



FP2020

WOMEN AT THE CENTER

2018-2019

Cover photo by Paula Bronstein
The Verbatim Agency/Getty Images



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FP2020 WOMEN AT THE CENTER

2018–2019

Condensed Print Version

THE FP2020 PROGRESS REPORT IS DIGITAL THIS YEAR.

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

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



MORE IN THE DIGITAL REPORT

Full **WOMEN & GIRLS
AT THE CENTER** Section

Full **PARTNERSHIP** Section

Additional graphics and
analyses in the **FINANCE**
Section

Additional graphics
and analyses in the
MEASUREMENT Section

Full **ESTIMATE TABLES**
Section

EXECUTIVE SUMMARY

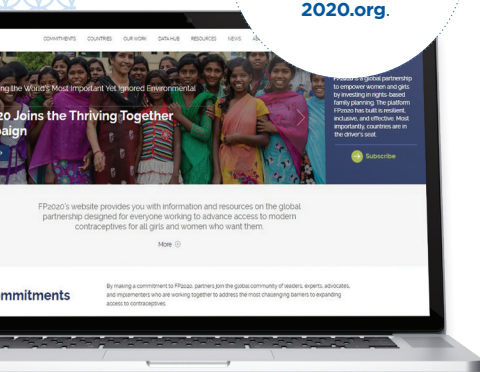
Photo by Clément Tardif
Intrahealth International

The quest for a more peaceful, prosperous, and equitable world is inextricably linked with the rights and dignity of women and girls. Only when women and girls are truly empowered—able to shape their own lives and contribute to society as equals—can we hope to eradicate poverty and unlock the fullness of human potential.

This truth was first acknowledged by the global community at the 1994 International Conference on Population and Development (ICPD) in Cairo, and has remained a touchstone of development ever since.

Family Planning 2020 is one of many initiatives launched in the footsteps of Cairo, and is part of the 25-year arc of progress that has lifted up hundreds of millions of women and girls since 1994. Our focus is on a central and crucial element of the Cairo agenda: ensuring that every woman and girl has the ability to control her own fertility and decide for herself whether and when to get pregnant.¹ This ability is the bedrock of women’s empowerment, and the wellspring of better health and greater life opportunities for women and girls everywhere in the world.

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



¹ References in this report to “girls” in the context of family planning should be understood to mean adolescent girls. Family planning statistics include only older adolescents (aged 15–19). While there are no universally accepted definitions of adolescence and youth, the United Nations understands adolescents to include persons aged 10–19 years and youth as those aged 15–24 years. Together, adolescents and youth are referred to as young people, encompassing the ages of 10–24 years. For statistical purposes, the following age groups are defined: 10–14, 15–19, and 20–24. See UNFPA’s *Adolescent and Youth Demographics: A Brief Overview* (unfpa.org/resources/adolescent-and-youth-demographics-brief-overview).



*The number of users of modern contraception in the 69 FP2020 focus countries has grown by **53 million** since FP2020 was launched, including **9 million** additional users just since last year.*

When FP2020 was launched in 2012, it was with the recognition that the important work of expanding global contraceptive access had stalled, and that a new partnership was needed to jumpstart progress. In the past seven years we have made enormous strides—not only in reaching millions of women and girls with modern contraception, but in strengthening a robust international community of practice that will carry this work forward.

As 2020 approaches and we enter the final year of this initiative, FP2020 partners are continuing to press onward toward our individual and collective 2020 goals. At the same time, the global family planning community is creating a shared vision that will take us past 2020 and onto 2030.

REACHING MORE WOMEN AND GIRLS

The number of users of modern contraception in the 69 FP2020 focus countries has grown by 53 million since FP2020 was launched, including 9 million additional users just since last year. There are now nine countries on track to achieve the FP2020 goals they set for growth in modern contraceptive use, and another 13 countries are within a few percentage points of reaching their goals.

The modern contraceptive prevalence rate (MCPR) across all FP2020 focus countries has risen by a total of more than 2 percentage points since 2012. The sharpest increase has occurred in Eastern and Southern Africa, where MCPR for the region has increased by a total of 7 percentage points since 2012.

In addition to the rise in modern contraceptive prevalence, countries are also seeing a greater number of family planning clients simply due to population growth. There are now 100 million more women of reproductive age (WRA) in FP2020 countries than there were in 2012. Continuing to maintain and expand service capacity will be crucial in the years ahead, as the number of WRA in FP2020 countries is expected to surpass 1 billion before 2025.

FINANCING FOR FAMILY PLANNING

Donor government funding for family planning rose to US\$1.5 billion in 2018, the highest level since FP2020 was launched. Seven donors increased their funding in 2018: Canada, Denmark, Germany, the Netherlands, Norway, the UK, and the US. While the rise in funding from the US is largely due to the timing of disbursements, the other increases reflect the impact of the 2017 Family Planning Summit and renewed commitments from several donors.

Domestic government expenditures accounted for approximately 32% of total expenditures on family planning in 2017. (Domestic expenditure estimates lag behind the bilateral donor reporting by one year, owing to the time required to finalize government accounts and develop estimates). Total expenditures on family planning in 2017 are estimated at approximately US\$3.8 billion, with international donors contributing approximately 45%, domestic governments 32%, consumers 19%, and other domestic sources 4%.

THE FP2020 PARTNERSHIP

The FP2020 partnership continues to expand, with new commitments this year from Angola, the Central African Republic, The Gambia, the Elizabeth Glaser Pediatric AIDS Foundation, and UNAIDS. The total number of commitment makers now stands at 132, including 46 of the 69 FP2020 focus countries.²

Young people are playing an increasingly important role in the partnership. By the end of 2019, youth focal points will have been appointed for every commitment-making country, taking their seats alongside focal points representing the government, donors, and civil society. The *Global Consensus Statement on Meaningful Adolescent & Youth Engagement (MAYE)*, launched by the International Youth Alliance for Family Planning (IYAFFP), the Partnership for Maternal, Newborn and Child Health (PMNCH), FP2020, and partners in late 2018, is now buttressed by a youth-led accountability framework.

Cross-sector collaborations are flourishing: the past year has been marked by an especially close partnership between the family planning and HIV communities, deepening connections with the humanitarian sector, the emergence of a new consensus on family planning and environmental conservation, and growing integration with the maternal health community.

As a follow-up to the FP2020 Secretariat's Accountability Framework published last year, this year's report includes a discussion of civil society-led mutual accountability mechanisms. This is part of the preparatory work for the post-2020 partnership, along with studies commissioned to explore meaningful youth engagement, the role of men and boys, partnership opportunities with faith-based organizations, and the impact of the FP2020 initiative on rights-based family planning programming.³

WOMEN AND GIRLS AT THE CENTER

The family planning community's preparations for the next phase of the FP2020 partnership coincide, fittingly, with the 25th anniversary of the ICPD in Cairo. Progress on family planning is critical to progress on the ICPD agenda, and the convergence of these two global moments offers an opportunity to advance on both fronts.

As we look ahead to our post-2020 framework, the importance of placing women and girls at the center of development—first articulated so clearly in Cairo—remains uppermost. Our challenge is to deepen that commitment and build on it, interrogating our systems and approaches to ensure that our efforts are appropriate and effective.

We began that process this year, consulting the global family planning community on the key themes and principles that should inform our post-2020 collaboration, and will continue over the next year with detailed work on the structure of the partnership. The vision that is emerging calls for integrated services that are accountable to women and girls and responsive to their needs, that advances the gender transformative potential of engaging men and boys as critical partners, that prioritize adolescents and youth, and that leave no one behind. It calls for a framework that is country-led, sustainably financed, inclusive of young people, synced with the shift toward universal health coverage, and aligned with the Sustainable Development Goals.

The full promise of FP2020, and of Cairo, has yet to be realized. But the progress we've made and the lessons we've learned will guide us into the next phase of our collaboration—and of our journey to the future we want.

² South Africa and Angola are included in the number of total commitment makers, but are not counted as focus countries. Their GNI levels did not qualify them as among the world's poorest countries at the time of the London Summit, based on the World Bank 2010 classification using the Atlas Method.

³ See *Family Planning 2020: Rights and Empowerment Principles for Family Planning* (familyplanning2020.org/sites/default/files/FP2020_Statement_of_Principles_11x17_EN_092215.pdf).

THE FP2020 PARTNERSHIP

FP2020 COUNTRIES



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

DONOR GOVERNMENTS



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

FOUNDATIONS



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

CIVIL SOCIETY ORGANIZATIONS



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

MULTILATERAL INSTITUTIONS



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

PRIVATE SECTOR



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

CORE CONVENERS



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

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

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





Photo by Jonathan Torgovnik
Reportage by Getty Images

REACHING MORE WOMEN AND GIRLS

AS OF JULY 2019

314

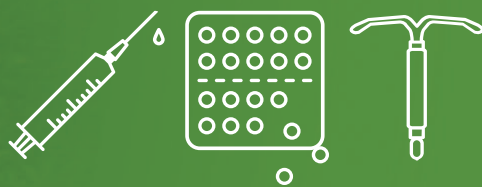
MILLION women and girls are using modern contraception in 69 FP2020 focus countries

+53 

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

AS A RESULT OF MODERN CONTRACEPTIVE USE

from July 2018 to July 2019



119

MILLION unintended pregnancies were prevented

21

MILLION unsafe abortions were averted

134

THOUSAND maternal deaths were averted

IN 2018, DONOR GOVERNMENTS PROVIDED

\$1.5

BILLION USD in bilateral funding for family planning

FROM THE FP2020 REFERENCE GROUP CO-CHAIRS

Photo by
Jenny Matthew
IPPF

FP2020 has a unique position in the global sustainable development architecture.

As a partnership entirely dedicated to family planning, FP2020 carries the flag for one of the most critical items on the global health agenda.

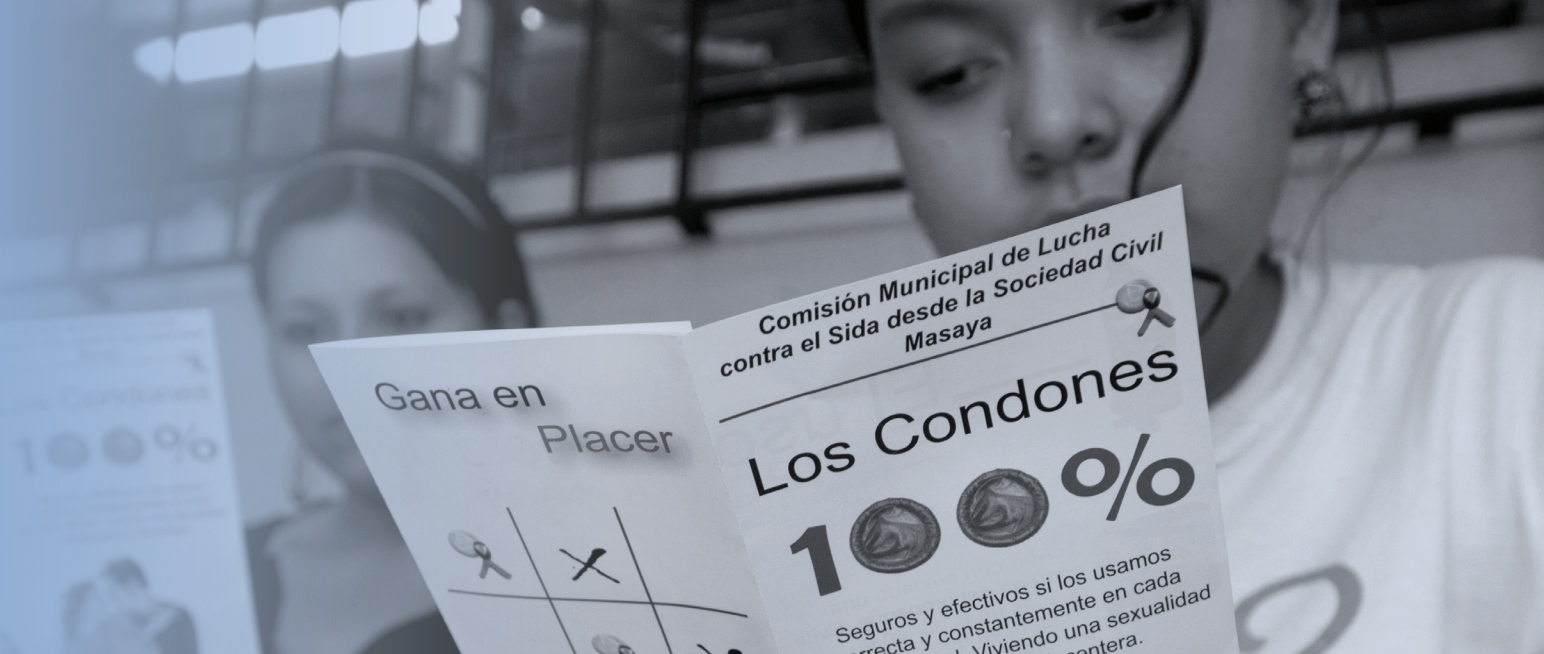
Family planning is essential for women's health, rights, and empowerment. There can be no sustainable development without the participation of women and girls, and family planning is essential for enabling their participation.

Equally unique is the role FP2020 plays in the family planning field. Its singular platform encourages and facilitates country commitments to deliver rights-based family planning. In doing so, it aligns the efforts of civil society organizations, bilateral donors, multilateral partners, private foundations, and grassroots activists to support the full realization of those national commitments.

The strength of this partnership is what made it possible to accelerate progress on family planning over the past seven years. The global goal set in 2012 for this initiative—to reach 120 million additional users of contraception—was extremely ambitious, and will not be achieved by 2020 despite concerted efforts by a wide array of stakeholders. But we *have* bent the curve significantly, with gains that are nearly 30 percent above the historic trend line. It is worth noting that several countries within the partnership have already achieved or are on track to achieve the national goals they set in their FP2020 commitments.

At the same time, we have made tremendous advances in our understanding of how to do this work most effectively, globally and in countries. We have learned important lessons about how to align our efforts and pool our resources, collect and use data, grapple with political and social challenges, build mechanisms for accountability and transparency, establish sustainable financing streams, and strengthen rights-based approaches in our programming.

The time has now come to take stock of what we have learned and redefine the best way to accelerate progress over the next decade. Indeed, we have spent the past year engaged in the first step of that process: a wide-ranging global consultation



The time has now come to take stock of what we have learned and redefine the best way to accelerate progress over the next decade.

to develop a community-led vision for the next iteration of this partnership. The findings were used to craft an emerging vision statement that will be presented in full at the Nairobi Summit on ICPD25. We hope this shared vision will galvanize the family planning sector, sustain the momentum we have generated, and propel us forward to 2030 and the Sustainable Development Goals.

The global consultation process reaffirmed that this partnership has strengthened the ability of the family planning community to deliver for women, but it also pointed to new opportunities and blind spots. The lessons we have learned over the course of this partnership will inform its next phase.

Over the next year, we will work with key partners and constituencies to determine what structures and capacities need to be in place to enhance and deepen support to countries. FP2020 Focal Point Workshops in Africa and Asia will be important platforms to discuss and review the post-2020 framework. Reference Group meetings in spring and fall of next year will also be critical inflection points.

We look forward to our continued collaboration to support country-led efforts to operationalize family planning commitments within a strong universal health coverage framework. By the end of 2020, we expect to start the transition to new or enhanced structures to support the next phase of this partnership.

None of this would be possible without the deep engagement of family planning partners and stakeholders all across the globe. That is the strength of FP2020. Thank you for your steadfast commitment to tackling tough issues, standing tall in the face of adversity, defending the rights of women and girls at a time when it is most needed, and challenging one another to build a more equitable and prosperous future for all.

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

Dr. Natalia Kanem
Executive Director
UNFPA

FROM FP2020'S

EXECUTIVE DIRECTOR

Photo by
Paula Bronstein
*The Verbatim Agency/
Getty Images*

Behind every uptick in FP2020 metrics are the real lives of women and girls: their struggles, their needs, their hopes, their plans. As we look ahead to the post-2020 framework, we'll be drawing on the lessons we've learned over the past seven years of this initiative.

We're starting in a very different place than when we first launched in 2012, with a wealth of experience in what works, what's important, and why.

Our collective understanding of what *progress* means in family planning has deepened, and with it our sensitivity to the different goals that can be set and the various outcomes that can be measured. Raising the modern contraceptive prevalence rate is one indicator of success, but so is reducing inequity, increasing the number of skilled providers, eliminating stock-outs, and moving the needle on social norms. Those are all critical elements that contribute to an environment in which everyone—women, men, adolescents, and young people, no matter where they live or who they are—can make an informed decision about family planning.

Over the years we've also expanded our understanding of how the family planning agenda embraces a multitude of concerns—human rights, development of adolescents and youth, male engagement—and is in turn linked with a broader array of issues: reproductive health care and HIV/AIDS, humanitarian action, environmental conservation, sustainable development and economic growth, and more.

Those lessons will be reflected in the post-2020 framework as well. The FP2020 Secretariat has commissioned a series of assessments by external experts on key



After five years with FP2020, I'm confident about the future. I know that this community's commitment to women and girls is unwavering.

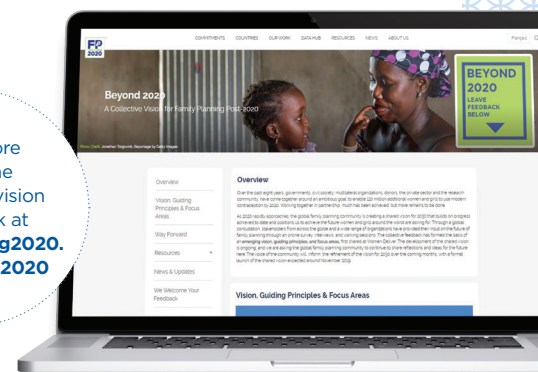
themes that will be crucial going forward: rights-based family planning, meaningful youth engagement, the role of men and boys, civil society-led accountability, and faith-based partnerships. Those papers are highlighted in this report and will be available on the FP2020 website.

After five years with FP2020, I'm confident about the future. I know that this community's commitment to women and girls is unwavering. I know its fierce insistence on human rights, its dedication to facts and evidence, its constant striving to do better and be better.

We're going to build the next partnership using what we've learned from *this* partnership. Together, we can create a world where every woman and girl has the chance to grow, thrive, and plan the family she wants.

Beth Schlachter
Executive Director
Family Planning 2020

Learn more about the post-2020 vision framework at familyplanning2020.org/Beyond2020



SECTION 01

WOMEN & GIRLS AT THE CENTER

Photo by
Paula Bronstein
The Verbatim Agency/
Getty Images

A quarter of a century ago, the world of development changed.

At the 1994 International Conference on Population and Development (ICPD) in Cairo, the international community agreed on a new approach, one that would be grounded in human rights.

Adopted by 179 governments, the ICPD Programme of Action asserted that “the true focus of development policy must be the improvement of individual lives.”⁴ It called for a shift away from demographic targets, instead outlining an agenda that emphasized the needs, aspirations, and rights of individuals.

Crucially, the Programme of Action asserted that women’s health and empowerment must be at the center of development. Governments recognized that empowering women and girls is both the right thing to do and the most reliable pathway to achieving social and economic growth.

The Programme of Action defined sexual and reproductive health and reproductive rights for the first time in an international policy document, and identified *women’s ability to control their own fertility*⁵ as a cornerstone of development.

The consensus achieved at the ICPD has endured. Cairo changed how countries, donors, and NGOs think about the health and rights of women and girls, about family planning, and about development. The importance of women’s empowerment and equality, and of providing family planning in the context of the broader reproductive health and rights agenda, is widely acknowledged.

Yet despite tremendous progress, the Programme of Action remains unfinished business. Twenty-five years after Cairo, women are still fighting for their rights. Women’s health care is still inadequate in too many places, and underfunded everywhere in the world. Approximately 230 million women and girls in developing regions still have an unmet need for family planning.⁶

⁴ United Nations Population Fund (UNFPA). Programme of Action of the International Conference on Population and Development, Twentieth Anniversary Edition. New York: UNFPA, 2014.

⁵ United Nations Population Fund (UNFPA). Programme of Action of the International Conference on Population and Development. New York: UNFPA, 1994.

⁶ According to the UN Population Division 2019 estimate, 230 million women in developing regions report that they do not want to become pregnant but are not using a modern method of contraception.



FP2020 AND RIGHTS-BASED FAMILY PLANNING

The rights and ethical principles outlined in the ICPD Programme of Action have been confirmed and codified in international agreements since Cairo and formalized in frameworks from the World Health Organization and FP2020, among others. These international norms serve as a bulwark for women and family planning champions all over the world.

See FP2020's Rights and Empowerment Principles for Family Planning.

FROM CAIRO TO NAIROBI

As we commemorate the anniversary of the ICPD and renew our commitment to its agenda, we're also looking ahead to the Sustainable Development Goals and family planning's post-2020 framework. How do we go forward? How can we help deliver a world where women and girls are healthy, empowered, and free to shape their own lives?

If Cairo put a woman's face on development, perhaps now is the time to take that a step further. What does development look like through a woman's eyes?

What would it mean for systems to be structured around the needs of women and adolescent girls? What does health care look like from their perspective? What happens when women and young people themselves are the architects of those systems?

One answer that is bubbling up across sectors and institutions is *integration*. Integrated services, integrated care.

This is not a new idea. We know that when health system development is driven primarily by donors, it tends to become fragmented. One funding stream for HIV, another funding stream for family planning, another for maternal health. But no woman *just* has HIV, or *just* needs family planning, or *just* needs maternal care. There is only the one woman with many needs.

Only the one woman: one woman who ages from childhood to adolescence, maturity, menopause, and elderhood. One woman who needs to protect herself from HIV and STIs; who needs the ability to plan the pregnancies she wants and prevent the ones she doesn't; who needs antenatal and maternal and postpartum care; who needs cancer screenings and other preventive services; who needs to have her basic health care needs met in *one* place.

The challenge for countries and their partners is to transcend the artificial distinctions imposed by vertical funding and embrace a woman-centered, whole-woman approach—an approach that goes beyond traditional measurements of service delivery and instead is accountable to the women and girls it seeks to serve. This also requires, crucially, that women themselves—including adolescents and young women—be the drivers and shapers of programs and policies.



Photo by Onyinye Edeh
FP2020



WOMEN AND GIRLS

The path to healthy, empowered womanhood begins in girlhood. The ICPD Programme of Action recognized that women and girls face persistent inequities that must be addressed beginning at birth. The Cairo agenda calls for eliminating harmful practices such as child marriage and female genital mutilation, ensuring that girls can go to school, and providing them with the reproductive health information and services they need. Unmet need for family planning is especially high among adolescent girls, a quarter of whom are already married.⁷ Meeting the needs of women *and* girls is essential for global development and central to FP2020's aims.

MEN AND BOYS

Gender equality cannot be achieved without the involvement of men and boys. The ICPD Programme of Action emphasized men's shared responsibility to promote sexual and reproductive health and to support the empowerment of women and girls. Meeting the sexual and reproductive health needs of men and boys and engaging them as partners in family planning is critical for cultivating healthy norms and behaviors that will lead to better health outcomes and lasting social change.

⁷ United Nations Population Fund (UNFPA). *Facing the Facts: adolescent girls and contraception*. New York: UNFPA, 2016.

ECHO: A CALL TO ACTION

The urgent need for greater integration in health care for women and girls was thrown into sharp relief this year by the Evidence for Contraceptive Options in HIV Outcomes (ECHO) trial, a landmark study on a public health issue of critical importance.

ECHO was a randomized clinical trial to determine if there were any significant differences in the risk of HIV acquisition among women using one of three popular contraceptive methods: intramuscular injectable DMPA (the predominant contraceptive in many African countries where HIV is common), the levonorgestrel implant, and the copper IUD.

“A key question about DMPA has been answered but that does not mean the method can continue to dominate women’s contraceptive programs in East and Southern Africa. We don’t believe that DMPA should continue to be the only method available for too many black and brown women who want choices, dislike side effects, and deserve equity with high quality contraceptive programs in high income countries.”

— HC/HIV Civil Society Advocacy Working Group
Call to Action on World Contraception Day,
September 26, 2019



Photo by Jonathan Torgovnik, Reportage by Getty Images

The study was conducted in four African countries—Eswatini, Kenya, South Africa, and Zambia—and women in civil society played an active role in advising and preparing for the study results, announced in June 2019.

Importantly, the study found no significant difference in the risk of HIV infection between the three methods. All three contraceptives were confirmed as safe. What was alarming was that despite receiving the highest standard of care available, almost 4% of women in the study acquired HIV—the same acquisition rate as that of sexually active women in the same region who were *not* part of the study.

It’s abundantly clear that we must do a better job of meeting the needs of women and girls for HIV prevention as well as contraception. The family planning and HIV communities are already converging on a set of critical “asks” going forward—for a wider range of contraceptive methods, integrated services (for family planning, HIV, STIs, and cervical cancer) at the clinic level, support from donors for flexible funding, and a central role for women and girls in creating programs and policies.

We can’t go back to business as usual. Women and girls are counting on this moment to change how we work, and we can’t fail them. Country leaders, policy makers, donors, and civil society must insist on new partnerships and approaches to deliver the integrated, comprehensive health care that is so urgently needed.

REACHING ADOLESCENTS & YOUTH

A holistic, person-centered approach will be especially critical for meeting the needs of adolescent girls and young women.

Adolescents aged 10–19 are the only age group in which AIDS-related deaths are not decreasing.⁸ Globally, young women are twice as likely to acquire HIV as young men.⁹ In sub-Saharan Africa, adolescent girls and young women aged 15–24 accounted for one in five new HIV infections in 2017, despite being just 10% of the population.¹⁰

Unmet need for *contraception* (the more relevant term for adolescents, who typically don't identify with “family planning”) is more than twice as high among adolescent girls aged 15–19 than it is among all women of reproductive age (15–49), and roughly half of adolescent pregnancies are unintended.¹¹ Unprotected sex and unintended pregnancy lead to millions of girls resorting to unsafe abortions every year. Globally, complications during pregnancy and childbirth are the leading cause of death for girls aged 15–19.¹²

These statistics underscore the importance of seeing adolescents and youth as whole persons with complex lives in need of a wide range of different services and information. Health care for young people must be accessible, relevant, and responsive to their needs. Service providers must be well trained and respectful of young people's rights. And young people themselves must be enlisted as leaders and decision makers in designing adolescent and youth programs.

A holistic, person-centered approach will be especially critical for meeting the needs of adolescent girls and young women.



Photo by Peculiar Kargbo

⁸ Joint United Nations Programme on HIV and AIDS (UNAIDS). Ending the AIDS epidemic for adolescents, with adolescents. Geneva: UNAIDS, 2016.

⁹ Joint United Nations Programme on HIV and AIDS (UNAIDS). Women and Girls and HIV. Geneva: UNAIDS, 2018.

¹⁰ Joint United Nations Programme on HIV and AIDS (UNAIDS). Women and HIV: A Spotlight on Adolescent Girls and Young Women. Geneva: UNAIDS, 2019.

¹¹ Guttmacher Institute. Adding it up: costs and benefits of meeting the contraceptive needs of adolescents in developing regions, Fact Sheet. New York: Guttmacher Institute, 2018.

¹² World Health Organization (WHO). Adolescent pregnancy, Fact Sheet. Geneva: WHO, 2018.

LEAVING NO ONE BEHIND

The same is true for those who have been marginalized or displaced. Putting women and girls at the center means *all* women and girls, including those with disabilities, LGBTI and other vulnerable populations, and the millions of individuals living in humanitarian and fragile contexts.

Women and girls with disabilities are four times more likely to experience sexual violence than their non-disabled peers,¹³ yet are routinely denied access to reproductive health care and sexuality education. They are also frequently subjected to the grossest of human rights violations, including involuntary sterilization and forced abortion.

LGBTI individuals face steep barriers to accessing reproductive health care: social stigma, discrimination (often legal), and provider bias are widespread problems. LGBTI youth experience higher rates of unintended pregnancy than their exclusively heterosexual peers, are subjected to higher rates of sexual violence, and are at greater risk for STIs.^{14, 15} And LGBTI individuals and couples are broadly excluded from accessing basic family planning information, services, and commodities.



Photo by Activists Alliance Foundation Pakistan

Other populations are marginalized by poverty, social exclusion, and geographical isolation. These can produce deep inequities in a country's family planning program, with more privileged individuals having access to services while others are barred or ignored. What is essential in all cases is to identify the particular context of each group, involve them directly in shaping the policies and programs that will affect them, and commit to delivering high-quality, integrated services that genuinely meet their needs.

WOMEN AND GIRLS IN HUMANITARIAN SETTINGS

The number of refugees and displaced persons is now at an all-time high. At the end of 2018, more than 70 million people worldwide were forcibly displaced as a result of persecution, conflict, violence, or human rights violations.¹⁶ Displacements are also lasting longer than ever, with more and more people trapped in protracted situations with no prospect of returning home.

These trends show no signs of reversing. This is the reality we face: a world where tens of millions of women and girls are living in refugee camps or temporary shelters for years at a time. Development and humanitarian actors must find new methods of working together to ensure that their reproductive health care needs are met.

One way to do that is to put more power and resources in the hands of women and girls themselves. Women who work in health care are often among those displaced, and can play a key role in designing, implementing, and monitoring the humanitarian response that is meant to reach their communities. They know how critical it is to have access to reproductive health care, including family planning, and they are most knowledgeable about the cultural context.

Women and girls can also bring a holistic and transformative perspective to humanitarian action. They are alive to the deep-rooted challenges in their communities—including gender inequity and gender-based violence—and see how to bridge humanitarian response with longer-term development and peacebuilding efforts.

¹³ United Nations Human Rights Council. Thematic study on the issue of violence against women and girls and disability: Report of the Office of the United Nations High Commissioner for Human Rights. 30 March 2012.

¹⁴ Stoffel, Cynthia, and Emma Carpenter, Bethany Everett, Jenny Higgins, Sadia Haide. "Family Planning for Sexual Minority Women." *Seminars in Reproductive Medicine* Vol. 35,5 (2017): 460-468. DOI:10.1055/s-0037-1604456.

¹⁵ Hafeez, Hudaisa, and Muhammad Zeshan, Muhammad A. Tahir, Nusrat Jahan, Sadiq Naveed. "Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review." *Cureus* Vol. 9,4 e1184. 20 Apr. 2017, DOI:10.7759/cureus.1184

¹⁶ United Nations High Commissioner for Refugees (UNHCR). *Global Trends: Forced Displacement in 2018*. Geneva: UNHCR, 2019.

“Primary health care is the arrowhead for transforming health systems to achieve the desired progress through high-impact, often neglected, services such as sexual and reproductive health and rights and nutrition. It lays a strong foundation for countries to achieve UHC in an equitable, and progressive, way.”

— Dr. Muhammad Pate,
Director of the Global
Financing Facility



Photo by Carly Learson, UNFPA Bangladesh

HEALTH FOR ALL

The most promising policy platform for achieving all these ambitions is universal health coverage (UHC). Countries that develop UHC frameworks have an unparalleled opportunity to construct health systems with the capacity to serve all of their citizens—including the poorest and most marginalized—and the resilience to withstand shocks and stresses.

At the UN High Level Meeting on Universal Health Coverage in September 2019, governments adopted the world’s first-ever Political Declaration on UHC, pledging to “accelerate efforts toward the achievement of universal health coverage by 2030 to ensure healthy lives and promote well-being for all throughout the life course.” The Political Declaration also includes a commitment to “ensure, by 2030, universal access to sexual and reproductive health-care services, including for family planning, information, and education.”¹⁷

The fact is that health for all will be impossible unless we prioritize the needs of women and girls. What was true in Cairo is true today: the health and empowerment of women and girls is crucial for social and economic progress. Closing the gap on sexual and reproductive health is absolutely critical.

The key will be to ensure that UHC is built on a foundation of primary health care, and that primary health care includes a strong focus on sexual and reproductive health and family planning.

The family planning community has an important role to play in framing the discussion. Together with our partners in other sectors, we can strengthen universality in health care by directing UHC toward community-based, high-quality, client-centered services.

Above all, we must ensure that the central focus remains, as in Cairo, on the individual woman or girl: her rights, her needs, her continuum of care.

¹⁷ United Nations General Assembly. Political Declaration on Universal Health Coverage. 23 September 2019.



NEW COMMITMENTS

Angola, the Central African Republic, The Gambia, the Elizabeth Glaser Pediatric AIDS Foundation, and UNAIDS join the FP2020 partnership.

Photo by UNFPA The Gambia

President Adama Barrow of The Gambia shakes hands with UNFPA Executive Director Dr. Natalia Kanem after making The Gambia's commitment to FP2020.

PARTNER PROGRESS NOTES

Partners are launching new initiatives, expanding their existing programs, and contributing additional resources and fresh momentum.

Photo by CJ Clark, Save the Children



SECTION 02

PARTNERSHIP

As 2020 rapidly approaches, the FP2020 community is moving forward with greater momentum than ever. The past year has been one of continued progress on our existing 2020 commitments along with intense planning for what comes *after* 2020.

It has also been a year bracketed by major global moments for the family planning community. We launched last year's progress report at the 2018 International Conference on Family Planning in Kigali, and we're launching this one at the ICPD+25 Conference in Nairobi.

COUNTRY PROGRESS NOTES

Countries are rolling out new contraceptive methods, training family planning providers, and implementing new policies and programs to expand access to contraception.

Photo by Em Chadband, FP2020



YOUTH UPDATE

Youth Focal Points from each commitment country made their debut at the workshop in Ethiopia, taking their place alongside government, donor, and civil society focal points.

Photo by Em Chadband, FP2020



POPULATION, HEALTH, AND ENVIRONMENT

The Thriving Together campaign represents a new consensus on family planning and environmental conservation, with more than 150 organizations around the world lending support.

Photo by Garth Cripps,
Blue Ventures



ANGLOPHONE AFRICA REGIONAL FOCAL POINT WORKSHOP

In May we gathered in Ethiopia for the largest regional focal point workshop yet, with an agenda designed by the focal points themselves and deep dives on faith, financing, and young people.

Photo by Em Chadband, *FP2020*

The FP2020 partnership is continuing to expand, with five new commitment makers in 2019. We've strengthened our focal point system immeasurably with the addition of youth focal points in every commitment-making country, and in May hosted our largest regional focal point workshop yet.

FP2020 countries and partners are continuing to deliver on their commitments: providing more services, investing more resources, reaching more women and girls. And our collaborations with the HIV/AIDS sector, humanitarian partners, the environmental movement, and the maternal health community are flourishing.

➤ Our digital report features updates and progress notes, details on new commitments, interviews with youth and civil society leaders, and highlights from the past year—including Women Deliver 2019.

MATERNAL HEALTH

The partnership between the family planning and midwifery communities is growing, with midwives ideally positioned to provide family planning in the context of maternal, newborn, and child health.

Photo by Alison Gatto, *FP2020*



HIV/AIDS

Family planning and HIV partners joined forces this year to prepare for the ECHO trial results—and will continue to collaborate in calling for better integration of services.

Photo by AVAC

LOOKING TO THE FUTURE

“Meaningful adolescent and youth engagement is an inclusive, intentional, mutually-respectful partnership between adolescents, youth, and adults whereby power is shared, respective contributions are valued, and young people’s ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms, and organizations that affect their lives and their communities, countries, and world.”

— Global Consensus Statement on Meaningful Adolescent & Youth Engagement

The next phase of this partnership will be built on the foundations we’ve laid and the lessons we’ve learned over the past seven years. It will also be informed by ongoing consultations and research in the family planning community to ensure that our post-2020 framework is inclusive, effective, and transformative.

FOCUS ON ADOLESCENTS AND YOUTH: MEANINGFUL ENGAGEMENT

Young people are at the heart of the FP2020 agenda. FP2020 is committed to improving the ability of adolescents and youth¹⁸ to embrace healthy behaviors, including the use of contraception, and is equally committed to engaging those young people as full partners in this work and as co-creators of policies and programs.

“Meaningful engagement” is a key concept in adolescent and youth development, and will be a guiding principle for the post-2020 partnership. But what exactly does it mean? To help answer that question, FP2020 joined with IYAFP, PMNCH, and more than 30 youth-led and youth-serving organizations to develop the **Global Consensus Statement on Meaningful Adolescent & Youth Engagement (MAYE)**, launched at the 2018 International Conference on Family Planning. The statement defines “meaningful engagement” and outlines the key principles that should govern engagement with young people.

To date more than 200 NGOs, donors, multilateral agencies, and government ministries have signed the statement, and a group of youth-led organizations have developed an accountability framework to monitor it. The MAYE Accountability Framework was launched in August 2019 in concert with International Youth Day, and will feature three main components: a reporting process, an experience and knowledge sharing platform, and an organizational assessment process. A steering committee supported by IYAFP will oversee the reporting process.

As part of the process of shaping the post-2020 framework, FP2020 commissioned Restless Development, an international youth-led NGO, to conduct an external assessment of how well the partnership has lived up to its goals for meaningful adolescent and youth engagement. An executive summary of the report is available on the FP2020 website: *Walking the Talk: FP2020’s Approaches to Meaningful Youth Engagement*.

➤ **What does it mean to share power across generations? The digital report features a dual interview with Alvaro Bermejo, Director General of the International Planned Parenthood Federation (IPPF), and Alice Ackermann, the youngest member of the IPPF Executive Committee.**

¹⁸ References in this report to “girls” in the context of family planning should be understood to mean adolescent girls. Family planning statistics include only older adolescents (aged 15–19). While there are no universally accepted definitions of adolescence and youth, the United Nations understands adolescents to include persons aged 10–19 years and youth as those aged 15–24 years. Together, adolescents and youth are referred to as young people, encompassing the ages of 10–24 years. For statistical purposes, the following age groups are defined: 10–14, 15–19, and 20–24. See UNFPA’s Adolescent and Youth Demographics: A Brief Overview.

In the FP2020 view, accountability is best understood as an opportunity for cooperation and collaboration.

FOCUS ON ACCOUNTABILITY: THE ROLE OF CIVIL SOCIETY

In the FP2020 view, accountability is best understood as an opportunity for cooperation and collaboration. The concept of accountability implies much more than just tracking results; it is fundamentally about dialogue and shared responsibility between commitment makers and their stakeholders and constituents. A well-constructed accountability mechanism can function as a highly productive joint endeavor, enabling governments and other commitment makers to achieve their goals and serve their constituents in the most effective way possible.

Civil society organizations (CSOs) are ideally situated to partner with governments in this type of mutual accountability relationship. CSO-led accountability mechanisms create a platform for citizens to help shape the commitments that are made and how they are structured, to participate directly in the implementation of programs, to monitor progress in real time, and to insist that their needs be met and their rights upheld. It's a vital pathway to inclusion, participation, and transparency.

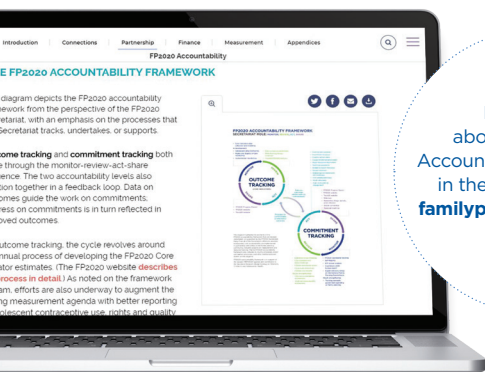
Building on the FP2020 Secretariat's Accountability Framework published in last year's report, FP2020 is developing a robust accountability framework for the post-2020 partnership. As the first step in this process, FP2020 commissioned a landscape assessment of civil society-led accountability mechanisms currently in use. The assessment will be available in 2020.

➤ **The Motion Tracker is a CSO-led accountability mechanism being used in several FP2020 countries. The digital report includes interviews with civil society leaders in Indonesia and Zambia who are implementing the tool.**

RIGHTS, GENDER, AND FAITH

FP2020 has commissioned or collaborated on additional papers exploring key themes and focus areas for the post-2020 framework, all of which are available on the FP2020 website:

- **Rights-Based Family Planning:** *Contributions of FP2020 in Advancing Rights-Based Family Planning: Upholding and Advancing the Promise of Cairo* is an assessment of FP2020's impact on rights-based programming for family planning.
- **Men and Boys:** FP2020 collaborated with Promundo on a review of current male engagement efforts in family planning: *Long Way to Go: An Analysis of the Proposed Engagement of Men and Boys in Thirteen Country Implementation and Action Plans.*
- **Faith Community:** FP2020 teamed up with World Vision and Faith To Action to explore the potential for faith-based partnerships: *Engaging the Faith Community in Family Planning: An Informative Brief to Drive Collaboration and Progress for FP2020.*



Learn more about the FP2020 Accountability Framework in the digital report at familyplanning2020.org/progress

SECTION 03

FINANCE



MORE IN THE DIGITAL REPORT

[Link to Countdown 2030 Europe analysis](#)

[FP2020 country financial commitments: tracking progress](#)

[Interactive graphics and additional charts on bilateral funding, including US](#)

Unlocking resources and cultivating sustainable revenue streams for family planning is a core element of the FP2020 agenda, and will continue to be a central concern for the post-2020 partnership.

But the financial landscape for family planning has evolved considerably since FP2020 was launched in 2012. While donor funding remains critically important, an increasing number of countries are seeking domestic resources to fund their family planning programs. The creation of the Global Financing Facility has introduced an important new mechanism for funding reproductive health programs, including family planning. Perhaps most significant is the growing global momentum toward UHC, with the potential to shift resources away from vertical funding models toward a broader investment in health systems and integrated service delivery.

Family planning programs in FP2020 countries are currently funded by a wide range of sources, from development aid furnished by international donors to out-of-pocket purchases made by ordinary citizens. For the past seven years we have reported annually on bilateral donor funding for family planning. Last year we began reporting on domestic government expenditures with data from 31 countries, and we will report estimates for at least that many countries again this year. (Data are still being reviewed and confirmed at press time.) We have also continued to improve our understanding of total expenditures on family planning, including out-of-pocket spending by consumers. These analyses provide important clarity on resource flows and constraints for family planning, and will help inform financing strategies for the post-2020 agenda.



Photo Courtesy of
Jonathan Torgovnik
Reportage by Getty
Images

*Bilateral donor
funding in 2018
reached **US\$1.5
billion**, the highest
level since the
London Summit
in 2012*

- **Bilateral donor funding** in 2018 reached US\$1.5 billion, the highest level since the London Summit in 2012. Seven donors increased their funding in 2018: Canada, Denmark, Germany, the Netherlands, Norway, the UK, and the US. While the rise in funding from the US is largely due to the timing of disbursements (allocations for family planning from the US having remained essentially flat), the other increases reflect the impact of the 2017 Family Planning Summit and renewed commitments from several donors.
- **Domestic government expenditures** accounted for approximately 32% of total expenditures on family planning in 2017. (Note that the domestic expenditure estimates lag behind the bilateral donor reporting by one year, owing to the time required to finalize government accounts and develop estimates).
- **Total expenditures** on family planning in 2017 are estimated at approximately US\$3.8 billion. (The estimate is for 2017 because of the one-year lag in domestic expenditures.) International donors contributed approximately 45%, domestic governments 32%, consumers 19%, and other domestic sources 4%.

The digital report features a link to analysis from Countdown 2030 Europe on trends and developments among European donors, as well as a review of the progress FP2020 countries have made in the past year in delivering on their financial commitments. The digital report also includes additional graphics, tables, and detailed notes on methodology and sources.

Learn more about
expenditures on
family planning in
specific FP2020
countries in the
digital report at
[familyplanning2020.org/
progress](http://familyplanning2020.org/progress)



DONOR GOVERNMENT FUNDING FOR FAMILY PLANNING IN 2018: KAISER FAMILY FOUNDATION ANALYSIS

The Kaiser Family Foundation (KFF) began conducting an annual analysis of donor government funding for family planning activities following the London Summit on Family Planning in 2012. This established a baseline for tracking funding levels over time and assessing donor government progress in meeting FP2020 commitments, including new and renewed commitments made at the 2017 Family Planning Summit. Donor governments account for almost 50% of total funding for family planning in low and middle income countries. With 2020 fast approaching, tracking donor government funding will continue to provide important insights into resource availability, trends over time, and potential gaps.

The findings presented below are based on analysis of data from 30 donor governments that were members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) in 2018 and had reported Official Development Assistance (ODA) to the DAC. Data were collected directly from 10 of these governments, which account for 99% of all donor government funding for family planning; data for the remaining donors were obtained from the OECD Credit Reporting System (CRS). Key findings from 2018 are as follows:

BILATERAL FUNDING

- In 2018, bilateral family planning funding from donor governments reached US\$1.5 billion, the highest level since the London Summit in 2012, even after accounting for inflation and exchange rate fluctuations. Funding in 2018 was more than US\$200 million above the 2017 level of US\$1.26 billion (Figure 1).¹⁹
- Funding increased from seven donors (Canada, Denmark, Germany, the Netherlands, Norway, the UK, and the US) and decreased for three (Australia, France, and Sweden). These trends were the same in currency of origin.
- Funding from the US rose significantly in 2018 (from US\$474.7 million in 2017 to US\$630.6 million in 2018), largely due to the timing of US disbursements;

US appropriations for family planning have been essentially flat for several years.²⁰

- The US was the largest bilateral donor to family planning in 2018, accounting for 42% of total bilateral funding. The UK was the second largest donor (US\$292.2 million, 19%), followed by the Netherlands (US\$215.6 million, 14%), Sweden (US\$107 million, 7%), and Canada (US\$81.8 million, 5%).

DONOR CONTRIBUTIONS TO UNFPA

- In addition to bilateral disbursements for family planning—which may include non-core contributions to UNFPA for specific family planning programs, such as UNFPA Supplies—donors also contribute to UNFPA’s core resources, which are used for programmatic activities (family planning, population and development, HIV/AIDS, gender, and sexual and reproductive health and rights) as well as operational support.
- In 2018, core contributions from the donors profiled totaled US\$373.9 million, an increase of almost US\$30 million compared to 2017 (US\$344.4 million).
- Among the donors profiled, two increased funding to UNFPA’s core resources (Norway and Sweden), five remained flat (Australia, Canada, France, Germany, and the UK), and two decreased (Denmark and the Netherlands). In 2018 the US administration invoked the Kemp-Kasten amendment for the second consecutive year to withhold funding—both core and non-core contributions—to UNFPA.²¹
- Sweden provided the largest core contribution to UNFPA in 2018 (US\$83 million), followed by Norway (US\$63.8 million), the Netherlands (US\$37.5 million), and Denmark (US\$37.1 million).
- In 2018 UNFPA spent US\$356.2 million (40.8% of UNFPA’s total program expenses) on family planning and related activities (US\$62.5 million from core resources and US\$293.7 million from non-core resources). This includes US\$237.3 million (27.2% of UNFPA’s total program expenses) for family planning-specific activities, such as creation of enabling environments, supply of commodities, provision of services, and systems strengthening, and US\$118.9 million (13.6%) in other areas that impact family planning.²²

¹⁹ For purposes of this analysis, family planning bilateral expenditures represent funding specifically designated by donor governments for family planning as defined by the OECD DAC (see methodology note in the digital report), and include: standalone family planning projects; family planning-specific contributions to multilateral organizations (e.g., contributions to UNFPA Supplies); and, in some cases, projects that include family planning within broader reproductive health activities.

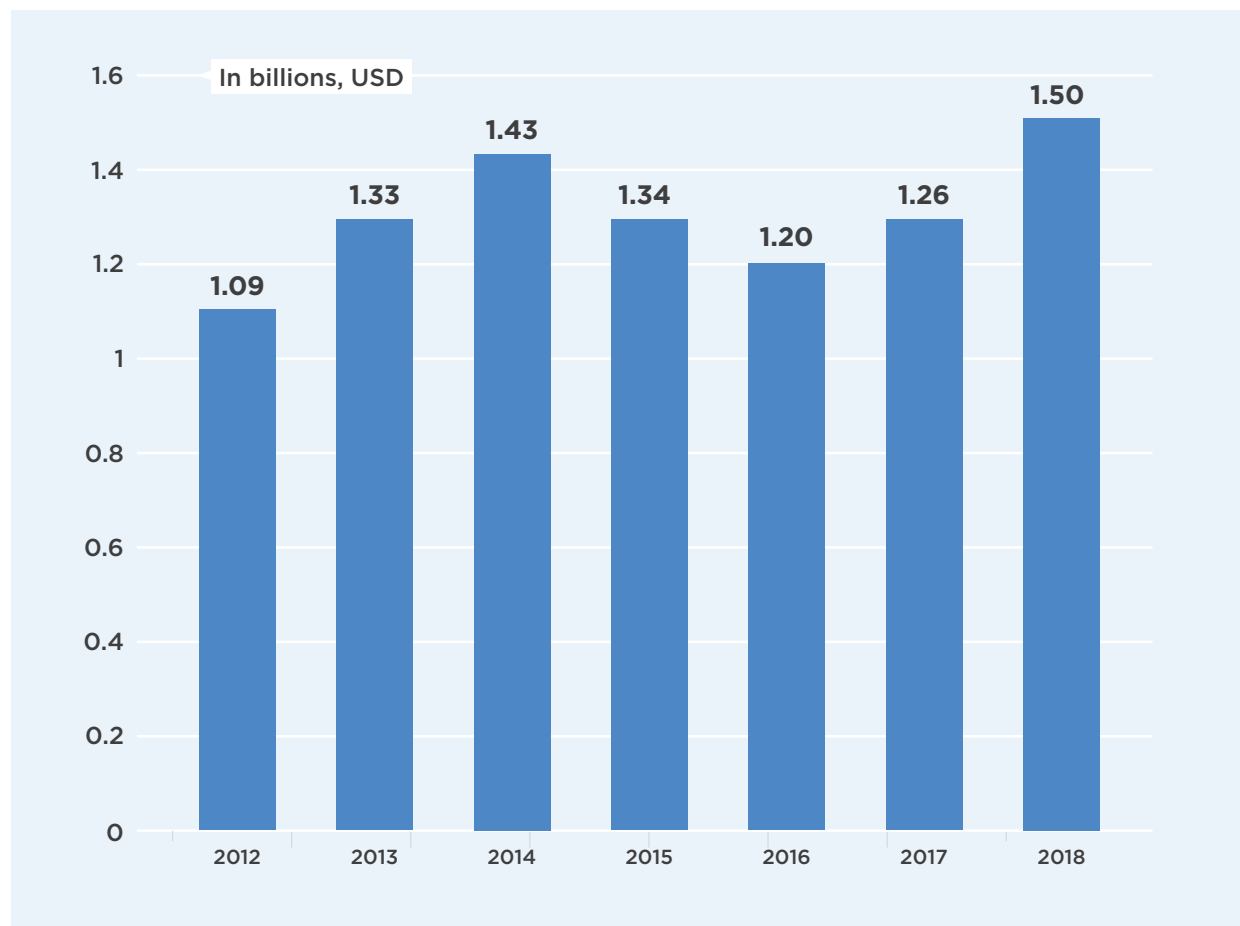
²⁰ By law, annual US government appropriations for development assistance, including for family planning activities, may be disbursed over a multi-year period.

²¹ In 2016, US contributions to UNFPA had totaled US\$69 million, including US\$30.7 million in core resources and an additional US\$38.3 million in non-core resources for other project activities. (See KFF’s “UNFPA Funding & Kemp-Kasten: An Explainer.”)

²² Personal communication, UNFPA, September 2019.

FIGURE 1
DONOR GOVERNMENT BILATERAL ASSISTANCE FOR FAMILY PLANNING, 2012-2018

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



PROGRESS TOWARD COMMITMENTS AND LOOKING AHEAD

At the Family Planning Summit in 2017, nine of the ten donor governments profiled in this report made new or renewed funding commitments to family planning, either directly or as part of broader development assistance activities (e.g., sexual and reproductive health and rights, humanitarian assistance): Australia, Canada, Denmark, France, Germany, Netherlands, Norway, Sweden, and the UK. Total family planning

funding from these donors increased in both 2017 and 2018. As the global community begins to consider the post-2020 agenda, KFF and FP2020 will continue to work with donor governments to track funding for family planning and measure progress toward the commitments made in 2017.

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

TABLE 1 DONOR GOVERNMENT BILATERAL DISBURSEMENTS FOR FAMILY PLANNING, 2012–2018*

In millions, USD

COUNTRY	2012	2013	2014	2015	2016	2017	2018
Australia	\$43.2	\$39.5	\$26.6	\$12.4	\$24.9	\$25.6	\$22.2
Canada	\$41.5	\$45.6	\$48.3	\$43.0	\$43.8	\$69.0	\$81.8
Denmark	\$13.0	\$20.3	\$28.8	\$28.1	\$30.7	\$33.1	\$38.5
France	\$49.6	\$37.2	\$69.8	\$68.6	\$39.9	\$19.2	\$17.0
Germany	\$47.6	\$38.2	\$31.3	\$34.0	\$37.8	\$36.8	\$51.3
Netherlands	\$105.4	\$153.7	\$163.6	\$165.8	\$183.1	\$197.0	\$215.6
Norway	\$3.3	\$20.4	\$20.8	\$8.1	\$5.7	\$2.2	\$13.0
Sweden	\$41.2	\$50.4	\$70.2	\$66.0	\$92.5	\$109.2	\$107.0
UK	\$252.8	\$305.2	\$327.6	\$269.9	\$204.8	\$285.1	\$292.2
US	\$485.0	\$585.0	\$636.6	\$638.4	\$532.5	\$474.7	\$630.6
Other DAC Countries**	\$11.0	\$29.5	\$9.0	\$10.1	\$3.3	\$9.6	\$29.6
TOTAL	\$1,093.6	\$1,325.0	\$1,432.7	\$1,344.5	\$1,199.0	\$1,261.4	\$1,498.8

NOTES

Australia has now identified AUD 31.5 million in bilateral FP funding for the 2017-18 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 contributions to multilateral institutions. However, it was not possible to identify and adjust for funding to other non-FP-specific activities in most cases.

Bilateral funding is for family planning and reproductive health components of combined projects/activities in FY18-19. Reproductive health activities without family planning components are not reflected. This is a preliminary estimate. In support of its feminist international agenda, Canada committed to doubling its funding for sexual and reproductive health and rights (SRHR) with an additional CAD 650 million from 2017-2020. Canada is taking a comprehensive approach to SRHR. Efforts focus on providing comprehensive sexuality education, strengthening reproductive health services, and investing in family planning and contraceptives. Programs will also help prevent and respond to sexual and gender-based violence, including child, early, and forced marriage and female genital mutilation and cutting, and support the right to choose safe and legal abortion, as well as access to post-abortion care.

Bilateral funding is for family planning-specific activities and reproductive health-coded activities with a family planning focus.

Bilateral funding is for a mix of family planning, reproductive health, and maternal and child health activities in 2012-2018; family planning-specific activities cannot be further disaggregated. 2018 data is preliminary.

Bilateral funding is for family planning-specific activities, as well as elements of multipurpose projects.

The Netherlands budget provided a total of EUR 445 million in 2018 for "Sexual and Reproductive Health & Rights, including HIV/AIDS," of which an estimated EUR 182.7 million was disbursed for bilateral family planning and reproductive health activities (not including HIV).

Bilateral funding is for family planning-specific activities, narrowly defined under the corresponding DAC subsector 13030. Additional Norwegian bilateral family planning activities are for the most part not standalone, but rather are integrated as elements of other activities. In line with Norway's methodology for SRHR monitoring of its Family Planning Summit 2017 pledge, Norwegian SRHR support comprises all projects using DAC Sector 130, 100% of UNFPA and UNAIDS core contributions, 50% of contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and 28% of contributions to the Global Financing Facility. Using these parameters, Norwegian SRHR funding totaled NOK 1.3347 billion in 2017 and NOK 1.5804 billion in 2018.

Bilateral funding is for combined family planning and reproductive health activities. 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. More broadly, total Swedish bilateral SRHR activities appear to have accounted for at least SEK 1.3 billion in 2018. Of this, at least SEK 246 million is estimated to have been related to family planning.

In the financial year 2018/19, total UK spending on family planning was £260.7 million. This is a provisional estimate based on 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 £222.3 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. 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 2018/19 in 2020.

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.

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 2018 are the 2017 totals, the most recent year available; 2017 presents 2016 totals; etc.).

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

Note: Some of the figures for previous years are different from the data reported last year due to updates after the 2018 report was published. Donor amounts do not exactly sum up to total amounts due to rounding.

DOMESTIC GOVERNMENT EXPENDITURES ON FAMILY PLANNING

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

Estimates of domestic government expenditures on family planning come from multiple sources, including the WHO System of Health Accounts, the Family Planning Spending Assessment (Track20 and the Centre for Economic and Social Research in Nairobi), the Netherlands Interdisciplinary Demographic Institute (NIDI) in partnership with UNFPA, and official government reports.

The organizations involved in collecting and reporting domestic government expenditures have worked over the past several years to align their efforts, developing an agreed-upon process for reviewing data with countries to ensure consensus on the estimates. This process enabled us to report domestic government expenditures on family planning for the first time in last year's progress report, with estimates from 31 countries for expenditures in 2016 or earlier.

This year, as the 2018–2019 Progress Report goes to print, data are still being reviewed and confirmed. Nevertheless, it is already possible to estimate that domestic government expenditures accounted for approximately 32% of total expenditures on family planning in 2017. While this estimate does not include all countries, it does represent 93% of all family planning users in FP2020 focus countries. India, Bangladesh, and Indonesia continue to be the countries with the highest levels of domestic government expenditures.

By the end of the year more than 30 countries will have reported 2017 domestic expenditures, with several countries now having multiple years of data. As the collection and reporting of domestic expenditures continues to improve, countries and stakeholders will gain a greater understanding of measurement improvements, ongoing challenges, and financing trends. Through this greater visibility into the domestic financing of family planning, countries will also be able to better monitor their progress toward financial commitments.

➔ The digital report includes domestic government expenditure estimates for more than 30 individual countries.

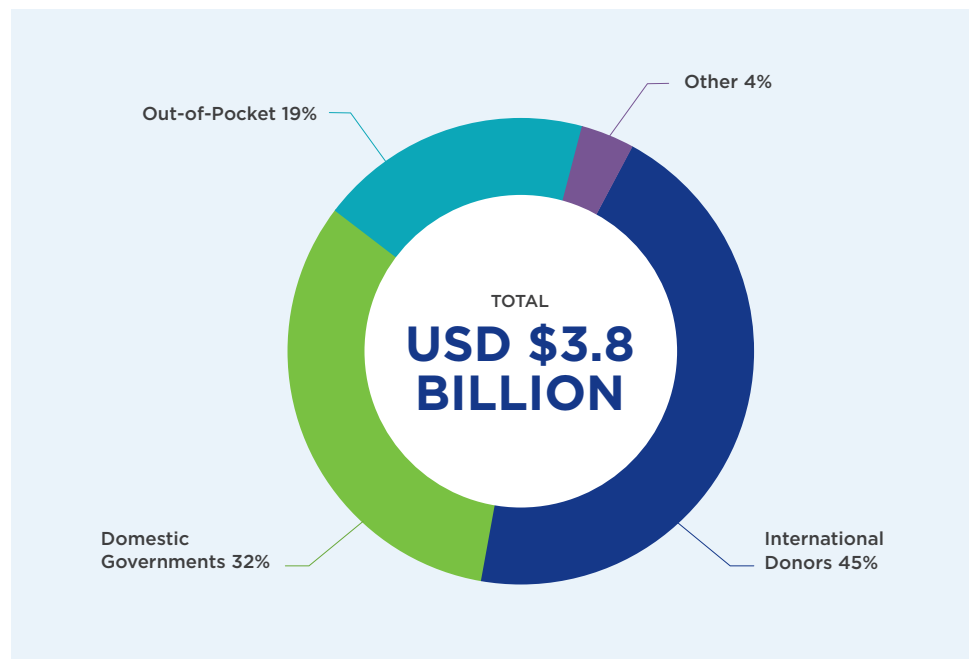


The Kyrgyz Republic Deputy Minister of Health Launches FP2020 Commitment.

Photo by UNFPA Kyrgyz Republic

FIGURE 2
DISTRIBUTION
OF FAMILY
PLANNING
EXPENDITURES
IN 69 FP2020
COUNTRIES BY
SOURCE OF
FUNDS, 2017

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



TOTAL EXPENDITURES ON
FAMILY PLANNING

Financial resources for family planning come from three main sources: domestic government expenditures, international donor contributions, and out-of-pocket spending by consumers who access services in the private sector or make co-payments for public sector services. Other domestic sources also contribute to the total.

Domestic Government Expenditures: Various partners track domestic government expenditures on family planning, as described above. It is estimated that domestic government expenditures accounted for 32% of total spending across FP2020 countries in 2017.

International Donors: The Kaiser Family Foundation (KFF) tracks contributions by the major donor countries, as described above. The Bill & Melinda Gates Foundation reports expenditures directly to FP2020. The Institute for Health Metrics Evaluation (IHME) tracks development assistance by other US foundations, US NGOs, international NGOs, and the World Bank. The expenditures from all these sources is estimated at 45% of total spending in 2017.

Out-of-Pocket Spending: The Reproductive Health Supplies Coalition (RHSC) prepares an annual commodity gap analysis estimating out-of-pocket

spending on family planning. This estimate uses survey data to determine the proportion of family planning users who obtain services in the private sector and the proportion who pay for public sector services. The prices of subsidized and non-subsidized services are based on data from DHS, IQVIA, DKT, PSI, MSI, and PMA2020. RHSC estimates that out-of-pocket spending in FP2020 countries amounted to 19% of total family planning expenditures in 2017.

Other Domestic Sources: NIDI/UNFPA assess family planning expenditures by national NGOs, corporations, and insurance companies in about 80 countries each year. These expenditures are estimated at 4% of total spending in 2017.

Trends over time are only reliable for international donor expenditures, which have been tracked and analyzed using the same methodology for many years. Methods to estimate the other components have improved over time and expanded to include more countries, so these latest estimates should not be compared with previous estimates to observe trends.

➔ **The digital report includes selected country-specific graphs that illustrate the variation in expenditures by international donors, domestic governments, and consumers in different FP2020 countries.**

SECTION 04

MEASUREMENT

Photo by
Jenny Matthew
IPPF

At the outset of this time-bound initiative, FP2020 committed to a measurement agenda that aimed to transform the monitoring of family planning and provide annual reports on country progress.

FP2020 data partners have worked to improve the methods, infrastructure, and capacity for generating more frequent, high-quality data for decision making. These efforts led to an established set of Core Indicators, alignment on key measures, more regular data collection and analysis, and an annual FP2020 Progress Report. The reporting process has also created new spaces and opportunities for country, regional, and global decision makers to review data and identify opportunities for action.

In addition to these advances, the FP2020 measurement agenda has helped the family planning measurement community identify measurement gaps and revealed outstanding challenges. Over the coming year, FP2020's Performance Monitoring & Evidence Working Group, together with Track20 and partners, will examine both measurement progress and obstacles to help the FP2020 partnership learn from its successes and challenges as it looks to strengthen efforts to 2020 and beyond to 2030.

THE ANNUAL MEASUREMENT PROCESS

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

FP2020's annual process of producing and reviewing data, building consensus, and reporting at national and global levels (**Figure 3**) 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.



MORE IN THE DIGITAL REPORT

Core Indicator
definitions and data
sources

Interactive data graphics

Estimate Tables

Adolescent and youth
data tables



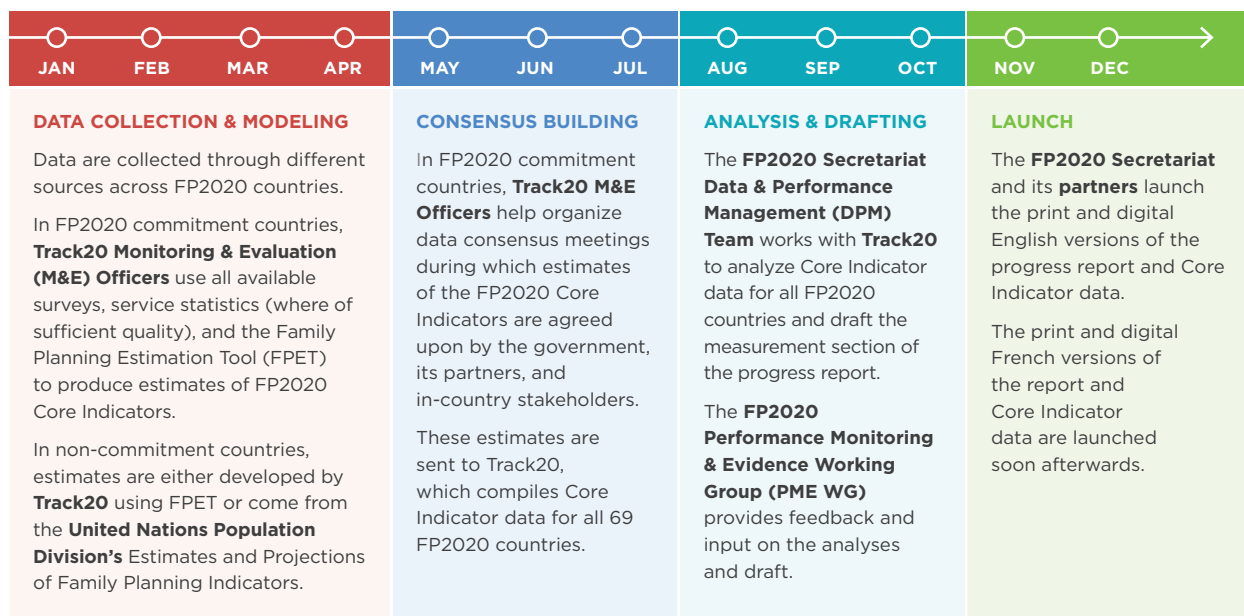
➔ The digital report features an infographic depicting the FP2020 Core Indicators Results Framework. The digital report also includes definitions and data sources for each of the indicators.

CORE INDICATORS

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

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

FIGURE 3 FP2020 ANNUAL MEASUREMENT AND REPORTING PROCESS



PROGRESS ON CONTRACEPTIVE USE AND NEED

Core Indicator 1, the number of additional users of modern methods of contraception, measures progress toward the FP2020 goal of reaching 120 million additional users of modern contraception by 2020. As of July 2019, there were 53 million additional users of modern contraception in the 69 FP2020 focus countries as compared to 2012, the time of the London Summit (**Figure 4**). This is 9 million more women and girls²³ using a modern method of contraception as compared to just a year ago. While the rate of growth is well short of the pace needed to reach 120 million additional users by 2020, there are signs of progress across many countries and many indicators, and the 120 million goal remains a critical benchmark on the path to achieving the Sustainable Development Goals by 2030.

As of July 2019, there were 314 million total users of modern methods in the 69 FP2020 focus countries.²⁴ Meeting the contraceptive needs of millions of additional women and girls each year requires countries to maintain services for the large base of existing users of modern contraception, keep pace with the health care needs of a growing number of women of reproductive age, and provide services to the rising percentage of women and girls who want to use modern contraception to avoid an unintended pregnancy. At the same time, countries are striving to fulfill growing demands for expanded contraceptive method choices.

For data on contraceptive use and need among adolescents and youth, check out the digital report.



COUNTRIES KEEPING PACE WITH THE GROWING NUMBER OF WOMEN OF REPRODUCTIVE AGE

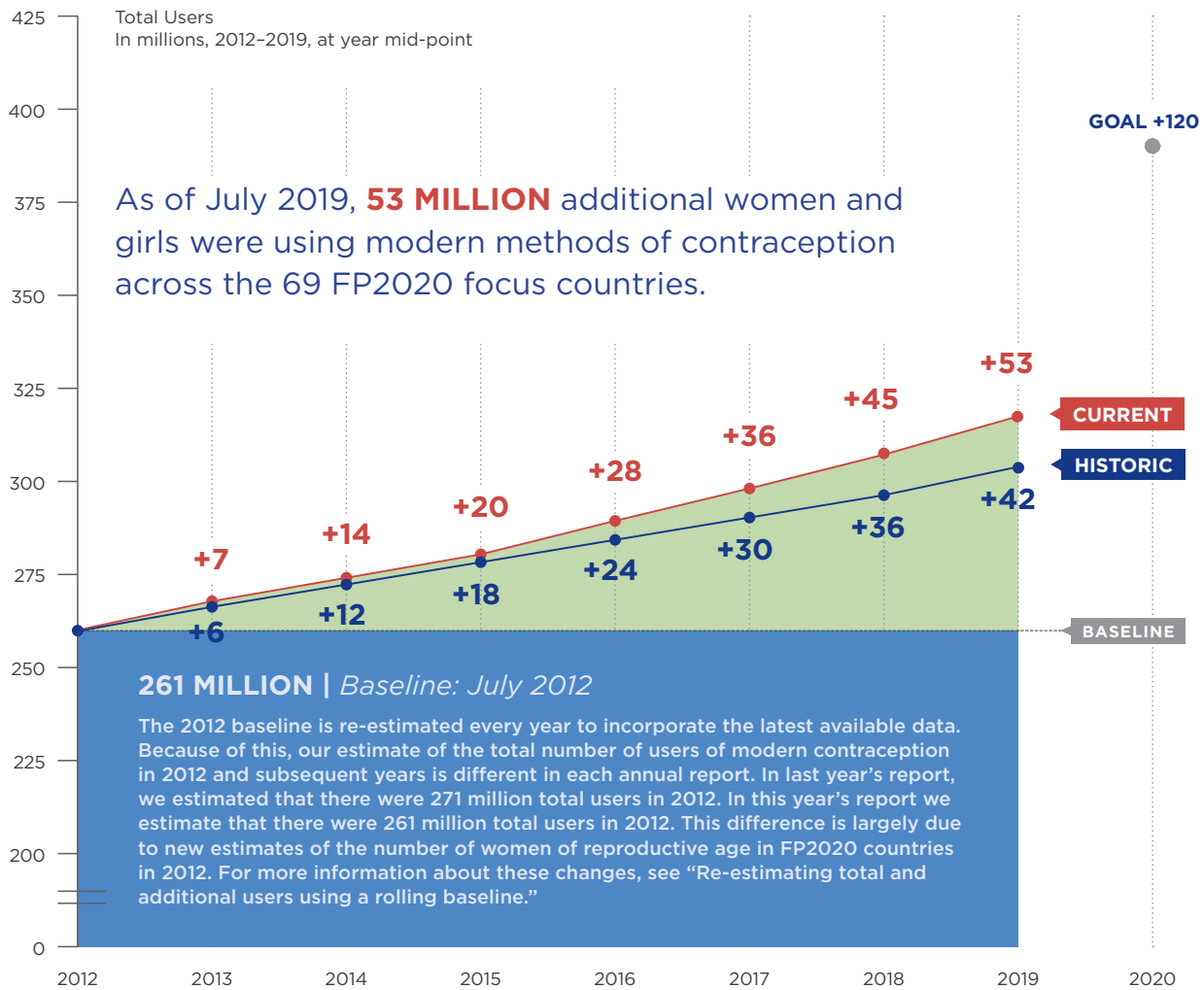
As of 2019, there are an estimated 926 million women of reproductive age in the 69 FP2020 focus countries, compared to 822 million in 2012: an increase of more than 100 million women. Just keeping up with population growth means that even with no change in contraceptive prevalence, many more women and girls will need contraceptive services each year. In India, for example, the population of women of reproductive age increases by almost 4 million women each year. If contraceptive prevalence were to remain steady, this would still require providing contraceptive services to an additional 1.5 million women each year.

But in India, as in almost all 69 FP2020 focus countries, modern contraceptive prevalence among all women (MCPR), **Core Indicator 2**, is rising. This increase in MCPR is an important contributor to the increase in additional users. Across the 69 FP2020 focus countries, MCPR among all women of reproductive age has risen by more than 2% since 2012.

²³ References in this report to “girls” in the context of family planning should be understood to mean adolescent girls. Family planning statistics include only older adolescents (aged 15–19). While there are no universally accepted definitions of adolescence and youth, the United Nations understands adolescents to include persons aged 10–19 years and youth as those aged 15–24 years. Together, adolescents and youth are referred to as young people, encompassing the ages of 10–24 years. For statistical purposes, the following age groups are defined: 10–14, 15–19, and 20–24. See UNFPA’s Adolescent and Youth Demographics: A Brief Overview.

²⁴ Although this is fewer total users than were reported last year, the difference is not due to an actual decline in users, but instead due to our rolling baseline methodology and a change in our estimate of the 2012 baseline (see “Re-estimating total and additional users using a rolling baseline on page 39).

FIGURE 4 TOTAL AND ADDITIONAL USERS OF MODERN CONTRACEPTION, 2012-2019

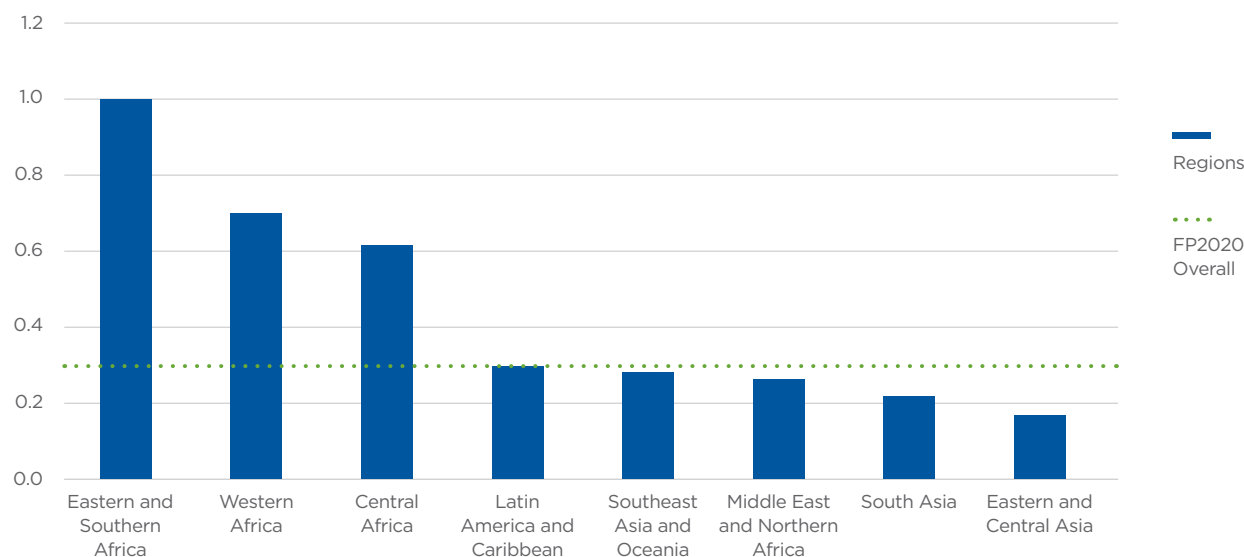


Looking at both population growth and increases in MCPR, we can see the progress that countries have made in providing services to increasing numbers of women and girls. Since 2012, 25 countries have each gained more than 500,000 additional users of modern methods. Among these countries, 12 have seen the number of additional users grow by more than 1 million women and girls. In Uganda the number of users of modern contraception has almost doubled

since 2012, from 1.6 million to 3 million. This rate of increase is a sign that health systems and service providers are doing more than just keeping pace; they are also expanding services. Maintaining these gains beyond 2020 is critical, as the population of women of reproductive age in the 69 FP2020 focus countries will surpass 1 billion before 2025 and continue growing through 2030 and beyond.

FIGURE 5 ANNUAL MCPR GROWTH BY REGION

This graphic shows the average annual percentage point increase in MCPR (among all women) from 2012-2019 for FP2020 regions and for all FP2020 countries overall.



GAINS IN MODERN CONTRACEPTIVE PREVALENCE ACROSS REGIONS AND COUNTRIES

As part of their FP2020 commitments, 45 countries have established goals of increasing contraceptive prevalence through voluntary family planning programs. Progress on reaching a greater percentage of women varies greatly by region and country. In FP2020 focus countries in Asia, approximately 38% of women of reproductive age were using a modern method as of July 2019, and the average growth across all of the regions of Asia has been 0.2 percentage points per year since 2012. In contrast, the pace of MCPR growth in FP2020 countries in Africa has been much faster. As of July 2019, almost 25% of women of reproductive age in these countries were using a modern method, and in Eastern and Southern Africa, MCPR has grown by 1 percentage point per year since 2012. Growth has been nearly as fast across Central Africa and Western Africa, which started at lower levels of MCPR.

Looking at progress from a regional perspective provides additional insight into the variability of growth in modern contraceptive use. **Figure 5** shows both the weighted regional averages in annual percentage point change in MCPR and the average annual growth across all 69 FP2020 focus countries.

Using West Africa as an example, the graph shows a regional average of 0.7 percentage point growth per year, with four countries falling below the average and 11 countries either equal to or above the average. Because this average is weighted by the size of each country's population of women of reproductive age, large countries that are growing slowly will have a greater effect. In the case of West Africa, the population of women of reproductive age in Nigeria makes up roughly half of all women of reproductive age in the region. Although Nigeria's MCPR is growing at approximately the average rate of FP2020 focus countries as a whole (0.3 percentage points per year), it is the second slowest growing country in its region. Without Nigeria included, the average annual MCPR growth rate for the other West African countries is 1 percentage point per year, almost the same as Eastern and Southern Africa.

Looking in more depth at country progress, as of 2019 there are 13 FP2020 focus countries with MCPR growth rates greater than 1 percentage point per year since 2012,²⁵ and all but one of these are FP2020 commitment makers. Mozambique has consistently been the fastest growing country, a testament to the commitment of the government and partners to reach all women, including adolescents, with a range of contraceptive choices. It is one of nine countries that are on track to achieve the MCPR goals they

²⁵ Burkina Faso, Cameroon, Côte d'Ivoire, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mozambique, Senegal, Sierra Leone, Tanzania, and Uganda.

established in their FP2020 commitments. Another 13 countries are only 2–5 percentage points away from their FP2020 goals for MCPR, and, with a bit more acceleration, will be within reach of achieving them.

Countries can gain additional insights on progress and variations in MCPR growth by looking at a graphic of the S-Curve (**Figure 6**), which illustrates different rates of growth at different levels of contraceptive use based on historical patterns. Countries with lower MCPR tend to have slow growth, countries in the middle tend to have higher rates of growth, and

as MCPR levels rise, MCPR growth tends to slow down. Since 2012, several countries that had very low prevalence have begun to experience increases in MCPR. In 2012, there were 11 countries that had MCPR among married women below 10%; today that number is down to just four. As countries transition through different MCPR levels, the S-Curve concept provides a guide for countries to assess their priorities and contextualize expectations for growth in contraceptive prevalence. Similarly, looking at MCPR levels sub-nationally can help countries prioritize actions and establish context specific approaches.

RE-ESTIMATING TOTAL AND ADDITIONAL USERS USING A ROLLING BASELINE

There are three main types of data that influence estimates of total (and additional) users of modern contraceptive methods: the number of women of reproductive age in a country, the proportion of women that are married/in-union, and the proportion who use modern contraception. A change in any or all of these will result in a change to the estimated number of women using modern contraceptives.

The UN Population Division has been estimating and projecting the world's population since 1951. These estimates are based on all available sources of data on population size and levels of fertility, mortality, and international migration for 235 countries or areas. A revised set of estimates is produced every two years. For each revision, any new information (recent or historical) that has become available is considered to produce updated population estimates for each country or area for every year from 1950 to today. For the most recent revision—**World Population Prospects: The 2019 Revision**—the results of 1,690 population censuses conducted between 1950 and 2018, information on births and deaths from vital registration systems for 163 countries, and demographic indicators from 2,700 surveys were considered.

Estimates of modern contraceptive prevalence come from the Family Planning Estimation Tool (FPET). Each year, Track20 works with countries to collect and review all available survey data and service statistics to produce annual estimates of contraceptive use and unmet need. This process produces estimates for the current year and also re-estimates the trend back to the 2012 baseline year. This re-estimation of contraceptive use, along with the UN Population Division's biennial revision to estimates of the population of women of reproductive age, together result in what FP2020 refers to as a “rolling baseline.” So not only is the 2012 estimate updated, but so are the 2013–2019 estimates. This means that the

number of total users and additional users of modern contraception 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.

Additional users of family planning are calculated by comparing the total number of users of modern contraception in any given year with the number of users there were in 2012 (FP2020's baseline year).

$$\text{Additional Users}_{2019} = \text{Total Users}_{2019} - \text{Total Users}_{2012}$$

The total number of users of modern contraception is calculated using **Core Indicator 2**, the prevalence of use of modern contraception among all women in a country (MCPR), and the total population of women of reproductive age (15–49) in each country (WRA).

$$\text{Total Users} = \text{MCPR} \times \text{WRA}$$

In 2012, at the time of the London Summit, it was estimated that there were 258 million users of modern methods of contraception in the FP2020 focus countries, based on the data available at the time. Over the last several years, new modeling approaches, data, and population revisions resulted in gradual revisions to the baseline number of users, and last year's progress report indicated that there were 271 million users in 2012. This year's data reveal a substantial change in the estimated baseline of users in 2012—from 271 million in last year's report to 261 million this year—based principally on a downward revision in the UN Population Division's estimate of women of reproductive age. As a result of this shift, the total number of users estimated for 2019 is lower than that estimated for last year (314 million in 2019 versus 317 in 2018). The rolling baseline allows us to adjust to these changes and continue to produce consistent estimates of additional users, since both the baseline and all subsequent years, including the current year, are re-estimated.

FIGURE 6 S-CURVE PATTERN OF MCPR GROWTH

The S-Curve pattern of MCPR growth helps countries examine and understand their current growth rates. The S-Curve is based on historical patterns and suggests that countries grow at different rates based on their levels of contraceptive use.

LOWER PREVALENCE: SLOW GROWTH

When MCPR is very low, countries tend to see slow annual growth in MCPR.

Efforts are needed to change social norms around family planning, stimulate demand, and establish the infrastructure and providers to deliver quality family planning services.

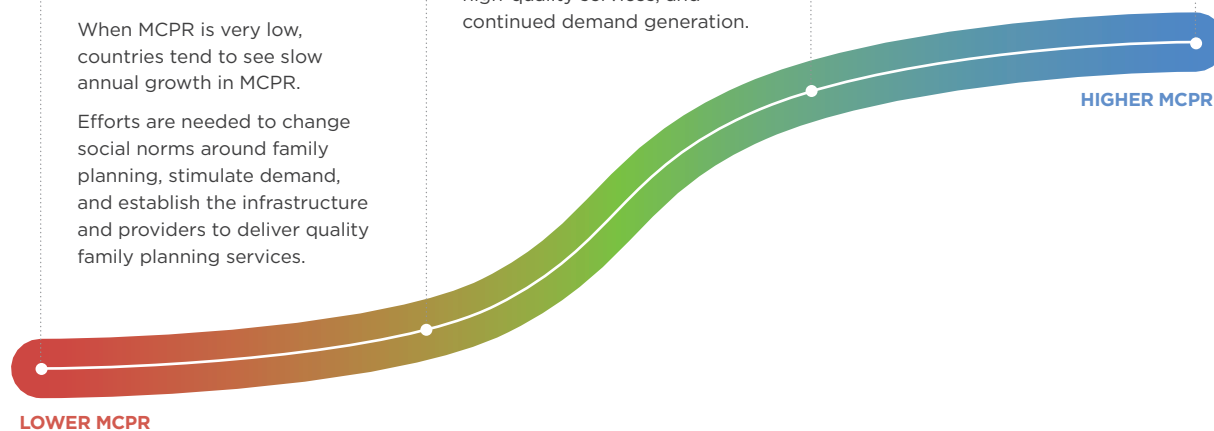
PERIOD WHERE RAPID GROWTH CAN OCCUR

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

HIGHER PREVALENCE: GROWTH SLOWING AND LEVELING OFF

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

Programs at this stage need to focus on long-term sustainability, continued improvements in service quality, expanding the range of methods available, and striving to reach underserved groups.



CHANGES IN UNMET NEED AND DEMAND SATISFIED

Core Indicator 3, the percentage of women with an unmet need for modern methods of contraception, indicates the percentage of women of reproductive age who report wanting no more children or wanting to postpone having the next child, but were not using a modern contraceptive method at the time of the survey. Over the last several decades, estimates of the numbers of women with an unmet need for modern contraception have served as a call to action for the family planning community, as these women are at relatively higher risk of unintended pregnancy. Unmet need should not, however, be interpreted as a direct measure of lack of access to contraception. There are many reasons why a woman who does not want to become pregnant would not use modern contraception. These include use of traditional methods, limited access to modern methods, as well as a wide range of other issues, such as perceived health side effects from modern methods or social disapproval of contraceptive use. Understanding the barriers to use within each country's context is

important to ensure that programs can address the needs of women across different settings and situations.

Few patterns can be seen in unmet need across FP2020 countries. Only Eastern and Southern Africa, the region experiencing the greatest growth in contraceptive use, has seen a substantial decline in unmet need for family planning since 2012. In other regions unmet need has remained largely unchanged over the period, with some variation across countries. Among low prevalence countries, where growth in contraceptive use in the short term is expected to be slow, an increase in unmet need may be a sign of changing social norms, with a greater percentage of women beginning to indicate that they want to avoid a pregnancy but are not yet using family planning. Examination of data on unmet need does not indicate any clear patterns across low prevalence countries, and it may be that increases in contraceptive prevalence in West and Central Africa have kept up with the growing desire to avoid pregnancy, resulting in neither an increase nor a decrease in unmet need since 2012.

➔ **The digital report provides a link to the Maximum Contraceptive Prevalence “Demand Curve”, a conceptual tool to help countries assess the balance between expanding family planning services and undertaking social and behavior change activities.**

Core Indicator 4, demand satisfied with a modern method of contraception, is an indicator for the Sustainable Development Goals (SDG) target 3.7: ensuring universal access to sexual and reproductive health care services, including for family planning, by 2030. This indicator takes a wider view to try to assess the degree to which governments and the broader family planning community are meeting the commitment to make family planning services accessible to all who want them. Total demand is constructed based on the percentage of women of reproductive age using modern methods and the percentage with an unmet need for modern methods, with the proportion of demand that is met with modern methods termed “demand satisfied.” Of the 69 FP2020 countries, 15 are on track to surpass at least 75% of demand satisfied with modern methods among all women, and 18 countries are on track to surpass this level among married women. Members of the family planning community have suggested “at least 75% demand satisfied with modern methods” as a benchmark that all countries should strive for both nationally and among population sub-groups. There is great variation across and within countries in terms of progress toward this SDG benchmark, suggesting that all countries need to accelerate their efforts to achieve SDG target 3.7 by 2030.

Core indicator 5, a measure of the work that remains to eliminate unintended pregnancy, indicates that from July 2018 to July 2019, there were more than 50 million unintended pregnancies across the 69

FP2020 focus countries. Most of these unintended pregnancies were due to women and girls not using contraception despite not wanting to get pregnant, while some were due to women and girls experiencing a contraceptive failure. The number of unintended pregnancies occurring each year has not declined, despite increasing contraceptive use, because the number of women of reproductive age has grown. Increased contraceptive use is, however, having an immense impact on the lives of women and girls.

Core Indicators 6, 7, and 8 provide estimates of the impact of modern contraceptive use. As a result of contraceptive use by more than 314 million women and girls, more than 119 million unintended pregnancies, 21 million unsafe abortions, and 134,000 maternal deaths were prevented in the last year alone. These impacts of contraceptive use have increased substantially since 2012, and today 20 million more unintended pregnancies, 4.3 million more unsafe abortions, and 37,000 more maternal deaths are prevented each year as compared to 2012.

The regional averages and country data presented in this section provide a high-level snapshot of progress toward the FP2020 goal of 120 million additional women and girls using modern contraception by 2020. However, it is important to remember that these aggregate numbers belie the complexity of country dynamics as well as the differences that exist sub-nationally and among population sub-groups. The FP2020 reporting process creates an opportunity for discussion of these complex dynamics and exploration and analysis of more data. Additional data on each country and reports on progress toward their commitments are available online through the FP2020 country pages (familyplanning2020.org/countries). In addition, FP2020 reports data disaggregated by age group, wealth, and rural/urban status for many indicators in the FP2020 Estimate Tables (familyplanning2020.org/progress).

ADOLESCENT AND YOUTH DATA

Building on last year’s publication of supplementary data on adolescent demographics, key life events, and contraceptive use and unmet need, FP2020 has updated the Adolescent and Youth Data Tables based on recent surveys: familyplanning2020.org/progress. The youth population comprises a large proportion of the total number of women and men of reproductive age in FP2020 countries. Empowering young people

with the tools they need to thrive is central to achieving both FP2020 goals and the Sustainable Development Goals. Reaching them with information about preventing pregnancy and contraceptive services is critical as the patterns of behavior that young people develop today will affect the entire trajectory of their lives.



Photo by Perttu Saralampi, Promundo

COMMUNICATING ESTIMATES: RANGES, CONFIDENCE, AND DATA REGENCY

Uncertainty exists around all point estimates, whether they are directly from surveys or from modeling that is based on surveys and other data. This is usually expressed as an interval around a median estimate, which shows the range within which one can be 95% certain that the true value lies. The size of the interval is based on many factors. For FP2020 estimates of M CPR, unmet need, and demand satisfied, the size of the intervals varies based on the data available in each country. Below are three examples illustrating intervals (purple lines) around point estimates (blue lines) with the circles and triangles representing surveys and service statistics data.

The first graphic shows a country that has not had a recent survey. The last survey was in 2012, so estimating M CPR in 2019 requires using FPET to project forward six years from the last survey. In each year after the survey the interval widens. The second graphic shows the addition of country service

statistics after the last survey to inform the FPET projection. In this example, the interval is narrower because of the additional data that has been added to FPET to produce the estimate. In the last example, a new survey has been conducted and the addition of the survey in FPET has further reduced the uncertainty range around the current year M CPR estimate.

Other global health partners who produce national estimates of health indicators, such as new HIV infections (UNAIDS) and maternal mortality rates (WHO), communicate ranges of uncertainty around those estimates. FP2020's Performance Monitoring & Evidence, and Evidence Working Group has urged FP2020 and family planning partners to similarly advance toward communicating uncertainty intervals around estimates, and over the coming months will put together additional resources that indicate ranges for some indicators.

FIGURE 7 UNCERTAINTY INTERVALS AROUND M CPR ESTIMATES

This graphic shows intervals around modeled estimates of modern contraceptive prevalence (M CPR). The first graph shows estimates and intervals based on three surveys, the second shows estimates and intervals after the inclusion of service statistics, and the third shows estimates and intervals after the inclusion of a new survey.



CONTRACEPTIVE METHOD CHOICE

While no one indicator can completely measure full, free, voluntary, and informed choice, FP2020 annually monitors several indicators linked to these principles as they relate to method choice.

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

A wide range of factors determine the choices that individuals make in selecting a contraceptive method, including prior experience with contraception, knowledge of contraceptive methods, and considerations of cost, effectiveness, and side effects of the various methods. Where women and girls are in their reproductive life course, their sexual behaviors, and their long and short-term fertility intentions also contribute to contraceptive decisions. Partner and family pressure, as well as societal norms and religious prohibitions concerning specific methods or contraceptive use in general, may influence which (if any) methods are acceptable. The ability to access the method of choice may also be limited by stock-outs at accessible facilities, provider preferences, limited information at facilities on the full range of methods, a lack of trained providers, or local and national policies around family planning.

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

➔ **The digital report features the FP2020 Rights and Empowerment Principles infographic, which identifies the Core Indicators associated with each principle.**

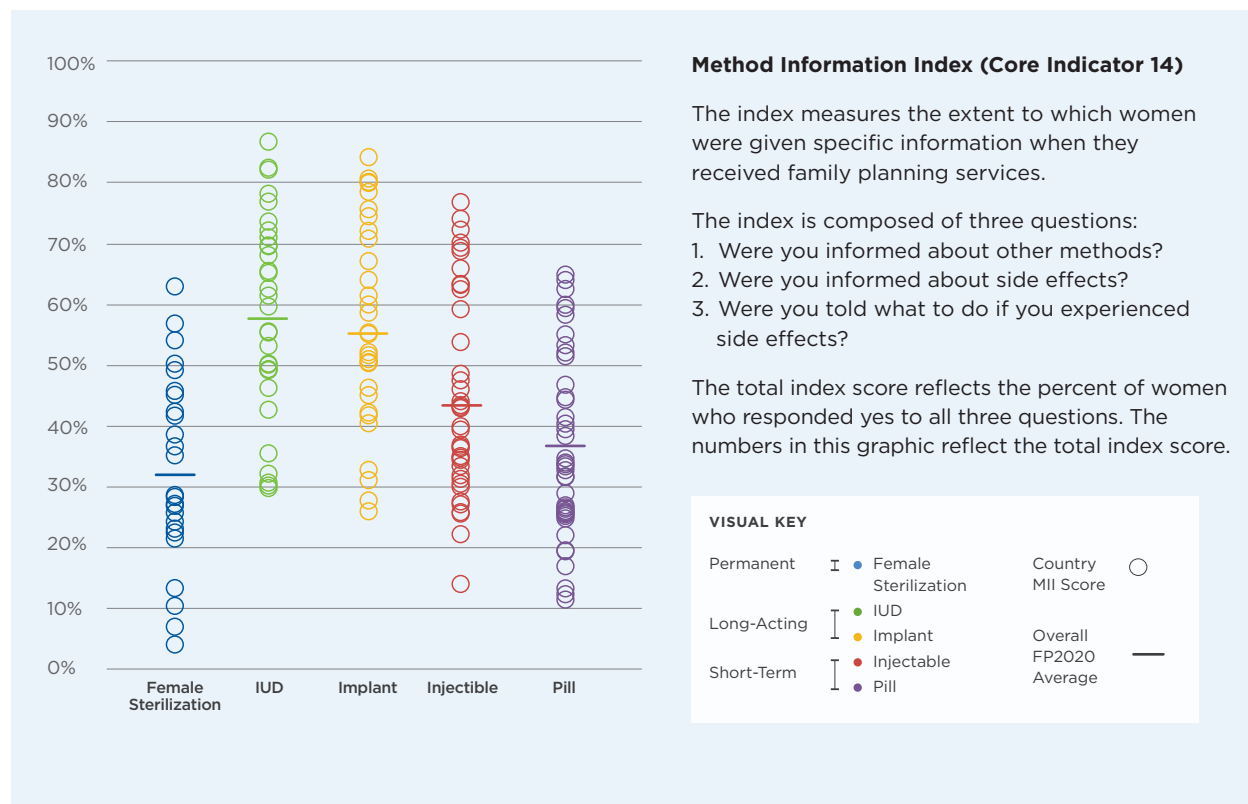
RIGHTS AND EMPOWERMENT PRINCIPLE: INFORMED CHOICE

To ensure that women, girls, and couples can determine the method that best meets their needs, health care providers must provide appropriate information and counseling about the full range of contraceptive options. **Core Indicator 14**, the Method Information Index (MII), measures the extent to which women report receiving specific information when they first started using their current method and being informed about side effects and alternate methods. The index is composed of three questions: When you started your current contraceptive method (1) Were you informed about other methods? (2) Were you informed about side effects of the method? (3) Were you told what to do if you experienced side effects from the method?

Across the 40 FP2020 countries with available data since 2012, the highest MII score was seen in Senegal, where 73% of current users reported that they received all three elements of the MII. In contrast, the lowest MII score was seen in Pakistan, where, according to the 2017 DHS, only 16% of current contraceptive users reported receiving information on other methods, side effects, and what to do if they experienced side effects—a clear indication of the need to improve the quality of contraceptive counseling. In terms of the individual components of the

FIGURE 8 METHOD INFORMATION INDEX SCORE BY METHOD

This graphic shows the Method Information Index (MII) score for FP2020 countries, by method, as well as the overall average for all FP2020 countries with available data.



MII, on average the highest scoring component is the percentage of women reporting receipt of information on other methods (64%, unweighted average across countries), as opposed to the percentage who report being informed about side effects (57%) or how to handle them (52%).

On average, users of implants and IUDs have the highest MII scores (55% and 58% respectively), while users of female sterilization have the lowest (32%). Understanding the context is important in interpreting these scores. Depending on when and where women accessed these services, their experiences may reflect different types of providers, varying quality in provider training, and evolving standards of care for counseling. In addition, women’s past experience with contraception as well as their current relationship with a healthcare provider may affect whether all elements of MII were relevant as part of the provision of their current method. The average MII of 43% (with a range of 16–73%) across the 40 countries indicates

substantial room for improvement in counseling and quality of care. Improving the quality of care afforded to women and girls, including adequate and appropriate information, increases the likelihood of continued contraceptive use.²⁶

RIGHTS AND EMPOWERMENT PRINCIPLE: AVAILABILITY

Health care facilities, trained providers, and contraceptive methods must be both available and accessible to enable full choice. Barriers such as cost, distance, limited provider training, and stock-outs may limit the ability of women to access services to meet their family planning needs and choose from a full range of methods. **Core Indicator 10** (stock-outs) and **Core Indicator 11** (method availability) reflect the availability of individual methods and the range of available methods at a facility at a point in time (the day of a facility survey), providing an indication of supply-side barriers to women’s ability

²⁶ Chakraborty, Nirali M., and Karen Chang, Benjamin Bellows, Karen A. Grépin, Waqas Hameed, Amanda Kalamar, Xaher Gul, Lynn Atuyambe, Dominic Montagu. “Association Between the Quality of Contraceptive Counseling and Method Continuation: Findings from a Prospective Cohort Study in Social Franchise Clinics in Pakistan and Uganda.” *Global Health: Science and Practice* Mar 2019, GHSP-D-18-00407; DOI: 10.9745/GHSP-D-18-00407.

to access contraception. Stock-outs refer to the temporary unavailability of contraceptive commodities (or supplies and/or trained staff in the case of sterilization) at a health facility where the method or service is offered. Method availability measures the number of methods available to women and girls at primary and secondary/tertiary facilities.

Stock-outs have the effect of restricting choice; when a woman arrives at a facility to access family planning services, her options are limited to methods in stock that day rather than inclusive of all methods that a facility could provide. This may result in women and girls having to switch from their chosen method, choosing a method that is not as well suited to their needs and preferences, or leaving without a method. Ensuring that a minimum number of methods are available at various levels of the health care system guarantees that individuals and couples have options when choosing a contraceptive method.

Among the 23 countries providing stock-out data by method this year, the level of stock-outs ranges widely: from Burkina Faso, where no method saw stock-outs greater than 10% on the day of assessment, to Cameroon, where more than 50% of facilities were stocked out of each of the 9 assessed methods.²⁷ Stock-outs may be particularly problematic when occurring among the most popular or commonly-used methods, especially short-term methods that require frequent revisits to maintain protection against unintended pregnancy. For example, in Sierra Leone 13% of married women (half of modern contraceptive users) rely on injectables as their method of contraception. Yet 40% of facilities were stocked out of injectables on the day of assessment in 2018, meaning that many women who came for injectables on that day could not access their method of choice. Stock-outs of the most common method in use ranged from very low levels (0% of facilities stocked out of injectables in Rwanda and 1% of facilities stocked out of pills in Lao PDR) to extremely high levels (80% of facilities stocked out of condoms in Cameroon). In the aggregate, stock-outs of the most common method are relatively low, with a median of 10% of facilities stocked out of the most common method across 22 of the 23 countries with available data.²⁸ This may suggest that many countries are successfully monitoring key commodities within supply chains to ensure access to the most commonly used and in-demand methods, but it could also indicate that stock availability is driving method choice.

Method availability was relatively high across the FP2020 countries with data for 2018, with a median of 89% of primary level facilities offering 3+ methods and 88% of secondary/tertiary facilities offering 5+ methods on the day of assessment. At the primary level, only five of the 25 countries saw fewer than 50% of facilities with 3+ methods on offer on the day of assessment: Liberia, Malawi, Mali, Mauritania, and Timor-Leste. Four countries—Côte d'Ivoire, Liberia, Malawi, and Mali—saw fewer than 50% of secondary and tertiary facilities with 5+ methods on offer on the day of assessment.²⁹ In contrast, 12 countries saw more than 90% of primary facilities offering 3+ methods and 10 countries saw more than 90% of secondary/tertiary facilities offering 5+ methods. These data do not indicate the availability of specific methods or method types (short-term, long-acting, or permanent methods), but do suggest that in some countries, women's ability to choose from a full range of contraceptive methods may be constrained at various levels of the health care system.

RIGHTS AND EMPOWERMENT PRINCIPLE: AGENCY AND AUTONOMY

Women and girls must be free to make their own decisions about their reproductive health care and to seek contraceptive services without risk of discrimination, coercion, or violence. While not all women and girls are free to make their own choices about contraception, across the 41 FP2020 countries with available data, on average 90% of married modern users report that the decision to use family planning was made on their own or jointly with their husband or partner (as opposed to primarily by their husband or partner). **Core Indicator 16** shows high levels of women's participation in contraceptive decision making among contraceptive users, ranging from 71% of women using a method in Comoros to 98% of women using a method in Egypt, Myanmar, and Rwanda.

Indicator 16, however, paints an incomplete picture of empowerment and voluntary decision-making. Given that the indicator scores are high and vary little across countries, years, or respondent characteristics, the indicator may not be capturing many of the challenges that women face in deciding to use contraceptives and selecting a method. Furthermore, Indicator 16 only measures the decision-making power of women who are currently using a method, and gives no insight

²⁷ Methods assessed for stock-outs were: female sterilization, male sterilization, IUD, implant, injectable, pill, male condom, female condom, and emergency contraception.

²⁸ Stock-outs of the most common method could not be assessed in Guinea as LAM is the most common method in use.

²⁹ Note that this indicator could not be calculated for Mauritania, but only 8% of secondary and 0% of tertiary facilities reported availability of at least 5 methods, so we can assume they would be included in this group.

into the experiences of women who are not using a method and how that decision was made.

As a result of updates to the DHS questionnaire, data on contraceptive decision making among married non-users is now available for most DHS surveys conducted after 2015, including 14 surveys conducted in FP2020 focus countries. On average across these countries, 91% of married women using contraception and 86% of married women *not* using contraception but at risk of pregnancy³⁰ report that they made the decision to use or not use contraception alone or jointly with their husband/partner. The largest disparity was seen in Pakistan, where 94% of contraceptive users made their decision alone or jointly compared to 76% of non-users. By contrast, in Nepal the proportion of women who were the primary or joint decision-maker was very similar for non-users and users (87% and 85%). These new data shed some light on women's autonomy in decisions not to use contraception. On average, a slightly larger proportion of women are involved in the decision to use contraception than in the decision not to use it. Nevertheless, levels of involvement for both decisions are quite high across all countries with available data (>75%).

Of potential concern, related to issues of autonomy and choice in contraceptive decision making, are the 4% to 24% of women across these countries who report that decisions about contraception were made primarily by their husbands or "someone else" (answer category "other" in response to the question about who was the primary decision maker for the decision to use or not use contraception). From a rights-based perspective, women and girls should always be free to make decisions about their reproductive health without coercion or pressure from partners or others. From a measurement perspective, the lack of clarity on the "other" answer category for this question on the DHS questionnaire poses challenges in interpretation, given that respondents may use the "other" category to describe other people in their lives who participate in the decision jointly or others who make the decision for them.

CONTRACEPTIVE DISCONTINUATION AND SWITCHING

Fundamental to the right to free and informed choice is the ability to switch to a contraceptive method that better meets one's needs or choose to discontinue contraceptive use entirely.

As women move through their reproductive lives, contraceptive discontinuation is expected at certain

times because of lack of need: during attempts to get pregnant, during periods of infrequent sex or a husband's absence, following a marital separation, or when a woman determines that she is infertile or has completed menopause. But method discontinuation and switching can also be indicative of barriers to free and informed choice, especially when women discontinue for reasons other than lack of need. Health concerns and side effects, inconvenience of using a method, lack of access, and opposition from a husband are just a few of the reasons that women report for discontinuation.

Core Indicator 18a, contraceptive discontinuation, and **Core Indicator 18b**, contraceptive method switching, can help contextualize MCPR and the total number of contraceptive users by illustrating the churn of users in and out of episodes of use, and by highlighting the effort required to maintain, let alone increase, contraceptive prevalence. These indicators can also draw attention to the changing needs of women and potential issues with method provision that may be limiting choice. Across FP2020 focus countries with available data on discontinuation, the highest rates of first year discontinuation are generally seen with short-term methods, which can be passively discontinued by simply stopping use of the method. On average 36% of episodes of injectable use, 41% of episodes of pill use, and 38% of episodes of condom use are discontinued in the first year of use. Discontinuation rates are much lower for methods that require a woman to go to a provider to have the method removed; 16% of episodes of IUD use and 11% of episodes of implant use are discontinued in the first year.

Most important is to look at discontinuation rates while in need, which indicate the rates of first-year discontinuation of a method for reasons unrelated to the desire to get pregnant or other "lack of need" reasons cited above. Analysis of 33 countries with survey data since 2012 shows average rates of discontinuation of short-term methods while in need that are around 20%, meaning that a fifth of episodes of use of these methods stopped within 12 months despite the user still potentially needing contraception. These rates could reflect passive discontinuation by women who just stop using, but could also point to challenges women face in accessing methods that require resupply, dissatisfaction with these methods, or side effects, among other possible reasons. Rates of discontinuation of long-acting reversible contraceptives (LARCs) while in need are generally lower, with an average of 11% of IUD episodes and 8% of implant episodes discontinuing within the first year of use. This may indicate higher satisfaction

³⁰ Analysis was limited to married women who were not using contraception, were not pregnant or postpartum amenorrheic, and were not categorized as infecund—based on standard categorizations for unmet need—in order to focus on women for whom not using contraception would be a meaningful decision.

with these methods or better advance counseling, but could also point to limitations on access to IUD and implant removal.

Rates of method switching³¹ can provide additional insights on contraceptive dynamics. A woman may decide to stop using a method in favor of one she prefers, or may switch from a less effective short-term method to a more effective long-acting 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. Very low rates of method

switching could suggest that women are more satisfied with the given method, or conversely that they may not be able to act on their preferences to change methods or that method availability is limited. Overall, rates of switching are quite low, with less than 10% of users of any method switching to another method within the first year of use. The lowest rates of switching are seen among LARC users: an average of 4% of IUD episodes and only 3% of implant episodes ended with a switch to another method within the first year, which could again relate to the need to see a provider to remove these methods.

FURTHER ANALYSIS AND IMPROVEMENTS TO DISCONTINUATION INDICATORS

FP2020 added and reported contraceptive discontinuation and switching indicators for the first time in 2017. Since the adoption of these new Core Indicators, FP2020's PME Working Group has continued to discuss how to improve the interpretability of these complicated measures. Over the past year the group has begun to look more closely at switching, noting that FP2020's definition of in-need discontinuation includes episodes of contraception that end with a switch within a month's time to another method. This definition is consistent with the way that the Demographic Health Survey treats switching, but does mean that a portion of reported in-need discontinuation is actually contraceptive method switching. The graphic below illustrates 12-month discontinuation rates for

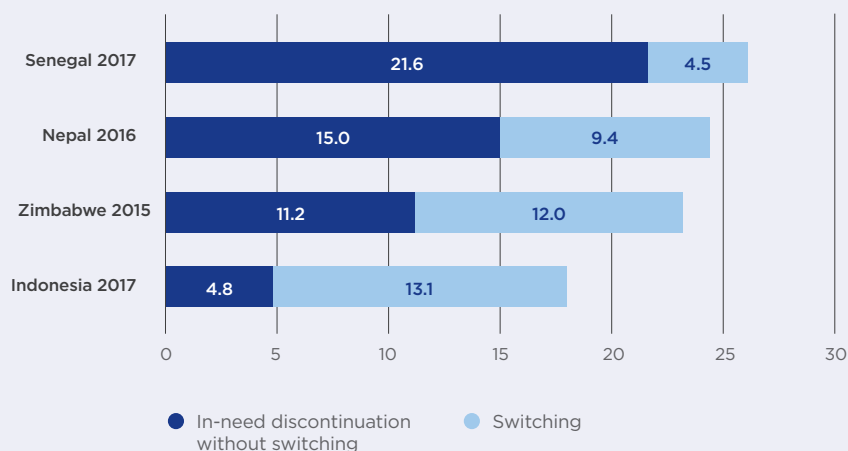
injectables in four countries and shows the portion of discontinuation while in need that constitutes switching to another method.

Based on the PME Working Group's recommendation, FP2020 anticipates making further changes in the coming years to ensure that discontinuation data are more interpretable, actionable, and comparable over time. These changes will include separating switching from in-need discontinuation and a change in the way discontinuation rates are calculated to ensure they are comparable across time and across countries. In addition, FP2020 will produce a special analysis of contraceptive discontinuation and switching to further examine, explain, and illustrate contraceptive dynamics.

FIGURE 9
DISCONTINUATION AND SWITCHING RATES FOR INJECTABLES

This graphic breaks down the 12-month in-need discontinuation rate for injectables into two parts: the rate of in-need discontinuation that ends by switching to another method, in light blue, and discontinuation that ends with ceasing contraceptive use, in dark blue.

Note: The data come from the most recent DHS.



³¹ A woman is considered to have switched methods if a) she stops using one method and immediately begins using a different method or b) she stops using one method due to "wanting a more effective method" and begins using a different method within one month. Outside of these two scenarios, she is considered to have discontinued contraceptive use.

MODERN CONTRACEPTIVE METHOD MIX

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

While there is no “right” or “ideal” method mix, there is consensus that a wide variety of methods should be available to meet the varied and changing needs of women and girls, including short-term, long-acting reversible, and permanent methods.³² Based on Indicator 9, more than one-third (26) of FP2020 focus countries have 5 or more modern methods in use,³³ representing at least one permanent, one long-acting reversible, and one short-term method. In 11 of the 69 FP2020 focus countries, both types of long-acting reversible contraception (IUDs and implants) are used by more than 5% of modern users, indicating some level of availability and choice in reversible methods. Expanding the number of methods available to women and girls increases the likelihood that they will be able to choose a method that meets their needs as they move through the reproductive life cycle, including reversible methods to delay or space pregnancies and permanent methods once desired fertility has been reached.

Modern contraceptive method mix varies greatly across the FP2020 focus countries, reflecting women's preferences but also the diverse contexts in which they live, including local availability and provider biases. One way to explore this variation is to examine the most common method in use. There are seven methods³⁴ that appear as the most common modern method in at least one FP2020 country, with some distinct regional patterns. Injectables continue to be the most common contraceptive in use in the largest number of countries (25 of 69), including countries in nearly every region. Similarly, the 16 countries where pills are the most common method are spread across

all the regions. In contrast, IUDs and implants seem to be more regionally concentrated. IUDs are the most common method in use in eight countries, all in Asia or MENA, while implants are the most common method in four countries, all in Western Africa (Ghana, Gambia, Benin, and Burkina Faso).

In 11 countries, the most common method is used by more than 60% of modern users, indicating substantial method skew. Substantial skew toward pills is seen in Sudan (78%), Somalia (73%), and Mauritania (67%). In Liberia, Madagascar, and Ethiopia, slightly more than 60% of modern users rely on injectables. In India the method mix is skewed toward female sterilization, which represents 75% of modern use in the country. Method skew can be indicative of individual preferences and socio-cultural norms promoting or discouraging particular methods. Skew toward a method in the method mix 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 drive women to shops and pharmacies, where they are generally limited to pills and condoms, while public sector implementation of task-sharing may dramatically expand access and use of methods like implants and injectables.

Analysis of 39 FP2020 focus countries with new surveys since 2014³⁵ reveals some meaningful shifts in method mix. In 32 of the 39 countries, implants have assumed a substantially greater proportion of modern use. Injectables have also grown as a proportion of the method mix, but in fewer countries (13). More than 20 countries saw declines in the contribution of pills to the method mix, generally displaced by implants, injectables, or both, indicating shifts toward more effective methods. Only a few countries³⁶ have seen a change in the most common method in use, and these shifts generally represent a move toward more effective methods. In Benin, implants displaced injectables as the most common method in use, as women shifted away from private pharmacies and toward the public sector for family planning services. In Nigeria and Sierra Leone, injectables have risen to become the most common method in use, displacing less effective short-term methods.

³² “Method Mix.” Family Planning and Reproductive Health Indicators Database, MEASURE Evaluation, www.measureevaluation.org/prh/rh_indicators/family-planning/method-choice/method-mix.

³³ “Methods in use” is defined here as methods representing greater than 5% of modern use (>5% of users using). Methods included are: female sterilization, male sterilization, IUD, implant, injectable, pill, male condom, female condom, lactational amenorrhea method (LAM), diaphragm, foam or jelly, standard days method (SDM), and emergency contraception (EC). Note that no country had greater than 5% of users using female condom, diaphragm, foam or jelly, SDM, or EC. “Other modern methods” was excluded as it represents an aggregate of individual methods.

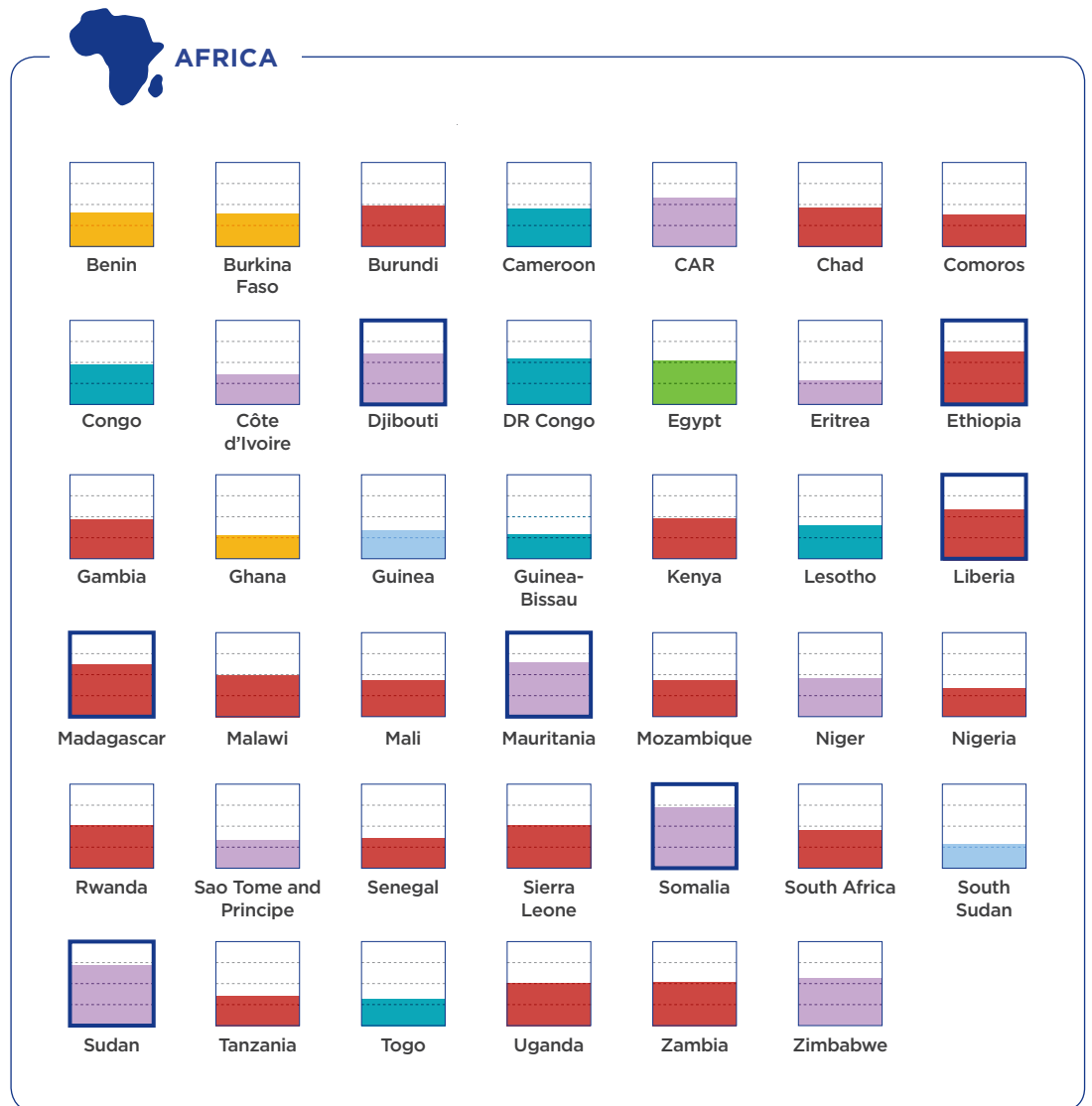
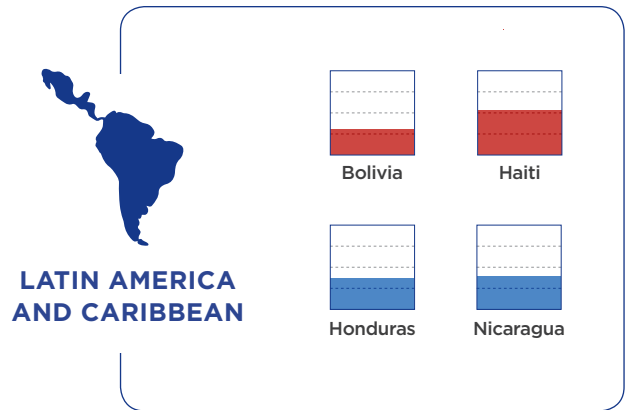
³⁴ Female sterilization, IUD, implant, injectable, pill, condom, and LAM are the most common method in at least one country.

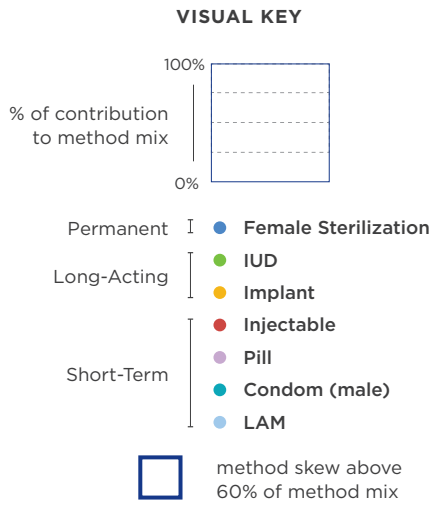
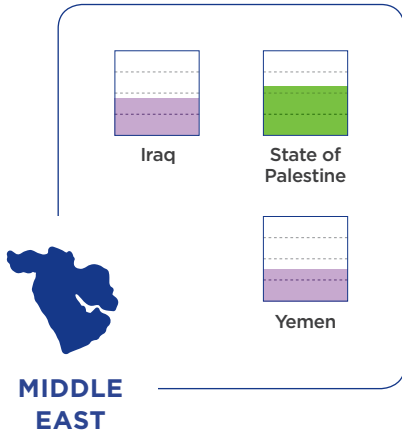
³⁵ The analysis looked at countries with one survey post-2014 and a survey of the same type prior to 2013 (no more than 10 years apart) in order to observe changes that occurred during the initiative; 2014 was set as the benchmark since the initiative began in mid-2012.

³⁶ Benin, Nigeria, Sierra Leone, Lesotho, and Guinea.

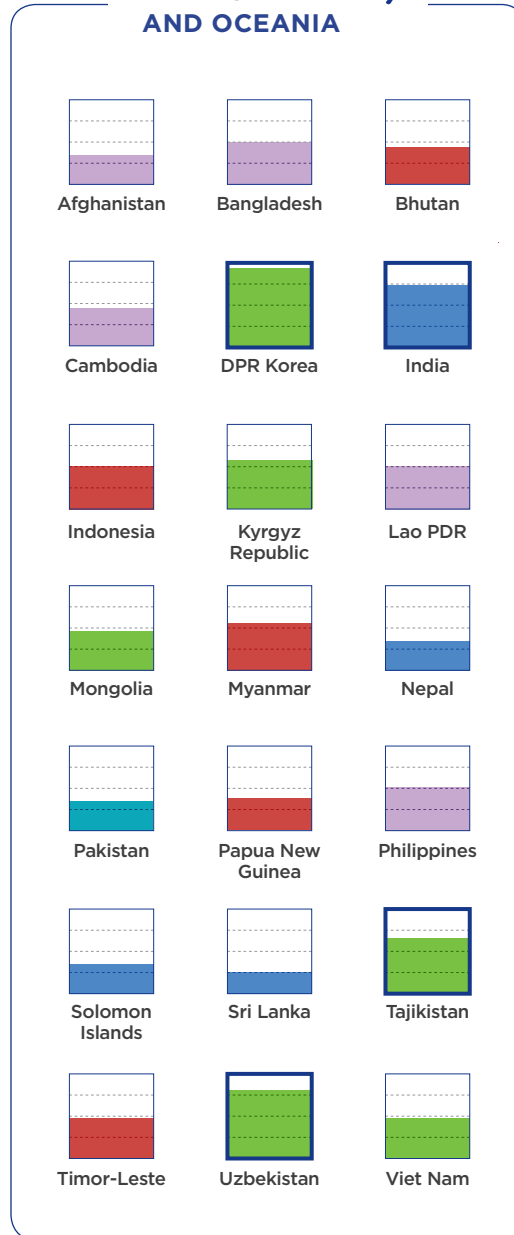
FIGURE 10 MOST COMMON METHOD

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





ASIA AND OCEANIA



These observed shifts toward more effective methods are contributing to increases in the average effectiveness³⁷ of the method mix in 26 of the analyzed countries. The largest changes were seen in Benin, Mali, Côte d'Ivoire, and Guinea-Bissau, where increases in implant prevalence (or injectable prevalence in Côte d'Ivoire) have improved the average effectiveness of the method mix, reducing the risk of method failure among contraceptive users. While a few countries have seen declines in method effectiveness, these appear to be driven largely by shifts away from sterilization as a wider array of methods become available—such as in Nepal, India, and the Philippines—and by the expansion of LAM, a popular postpartum method, as part of the method mix in countries such as Chad and Guinea.

Shifts in method mix can indicate where programmatic changes and interventions are successfully expanding access to information and increasing the availability of a broad range of methods; but lack of change in the method mix shouldn't necessarily be interpreted as a lack of progress. Women's preferences may not change as rapidly, or at all, compared to changes in method availability. Understanding how these many determinants of contraceptive choice fit together is best done with an understanding of country context and dynamics.

SUMMARY

Measuring free, full, and informed contraceptive choice among women and girls across the 69 FP2020 countries is a complicated endeavor. A range of factors may simultaneously encourage and inhibit women's ability to make decisions about their reproductive health and choose a method that best meets their needs. Among these factors are the availability of a wide range of methods to choose from, the provision of full information about available methods, and the involvement of partners or healthcare providers in decision making.

No one metric can fully capture free and informed contraceptive choice, and FP2020 is working to improve measurement of key elements and enabling factors of rights-based family planning. It is essential that these measurement efforts continue and grow as the community improves its understanding of the interconnected drivers of contraceptive choice. The process of monitoring these indicators draws attention to progress, and lack thereof, among FP2020 countries and helps to ensure that the rights of women and girls are central to family planning programming.

The emphasis on rights-based family planning and ensuring a full range of contraceptive methods is also fundamental to countries' ability to reach their goals of increasing contraceptive prevalence. Global analysis has shown that increasing the number of methods available and expanding women's and girls' access to a broad range of methods have significant potential to increase contraceptive use.³⁸ Successful family planning programs must respect the rights and meet the needs of the women, girls, and communities they serve.

➔ **The digital report includes a discussion of the 2019 WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights, with updates on self-administered injectable contraception and over-the-counter oral contraceptive pills.**

³⁷ Average effectiveness of the method mix is the weighted average of the method effectiveness (the inverse of the method failure rate) of the methods in use. This value, between 0% and 100%, indicates the percentage of modern users who would not experience an unintended pregnancy as a result of method failure in a given year.

³⁸ Ross, John, and John Stover. "Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009." *Global Health: Science and Practice* Aug 2013, 1 (2) 203-212; DOI: 10.9745/GHSP-D-13-00010.

UNDERSTANDING TRADITIONAL METHOD USE

While the focus of the FP2020 initiative is on modern contraceptive use, examination of survey data indicates that a large number of women in FP2020 focus countries still rely on traditional methods (periodic abstinence and withdrawal) to delay or prevent pregnancy. Traditional methods have been in use since before the advent of modern contraception as a means of birth spacing and limiting. Although modern methods generally have higher rates of effectiveness, some research suggests traditional methods can be as effective. For example, typical use of withdrawal has similar effectiveness as female condoms—preventing around 80% of pregnancies in a year of use.³⁹ In recent decades advances have been made on fertility awareness methods that support periodic abstinence, including new methods such as the Standard Days Method,⁴⁰ the Two-Day Method, and Dynamic Optimal Timing. All of these methods have lower failure rates than periodic abstinence at typical use.⁴¹

As of 2019, over 35 million married women⁴² across 52 FP2020 countries with available data⁴³ were using a traditional method;⁴⁴ among these, about half report using periodic abstinence and the other half withdrawal as their primary method. In 18 of the 52 countries, traditional method prevalence⁴⁵ among married women is over 5%, and in seven countries it is over 10% (Cameroon, Cambodia, DR Congo, Iraq, Philippines, State of Palestine, and Viet Nam). Viet Nam has the highest prevalence of traditional method use at 19%.

While traditional method use is prevalent in many countries, it has been steadily declining over time in every FP2020 country except for Nepal and Ghana. In Nepal, traditional method use increased by more than 3 percentage points between 2011 and 2016, whereas in Ghana the growth in traditional method use was more modest—1.5 percentage points. In Nepal the

increase was largely driven by an increase in reliance on withdrawal, while the increase in Ghana was due to an increase in periodic abstinence.

In general, looking across the 52 countries with available data, traditional method use tends to be most common among women in urban areas, in the highest wealth quintile, and with secondary or higher education. Furthermore, in most countries traditional method users have a higher median age than modern method users. There are, however, exceptions, such as DR Congo, Lesotho, Mali, Zambia, CAR, Mauritania, Cameroon, South Sudan, and India, where traditional method use is more common among women in lower wealth quintiles.

Continued reliance on these methods indicates that they are likely meeting the reproductive needs of some women and couples. The profile of traditional method users in many countries—wealthy, educated, and urban—could indicate that some women are choosing traditional methods in spite of having access to modern methods. The data from some of the other countries mentioned above, however, suggest that some women who face barriers to modern method use, including young women and women in hard-to-reach areas, may use traditional methods because they do not require interaction with a health care provider.

The continued reliance on traditional methods in many contexts indicates the need for better understanding of the reasons for traditional versus modern method use. As understanding of traditional use improves, family planning programs can determine whether traditional use represents an opportunity to remove barriers to modern methods, and/or an opportunity to better support women's fertility intentions and contraceptive choice with an increased focus on traditional methods.

³⁹ Hatcher, Robert A., and Ward Rinehart, Richard Blackburn, Judith S. Geller, James D. Shelton, et al. *The Essentials of contraceptive technology: a handbook for clinic staff*. Baltimore: Population Information Program, Johns Hopkins University, School of Public Health, 1997. Fourth printing, 2003. apps.who.int/iris/handle/10665/42331.

⁴⁰ Standard Days Method is considered a modern method although it is non-hormonal.

⁴¹ See <http://irh.org/standard-days-method/>, www.twodaymethod.com/faq, and <https://www.ncbi.nlm.nih.gov/pubmed/30880509>

⁴² Analysis was limited to married women to allow for comparability between countries that didn't include unmarried women in their sample.

⁴³ Analysis included only national surveys from 2012 and later. The 2019 Revision of World Population Prospects was used to calculate the number of married traditional methods users. The UN Population Division also calculates contraceptive use through a Bayesian modeling technique: un.org/en/development/desa/population/theme/family-planning/cp_model.asp.

⁴⁴ "Traditional method" refers to withdrawal and periodic abstinence.

⁴⁵ Traditional method prevalence is the proportion of women of reproductive age (15–49) who use withdrawal or periodic abstinence as their primary method of family planning.

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FAMILY PLANNING 2020

www.familyplanning2020.org

Family Planning 2020 (FP2020) is a global partnership that supports the rights of women and girls to decide—freely and for themselves—whether, when, and how many children they want to have.

FP2020 works with governments, civil society, multilateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

An outcome of the 2012 London Summit on Family Planning, FP2020 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 services and rights by 2030, as laid out in Sustainable Development Goals 3 and 5. FP2020 is in support of the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health.

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