	14,000
○ ○ ●	Côte d'Ivoire	61,000	88,000
○ ● ○	Djibouti	2,000	3,000
• ○ ○	DPR Korea	3,000	3,000
○ ● ○	DR Congo	74,000	112,000
○ ● ○	Egypt	1,171,000	1,278,000
• ○ ○	Eritrea	3,000	5,000
○ ○ ●	Ethiopia	362,000	549,000
○ ● ○	Gambia	2,000	3,000
○ ○ ●	Ghana	91,000	124,000
○ ○ ●	Guinea	14,000	23,000
○ ● ○	Guinea-Bissau	7,000	10,000
○ ● ○	Haiti	25,000	30,000
• ○ ○	Honduras	98,000	112,000
○ ● ○	India	11,161,000	11,966,000
○ ○ ●	Indonesia	2,974,000	3,087,000

RECENCY	COUNTRY	2012	2017
● ○ ○	Iraq	94,000	120,000
○ ○ ●	Kenya	308,000	438,000
○ ● ○	Kyrgyzstan	30,000	34,000
● ○ ○	Lao PDR	50,000	62,000
○ ● ○	Lesotho	10,000	13,000
○ ○ ●	Liberia	15,000	24,000
○ ● ○	Madagascar	114,000	160,000
○ ● ○	Malawi	114,000	165,000
○ ● ○	Mali	29,000	47,000
○ ● ○	Mauritania	5,000	8,000
○ ● ○	Mongolia	300	300
○ ○ ●	Mozambique	69,000	151,000
○ ● ○	Myanmar	381,000	452,000
○ ○ ●	Nepal	223,000	277,000
● ○ ○	Nicaragua	93,000	100,000
○ ○ ●	Niger	23,000	35,000
○ ○ ●	Nigeria	336,000	476,000
○ ○ ●	Pakistan	582,000	806,000
● ○ ○	Papua New Guinea	4,000	5,000
○ ● ○	Philippines	525,000	629,000
○ ○ ●	Rwanda	58,000	72,000
○ ● ○	Sao Tome and Principe	700	1,000
○ ● ○	Senegal	32,000	53,000
○ ○ ●	Sierra Leone	21,000	36,000
● ○ ○	Solomon Islands	300	400
● ○ ○	Somalia	1,000	2,000
○ ○ ●	South Africa*	341,000	349,000
● ○ ○	South Sudan	2,000	4,000
● ○ ○	Sri Lanka	242,000	251,000
○ ● ○	State of Palestine	11,000	14,000
○ ● ○	Sudan	101,000	140,000
○ ● ○	Tajikistan	33,000	40,000
○ ○ ●	Tanzania	226,000	313,000
○ ○ ●	Timor-Leste	3,000	3,000
○ ○ ●	Togo	22,000	36,000
○ ○ ●	Uganda	132,000	205,000
● ○ ○	Uzbekistan	317,000	335,000
○ ● ○	Viet Nam	1,114,000	1,173,000
○ ● ○	Yemen	47,000	66,000
○ ● ○	Zambia	80,000	110,000
○ ○ ●	Zimbabwe	123,000	156,000
	TOTAL	**23,500,000**	**26,630,000**

*Not included in totals

INDICATOR NO. 8

Number of maternal deaths averted due to modern contraceptive use

DEFINITION	The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara); 2012 and 2017 figures shown here, figures for intervening years available in online progress report.
SOURCE	Core Indicator 1-9 Calculator, using country, regional and global parameters from surveys and other sources.

RECENCY KEY

OLD · RECENT · NEW

Before 2012 · 2012-2015.5 · 2016-Present

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

RECENCY	COUNTRY	2012	2017
○ ○ ●	Afghanistan	800	1,000
○ ● ○	Bangladesh	5,000	5,000
○ ○ ●	Benin	100	300
• ○ ○	Bhutan	20	20
• ○ ○	Bolivia	200	200
○ ○ ●	Burkina Faso	400	700
○ ○ ●	Burundi	600	600
○ ● ○	Cambodia	200	200
○ ○ ●	Cameroon	900	1,000
• ○ ○	CAR	100	200
○ ● ○	Chad	100	200
○ ● ○	Comoros	10	10
○ ● ○	Congo	100	200
○ ○ ●	Côte d'Ivoire	900	1,000
○ ● ○	Djibouti	10	20
• ○ ○	DPR Korea	100	100
○ ● ○	DR Congo	1,000	2,000
○ ● ○	Egypt	1,000	1,000
• ○ ○	Eritrea	50	70
○ ○ ●	Ethiopia	3,000	5,000
○ ● ○	Gambia	40	50
○ ○ ●	Ghana	600	800
○ ○ ●	Guinea	200	300
○ ● ○	Guinea-Bissau	100	100
○ ● ○	Haiti	300	300
• ○ ○	Honduras	100	200
○ ● ○	India	39,000	42,000
○ ○ ●	Indonesia	13,000	13,000

RECENCY	COUNTRY	2012	2017
● ○ ○	Iraq	100	200
○ ○ ●	Kenya	4,000	5,000
○ ● ○	Kyrgyzstan	50	60
● ○ ○	Lao PDR	100	100
○ ● ○	Lesotho	200	200
○ ○ ●	Liberia	200	400
○ ● ○	Madagascar	1,000	1,000
○ ● ○	Malawi	1,000	2,000
○ ● ○	Mali	200	400
○ ● ○	Mauritania	70	100
○ ● ○	Mongolia	5	6
○ ○ ●	Mozambique	900	2,000
○ ● ○	Myanmar	900	1,000
○ ○ ●	Nepal	1,000	1,000
● ○ ○	Nicaragua	200	200
○ ○ ●	Niger	300	400
○ ○ ●	Nigeria	6,000	9,000
○ ○ ●	Pakistan	2,000	3,000
● ○ ○	Papua New Guinea	100	100
○ ● ○	Philippines	800	900
○ ○ ●	Rwanda	400	500
○ ● ○	Sao Tome and Principe	5	6
○ ● ○	Senegal	200	400
○ ○ ●	Sierra Leone	700	1,000
● ○ ○	Solomon Islands	5	6
● ○ ○	Somalia	30	50
○ ○ ●	South Africa*	1,000	1,000
● ○ ○	South Sudan	60	90
● ○ ○	Sri Lanka	100	100
○ ● ○	State of Palestine	20	20
○ ● ○	Sudan	700	1,000
○ ● ○	Tajikistan	20	20
○ ○ ●	Tanzania	2,000	3,000
○ ○ ●	Timor-Leste	10	10
○ ○ ●	Togo	200	300
○ ○ ●	Uganda	1,000	1,000
● ○ ○	Uzbekistan	200	200
○ ● ○	Viet Nam	800	900
○ ● ○	Yemen	600	800
○ ● ○	Zambia	400	600
○ ○ ●	Zimbabwe	1,000	1,000
	TOTAL	**103,000**	**125,000**

*Not included in totals

INDICATOR NO. 9

Percentage of women using each modern method of contraception

DEFINITION	The percentage of total family planning users using each modern method of contraception.
SCOPE	Reported annually, for all 69 FP2020 focus countries (except Western Sahara).
SOURCE	Most recent survey, which may be: DHS, MICS, PMA2020, other national surveys.

RECENCY KEY

OLD • Before 2012

RECENT ● 2012-2015.5

NEW ● 2016-Present

Surveys dated 2015.5 are those for which field work started in 2015 and ended in 2016.

				PERMANENT		LONG-ACTING	
RECENCY			COUNTRY	STERILIZATION (FEMALE)	STERILIZATION (MALE)	IUD	IMPLANT
○	●	○	Afghanistan	9.1	0.0	7.1	1.0
○	●	○	Bangladesh	8.5	2.2	1.1	3.2
○	●	○	Benin	1.6	0.0	8.1	21.8
•	○	○	Bhutan	11.1	19.0	5.6	0.2
•	○	○	Bolivia	17.9	0.4	23.3	0.0
○	○	●	Burkina Faso	0.5	0.0	2.9	39.8
○	○	●	Burundi	2.2	0.4	3.9	26.3
○	●	○	Cambodia	8.3	0.4	11.3	5.7
○	●	○	Cameroon	1.2	0.0	1.9	8.1
•	○	○	CAR	2.2	0.0	0.0	2.2
○	●	○	Chad	5.1	0.0	0.0	23.1
○	●	○	Comoros	6.1	0.0	0.0	11.2
○	●	○	Congo	1.1	0.0	0.0	2.2
•	○	○	Côte d'Ivoire	0.7	0.0	0.7	0.7
○	●	○	Djibouti	0.0	0.0	0.0	3.3
•	○	○	DPR Korea	4.9	0.0	94.0	0.0
○	●	○	DR Congo	6.3	0.0	1.3	6.3
○	●	○	Egypt	2.1	0.0	52.9	0.9
•	○	○	Eritrea	1.9	0.0	5.8	0.0
○	○	●	Ethiopia	0.8	0.0	2.2	24.1
○	●	○	Gambia	6.2	0.0	4.6	7.7
○	●	○	Ghana	2.1	0.4	2.1	17.8
○	●	○	Guinea	1.4	0.0	2.8	1.4
○	●	○	Guinea-Bissau	0.4	0.0	24.9	24.5
○	●	○	Haiti	4.2	0.5	0.0	5.1
•	○	○	Honduras	37.1	0.5	10.7	0.0
○	●	○	India	75.3	0.6	3.1	0.0

		SHORT-TERM						
	COUNTRY	INJECTABLE	PILL	CONDOMS (MALE)	LAM*	OTHER MODERN METHODS	SOURCE	POPULATION
	Afghanistan	24.9	34.5	16.8	6.6	0.0	2015 DHS	Married
	Bangladesh	23.0	50.1	11.9	0.0	0.0	2014 DHS	Married
	Benin	29.0	21.0	9.7	8.9	0.0	2014 MICS	Married
	Bhutan	44.1	11.5	8.4	0.0	0.0	2010 MICS	All
	Bolivia	30.8	10.0	15.0	2.1	0.4	2008 DHS	All
	Burkina Faso	34.5	13.4	8.2	0.0	0.7	2014-15 PMA2020 R1-R2	All
	Burundi	50.9	7.5	5.3	0.9	2.6	2016-17 pDHS	Married
	Cambodia	23.4	45.3	5.7	0.0	0.0	2014 DHS	All
	Cameroon	28.0	14.3	45.3	0.0	1.2	2014 MICS	Married
	CAR	4.5	58.4	30.3	0.0	2.2	2010 MICS	All
	Chad	46.2	7.7	17.9	0.0	0.0	2014-15 DHS	All
	Comoros	37.8	20.4	19.4	5.1	0.0	2012 DHS	All
	Congo	15.7	25.4	48.1	4.9	2.7	2014-15 MICS	Married
	Côte d'Ivoire	13.6	43.6	35.7	2.9	2.1	2011-12 DHS	All
	Djibouti	33.9	60.6	0.0	0.0	2.2	2012 PAPFAM	Married
	DPR Korea	0.3	0.3	0.3	0.0	0.2	2010 RHS	Married
	DR Congo	11.3	8.8	57.5	0.0	8.8	2013-14 DHS	All
	Egypt	14.9	28.1	0.9	0.0	0.2	2014 DHS	Married
	Eritrea	34.6	19.2	11.5	26.9	0.0	2002 DHS	All
	Ethiopia	63.5	7.2	1.4	0.3	0.6	2016 PMA2020 R4	All
	Gambia	46.2	23.1	12.3	0.0	0.0	2013 DHS	All
	Ghana	36.0	16.1	10.2	0.4	14.8	2015 PMA2020 R4	All
	Guinea	22.5	22.5	33.8	15.5	0.0	2012 DHS	All
	Guinea-Bissau	4.7	6.6	28.4	6.6	3.9	2014 MICS	All
	Haiti	54.2	7.9	26.9	0.9	0.5	2012 DHS	All
	Honduras	26.1	17.2	8.4	0.0	0.0	2011-12 DHS	All
	India	0.0	8.6	11.7	0.0	0.6	2015-16 NFHS-4	Married

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

		PERMANENT		LONG-ACTING	
RECENCY	COUNTRY	STERILIZATION (FEMALE)	STERILIZATION (MALE)	IUD	IMPLANT
○ ○ ●	Indonesia	4.6	0.2	6.7	10.2
• ○ ○	Iraq	8.6	0.0	26.0	0.3
○ ● ○	Kenya	5.6	0.0	5.9	18.2
○ ● ○	Kyrgyzstan	3.1	0.0	55.1	0.0
• ○ ○	Lao PDR	10.7	0.0	3.7	0.2
○ ● ○	Lesotho	2.3	0.0	2.1	2.5
○ ● ○	Liberia	1.0	0.0	0.0	11.2
○ ● ○	Madagascar	4.2	0.0	2.1	7.8
○ ● ○	Malawi	18.4	0.2	1.8	19.9
○ ● ○	Mali	1.1	0.0	3.2	25.5
○ ● ○	Mauritania	0.6	0.0	1.9	5.1
○ ● ○	Mongolia	6.8	0.0	47.4	1.1
• ○ ○	Mozambique	1.7	0.0	1.7	0.0
○ ● ○	Myanmar	9.3	0.6	5.5	1.9
○ ● ○	Nepal	38.6	9.9	3.6	2.8
• ○ ○	Nicaragua	38.9	0.5	4.6	0.0
○ ● ○	Niger	0.9	0.0	0.9	2.7
○ ● ○	Nigeria	2.7	0.0	7.1	2.7
○ ● ○	Pakistan	33.2	1.1	8.8	0.0
• ○ ○	Papua New Guinea	35.8	1.7	0.0	0.0
○ ● ○	Philippines	22.9	0.4	9.3	0.0
○ ● ○	Rwanda	2.5	0.4	2.5	16.9
○ ● ○	Sao Tome and Principe	1.3	0.0	4.3	5.6
○ ● ○	Senegal	2.0	0.0	5.2	24.8
○ ● ○	Sierra Leone	1.4	0.0	1.0	18.4
• ○ ○	Solomon Islands	45.4	1.0	6.8	0.0
• ○ ○	Somalia	0.0	0.0	9.1	0.0
○ ○ ●	South Africa	10.0	0.7	2.1	6.7
• ○ ○	South Sudan	5.9	0.0	0.0	0.0
• ○ ○	Sri Lanka	32.1	1.3	12.0	0.6
○ ● ○	State of Palestine	4.1	0.0	59.3	0.0
○ ● ○	Sudan	0.0	0.0	3.5	2.6
○ ● ○	Tajikistan	2.3	0.0	72.4	0.0
○ ● ○	Tanzania	10.6	0.3	2.8	20.9
○ ○ ●	Timor-Leste	5.8	0.0	8.3	25.6
○ ● ○	Togo	1.2	0.0	3.6	20.4
○ ● ○	Uganda	5.9	0.4	1.2	16.1
• ○ ○	Uzbekistan	3.5	0.2	80.4	0.2
• ○ ○	Viet Nam	6.7	0.2	51.3	0.4
○ ● ○	Yemen	7.9	0.3	20.2	2.1
○ ● ○	Zambia	4.0	0.0	2.8	12.9
○ ● ○	Zimbabwe	1.3	0.0	0.8	16.9

	SHORT-TERM						
COUNTRY	INJECTABLE	PILL	CONDOMS (MALE)	LAM*	OTHER MODERN METHODS	SOURCE	POPULATION
Indonesia	54.0	22.5	1.7	0.1	0.0	2016 RPJMN	All
Iraq	8.6	43.8	5.0	6.4	1.4	2011 MICS	Married
Kenya	47.9	14.1	7.9	0.3	0.0	2014 DHS	All
Kyrgyzstan	0.7	10.1	27.2	3.8	0.0	2014 MICS	All
Lao PDR	31.8	49.5	2.6	1.4	0.0	2011-12 MICS/DHS	Married
Lesotho	34.8	18.8	39.2	0.0	0.4	2014 DHS	All
Liberia	60.7	21.4	4.9	0.0	1.0	2013 DHS	All
Madagascar	59.6	19.8	3.0	3.6	0.0	2012-13 EN OMD	All
Malawi	49.8	3.8	5.8	0.0	0.4	2015-16 DHS	All
Mali	40.4	27.7	2.1	0.0	0.0	2012-13 DHS	All
Mauritania	22.8	67.7	1.3	0.6	0.0	2015 MICS	Married
Mongolia	7.6	18.2	18.7	0.0	0.3	2013 MICS	All
Mozambique	35.5	35.5	24.0	0.8	0.8	2011 DHS	All
Myanmar	53.7	26.7	1.9	0.0	0.3	2015-16 DHS	All
Nepal	27.3	9.9	7.7	0.0	0.3	2014 MICS	All
Nicaragua	33.9	14.8	7.0	0.0	0.3	2011-12 National	Married
Niger	17.3	45.5	0.9	31.8	0.0	2012 DHS	All
Nigeria	22.3	17.0	40.2	2.7	5.4	2013 DHS	All
Pakistan	10.7	6.1	33.6	5.7	0.8	2012-13 DHS	Married
Papua New Guinea	36.9	18.4	7.3	0.0	0.0	2006 National Survey	All
Philippines	9.7	50.0	5.9	1.3	0.4	2013 DHS	All
Rwanda	51.1	16.9	7.9	0.4	1.4	2014-15 DHS	All
Sao Tome & Princ.	27.9	33.6	24.9	0.0	2.3	2014 MICS	All
Senegal	37.9	22.2	7.2	0.7	0.0	2015 DHS	All
Sierra Leone	47.3	24.6	3.4	3.4	0.5	2013 DHS	All
Solomon Islands	32.2	4.4	9.8	0.5	0.0	2006-07 DHS	All
Somalia	18.2	72.7	0.0	0.0	0.0	2006 MICS	Married
South Africa	42.7	12.3	25.0	0.0	0.5	2016 pDHS	Married**
South Sudan	23.5	17.6	23.5	29.4	0.0	2010 SHHS2	Married
Sri Lanka	28.5	15.0	10.4	0.2	0.0	2006-07 DHS	Married
State of Palestine	2.0	18.1	12.7	3.6	0.2	2014 MICS	Married
Sudan	12.2	78.3	0.0	3.5	0.0	2014 MICS	Married
Tajikistan	7.5	8.6	8.6	0.6	0.0	2012 DHS	All
Tanzania	39.3	17.1	7.5	1.6	0.0	2015-16 DHS	All
Timor-Leste	48.3	9.1	0.4	0.8	1.7	2016 pDHS	Married
Togo	30.5	11.4	32.3	0.0	0.6	2013-14 DHS	All
Uganda	51.8	8.2	13.7	0.0	2.7	2015 PMA2020 R3	All
Uzbekistan	4.2	3.7	3.5	4.2	0.0	2006 MICS	All
Viet Nam	2.8	16.9	21.1	0.4	0.1	2010-11 MICS	All
Yemen	14.4	39.7	1.7	13.7	0.0	2013 DHS	Married
Zambia	42.5	24.6	10.8	1.5	0.9	2013-14 DHS	All
Zimbabwe	15.1	56.5	8.8	0.4	0.2	2015 DHS	All

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

INDICATOR NO. 10

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

DEFINITION	Percentage of facilities stocked out of each type of contraceptive offered, on the day of assessment.
SCOPE	2015-2016, 27 countries (those with sufficient data).
SOURCE	UNFPA facility surveys; PMA2020 facility surveys; other facility surveys and LMIS data.

	PERMANENT		LONG-ACTING	
COUNTRY	STERILIZATION (FEMALE)	STERILIZATION (MALE)	IUD	IMPLANT
Burkina Faso	14.8	17.1	5.2	3.1
Cameroon	90.9	85.3	58.6	69.0
Congo			43.3	48.5
Côte d'Ivoire	18.0	31.1	61.2	26.2
Ethiopia	34.4	42.2	17.1	15.3
Guinea	71.6	75.6	23.2	21.8
Ghana			19.5	12.6
Haiti	83.3	88.6	84.1	39.4
Honduras			10.9	27.3
Indonesia			4.0	5.9
Kenya			5.0	5.0
Lao PDR	18.5	44.6	24.9	2.5
Malawi	30.4	40.0	52.9	8.0
Myanmar	88.4		69.0	94.4
Nepal	42.6	40.5	23.0	16.7
Niger	65.9	75.6	14.6	13.8
Nigeria	34.2	28.3	5.9	5.7
Rwanda	0.0	14.0	8.6	2.5
Sao Tome and Principe	0.0	0.0	0.0	0.0
Senegal	2.0	2.3	5.3	22.2
Sierra Leone	48.3	56.6	46.7	48.1
Sudan			35.2	47.5
Tanzania	60.5	74.3	34.0	18.9
Timor-Leste			9.0	14.0
Togo			18.0	11.2
Uganda			9.9	10.7
Zimbabwe	13.5	17.4	5.0	6.4

*Blank cells indicate no available data

	SHORT-TERM					
COUNTRY	INJECTABLE	PILL	CONDOMS (MALE)	CONDOMS (FEMALE)	OTHER MODERN METHODS (INC. EC)	SOURCE
Burkina Faso	2.0	2.5	3.0	11.1		2016 UNFPA
Cameroon	87.9	70.7	81.5	49.1	51.3	2016 UNFPA
Congo	75.3	51.5	70.8	22.0	38.1	2016 UNFPA
Côte d'Ivoire	5.1	17.4	39.6	60.7	64.4	2016 UNFPA
Ethiopia	5.9	11.8	14.1	98.7	39.4	2016 UNFPA
Guinea	12.7	19.1	16.9	57.7	55.3	2016 UNFPA
Ghana	2.4	21.6	12.9		50.7	2016 PMA2020*
Haiti	12.9	9.1	7.6			2016 UNFPA
Honduras	8.1	5.5	29.1	71.9		2016 UNFPA
Indonesia	7.6	4.1	8.5			2016 PMA2020*
Kenya	8.0	17.0	12.0			2016 PMA2020*
Lao PDR	1.4	2.2	8.9	94.7		2015 UNFPA
Malawi	9.7	9.8	6.8	36.9	20.0	2016 UNFPA
Myanmar	20.9	12.7	55.3	98.4	71.7	2016 UNFPA
Nepal	2.1	1.1	0.0		9.5	2016 UNFPA
Niger	10.6	9.8	13.8	22.8	24.4	2016 UNFPA
Nigeria	3.7	2.7	7.4	8.9	43.5	2016 UNFPA
Rwanda	3.1	3.1	3.1	31.5	3.1	2016 UNFPA
Sao Tome & Princ.	0.0	0.0	0.0	0.0	0.0	2016 UNFPA
Senegal	27.0	6.5	4.5	6.3	6.1	2016 UNFPA
Sierra Leone	43.4	14.2	6.6	36.8	49.1	2016 UNFPA
Sudan	38.9	23.0	33.6			2016 UNFPA
Tanzania	5.8	10.8	9.3	62.0	26.4	2016 UNFPA
Timor-Leste	6.0	8.0	15.0		8.0	2016 UNFPA
Togo	4.3	12.9	7.9	24.8	41.7	2016 UNFPA
Uganda	6.0	48.5	7.0	22.3	74.4	2015 UNFPA
Zimbabwe	1.1	3.0	0.8	1.0		2016 UNFPA

*Facility surveys from PMA2020 are not nationally representative, rather they are a survey of all facilities in selected enumeration areas.

INDICATOR NO. 11

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

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

DEFINITION	A. The percentage of service delivery points (SDPs) that have at least 3 modern methods of contraception available on the day of the assessment. B. The percentage of secondary and tertiary service delivery points (SDPs) that have at least 5 modern methods of contraception available on the day of the assessment.
SCOPE	22 countries (those with sufficient data).
SOURCE	UNFPA facility surveys; PMA2020 facility surveys.

COUNTRY	PERCENTAGE OF PRIMARY SDPs WITH AT LEAST 3 MODERN METHODS OF CONTRACEPTION AVAILABLE ON DAY OF ASSESSMENT	PERCENTAGE OF SECONDARY/ TERTIARY SDPs WITH AT LEAST 5 MODERN METHODS OF CONTRACEPTION AVAILABLE ON DAY OF ASSESSMENT	SOURCE
Burkina Faso	98.5	87.2	2016 UNFPA
Cameroon	48.3	81.7	2016 UNFPA
DRC	39.2	20.4	2016 UNFPA
Ethiopia	69.3	95.3	2016 UNFPA
Gambia	9.8	12.5	2016 UNFPA
Ghana	83.0	79.4	2016 PMA2020*
Honduras	81.2	95.7	2016 UNFPA
Indonesia	85.7	79.6	2016 PMA2020*
Kenya	94.0	79.6	2016 UNFPA
Lao PDR	89.6	89.2	2016 UNFPA
Malawi	93.9	100.0	2016 UNFPA
Nepal	81.9	78.6	2016 UNFPA
Nigeria	87.5	88.5	2016 UNFPA
Papua New Guinea	91.0	100.0	2016 UNFPA
Rwanda	67.2	97.7	2016 UNFPA
Sao Tome and Principe	100.0	100.0	2016 UNFPA
Sierra Leone	75.3	84.8	2016 UNFPA
Sudan	100.0	93.5	2016 UNFPA
Tanzania	66.1	92.4	2016 UNFPA
Timor Leste	71.0	38.9	2016 UNFPA
Uganda	51.0	73.7	2016 PMA2020*
Zimbabwe	98.0	90.0	2016 UNFPA

*Facility surveys from PMA2020 are not nationally representative, rather they are a survey of all facilities in selected enumeration areas.

INDICATOR NO. 13

Couple-Years of Protection (CYP)

DEFINITION	The estimated protection provided by family planning services during a one year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method.
SCOPE	2012-2016, 14 countries with sufficient available data.
SOURCE	Calculated from Health Management Information Systems (HMIS), Logistics Management Information Systems (LMIS) or other service statistics sources.

COUNTRY	2012	2013	2014	2015	2016	SOURCE	DATA TYPE
Cameroon					427,253	Service statistics	Products to facilities
Côte d'Ivoire					819,396	Service statistics	Products to clients
Ethiopia*	8,441,086	8,319,791	3,898,710	3,924,922		Health and annual quantification data	Commoditites distributed to facilities
Indonesia			48,452,903	45,856,646	47,154,775	Service statistics	Products to clients
Kenya	290,177	548,854	3,656,120	3,812,546	3,864,867	DHIS2	Products to clients
Madagascar*	626,769	966,516	1,188,165	1,157,740		Health and Demographic Service Statistics	Commodities distributed to clients
Malawi	1,061,204	1,110,594	1,644,769	2,038,004		HMIS	Products to clients
Myanmar			2,076,550	1,375,375	1,458,350	MOH & UNFPA	Products to facilities
Niger*	186,042	244,646	386,497	652,274		Statistics Division	Commodities distributed to clients (public facilities)
Tanzania			4,069,993	5,310,195	5,979,225	DHIS2	Client visits
Togo*	233,684	270,007	289,442	329,146		Ministry of Health	Commoditites distributed to clients (public facilities)
Uganda	974,021	1,647,436	1,769,172	1,424,182	1,801,388	DHIS2	Products to clients
Zambia*	641,952	957,616	1,254,078	1,117,341		HMIS-DHIS2	Commodities distributed to clients (public facilities)
Zimbabwe*	1,025,854	1,149,763	1,473,275	1,389,189		DHIS2	Products to facilities (public)

*Data reported from 2016 FP2020 Progress Report

INDICATOR NO. 14

Method Information Index

DEFINITION	An index measuring the extent to which women were given specific information when they received family planning services. The index is composed of three questions: 1) Were you informed about other methods? 2) Were you informed about side effects? 3) Were you told what to do if you experienced side effects? The reported Method Information Index value is the percent of women who responded "yes" to all three questions.
SCOPE	34 countries, reported for the year with the most recent national survey data, from 2012 to present.
SOURCE	For each country, the most recent national survey (DHS, PMA2020). Data reflect all women, except for Egypt, Pakistan and Yemen, which reflect married or in-union women.

	METHOD INFORMATION INDEX	PERMANENT	LONG-ACTING		SHORT-TERM	
COUNTRY	TOTAL	STERILIZATION (FEMALE)	IUD	IMPLANT	INJECTABLE	PILL
Afghanistan	34.8	28.5	48.4		45.9	26.5
Burkina Faso	37.8			42.3	41.4	38.4
Cambodia	67.4	62.5	86.7	80.4	70.1	59.2
Chad	38.8			40.2	42.4	34.4
Comoros	36.2	0.0	0.0	51.4	30.0	40.1
DR Congo	28.4	6.4	0.0	50.4	35.6	12.0
Egypt	28.8	25.4	30.4	27.3	30.0	25.5
Ethiopia	33.5		53.8	47.2	27.3	35.8
Gambia	31.0	0.0	29.9*	0.0	33.5	26.5
Ghana	37.5			66.4	57.9	15.8
Guinea	31.3	0.0	0.0	0.0	29.1	28.6
Haiti	51.7	30.0	0.0	62.1	54.3	38.7
Indonesia	30.4	27.3	39.7	34.1	31.2	32.5
Kenya	47.2	52.3	67.3	58.5	46.0	46.1
Kyrgyzstan	56.2	26.9*	59.5	0.0	0.0	46.5
Lesotho	27.0	3.9*	55.5*	44.3	26.7	24.4
Liberia	61.4	0.0	0.0	75.6	62.3	51.9
Malawi	62.7	45.7	70.8	70.5	63.1	58.1
Mali	33.3	0.0	50.1*	41.8	31.2	25.4
Myanmar	25.0	35.0	52.8	63.6	25.8	12.9
Niger	29.5			50.9	36.6	29.9
Nigeria	24.4	52.1	60.5	50.8	39.3	18.4
Pakistan	13.5	7.6	20.6	0.0	18.3	11.2
Philippines	52.1	45.9	69.5	0.0	58.5	50.5
Rwanda	57.9	23.9	65.1	61.4	59.1	53.0
Senegal	66.7		65.6	63.6	71.1	63.8
Sierra Leone	69.8	54.0*	76.7	78.0	72.1	59.7
Tajikistan	59.4	0.0	59.1	0.0	65.4	60.7
Tanzania	46.2	36.6	68.0	61.2	39.6	41.2
Togo	67.5	0.0	72.0	79.8	68.8	44.4
Uganda	44.6	48.6		62.6	48.3	42.3
Yemen	34.9	22.0	45.7	44.8	36.3	30.9
Zambia	71.8	49.9	82.3	83.8	73.8	62.4
Zimbabwe	44.5			63.7	43.0	38.2

*Small sample size
Note: Blank cells indicate that the sample size was too small for inclusion or that no data were available.

	RESPONSES TO INDIVIDUAL QUESTIONS AMONG USERS OF MODERN METHODS			
COUNTRY	TOLD OF OTHER METHODS	TOLD ABOUT SIDE EFFECTS	TOLD WHAT TO DO ABOUT SIDE EFFECTS**	SOURCE
Afghanistan	54.0	48.4	42.5	2015 DHS
Burkina Faso	62.7	54.2	48.0	2016 PMA2020 R4
Cambodia	75.7	79.6	77.5	2014 DHS
Chad	61.0	62.2	51.3	2014-15 DHS
Comoros	62.2	54.5	45.7	2012 DHS
DR Congo	50.8	57.2	47.5	2013-14 DHS
Egypt	56.0	45.0	34.5	2014 DHS
Ethiopia	59.1	48.1	39.2	2016 PMA2020 R4
Gambia	57.5	47.2	41.8	2013 DHS
Ghana	59.0	57.1	44.0	2016 PMA2020 R5
Guinea	48.6	48.6	43.1	2012 DHS
Haiti	64.6	70.2	63.7	2012 DHS
Indonesia	57.6	49.2	36.8	2015 PMA2020 R1
Kenya	69.7	59.0	53.2	2016 PMA2020 R5
Kyrgyzstan	64.6	70.5	67.1	2012 DHS
Lesotho	62.6	39.8	36.5	2014 DHS
Liberia	72.0	75.0	72.9	2013 DHS
Malawi	81.3	73.9	69.1	2015-16 DHS
Mali	56.8	53.1	46.3	2012-13 DHS
Myanmar	43.3	35.7	28.9	2015-16 DHS
Niger	54.9	41.5	33.2	2016 PMA2020 R1
Nigeria	44.6	36.9	29.5	2016 PMA2020 R1
Pakistan	28.2	34.0	28.1	2012-13 DHS
Philippines	71.4	67.8	67.9	2013 DHS
Rwanda	79.5	64.8	68.5	2014-15 DHS
Senegal	83.5	75.8	72.3	2015 DHS
Sierra Leone	82.7	75.7	74.9	2013 DHS
Tajikistan	68.1	77.0	71.8	2012 DHS
Tanzania	74.2	55.6	51.2	2015-16 DHS
Togo	82.7	78.1	74.6	2013-14 DHS
Uganda	62.3	60.8	51.2	2016 PMA2020 R4
Yemen	57.0	55.7	45.8	2013 DHS
Zambia	83.3	79.7	78.1	2013-14 DHS
Zimbabwe	67.9	58.3	51.2	2015 DHS

**Among all women who responded to this set of three questions, not just among those who were told about side effects.

INDICATOR NO. 15

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

DEFINITION	The percentage of women who were provided information on family planning within the last 12 months through contact with a health service provider or fieldworker.
SCOPE	32 countries, reported for year with most recent national survey data, from 2012 to present.
SOURCE	For each country, the most recent national survey (DHS, PMA2020). Data reflect all women, except for Pakistan and Yemen, which reflect married or in-union women.

		INDICATOR BY WEALTH QUINTILE					
COUNTRY	VALUE	POOREST	POORER	MIDDLE	RICHER	RICHEST	SOURCE
Afghanistan	23.0	20.6	20.6	21.3	26.4	26.4	2015 DHS
Burkina Faso	34.8	36.6	36.6	37.2	30.7	30.7	2016 PMA2020 R4
Cambodia	29.6	33.9	33.0	32.6	29.9	20.8	2014 DHS
Chad	13.9	15.8	12.7	11.9	12.0	16.8	2014-15 DHS
Comoros	16.2	19.5	17.7	15.7	13.9	14.6	2012 DHS
DR Congo	11.0	7.2	9.6	9.3	13.9	14.1	2013-14 DHS
Ethiopia	27.1	28.9	26.7	25.8	26.6	27.6	2016 PMA2020 R4
Gambia	9.7	12.4	11.9	10.3	8.1	7.2	2013 DHS
Ghana	25.3	28.5	31.0	22.4	20.5	22.8	2016 PMA2020 R5
Guinea	6.6	5.6	4.7	6.1	5.6	10.4	2012 DHS
Haiti	20.2	24.9	22.3	25.0	18.2	14.4	2012 DHS
Indonesia	18.3	21.7	17.0	18.4	18.7	16.6	2015 PMA2020 R1
Kenya	32.1	30.8	35.6	32.5	32.7	28.8	2016 PMA2020 R5
Kyrgyzstan	23.6	33.4	28.2	23.7	22.8	14.1	2012 DHS
Lesotho	23.0	23.7	25.5	23.0	22.1	22.1	2014 DHS
Liberia	52.4	47.0	52.8	58.2	55.8	48.4	2013 DHS
Malawi	32.2	35.3	35.5	34.8	34.1	23.2	2015-16 DHS
Mali	16.4	14.9	13.7	14.8	19.0	16.4	2012-13 DHS
Niger	24.4	25.1	25.1	24.8	23.6	23.6	2016 PMA2020 R1
Nigeria	23.7	16.8	21.2	22.5	27.5	27.3	2016 PMA2020 R1
Pakistan	40.6	39.7	43.4	45.8	42.3	31.7	2012-13 DHS
Philippines	28.8	45.2	38.2	30.6	22.0	15.7	2013 DHS
Rwanda	32.2	35.0	35.6	36.3	33.4	22.6	2014-15 DHS
Senegal	29.9	27.6	30.4	32.4	30.1	28.9	2015 DHS
Sierra Leone	42.4	41.3	46.3	48.0	49.8	29.6	2013 DHS
Tajikistan	27.8	25.3	24.7	28.4	31.4	29.2	2012 DHS
Tanzania	21.4	22.7	25.4	23.5	22.6	15.7	2015-16 DHS
Togo	20.1	29.9	24.5	23.4	16.4	15.5	2013-14 DHS
Uganda	39.3	49.4	40.1	37.0	37.1	34.2	2016 PMA2020 R4
Yemen	9.9	7.1	8.6	11.1	12.0	10.4	2013 DHS
Zambia	30.2	34.0	37.5	33.3	27.8	22.1	2013-14 DHS
Zimbabwe	29.4	32.2	31.3	32.4	29.1	24.4	2015 DHS

INDICATOR NO. 16

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

DEFINITION	The percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner.
SCOPE	35 countries, reported for year with most recent national survey data, from 2012 to present.
SOURCE	For each country, the most recent national survey (DHS, PMA2020).

		INDICATOR BY WEALTH QUINTILE					
COUNTRY	VALUE	POOREST	POORER	MIDDLE	RICHER	RICHEST	SOURCE
Afghanistan	87.5	92.1	84.2	85.6	87.3	88.2	2015 DHS
Bangladesh	91.1	89.6	91.6	91.1	92.0	90.9	2014 DHS
Burkina Faso	92.3	92.3	92.3	92.0	92.6	92.6	2016 PMA2020 R4
Cambodia	88.9	88.3	90.1	88.6	87.7	89.8	2014 DHS
Chad	81.7	79.1	78.6	89.9	81.1	80.3	2014-15 DHS
Comoros	71.0	72.0	73.0	71.0	72.0	69.0	2012 DHS
DR Congo	85.0	86.0	85.0	80.0	81.0	89.0	2013-14 DHS
Egypt	98.0	97.0	97.0	97.0	97.0	99.0	2014 DHS
Ethiopia	87.7	85.0	89.1	87.2	85.6	90.4	2016 PM2020 R4
Gambia	84.0	84.0	77.0	89.0	81.0	87.0	2013 DHS
Ghana	92.9	92.5	92.2	91.7	93.0	95.9	2016 PMA2020 R5
Guinea	92.0	80.0	97.0	98.0	95.0	87.0	2012 DHS
Haiti	91.4	91.0	92.0	92.0	91.0	91.0	2012 DHS
Indonesia	93.3	93.2	93.7	93.3	92.2	94.2	2015 PMA2020 R1
Kenya	96.3	96.5	95.0	95.8	97.1	97.4	2016 PMA2020 R5
Kyrgyzstan	95.0	94.0	95.0	96.0	93.0	97.0	2012 DHS
Lesotho	93.1	93.4	93.7	91.7	91.0	95.3	2014 DHS
Liberia	89.0	84.0	86.0	87.0	92.0	93.0	2013 DHS
Malawi	92.5	91.2	91.1	91.5	93.1	95.3	2015-16 DHS
Mali	81.0	85.0	86.0	79.0	82.0	79.0	2012-13 DHS
Myanmar	97.9	98.6	98.5	98.6	98.0	95.8	2015-16 DHS
Niger	93.8	92.3	92.3	95.5	93.7	93.7	2016 PMA2020 R1
Nigeria	85.6	84.9	83.2	84.3	85.2	87.7	2016 PMA2020 R1
Pakistan	92.0	93.0	94.0	91.0	92.0	93.0	2012-13 DHS
Philippines	92.0	91.0	93.0	92.0	93.0	94.0	2013 DHS
Rwanda	97.9	97.6	97.7	97.2	97.9	99.0	2014-15 DHS
Senegal	87.5	91.5	84.9	84.8	87.3	89.3	2015 DHS
Sierra Leone	82.0	84.0	78.0	83.0	82.0	83.0	2013 DHS
Tajikistan	86.0	86.0	80.0	89.0	82.0	92.0	2012 DHS
Tanzania	96.3	96.7	95.6	95.6	96.5	96.8	2015-16 DHS
Togo	84.0	82.0	90.0	87.0	82.0	81.0	2013-14 DHS
Uganda	92.5	89.7	90.2	91.9	94.1	94.4	2016 PMA2020 R4
Yemen	93.1	88.3	91.3	92.3	94.0	94.9	2013 DHS
Zambia	83.0	82.0	82.0	83.0	83.0	85.0	2013-14 DHS
Zimbabwe	93.2	92.6	92.3	93.0	92.8	94.9	2015 DHS

INDICATOR NO. 17

Adolescent birth rate (ABR)

DEFINITION	The number of births to adolescent females aged 15-19 occurring during a given reference period per 1,000 adolescent females.
SCOPE	49 countries, reported for year with most recent national survey data, from 2012 to present.
SOURCE	For each country, the most recent national survey (DHS, PMA2020, MICS).

COUNTRY	ABR	SOURCE
Afghanistan	78	2015 DHS
Bangladesh	113	2014 DHS
Benin	94	2014 MICS
Burkina Faso	126	2016 PMA2020 R3-R4
Burundi	58	2016-17 pDHS
Cambodia	57	2014 DHS
Cameroon	119	2014 MICS
Chad	179	2014-15 pDHS
Comoros	70	2012 DHS
Congo	111	2014-15 MICS
DR Congo	138	2013-14 DHS
Egypt	56	2014 DHS
Ethiopia	80	2016 pDHS
Gambia	88	2013 DHS
Ghana	77	2016 PMA2020 R4-R5
Guinea	146	2012 DHS
Guinea-Bissau	106	2014 MICS
Haiti	66	2012 DHS
Indonesia	38	2016 PMA2020 R2
Kenya	86	2016 PMA2020 R4-R5
Kyrgyzstan	65	2014 MICS
Lesotho	94	2014 DHS
Liberia	149	2013 DHS
Mali	151	2015 MICS
Malawi	136	2015-16 DHS
Mauritania	84	2015 pMICS
Mongolia	40	2013 MICS (SISS)
Myanmar	36	2015-16 DHS
Nepal	71	2014 MICS
Niger	173	2016 PMA2020 R2
Nigeria	120	2016 PMA2020 R3
Pakistan	44	2012-13 DHS
Philippines	57	2013 DHS
Rwanda	45	2014-15 DHS

COUNTRY	ABR	SOURCE
Sao Tome and Principe	92	2014 MICS
Senegal	80	2015 DHS
Sierra Leone	125	2013 DHS
South Africa	71	2016 pDHS
State of Palestine	48	2014 MICS
Sudan	87	2014 MICS
Tajikistan	54	2012 DHS
Tanzania	132	2015-16 DHS
Timor-Leste	42	2016 pDHS
Togo	84	2013-14 DHS
Uganda	155	2016 PMA2020 R3-R4
Viet Nam	45	2013-14 MICS
Yemen	67	2013 DHS
Zambia	141	2013-14 DHS
Zimbabwe	110	2015 DHS

INDICATOR NO. 18

A. Contraceptive discontinuation rate[1]

DEFINITION	A. Among women of reproductive age who began an episode of contraceptive use 3-62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use, reported by whether the woman discontinued while in need of contraception, discontinued because she is not in need of contraception, and the total all-reasons discontinuation rate.
SCOPE	28 countries, reported for year with most recent national survey data, from 2012 to present.
SOURCE	For each country, the most recent DHS survey.

DISCONTINUATION WHILE IN NEED[2]

	LONG-ACTING		SHORT-TERM		
COUNTRY	**IUD**	**IMPLANT**	**INJECTABLE**	**PILL**	**CONDOMS (MALE)**
Afghanistan	8.8		9.6	8.3	9.9
Bangladesh		3.5	17.8	17.9	22.6
Cambodia	8.6	6.1	23.3	17.7	21.6
Comoros			15.2	8.7	
Egypt	9.0	11.9	22.1	23.1	23.4
Ethiopia	11.3	6.4	19.7	47.3	
Gambia			17.2	22.2	
Ghana		6.2	20.7	19.0	11.6
Honduras	23.3		34.9	40.1	46.3
Indonesia	4.2	6.3	16.1	27.7	21.6
Kenya	5.2	7.2	21.0	32.7	10.2
Kyrgyz Republic	6.3			30.3	19.5
Lesotho			16.9	21.1	13.0
Liberia		2.7	21.0	27.7	
Malawi	7.9	5.8	26.0	44.1	35.3
Mali		10.9	32.0	28.1	
Myanmar	6.1		27.4	21.5	
Niger			24.3	15.8	
Nigeria	3.2		14.6	11.2	5.6
Pakistan	22.9		46.9	41.3	21.7
Rwanda		2.4	20.0	33.0	27.5
Senegal		5.7	24.6	29.7	
Sierra Leone		7.6	18.9	20.1	22.9
Tajikistan	5.3		26.6	15.9	18.6
Tanzania		7.3	23.2	23.8	16.2
Yemen	14.4	23.0	35.0	28.3	34.2
Zambia	11.1	3.5	17.4	21.1	15.4
Zimbabwe		5.7	23.2	13.1	19.9

[1] The rate is calculated using a multiple decrement life-table approach, which takes into account competing reasons for discontinuation.
[2] Reasons for discontinuation while a woman is in need include: method failure, health concerns or side effects, wanting a more effective method, inconvenience of using a method, lack of access to a method or a method being too far, cost of a method, opposition from a husband, and other context-specific reasons.

DISCONTINUATION WHILE NOT IN NEED[3]

	LONG-ACTING		SHORT-TERM		
COUNTRY	IUD	IMPLANT	INJECTABLE	PILL	CONDOMS (MALE)
Afghanistan	1.6		7.2	12.1	8.7
Bangladesh		2.7	6.4	14.6	16.2
Cambodia	0.5	1.1	9.3	8.9	16.6
Comoros			8.1	4.8	
Egypt	5.3	2.8	13.6	18.5	8.5
Ethiopia	2.0	4.5	18.5	22.8	
Gambia			8.0	10.2	
Ghana		0.7	8.4	10.6	23.5
Honduras	1.9		11.6	19.7	28.4
Indonesia	1.3	1.3	7.9	11.4	8.6
Kenya	0.6	0.5	8.2	10.2	26.7
Kyrgyz Republic	3.0			12.4	9.3
Lesotho			3.2	5.8	6.3
Liberia		5.8	3.3	4.4	
Malawi	5.4	1.7	13.8	16.7	24.9
Mali		5.9	17.7	20.0	
Myanmar	1.0		14.0	21.6	
Niger			28.9	26.9	
Nigeria	5.2		6.7	12.5	11.3
Pakistan	2.3		11.3	13.9	14.6
Rwanda		0.6	6.9	7.2	8.7
Senegal		2.5	16.7	16.8	
Sierra Leone		1.2	5.0	5.7	12.7
Tajikistan	3.1		11.3	10.6	8.8
Tanzania		2.3	8.8	9.9	11.6
Yemen	3.6	3.3	10.1	17.1	11.9
Zambia	0.0	0.4	7.4	8.8	7.4
Zimbabwe		0.5	6.7	7.3	18.3

[3] Reasons for discontinuation because a woman is not in need include: wanting to become pregnant, infrequent sex or husband's absence, marital dissolution/separation, difficulty in getting pregnant/menopause.

TOTAL DISCONTINUATION (ALL REASONS)

	LONG-ACTING		SHORT-TERM		
COUNTRY	IUD	IMPLANT	INJECTABLE	PILL	CONDOMS (MALE)
Afghanistan	10.3		17.1	20.7	18.6
Bangladesh		6.2	25.2	33.9	40.4
Cambodia	9.4	7.2	32.7	26.8	38.4
Comoros			25.1	18.3	
Egypt	14.3	14.7	35.7	41.5	31.9
Ethiopia	13.3	10.9	38.3	70.1	
Gambia			27.1	36.7	
Ghana		6.9	29.1	29.6	35.1
Honduras	25.6		47.5	61.0	77.4
Indonesia	5.7	7.9	24.7	40.7	31.2
Kenya	6.4	8.0	30.9	44.9	42.9
Kyrgyz Republic	9.3			43.2	29.3
Lesotho			20.7	27.2	20.2
Liberia		8.5	25.0	34.8	
Malawi	13.3	7.6	40.7	61.9	61.9
Mali		17.6	50.8	48.3	
Myanmar	7.1		41.5	43.0	
Niger			58.2	46.3	
Nigeria	9.1		23.1	26.1	20.1
Pakistan	25.5		60.7	56.4	37.8
Rwanda		3.1	27.5	41.5	37.3
Senegal		8.2	41.3	46.4	
Sierra Leone		8.8	24.9	26.4	42.4
Tajikistan	9.4		41.2	36.0	31.3
Tanzania		9.6	32.0	34.0	27.9
Yemen	18.5	26.5	48.5	47.6	48.2
Zambia	11.8	4.2	26.7	32.6	29.8
Zimbabwe		6.1	30.0	20.5	38.4

INDICATOR NO. 18

B. Contraceptive method switching

DEFINITION	B. Among women of reproductive age who began an episode of contraceptive use 3-62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use, and use of a different method begins after no more than one month of non-contraceptive use.
SCOPE	28 countries, reported for year with most recent national survey data, from 2012 to present.
SOURCE	For each country, the most recent DHS survey.

SWITCHING TO A DIFFERENT METHOD[4]

	LONG-ACTING		SHORT-TERM			
COUNTRY	**IUD**	**IMPLANT**	**INJECTABLE**	**PILL**	**CONDOMS (MALE)**	**SOURCE**
Afghanistan	0.9		1.6	2.3	2.3	2015 DHS
Bangladesh		2.6	12.7	10.9	18.2	2014 DHS
Cambodia	5.9	2.7	11.8	7.9	14.1	2014 DHS
Comoros			0.2	0.7		2012 DHS
Egypt	4.6	6.5	9.9	8.9	16.6	2014 DHS
Ethiopia	3.4	2.4	4.4	24.2		2016 DHS
Gambia			4.0	6.7		2013 DHS
Ghana		1.5	2.9	1.9	2.8	2014 DHS
Honduras	13.7		21.9	21.6	32.3	2011-12 DHS
Indonesia	3.1	4.3	12.0	19.6	18.3	2012 DHS
Kenya	3.8	3.7	10.2	21.5	4.6	2014 DHS
Kyrgyz Republic	2.2			12.5	3.2	2012 DHS
Lesotho			8.6	10.1	7.4	2014 DHS
Liberia		0.0	1.1	2.2		2013 DHS
Malawi	1.7	1.0	3.8	13.1	14.2	2015-16 DHS
Mali		2.2	3.5	4.4		2012-13 DHS
Myanmar	4.4		11.6	10.4		2015-16 DHS
Niger			10.0	4.4		2012 DHS
Nigeria	0.5		2.7	1.8	1.6	2013 DHS
Pakistan	8.5		16.5	13.8	5.7	2012-13 DHS
Rwanda		0.7	8.5	21.0	14.8	2014-15 DHS
Senegal		2.9	5.4	10.1		2015 DHS
Sierra Leone		1.5	4.1	4.8	17.6	2013 DHS
Tajikistan	1.1		8.7	7.2	5.3	2012 DHS
Tanzania		1.7	5.5	7.8	11.4	2015-16 DHS
Yemen	8.1	9.4	13.9	8.7	20.3	2013 DHS
Zambia	4.8	1.0	4.1	7.3	12.6	2013-14 DHS
Zimbabwe		1.7	12.3	5.3	11.3	2015 DHS

[4] This indicates either a) an episode of use of one method which is discontinued and immediately followed by an episode of use of another method or b) discontinuation of one method due to "wanting a more effective method," followed by no more than one month of non-contraceptive use before beginning to use a different contraceptive method (regardless of whether it is more or less effective than the original method). Switching is not exclusive of other reasons for discontinuation and is not included in the total discontinuation rate.

COUNTRY INFORMATION

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

COUNTRY	MOST RECENT SURVEY USED IN FPET	SERVICE STATISTICS INCLUDED IN FPET	SOURCE FOR % PREGNANCIES THAT ARE UNINTENDED (USED FOR INDICATOR 5)
Afghanistan	2015 DHS	Yes	2015 DHS
Bangladesh	2014 DHS		2014 DHS
Benin	2014 MICS	Yes	2011-12 DHS
Bhutan	2010 MICS		2010 MICS
Bolivia	2008 DHS		2008 DHS
Burkina Faso	2016 PMA2020 R4		2010 DHS
Burundi	2016-17 pDHS		2010 DHS
Cambodia	2014 DHS		2014 DHS
Cameroon	2014 MICS	Yes	2011 DHS
CAR	2010 MICS		1994-95 DHS
Chad	2014-15 DHS		2014-15 DHS
Comoros	2012 DHS		2012 DHS
Congo	2014-15 MICS		2011-12 DHS
Côte d'Ivoire	2011-12 DHS	Yes	2011-12 DHS
Djibouti	2012 PAPFAM (Djibouti Family Health Survey)		Regional Average
DPR Korea	2010 RHS (Reproductive Health Survey)		Regional Average
DR Congo	2013-14 DHS		2013-14 DHS
Egypt	2014 DHS		2014 DHS
Eritrea	2010 EPHS (Eritrea Population and Health Survey)		2002 DHS
Ethiopia	2016 pDHS/PMA2020 R4		2011 DHS
Gambia	2013 DHS		2013 DHS
Ghana	2016 PMA2020 R5		2015 PMA2020 R4
Guinea	2016 MICS		2012 DHS
Guinea-Bissau	2014 MICS		2014 MICS
Haiti	2012 DHS		2012 DHS
Honduras	2011-12 DHS		2011-12 DHS
India	2015-16 NFHS (National Family Health Survey)		2005-06 DHS
Indonesia	2016 RPJMN		2015 PMA2020
Iraq	2011 MICS		Regional Average
Kenya	2016 PMA2020 R5		2014 DHS
Kyrgyzstan	2014 MICS		2012 DHS
Lao PDR	2011-12 MICS/LSIS (Lao Social Indicator Survey)		2011-12 MICS/DHS
Lesotho	2014 DHS		2014 DHS
Liberia	2013 DHS	Yes	2013 DHS
Madagascar	2012-13 National Survey Monitoring MDGs		2008-09 DHS
Malawi	2015-16 DHS		2016 DHS
Mali	2015 MICS		2012-13 DHS
Mauritania	2015 MICS		2011 MICS
Mongolia	2013 SISS (Social Indicator Sample Survey)		2013-14 MICS
Mozambique	2014 DHS/AIS (AIDS Indicatory Survey)	Yes	2011 DHS
Myanmar	2015-16 DHS		Regional Average
Nepal	2014 MICS	Yes	2014 MICS

COUNTRY	MOST RECENT SURVEY USED IN FPET	SERVICE STATISTICS INCLUDED IN FPET	SOURCE FOR % PREGNANCIES THAT ARE UNINTENDED (USED FOR INDICATOR 5)
Nicaragua	2011-12 National		2006-07 RHS
Niger	2016 PMA2020 R1		2012 DHS
Nigeria	2017 MICS		2013 DHS
Pakistan	2012-13 DHS	Yes	2012-13 DHS
Papua New Guinea	2006 National		Regional Average
Philippines	2013 DHS		2013 DHS
Rwanda	2014-15 DHS	Yes	2014-15 DHS
Sao Tome and Principe	2014 MICS		2014 MICS
Senegal	2015 DHS		2014 DHS
Sierra Leone	2013 DHS	Yes	2013 DHS
Solomon Islands	2006-07 DHS		Regional Average
Somalia	2006 MICS		Regional Average
South Africa	2016 pDHS		2003 DHS
South Sudan	2010 MICS		2010 MICS
Sri Lanka	2006-07 DHS		Regional Average
State of Palestine	2014 MICS		2014 MICS
Sudan	2014 MICS		2014 MICS
Tajikistan	2012 DHS		2012 DHS
Tanzania	2015-16 DHS	Yes	2015-16 DHS
Timor-Leste	2016 pDHS		2009-10 DHS
Togo	2013-14 DHS	Yes	2013-14 DHS
Uganda	2016 pDHS		2015 PMA2020 R4
Uzbekistan	2006 MICS		1996 DHS
Viet Nam	2013-14 MICS		2013-14 MICS
Western Sahara			Regional Average
Yemen	2013 DHS		2013 DHS
Zambia	2013-14 DHS		2013-14 DHS
Zimbabwe	2015-16 DHS	Yes	2015 DHS

MODERN CONTRACEPTIVE PREVALENCE RATE, MCPR (married or in-union women)

Disaggregated from recent survey

	AGE IN 5 YEAR CATEGORIES						
COUNTRY	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Afghanistan	6.0	15.3	18.8	22.6	25.5	25.3	21.5
Bangladesh	46.7	54.5	62.7	64.7	60.6	45.2	25.0
Benin	8.3	9.7	12.2	13.7	15.4	13.8	10.2
Burkina Faso	12.4	25.3	27.7	33.3	24.3	20.8	12.6
Burundi	21.2	26.5	25.0	23.7	23.5	20.1	12.8
Cambodia	20.2	34.4	43.8	47.5	47.4	38.4	18.6
Cameroon	16.4	22.5	23.8	21.1	23.5	18.4	12.2
Chad	2.3	3.5	5.4	7.5	6.6	5.7	2.8
Comoros	13.5	14.3	14.9	14.5	16.8	14.4	5.3
DR Congo	5.4	8.2	6.9	10.3	8.3	7.8	5.1
Egypt	18.9	40.9	53.5	62.8	71.0	69.9	52.3
Ethiopia	28.8	45.7	43.2	36.8	34.9	33.3	21.7
Gambia	2.2	5.7	8.0	10.2	11.5	9.6	6.6
Ghana	23.1	34.4	31.2	31.4	32.7	19.0	15.7
Guinea	2.6	3.9	5.7	6.2	5.4	4.3	2.4
Guinea-Bissau	7.1	10.0	14.2	16.4	20.2	15.6	8.2
Haiti	24.0	34.1	37.2	35.9	31.3	26.6	16.9
Indonesia	51.8	56.8	59.2	64.5	62.8	61.5	46.5
Kenya	34.6	54.6	70.4	70.3	64.5	64.6	42.4
Kyrgyzstan	15.1	27.2	37.5	49.3	53.7	49.6	28.2
Lesotho	35.3	57.4	65.3	66.8	70.1	59.3	39.4
Liberia	13.2	22.5	22.9	22.5	20.3	14.7	6.2
Mali	6.5	10.0	9.5	11.8	11.9	10.5	5.5
Malawi	37.5	54.8	61.6	64.0	64.5	60.1	50.3
Mongolia	27.6	43.9	51.5	54.4	56.4	50.7	26.0
Myanmar	53.2	59.3	57.9	57.1	61.8	46.6	22.3
Nepal	14.5	23.9	37.0	47.5	57.4	58.4	55.5
Niger	6.5	14.2	17.0	18.3	15.0	18.1	6.1
Nigeria	6.4	10.7	16.2	18.9	20.4	18.3	15.8
Pakistan	6.9	14.9	21.0	31.4	36.6	33.3	26.8
Philippines	20.6	34.3	42.2	44.9	42.4	38.6	23.5
Rwanda	32.8	44.3	50.9	51.1	51.0	46.6	29.5
Sao Tome and Pr.	27.6	40.9	42.0	39.8	37.1	38.4	17.7
Senegal	5.5	18.6	22.6	28.7	27.9	28.9	20.8
Sierra Leone	7.8	13.6	15.2	20.1	18.2	16.5	10.5
State of Palestine	10.1	26.6	37.6	49.5	59.0	58.5	44.3
South Africa	36.7	52.9	60.5	57.2	61.1	50.7	38.9
Sudan	5.6	10.5	13.7	12.8	14.1	11.3	6.2
Tanzania	13.3	29.9	35.8	36.3	37.2	32.0	27.6
Tajikistan	1.8	9.5	24.8	37.4	43.9	34.6	17.0
Togo	7.6	15.3	19.3	19.3	18.4	18.5	11.8
Uganda	17.6	29.6	31.7	39.0	42.0	33.4	19.0
Viet Nam	29.4	43.8	56.4	65.4	66.1	61.6	43.4
Yemen	12.1	23.0	32.8	35.6	34.5	30.6	22.9
Zambia	35.8	44.1	48.6	48.7	47.1	44.2	27.5
Zimbabwe	44.9	63.7	68.0	70.2	71.4	66.2	54.1

	RESIDENCE		WEALTH					SURVEY
COUNTRY	URBAN	RURAL	LOWEST	SECOND	MIDDLE	FOURTH	HIGHEST	SOURCE
Afghanistan	29.0	17.0	15.0	16.1	15.7	22.0	30.5	2015 DHS
Bangladesh	56.2	53.2	55.1	54.9	55.8	51.9	53.2	2014 DHS
Benin	15.1	10.4	8.2	9.4	10.8	14.5	19.5	2014 MICS
Burkina Faso	39.2	21.0	20.9	20.9	20.4	33.0	33.0	2016 PMA2020 R3
Burundi	28.5	22.3	22.2	22.5	22.7	20.0	27.6	2016-17 pDHS
Cambodia	32.8	39.9	39.6	42.4	38.3	39.2	34.6	2014 DHS
Cameroon	26.7	16.3	9.1	15.8	24.9	27.0	30.0	2014 MICS
Chad	10.1	3.8	3.8	4.1	4.3	3.1	10.6	2014-15 DHS
Comoros	20.6	11.0	10.9	13.2	14.1	17.8	14.2	2012 DHS
DR Congo	14.6	4.6	3.3	4.7	4.5	11.0	17.2	2013-14 DHS
Egypt	59.5	55.5	54.2	54.3	58.0	58.1	59.3	2014 DHS
Ethiopia	50.0	34.4	27.0	31.6	38.0	40.7	52.4	2016 PMA2020 R4
Gambia	11.8	4.4	4.2	4.8	5.5	10.8	15.1	2013 DHS
Ghana	28.9	29.0	23.2	36.0	32.7	26.3	27.7	2015 PMA2020 R4
Guinea	7.4	3.5	2.9	3.2	4.2	4.8	8.9	2012 DHS
Guinea-Bissau	23.1	9.1	8.3	9.6	10.5	20.8	25.9	2014 MICS
Haiti	31.3	31.2	29.7	29.8	34.8	34.3	27.5	2012 DHS
Indonesia	57.4	61.3	57.0	61.9	63.2	60.0	54.5	2015 PMA2020 R1
Kenya	63.6	61.5	59.7	56.8	65.2	66.6	64.9	2016 PMA2020 R4
Kyrgyzstan	41.4	39.4	40.5	36.0	37.6	43.1	42.9	2014 MICS
Lesotho	65.2	57.3	49.9	56.3	62.3	60.8	65.9	2014 DHS
Liberia	21.6	16.3	13.2	16.5	21.1	24.5	20.7	2013 DHS
Mali	21.8	6.8	3.3	5.0	5.6	12.8	23.3	2012-13 DHS
Malawi	61.4	57.5	53.2	58.0	58.8	59.6	60.6	2015-16 DHS
Mongolia	43.9	55.3	57.8	49.8	47.7	44.8	41.5	2013 MICS (SISS)
Myanmar	57.3	49.1	46.3	50.2	49.8	54.7	55.9	2016 DHS
Nepal	44.2	40.6	41.8	44.8	42.6	41.7	43.0	2016 pDHS
Niger	25.6	12.2	8.6	8.6	10.1	24.4	24.4	2016 PMA2020 R1
Nigeria	21.0	11.8	5.8	12.7	18.6	20.5	23.2	2016 PMA2020 R1
Pakistan	32.0	23.1	18.1	22.9	26.9	30.3	31.6	2012-13 DHS
Philippines	37.8	37.4	32.9	40.3	41.4	39.1	33.9	2013 DHS
Rwanda	51.1	46.7	44.9	45.8	48.1	48.7	50.0	2014-15 DHS
Sao Tome and Pr.	34.8	42.6	35.2	36.8	40.2	39.6	35.2	2014 MICS
Senegal	31.3	17.2	13.4	18.3	26.5	29.3	28.7	2016 DHS
Sierra Leone	24.7	12.3	11.5	11.5	12.1	19.2	26.3	2013 DHS
State of Palestine	43.4	45.2	37.6	43.3	43.0	44.3	52.2	2014 MICS
South Africa	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2016 pDHS
Sudan	19.0	8.7	3.8	4.9	8.8	16.7	24.4	2014 MICS
Tanzania	35.0	30.6	19.2	29.4	36.0	40.2	35.2	2015-16 DHS
Tajikistan	29.0	24.8	23.3	22.7	23.7	25.8	33.3	2012 DHS
Togo	18.8	16.3	15.5	16.7	16.7	16.4	20.8	2013-14 DHS
Uganda	40.8	30.4	24.6	22.2	34.3	36.8	43.2	2016 PMA2020 R4
Viet Nam	54.7	58.0	61.2	58.9	55.7	53.0	56.7	2013-14 MICS
Yemen	40.2	24.0	13.6	21.0	30.5	35.8	42.2	2013 DHS
Zambia	53.4	39.0	31.3	39.3	44.8	49.5	58.3	2013-14 DHS
Zimbabwe	70.6	63.0	61.5	61.3	63.1	68.6	72.3	2015 DHS

PERCENTAGE OF WOMEN WITH AN UNMET NEED FOR ANY METHOD OF CONTRACEPTION

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

	AGE IN 5 YEAR CATEGORIES						
COUNTRY	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Afghanistan	20.9	27.2	29.3	27.5	26.2	18.6	10.4
Bangladesh	17.1	14.7	12.2	11.2	10.2	8.4	7.0
Benin	34.2	37.1	34.4	39.9	33.6	24.9	16.0
Burkina Faso*	28.2	30.2	34.8	33.6	32.3	25.2	20.0
Burundi	14.6	23.7	27.2	33.7	35.1	35.6	23.2
Cambodia	14.9	13.6	11.4	9.7	12.9	13.9	14.5
Cameroon	16.0	15.9	15.7	18.7	18.9	21.4	22.8
Chad	22.5	24.9	24.5	25.0	23.9	21.6	9.7
Comoros	47.4	42.9	30.7	34.6	31.8	20.0	16.4
DR Congo	30.8	29.2	30.4	29.1	27.8	25.0	12.4
Egypt	9.0	11.0	11.9	13.4	12.6	12.5	15.9
Ethiopia*	32.4	24.5	24.9	27.5	28.7	26.0	15.5
Gambia	16.9	23.5	28.2	25.6	26.4	27.8	18.9
Ghana*	48.7	30.5	29.6	27.4	27.6	38.2	23.7
Guinea	23.4	26.8	21.9	26.6	23.6	28.1	12.4
Guinea-Bissau	28.3	23.0	25.6	22.6	20.2	22.9	12.8
Haiti	56.6	41.1	34.9	32.1	35.8	34.7	23.8
Indonesia*	9.2	13.3	13.2	12.0	17.0	19.5	20.0
Kenya	37.4	21.9	14.7	17.6	21.7	18.0	19.8
Kyrgyzstan	19.3	22.0	21.1	19.5	13.5	16.6	20.8
Lesotho	28.9	21.5	17.4	16.3	15.1	19.8	14.1
Liberia	46.6	38.6	33.5	30.2	31.4	27.2	11.4
Mali	23.3	24.5	26.0	30.5	27.7	27.2	16.8
Malawi	22.2	18.4	17.5	19.2	19.0	19.7	15.7
Mongolia	36.4	19.3	16.2	12.0	11.1	15.0	25.5
Myanmar	18.9	13.5	13.6	14.7	13.6	20.6	21.2
Nepal	34.9	32.6	30.0	24.6	17.1	13.6	10.3
Niger*	25.8	23.8	24.7	30.3	29.4	21.3	30.9
Nigeria*	33.8	32.0	31.4	35.5	35.9	33.5	25.0
Pakistan	14.9	20.6	22.1	21.4	21.2	19.7	14.3
Philippines	28.7	22.2	18.2	14.7	16.1	16.8	16.6
Rwanda	3.6	14.8	18.1	21.9	22.0	19.7	13.8
Sao Tome and Pr.	42.2	32.3	36.6	32.5	30.0	26.6	30.6
Senegal	26.4	24.5	23.5	20.8	23.9	25.5	22.6
Sierra Leone	30.8	25.9	25.3	23.3	28.4	24.1	17.3
State of Palestine	12.5	15.3	11.5	10.1	7.4	8.5	11.8
South Africa	23.6	28.4	11.7	15.7	12.2	12.5	12.8
Sudan	24.8	25.0	27.8	30.2	27.5	26.6	18.6
Tanzania	23.0	22.7	23.4	21.0	22.9	24.3	14.8
Tajikistan	12.8	28.2	28.3	26.0	20.1	18.1	12.3
Togo	41.6	39.5	35.3	35.1	35.7	28.3	18.7
Uganda*	42.2	30.4	34.6	37.8	39.0	36.8	29.7
Viet Nam	10.8	11.4	6.2	6.1	3.0	5.7	6.2
Yemen	29.2	29.2	29.9	28.6	31.6	25.8	22.4
Zambia	25.1	22.0	18.9	20.8	23.2	23.0	16.2
Zimbabwe	12.6	10.1	10.0	8.6	11.1	12.3	11.6

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

	RESIDENCE		HOUSEHOLD WEALTH INDEX					SURVEY
COUNTRY	URBAN	RURAL	LOWEST	SECOND	MIDDLE	FOURTH	HIGHEST	SOURCE
Afghanistan	24.2	24.5	26.8	24.8	24.5	24.8	21.3	2015 DHS
Bangladesh	9.6	12.9	13.2	10.8	11.4	13.2	11.3	2014 DHS
Benin	34.1	32.4	31.9	33.8	34.6	35.2	30.2	2014 MICS
Burkina Faso*	24.8	31.8	31.9	31.9	34.4	24.4	24.4	2016 PMA2020 R3
Burundi	23.1	30.5	30.8	30.7	29.6	31.7	25.4	2016-17 pDHS
Cambodia	10.8	12.8	17.0	11.2	13.5	10.8	10.1	2014 DHS
Cameroon	17.5	18.3	20.9	17.1	17.5	18.0	15.9	2014 MICS
Chad	26.1	22.1	23.2	22.6	21.3	21.7	26.4	2014-15 DHS
Comoros	24.3	36.2	42.1	34.1	33.6	28.6	25.0	2012 DHS
DR Congo	28.4	27.3	28.4	26.8	28.3	28.7	26.1	2013-14 DHS
Egypt	11.8	13.0	15.4	15.0	11.1	11.1	11.0	2014 DHS
Ethiopia*	15.8	28.2	32.8	28.9	27.4	23.7	14.4	2016 PMA2020 R4
Gambia	24.4	25.4	24.3	26.7	25.2	24.8	23.5	2013 DHS
Ghana*	28.0	32.5	35.7	32.6	26.2	26.1	26.7	2015 PMA2020 R4
Guinea	25.7	22.9	21.6	21.3	21.9	27.1	27.4	2012 DHS
Guinea-Bissau	22.5	22.2	21.1	24.3	24.3	21.8	19.4	2014 MICS
Haiti	34.1	36.3	35.8	40.5	34.9	35.6	31.0	2012 DHS
Indonesia*	17.8	13.7	15.6	14.6	13.2	15.2	19.7	2015 PMA2020 R1
Kenya	17.8	20.1	19.6	24.1	17.9	14.8	18.4	2016 PMA2020 R4
Kyrgyzstan	17.5	19.8	17.6	20.1	21.9	19.5	16.3	2014 MICS
Lesotho	13.7	20.7	24.5	23.1	17.3	17.0	13.5	2014 DHS
Liberia	29.5	33.0	35.1	32.1	31.9	29.2	26.6	2013 DHS
Mali	23.9	26.5	25.1	25.5	28.3	27.6	23.4	2012-13 DHS
Malawi	16.1	19.2	20.8	19.7	18.6	18.3	16.1	2015-16 DHS
Mongolia	17.2	14.1	14.5	16.1	16.7	15.5	17.2	2013 MICS (SISS)
Myanmar	12.8	17.4	19.9	16.5	16.2	15.5	12.6	2016 DHS
Nepal	22.7	25.4	27.0	23.7	24.3	23.8	20.5	2016 pDHS
Niger*	23.2	27.0	28.0	28.0	26.5	24.7	24.7	2016 PMA2020 R1
Nigeria*	32.1	34.0	38.1	32.8	30.9	32.3	31.1	2016 PMA2020 R1
Pakistan	17.1	21.6	24.5	23.2	19.0	18.8	15.3	2012-13 DHS
Philippines	16.7	18.2	21.3	16.7	15.5	16.1	17.9	2013 DHS
Rwanda	17.3	19.3	22.2	21.3	17.5	17.6	16.1	2014-15 DHS
Sao Tome and Pr.	34.0	30.0	33.6	32.6	31.0	32.3	33.7	2014 MICS
Senegal	19.5	26.6	27.8	26.2	22.3	22.2	19.0	2016 DHS
Sierra Leone	26.1	24.6	23.8	26.2	25.3	24.7	25.0	2013 DHS
State of Palestine	10.8	10.8	11.8	10.3	11.9	11.4	9.0	2014 MICS
South Africa	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2016 pDHS
Sudan	24.4	27.5	n/a	n/a	n/a	n/a	n/a	2014 MICS
Tanzania	19.8	23.2	29.0	24.3	22.8	18.3	16.8	2015-16 DHS
Tajikistan	21.0	23.4	26.8	21.7	22.4	24.2	19.5	2012 DHS
Togo	33.0	34.0	34.8	34.0	33.5	35.8	30.1	2013-14 DHS
Uganda*	26.9	37.0	41.5	44.4	31.9	30.0	28.3	2016 PMA2020 R4
Viet Nam	5.9	6.2	7.4	5.9	6.7	5.6	5.1	2013-14 MICS
Yemen	20.3	32.7	43.1	33.7	28.8	22.4	18.0	2013 DHS
Zambia	16.7	24.1	25.2	25.7	23.3	19.1	12.6	2013-14 DHS
Zimbabwe	9.4	10.9	14.1	11.8	9.0	10.5	6.7	2015 DHS

PERCENTAGE OF WOMEN WHOSE DEMAND IS SATISFIED WITH ANY METHOD OF CONTRACEPTION (married or in-union women) - *Disaggregated from recent survey*

	AGE IN 5 YEAR CATEGORIES						
COUNTRY	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Afghanistan	27.1	39.3	41.6	49.0	52.6	60.5	69.0
Bangladesh	74.9	80.1	84.7	86.8	87.7	87.9	84.4
Benin	24.7	28.8	33.5	31.7	39.4	44.4	48.5
Burkina Faso*	30.5	45.6	44.3	49.8	42.3	45.2	38.8
Burundi	62.4	56.4	52.8	46.7	46.8	42.8	42.9
Cambodia	66.0	77.8	84.4	87.5	83.9	81.1	68.3
Cameroon	60.2	68.2	68.6	65.4	68.4	63.5	52.1
Chad	11.5	14.9	19.3	24.8	23.2	21.8	24.0
Comoros	29.3	30.8	41.0	36.8	39.3	50.1	33.9
DR Congo	28.9	39.9	38.5	46.3	46.1	47.2	53.1
Egypt	69.4	79.4	82.3	82.8	85.2	85.0	77.2
Ethiopia	47.1	65.1	63.5	57.3	54.9	56.1	58.4
Gambia	16.4	21.3	23.0	31.1	31.3	28.6	29.0
Ghana*	28.6	45.3	47.4	48.6	52.1	31.8	39.2
Guinea	10.6	15.6	24.2	21.1	21.9	15.8	19.0
Guinea-Bissau	21.4	33.4	38.3	44.1	52.2	43.2	43.8
Haiti	31.2	46.7	53.1	55.0	49.7	48.6	45.6
Indonesia*	84.9	80.3	81.5	83.4	77.5	75.4	69.6
Kenya	48.0	71.4	82.9	80.1	74.9	78.2	68.1
Kyrgyzstan	47.4	56.8	65.0	72.1	80.9	75.8	58.4
Lesotho	55.0	72.9	79.0	80.4	82.5	75.0	73.9
Liberia	22.1	37.4	42.6	43.0	40.2	38.1	40.2
Mali	22.4	29.6	27.7	28.6	30.9	29.6	26.3
Malawi	63.1	75.1	78.1	77.3	77.8	75.8	76.6
Mongolia	44.4	70.9	77.1	83.1	85.4	80.4	56.4
Myanmar	73.0	81.3	80.1	78.7	80.6	68.1	49.8
Nepal	58.0	64.6	75.9	83.2	85.6	82.9	75.7
Niger	20.2	37.3	40.9	37.6	33.8	45.9	16.4
Nigeria	15.9	25.0	34.1	34.8	36.3	35.4	38.7
Pakistan	41.0	50.9	58.5	66.1	69.3	69.2	70.7
Philippines	56.0	69.7	76.2	80.9	79.2	77.6	70.5
Rwanda	90.7	76.1	75.1	71.5	72.4	74.3	75.1
Sao Tome and Pr.	41.5	56.8	55.1	58.0	58.7	59.8	38.8
Senegal	33.1	44.7	47.2	52.5	54.7	56.6	46.1
Sierra Leone	20.1	35.4	38.5	47.3	40.9	43.0	42.5
State of Palestine	55.5	71.3	82.0	85.7	90.8	89.5	83.4
South Africa	60.9	65.2	84.2	78.7	83.4	80.2	75.2
Sudan	21.9	32.1	36.1	33.1	36.2	32.0	30.6
Tanzania	39.0	60.9	64.0	68.0	65.5	62.4	70.4
Tajikistan	15.6	26.1	48.4	61.1	69.8	67.6	61.2
Togo	16.7	30.6	38.1	37.9	37.4	45.0	41.5
Uganda*	29.4	49.3	47.8	50.8	51.8	47.6	39.0
Viet Nam	78.1	82.9	92.0	93.1	96.7	93.7	91.4
Yemen	31.2	46.5	54.9	58.4	56.2	59.1	56.6
Zambia	59.9	68.0	73.5	71.6	69.2	69.3	67.0
Zimbabwe	78.4	86.5	87.4	89.3	86.8	84.6	82.8

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

	RESIDENCE		HOUSEHOLD WEALTH INDEX					SURVEY
COUNTRY	URBAN	RURAL	LOWEST	SECOND	MIDDLE	FOURTH	HIGHEST	SOURCE
Afghanistan	59.0	43.3	37.0	41.3	41.7	50.9	63.2	2015 DHS
Bangladesh	87.3	82.6	82.6	85.3	84.8	82.0	84.8	2014 DHS
Benin	37.9	32.4	29.3	30.3	32.1	36.6	44.7	2014 MICS
Burkina Faso*	61.3	39.7	39.6	39.6	37.3	57.5	57.5	2016 PMA2020 R3
Burundi	60.8	47.7	45.4	47.0	49.0	45.6	58.3	2016-17 pDHS
Cambodia	84.7	81.4	75.6	83.2	79.9	84.2	86.0	2014 DHS
Cameroon	70.8	60.2	36.5	63.8	70.8	70.9	74.3	2014 MICS
Chad	30.0	16.2	16.3	16.1	18.9	13.9	30.8	2014-15 DHS
Comoros	54.9	28.4	23.5	33.5	36.2	45.3	47.6	2012 DHS
DR Congo	52.2	36.1	31.1	38.1	37.2	43.4	58.1	2013-14 DHS
Egypt	83.8	81.4	78.4	78.8	84.3	84.3	84.8	2014 DHS
Ethiopia	76.0	55.0	45.1	52.2	58.1	63.6	78.5	2016 PMA2020 R4
Gambia	34.8	16.4	16.1	18.0	18.6	32.8	41.2	2013 DHS
Ghana*	46.2	43.9	36.5	49.1	49.2	46.9	46.3	2015 PMA2020 R4
Guinea	25.3	16.0	12.2	18.7	17.5	18.4	27.2	2012 DHS
Guinea-Bissau	53.2	31.3	30.2	30.6	32.2	50.3	60.8	2014 MICS
Haiti	51.0	48.2	47.0	43.7	51.7	51.6	51.6	2012 DHS
Indonesia*	75.7	81.1	77.3	80.3	82.3	79.2	72.8	2015 PMA2020 R1
Kenya	78.3	75.4	75.3	70.2	78.6	81.9	78.0	2016 PMA2020 R4
Kyrgyzstan	71.1	67.6	70.7	65.3	64.1	69.8	73.6	2014 MICS
Lesotho	82.7	73.6	67.3	71.0	78.3	78.3	83.0	2014 DHS
Liberia	44.0	33.7	27.8	34.7	40.4	47.3	46.6	2013 DHS
Mali	48.8	21.1	12.1	17.3	17.5	33.0	50.6	2012-13 DHS
Malawi	79.7	75.3	72.2	75.0	76.3	76.8	79.5	2015-16 DHS
Mongolia	74.9	80.9	80.6	76.8	76.2	77.5	75.1	2013 MICS (SISS)
Myanmar	79.2	73.2	69.3	74.9	74.9	76.8	78.5	2016 DHS
Nepal	77.5	74.5	76.1	77.2	73.9	73.9	80.8	2016 pDHS
Niger	52.5	31.2	23.5	23.5	27.6	49.7	49.7	2016 PMA2020 R1
Nigeria	39.5	35.9	13.3	27.9	37.6	38.8	42.7	2016 PMA2020 R1
Pakistan	72.4	58.8	45.9	56.1	66.8	68.8	75.0	2012-13 DHS
Philippines	77.2	74.7	70.1	77.7	79.3	78.0	73.7	2013 DHS
Rwanda	76.6	73.2	68.6	70.1	75.7	76.2	77.9	2014-15 DHS
Sao Tome and Pr.	52.8	60.4	52.3	54.3	58.0	57.6	54.4	2014 MICS
Senegal	53.7	45.2	43.5	45.7	50.5	53.5	51.1	2016 DHS
Sierra Leone	50.4	34.6	34.4	31.6	33.6	45.3	53.0	2013 DHS
State of Palestine	84.0	84.8	80.7	84.5	82.5	83.6	88.1	2014 MICS
South Africa	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2016 pDHS
Sudan	47.4	26.4	n/a	n/a	n/a	n/a	n/a	2014 MICS
Tanzania	70.0	60.1	43.2	58.0	63.7	71.5	74.4	2015-16 DHS
Tajikistan	60.0	53.3	48.2	53.1	52.9	54.3	64.8	2012 DHS
Togo	40.0	35.3	32.7	35.7	36.4	35.1	44.9	2013-14 DHS
Uganda*	60.3	45.0	37.2	33.3	51.9	55.0	60.4	2016 PMA2020 R4
Viet Nam	92.8	92.4	90.8	92.9	91.9	93.0	93.9	2013-14 MICS
Yemen	70.1	45.2	25.2	41.6	54.0	65.4	73.4	2013 DHS
Zambia	77.2	64.5	60.5	62.8	67.5	73.3	83.1	2013-14 DHS
Zimbabwe	88.3	85.5	81.7	84.1	87.7	86.8	91.6	2015 DHS

APPENDICES

APPENDIX 1

FP2020 STRUCTURE AS OF OCTOBER 2017

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EXPERT ADVISORY COMMUNITY

The EAC comprises a volunteer network of more than 140 technical experts on a range of functional, regional, and country-specific family planning topics who can be mobilized to address specific challenges at the country and global levels.

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APPENDIX 2

FP2020 FOCUS COUNTRIES

EASTERN AND SOUTHERN AFRICA
Burundi
Comoros
Djibouti
Eritrea
Ethiopia
Kenya
Lesotho
Madagascar
Malawi
Mozambique
Rwanda
Somalia
Tanzania
Uganda
Zambia
Zimbabwe

CENTRAL AFRICA
Cameroon
Central African Republic
Chad
Congo
DR Congo
Sao Tome and Principe

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

MIDDLE EAST AND NORTHERN AFRICA
Egypt
Iraq
South Sudan
State of Palestine
Sudan
Western Sahara
Yemen

EASTERN AND CENTRAL ASIA
Kyrgyzstan
Mongolia
DPR Korea
Tajikistan
Uzbekistan

SOUTH ASIA
Afghanistan
Bangladesh
Bhutan
India
Nepal
Pakistan
Sri Lanka

SOUTHEAST ASIA AND OCEANIA
Cambodia
Indonesia
Lao PDR
Myanmar
Papua New Guinea
Philippines
Solomon Islands
Timor-Leste
Vietnam

LATIN AMERICA AND CARIBBEAN
Bolivia
Haiti
Honduras
Nicaragua

APPENDIX 3

COMMITMENT MAKERS AS OF OCTOBER 2017

COMMITMENT-MAKING COUNTRIES

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

COMMITMENT-MAKING DONOR COUNTRIES

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

COMMITMENT-MAKING INSTITUTIONS

CIVIL SOCIETY

- ActionAid
- Advance Family Planning
- Alliance des Jeunes Ambassadeurs pour la Santé de la Reproduction et la Planification Familiale en Afrique de l'Ouest Francophone
- Americares
- Blue Ventures
- CARE International
- CHASE Africa
- Comic Relief
- DKT International
- DSW (Deutsche Stiftung Weltbevoelkerung)
- EngenderHealth
- FHI 360
- Guttmacher Institute
- International Center for Research on Women (ICRW)
- International Planned Parenthood Federation (IPPF)
- International Rescue Committee
- International Youth Alliance for Family Planning
- IntraHealth International
- Ipas
- Jhpiego
- Management Sciences for Health (MSH)
- Margaret Pyke Trust, with the Population & Sustainability Network
- Marie Stopes International (MSI)
- Medicins du Monde
- Nutrition International
- Organization of Africa Youth-Kenya
- PAI
- PATH
- Pathfinder International
- Planned Parenthood Federation of America and Planned Parenthood Global
- Population Council
- Population Reference Bureau
- Population Services International
- Reproductive Health Supplies Coalition (RHSC)/Advocacy and Accountability Working Group (AAWG)
- Rotarian Action Group for Population and Development
- Save the Children
- Tanzania Youth and Adolescent Reproductive Health Coalition
- Uganda Youth and Adolescent Health Forum
- WomanCare Global and PSI

FOUNDATIONS

- Aman Foundation
- Bill & Melinda Gates Foundation
- Bloomberg Philanthropies
- Brush Foundation
- Children's Investment Fund Foundation
- The David and Lucile Packard Foundation
- The International Contraceptive Access Foundation
- The William and Flora Hewlett Foundation
- United Nations Foundation

MULTILATERALS/PARTNERSHIPS

- Norway, Bill & Melinda Gates Foundation, and the United Kingdom
- United Nations Population Fund (UNFPA)
- World Bank
- World Health Organization (WHO)

PRIVATE SECTOR

- Bayer HealthCare
- CARD-MRI
- Cycle Technologies
- Female Health Company
- Lindex
- Merck for Mothers
- Merck (MSD)
- MTV/Viacom
- Mylan
- NST
- Pfizer
- Reckitt Benckiser
- Shanghai Dahua
- Spark Minda
- The Chaudhary Foundation
- Tata Trusts
- Twinings
- Vodafone Foundation

APPENDIX 4

ACRONYMS

ABR	Adolescent birth rate
AU	African Union
AW	All women
BMGF	Bill & Melinda Gates Foundation
CAH	Community Action for Health
CIP	Costed implementation plan
CRS	Creditor Reporting System
CSO	Civil society organization
CYP	Couple-years of protection
DFID	UK Department for International Development
DHS	Demographic and Health Survey
DPM	Data & Performance Management Team
EAC	Expert Advisory Community
EC	Emergency contraception
ECOWAS	Economic Community of West African States
EWEC	*Every Woman Every Child*
FP	Family planning
FP2020	Family Planning 2020
FPET	Family Planning Estimation Tool
GFF	Global Financing Facility
HIP	High Impact Practice
IAWG	Inter-Agency Working Group for Reproductive Health in Crises
IGWG	Interagency Gender Working Group
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KFF	Kaiser Family Foundation
LAC	Latin American and Caribbean region
LAM	Lactational amenorrhea method
LAPM	Long-acting and permanent methods
LARC	Long-acting reversible contraceptives
LMIS	Logistics Management Information Systems
MCPR	Contraceptive Prevalence Rate, Modern Methods
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MII	Method Information Index
MISP	Minimum Initial Service Package
MSI	Marie Stopes International

MW	Married or in-union women
NCIFP	National Composite Index for Family Planning
NFHS-4	National Family Health Survey-4 (India)
NGO	Non-governmental organization
NIDI	Netherlands Interdisciplinary Demographic Institute
ODA	Official Development Assistance
OECD DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
OOP	Out-of-pocket payments
OP	Ouagadougou Partnership
PME WG	Performance Monitoring & Evidence Working Group (FP2020)
PMA2020	Performance Monitoring & Accountability 2020 (Project)
PMNCH	Partnership for Maternal, Newborn & Child Health
PPFP	Postpartum family planning
PPFP/PAFP	Postpartum and post-abortion family planning
PSI	Population Services International
RBFP	Rights-based family planning
RHS	Reproductive Health Survey
RHSC	Reproductive Health Supplies Coalition
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RMNCH+A	Reproductive, Maternal, Newborn, Child, and Adolescent Health (India)
RRM	Rapid Response Mechanism
SBC	Social and behavior change
SDM	Standard days method
SDP	Service delivery point
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STM	Short-term methods
SWEDD	Sahel Women's Empowerment and Demographic Dividend Project
TAG	Technical Advisory Group
UN	United Nations
UNF	United Nations Foundation
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAN	Visibility analytics network
WHO	World Health Organization
WRA	Women of reproductive age

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FAMILY PLANNING 2020

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 Goals 3 and 5. FP2020 is in support of the *Every Woman Every Child* Global Strategy for Women's, Children's and Adolescents' Health.

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