

FP2020 PARTNERSHIP IN ACTION

2012-2013



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FP2020
PARTNERSHIP
IN ACTION
2012-2013



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ISSUED NOVEMBER 2013
AMENDED DECEMBER 2013

When women have the tools they need to plan their families—information, access to contraceptives, and high-quality health care—they are much more likely to finish their education. That gives them the opportunity to do what they do best: build thriving families, communities, and nations.

MELINDA GATES
CO-CHAIR, BILL & MELINDA GATES FOUNDATION

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EXECUTIVE SUMMARY

Our goal is to expand access to contraceptives to an additional 120 million women and girls in the world's poorest countries by 2020.

At the 2012 London Summit on Family Planning, the leaders of 150 countries, international agencies, civil society organizations, foundations, the research and development community, and the private sector endorsed the goal of expanding access to family planning information, services, and supplies to an additional 120 million women and girls in the world's poorest countries by 2020.

Family Planning 2020 (FP2020) carries forward this momentum. Since its launch, more than 25,000 individuals and organizations have expressed interest in joining FP2020, and the constellation of stakeholders who are vested in improving women's and girls' lives continues to grow.

One-quarter of FP2020 commitment-making countries have launched detailed, costed national family planning plans. One-third of commitment-making countries have increased their national budget allocations for family planning services or supplies. Half of commitment-making countries have held national family planning conferences to emphasize high-level political support and to accelerate progress on family planning strategies.

Preliminary data on international donor expenditures indicate an increased level of disbursements on family planning programs. Concrete examples of progress on the local, national, and regional levels are detailed throughout this report.

A rigorous measurement and evaluation agenda has been established as a means of guiding progress in delivering on the promise set forth in London. Over the past year, FP2020

initiated a number of activities to establish the systems and infrastructure necessary to monitor the impact of family planning programs and to strengthen accountability for implementing financial, policy, and programming commitments. This undertaking included the selection of core indicators, collating corresponding baseline data, improving the way in which family planning expenditures are tracked, and launching electronic data collection in select countries.

Importantly, FP2020 also laid the groundwork to develop a transformative framework to measure and report on the autonomy, equity, and human rights-based dimensions of family planning programs.

Countries have made progress in addressing supply and demand barriers to accessing family planning.

This report describes significant actions taken in the past year, including price reduction agreements, innovations in contraceptive technology, improvements in service delivery and commodities distribution models, and outreach to vulnerable and marginalized groups, in the global effort to continue to expand access and choice for millions of women and girls.

The progress documented in this report demonstrates that we are moving forward—program by program, clinic by clinic, and community by community—toward a future in which all women, no matter what their circumstances, will have the information, services, and supplies they need to decide freely and for themselves whether, when, and how many children they want to have.

FOREWORD

Under the right conditions, bringing together a broad, diverse group can yield results far greater than the participants would achieve on their own.

It may defy the rules of mathematics, but there is truth to the observation that a whole can be greater than the sum of its parts. This insight lies at the heart of the Family Planning 2020 (FP2020) initiative. We believe that, under the right conditions, bringing together a broad, diverse group can yield results far greater than the participants would achieve on their own.

Last year, leaders from governments, civil society, multilateral organizations, donors, the private sector, and the research and development community converged at the London Summit on Family Planning to agree upon one extraordinary—but absolutely vital—goal: expand access to family planning information, contraceptives, and services to an additional 120 million women and girls in the world's 69 poorest countries by the year 2020. Seventy commitments were made, and donors and the private sector pledged US\$2.6 billion in new funding.

FP2020 carries forward the momentum of the Summit. It is not a new NGO, nor is it a vertical fund. Instead, it is a different way of working together: a creative network of cooperation that revolves around a hub to promote knowledge sharing and emergent thinking. Rather than duplicating efforts or pushing organizations into a new hierarchy, FP2020's structure encourages partners to align their agendas, pool their talents, and utilize existing structures in new and complementary ways. One year after the Summit, we have successfully formed new alliances among a broad range of partners from all sectors. We must now hold ourselves accountable.

We believe that the family planning community's greatest resource is the human energy of our diverse leaders, experts, advocates, and implementers. Some of the most exciting progress of the past year came from innovative partnerships

that harnessed market incentives to solve formerly intractable problems. Millions of women in the world's poorest countries will now have access to long-acting, reversible contraceptive methods thanks to the vision and dedication of colleagues representing governments, NGOs, pharmaceutical companies, donors, and multilateral organizations.

Accurate, timely, accessible information is the lifeblood of this initiative. That's why FP2020 is committed to expanding participation in the practices of measurement, evaluation, and adjustment, which for many countries are in their infancy. For the first time, this report documents the results of our collective effort to establish a measurement framework for the initiative. The indicators, methodologies, and data presented here will serve as the baseline to gauge our progress in future years. This is especially important because, though the world is spending more on family planning, funding is still inadequate. Budgets for international assistance have been cut and programs are under greater pressure than ever before. Through careful analysis we will diminish inefficiencies, leverage economies of scale, and focus on plans that work.

Expanding access to contraceptives for an additional 120 million women and girls will require the equivalent of US\$4.3 billion over the next eight years, over and above the US\$10 billion necessary to sustain current use. FP2020 will actively seek new funding, policy, and service delivery commitments. We will promote accountability for those commitments by tracking and reporting progress, linking with the UN Secretary General's Global Strategy for Women's and Children's Health, *Every Woman, Every Child*.

Insufficient funding is just one reason family planning programs may fail to reach women and girls. Social and cultural factors such as gender inequality, discrimina-

tion, and a lack of appreciation for cultural sensitivities and personal preferences are all formidable barriers. Family planning strategies will not succeed unless they are embedded in a continuum of care, protect human rights, and promote gender equality. No plan can be said to serve the needs of women and girls if it does not respect their agency.

As we present FP2020's first annual progress report, we look forward to the year ahead. We are inspired by the power and promise of information, the dynamic intelligence and creativity of our colleagues in all sectors, and our shared dedication to achieving our common goal. Reaching 120 million additional women and girls with life-saving contraceptives in just eight short years is an ambitious goal, but together we will succeed.



DR. CHRIS ELIAS

PRESIDENT, GLOBAL DEVELOPMENT
BILL & MELINDA GATES FOUNDATION



DR. BABATUNDE OSOTIMEHIN

EXECUTIVE DIRECTOR
UNITED NATIONS POPULATION FUND

- 07.12**
- London Summit on Family Planning. 70 commitments made toward increasing access to family planning for additional 120 million women and girls, including pledges amounting to US\$2.6 billion and commitments by more than 20 governments
 - Announcement to expand access to *Sayana® Press* injectable contraceptive

- 10.12**
- Kenya launches costed national family planning plan
 - Ghana holds national family planning conference, Kumasi

- 11.12**
- Ethiopia holds *National Family Planning Symposium*, Bahir Dar
 - India holds *National Review Meeting on Family Planning*, New Delhi
 - Nigeria holds *National Family Planning Conference*, Abuja
 - Senegal launches *National Strategic Plan for Family Planning Promotion*
 - Kenya amends *National Family Planning Service Provision Guidelines*, allowing trained community health workers to offer injectable contraceptives at community level

- 12.12**
- *Responsible Parenthood and Reproductive Health Act* signed, Philippines
 - Malawi approves *National Population Policy*
 - FP2020 Reference Group meets for the first time, New York

- 02.13**
- Niger launches costed national family planning plan
 - FP2020 Stakeholders meet
 - Agreement to reduce price of Jadelle® contraceptive implant

- 03.13**
- FP2020 Reference Group meets for the second time, Washington, D.C.

- 05.13**
- FP2020 commitment makers at *Women Deliver Third Global Conference*, Kuala Lumpur
 - PMA 2020 and Track 20 projects launch
 - Agreement to reduce price of IMPLANON® and IMPLANON NXT® contraceptive implants
 - FP2020 Reference Group meets for the third time, Kuala Lumpur

- 06.13**
- Burkina Faso launches national family planning plan
 - Memberships of FP2020 Country Engagement, Performance Monitoring & Accountability, and Rights & Empowerment Working Groups announced

- 07.13**
- Uganda's Parliament approves the *National Population Council Bill*
 - One-year anniversary of the London Summit on Family Planning
 - FP2020 Country Engagement Working Group convenes for first full meeting, Washington, D.C.
 - FP2020 Performance Monitoring & Accountability Working Group convenes for first full meeting, Geneva

- 08.13**
- FP2020 Rights & Empowerment Working Group convenes for first full meeting, Washington, D.C.
 - Burkina Faso launches *Consolidated Action Plan for Family Planning*

- 09.13**
- Indonesia holds *National Family Planning Summit*, Jakarta
 - Senegal launches nationwide scale-up of Informed Push Model of distribution for contraceptive commodities
 - Zambia launches *Costed Eight-Year Integrated Family Planning Scale-up Plan*
 - FP2020 Reference Group Meeting, New York
 - Family Planning Association of Pakistan holds *Towards Realizing Family Planning Vision 2020* seminar

- 10.13**
- Tanzania holds national family planning conference, Dar-es-Salaam
 - FP2020 Market Dynamics Working Group membership announced

- 11.13**
- *Third International Conference on Family Planning*, Addis Ababa. New FP2020 commitments announced

- 12.13**
- Uganda to hold national family planning conference



SECTION 01

Commitments and Accountability

Family planning programs have had a profound impact in a relatively short period of time. In the developing world, the contraceptive prevalence rate (modern methods) rose from negligible levels in the 1960s to 55% in 2000.¹ Although many groups were underserved, steady progress was manifest.

But the gains stopped, and the contraceptive prevalence rate leveled off. Support for family planning and reproductive health remained high, but the sense of urgency had waned. For far too

many decision makers, funding and implementing these programs were no longer priorities.

Today, this work remains far from finished. There are more than 220 million women in developing countries who don't want to get pregnant but lack access to the family planning information, services, and supplies they need. Nothing short of our full dedication is required to surmount the logistical, financial, geographical, and other barriers they face. It is to these women that FP2020 is ultimately accountable.

¹ Singh S and Darroch JE, Adding It Up: Costs and Benefits of Contraceptive Services, Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012, <http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>

WOMEN AND GIRLS AT THE HEART OF FP2020

Bridget Anyafulu is the founder and executive director of the International Centre for Women's Empowerment and Child Development (ICWECD). She is based in Delta District, Nigeria. She is a member of the FP2020 Rights & Empowerment Working Group, with whom she shared this story.

A project that brings fresh running water to a remote, impoverished village—how could it be anything other than a blessing?

The local women didn't see it that way.

In a small village in the Delta District of Nigeria, women would walk up to four kilometers every day to get water from the nearest river. These women had a secret.

Many were desperate to delay getting pregnant. Local people believed husbands should decide how many children to have, and men preferred big families. It was not unusual for women to give birth eight, nine, or 10 times. Motherhood started early; one assessment found that approximately 50% of the village's girls already had a child. Tragically, maternal and child deaths were common.

If a woman could get to a hospital, she could get access to contraceptives. But getting there was only part of the problem. By taking contraceptives, a wife was usurping her husband's authority. If she

was caught taking a pill, his wrath, and the wrath of his family, could be formidable.

The women devised a plan. They bundled up their contraceptives and hid them in a tree near the river. Every day, on their way to fetch water, they could take their pills out of sight of the men.

Then the pipes came. Now, with running water not 200 meters from their doorsteps, the women had no excuse to visit the tree by the river. They didn't want to get caught by their husbands, but no woman wants to die in childbirth or lose her newborn.

So they came up with a new plan. The women vandalized the water pipes.

When Bridget saw what had happened, she knew the problem was neither the pipes nor the women. She understood that the root of the trouble was the husbands' attitude toward family planning, and the cultural norms that kept women disempowered. She also knew that if this was a problem in one village, it was likely a problem in other Delta District communities.

Bridget's strategy was to convince husbands that women have the right to live and to see their children grow and thrive. To do that, women need to space their pregnancies and have fewer children.

She went from village to village and home to home, talking with leaders and individual husbands about the benefits of family planning. She persuaded them that having fewer children, who are healthy and educated, is a better legacy than having many children whose prospects are dim. She helped them understand that when a mother dies in childbirth, the whole family and the community suffer.

It took many years of hard work, but today, attitudes in Delta District have changed. Family size is smaller, and there are fewer maternal and newborn deaths. There is still a long road ahead, but the lessons are clear. Services should never be implemented without a deep understanding of the needs of all members of a community. Building a pipeline is not enough. For change to take root, we must place women's empowerment at the center of the development agenda.

FAMILY PLANNING 2020

The 2012 London Summit on Family Planning was intended to reenergize the global family planning community, but the enthusiasm it unleashed far exceeded expectations. Leaders from 150 donor and developing countries, international agencies, civil society organizations, foundations, and the private sector joined together to endorse the goal of expanding access to contraceptives to an additional 120 million women and girls in the world's poorest countries.

FP2020 carries forward this momentum. Since its launch, more than 25,000 individuals and organizations have expressed interest in joining FP2020, and the constellation of stakeholders continues to grow.

FP2020 has developed a platform that recognizes change must occur on multiple levels, across multiple sectors, by enabling a broad range of allies to participate in their area of expertise. The structure of FP2020 fosters the cross-pollination of ideas and creates a space to reach consensus, especially on crucial matters such as indicators to monitor progress.

Equally important are the things FP2020 does not do. It does not create bottlenecks by funneling all participants into one-size-fits-all strategies. In recognition that duplicative reporting structures create significant administrative burdens, FP2020 does not require

countries to adhere to a new reporting regime. FP2020 does not divert attention from its constituent stakeholders, but rather magnifies their ability to mobilize resources and deliver life-saving services.

FP2020 STRUCTURE

FP2020 is governed by a Reference Group that sets the overall strategic direction and drives coordination among the partnership's stakeholders. The Reference Group has 18 members representing governments, multilateral organizations, civil society, and the private sector.

The current Co-Chairs of the Reference Group are Dr. Babatunde Osotimehin, Executive Director of UNFPA, and Dr. Chris Elias, President of the Global Development Program at the Bill & Melinda Gates Foundation. To date, the Reference Group has met four times: in December 2012 and in March, May, and September 2013.

FP2020 has a Task Team responsible for the implementation of day-to-day activities. It is led by Valerie DeFillipo, reports to the Reference Group, and is hosted by the UN Foundation. The Task Team monitors overall progress for reporting to countries and to the Reference Group, coordinates across other entities and external groups, and supports Working Group strategies and implementation.

The imperatives of human rights and public health are not merely compatible; they are indivisible. FP2020 has four Working Groups that mirror the lateral, organic interrelation of the forces that contribute to rights-based family planning programs.

- Countries vary in the type of support they need to develop, implement, and monitor transformational national family planning strategies. The Country Engagement Working Group (CE WG) works with partners to provide support to accelerate the implementation of country plans within the context of their reproductive, maternal, newborn, and children's health strategies. CE WG facilitates access to technical, funding, and other assistance, and coordinates information sharing and peer-to-peer support. CE WG works with the Performance Monitoring & Accountability Working Group (PMA WG) to measure the impact of family planning programs and to strengthen countries' efforts to collect and utilize data on an ongoing basis to inform decision making.
- Substantial and consistent monitoring and evaluation efforts are central to FP2020's efforts to track advances, identify gaps and challenges, and promote accountability. The PMA WG strives to improve the quality and availability of information for use at the community, country, and global levels and to further explore methodologies to measure service quality, encourage the use of data in program management and policy development, and embed human-rights approaches recommended by the Rights & Empowerment Working Group (RE WG).
- FP2020 envisions a world where the right of women and girls, no matter where they live, to decide whether and when to have children is respected, protected, and fulfilled. The RE WG acts as a resource for expertise,

guidance, best practices, and tools to ensure that a rights-based approach underpins the design, implementation, monitoring, and evaluation of family planning programs. RE WG will collaborate with other Working Groups and partners to address the full range of barriers that limit or prevent many women from using family planning information, services, and supplies, and to prioritize human rights principles such as participation, accountability, non-discrimination, empowerment, transparency, and sustainability in all FP2020 activities.

- FP2020's Market Dynamics Working Group (MD WG) will improve global and national markets to sustainably ensure choice and equitable access to a broad range of high-quality, affordable contraceptive methods. MD WG is driven by the need to ensure that family planning commodities are available for an additional 120 million women and that the market is healthy enough to sustain this demand after 2020. A well-coordinated, expert working group focused on addressing tensions and information gaps in the market can unlock new and important opportunities to ensure that access to contraceptive supplies and services is expanded. That is the aim of market shaping, whether it is achieved by making products more affordable, ensuring appropriate product design, securing adequate and sustained supplies, improving product quality, or increasing product availability.

Each Working Group has an affiliated Consultative Network of stakeholders who will be engaged periodically for input on Working Group activities. The Consultative Networks provide additional expertise and are instrumental in identifying critical resources and materials that highlight success stories, high-impact practices, and innovations to share with decision makers at the country level.

The London Summit on Family Planning last year was a starting point for determined global action on family planning. Public, private and civil society partners from around the world agreed to a goal of giving an additional 120 million girls and women in the world's poorest countries access to voluntary family planning by 2020.

Investing in girls and women in this way is also the smart thing to do. It is about giving women in developing countries the choice over when to get married and how many children to have, control over their lives and their job prospects, and a voice in their communities.

I welcome the progress the FP2020 movement has made so far and the UK will continue to play its part. Our goal must be for all girls and women to have the opportunity to shape their own future.

THE RIGHT HONOURABLE JUSTINE GREENING
MP, SECRETARY OF STATE FOR INTERNATIONAL
DEVELOPMENT, UNITED KINGDOM

PROGRESS ON COMMITMENTS TO FP2020

The enthusiasm that emerged at the London Summit on Family Planning is yielding tangible results, and it is clear that countries² are leading the way. As of July 2013, countries comprised one-third of the 70 commitment makers to FP2020.

THE FP2020 COMMITMENT-MAKING COUNTRIES ARE:

- | | |
|---------------|---------------------------|
| Bangladesh | Pakistan |
| Burkina Faso | Philippines |
| Côte d'Ivoire | Rwanda |
| Ethiopia | Senegal |
| Ghana | Sierra Leone |
| India | Solomon Islands |
| Indonesia | South Africa ³ |
| Kenya | Tanzania |
| Liberia | Uganda |
| Malawi | Zambia |
| Mozambique | Zimbabwe |
| Niger | |
| Nigeria | |

FP2020 Commitment Makers



- Low- and Middle Income Countries (24): 34%
- Civil Society Organizations (23): 33%

- Donor Countries, Foundations, Private Sector (19): 27%
- Multilaterals and Partnerships (4): 6%

² FP2020's goal is to enable an additional 120 million women in the world's poorest countries (FP2020 focus countries) to use modern contraception by 2020. These countries—69 in total—are defined as those with a gross national income (GNI) of \$2,500 per year or less (based on the World Bank 2010 classification using the Atlas Method).

³ South Africa's GNI does not qualify as one of the world's poorest based on the World Bank 2010 classification using the Atlas Method.

Progress is driven by the governments of these countries, in collaboration with civil society organizations, service providers, advocates, industry leaders, and experts. Multilateral organizations, foundations, and other members of the global family planning community provide support and technical assistance.

One-quarter of FP2020 commitment-making countries have launched detailed, costed national family planning plans. One-third of commitment-making countries have increased their national budget allocations for family planning services or supplies. Half of commitment-making countries have held national family planning conferences to emphasize high-level political support and to accelerate progress on family planning strategies. Preliminary data on international donor expenditures indicate an increased level of disbursements for family planning programs. Concrete examples of progress on the local, national, and regional levels are detailed throughout this report.

Snapshot of Country-Led Progress

BURKINA FASO

National family planning plan launched
Introduction plan for Sayana® Press approved

ETHIOPIA

National Family Planning Symposium
National budget for family planning increased
Community Health Extension program expansion continued

GHANA

National Family Planning Conference

INDIA

National Review Meeting on Family Planning

INDONESIA

National Family Planning Summit
National budget for family planning increased
Family planning services and supplies available free of charge in national insurance program, commencing January 2014
National resources redirected to smaller islands and areas with greatest unmet need

KENYA

Costed national family planning plan launched
National budget for family planning services and commodities both increased
Guidelines changed to allow community health workers to provide injectables
Increased access to family planning services for the impoverished and youth

MALAWI

National Population Policy approved

NIGER

Costed national family planning plan launched
Introduction plan for Sayana® Press approved
Meeting of 80 traditional chiefs convened by government and UNFPA to discuss family planning
School for Husbands initiative expanded

NIGERIA

National Family Planning Conference organized
National budget for family planning commodities and services increased
Gombe State plan to expand access to family planning launched
Policy change to allow community health workers to provide injectable contraceptives
Cluster model of integrated services implemented by Nigeria Planned Parenthood
President launched Saving One Million Lives initiative
Family planning trainings scaled up
Trainings of community health workers on injectable contraceptives begin
Distribution of contraceptives to the last mile using review-resupply meeting model
BCC and media campaign to increase knowledge and awareness of female condoms
Detailed implementation plan to expand use of modern contraception developed

PAKISTAN

National budget for family planning increased for fiscal years 2012-2013
Provinces currently developing budget frameworks for financing of family planning

SENEGAL

National Strategic Plan for Family Planning Promotion launched
Informed Push Model of distribution scaled up nationwide
Introduction plan for Sayana® Press approved

SIERRA LEONE

National budget for family planning increased
Voucher system implemented for family planning services for the poor
School for Husbands initiative launched
Civil society organizations supported to monitor distribution of reproductive health commodities

SOUTH AFRICA

Revised policy to require public health facilities to offer all contraceptive methods

TANZANIA

National family planning conference
National budget for family planning increased
Framework contract for procurement of contraceptives endorsed by government
Guidelines approved to allow NGOs direct access to Medical Stores Department

UGANDA

Stakeholders meeting to develop FP2020 action plan
National budget for family planning supplies increased
Reproductive health subaccount established to track resource flows
Unified, costed, national family planning plan under development
Policy changed to allow health worker task sharing and administration of injectables
Introduction plan for Sayana® Press approved
Vouchers for postpartum IUDs
Planning under way for first national family planning conference (December 2013)
Parliament passed bill to establish National Population Council

ZAMBIA

Costed Eight-Year Integrated FP Scale-up Plan 2013-2020 launched
Pilot study on allowing community health workers to provide contraceptive injections
Implementing scale-up of mobile health services

Family planning is not a privilege, but a basic human right. By enabling women, particularly the most disadvantaged and hardest to reach, to make informed choices about the number, timing and spacing of their children, we help them exercise this right.

DR. BABATUNDE OSOTIMEHIN
EXECUTIVE DIRECTOR, UNFPA

A CLOSER LOOK: GHANA

GHANA'S COMMITMENT TO FP2020

Ghana is committed to making family planning free in the public sector and to supporting the private sector in providing services. Services will be available for young people through youth promoters and adolescent-friendly services. Improved counseling and customer care will be prioritized. Contraceptive choices are being expanded to include a wider range of longer-acting and permanent methods, along with task shifting options and improvement of post-partum and post abortion family planning services. The government has put in place a comprehensive multisector program to increase demand for family planning as a priority intervention in the MDG 5 Acceleration Framework, including advocacy and communications to improve male involvement, such as the "Real Man" campaign.



Ghana has a diverse and inspiring range of family planning and maternal health programs. The city of Tamale, for example, has a brand-new Marie Stopes clinic situated in the middle of an enormous open-air market. Fully stocked with a range of family planning information and modern contraceptive options, it makes access easy for the women who work in the crowded midday market.

Worlds away from the bustle of the city, there are clinics such as the one Planned Parenthood of Ghana, built in an isolated village north of Bolgatanga. It offers an integrated mix of family planning and other health education services. The local people are proud of their clinic. It is their only source of medical care.

Not long ago, UNFPA Ghana welcomed a delegation of leaders at the isolated clinic. To get there, they rode by bus from the nearest city for three hours on unpaved roads.

The delegation was greeted with enthusiasm and excitement. About 200 people—village elders, mothers and fathers, grandmothers and grandfathers, children—had come out to show support for their clinic. They talked about the difference the clinic was making in their lives.

The Planned Parenthood of Ghana clinic will help Afia keep herself and her baby healthy.

Stephanie Freid-Perenchio
photography/SFP STUDIO

As the delegation toured the facility, they happened to notice one person who wasn't taking part in the excitement. Her name was Afia, pictured here, and she sat very quietly in a corner, on a hard, wooden bench. A midwife was by her side.

Afia's face was etched in pain, but her cries were muted. With quiet dignity, and few of the trappings that attend births in wealthier countries, they found out she was in labor to deliver her first child. She had reason to be scared.

In Ghana, for every 100,000 women who go into labor, 350 die while giving birth or because of pregnancy-related complications.

The following day, the delegation learned that Afia had had a lovely baby girl, and both mother and child were happy and, most importantly, healthy.

In the coming months and years, the Planned Parenthood of Ghana clinic will help Afia keep herself and her baby healthy, and will give her the information and contraceptives she needs to plan her family and her future.

The London Summit on Family Planning was a defining event for Indonesia's family planning program. Our commitment there crystallized actions we were considering for revitalizing our program. FP2020 continues to be a catalyst, as was evident during Indonesia's Summit on Family Planning.

DR. JULIANTO WITJAKSONO
DEPUTY OF FAMILY PLANNING AND REPRODUCTIVE HEALTH OF INDONESIA'S NATIONAL POPULATION AND FAMILY PLANNING BOARD (BKKBN)

A CLOSER LOOK: INDONESIA

INDONESIA'S COMMITMENT TO FP2020

Starting January 1, 2014, family planning services and supplies will be available free of charge through Indonesia's universal health coverage system, and efforts are underway to improve 23,500 clinics and strengthen human resources in order to meet increased demand. Resources are being reallocated to focus on the most densely populated areas, and efforts will be concentrated on reaching populations in rural areas and on smaller islands. The government is committed to working with national and international partners to provide the technical support needed to provide gender-sensitive, high-quality family planning information and services to all people, including unmarried women, youth, and the poor.

Indonesia's Family Planning Summit and Commemoration of World Contraception Day, held on September 26, 2013, in Jakarta, was a resounding success. More than 1,700 participants were in attendance. The Vice President of Indonesia, Dr. Boediono, opened the meeting by reiterating the government's strong commitment to family planning and by personally pledging his full support. Five government ministers presided over the opening and high-level panel discussions.

Dr. Julianto Witjaksono, Deputy of Family Planning and Reproductive Health of Indonesia's National Population and Family Planning Board (BKKBN), serves

on the FP2020 Reference Group. BKKBN's Dr. Siti Fathonah serves on FP2020's CE WG, and Dr. Roy Tjiong of the Indonesian Planned Parenthood Association serves on PMA WG. All three played an active role in designing and executing the Indonesia summit.

Historically, Indonesia had one of the world's most successful family planning programs. However, progress has decelerated over the last decade, and the contraceptive choices available for women have diminished. Today, fewer women are using IUDs and implants than 15 years ago. Responding to this stagnation, Indonesia committed to improving the quality of its family planning program at the London Summit on Family Planning.

Responding to this commitment, BKKBN convened four FP2020 country meetings. The meetings, which were co-chaired by USAID and UNFPA, had a catalytic impact on the reproductive health community and reframed and reinforced the government's revitalization efforts.

BKKBN's new chair, Dr. Fasli Jalal, told the Indonesia Family Planning Summit attendees that family planning must be prioritized as a long-term, multisector development issue. To do so, it is essential to build support in the local governments of more than 500 districts. Some significant actions discussed during the summit include increasing access to long-acting methods of contraception, improving and increasing midwifery services, and mounting a communications campaign to raise awareness of family planning choices.

One highlight of the summit was a panel of young people who discussed the needs of youth in Indonesia and challenged the government to increase the legal age for marriage from 16 to 18 years old. They asked for more attention and resources for sexuality education and greater support for young people, especially the poor and most vulnerable. The Minister of Health, Dr. Nafsiah Mboi, spoke of the critical importance of family planning in reducing maternal and infant mortality, and underlined the need to collaborate across government programs to support the needs of women and girls. Attendees applauded midwives for their heroic efforts to improve maternal health and for the pivotal roles they play in improving access to family planning and expanding contraceptive options.

Another high point was the announcement that BKKBN and the Population Commission of the Philippines had signed a memorandum of understanding to support south-to-south collaboration, with a focus on Mindanao Island, a conflict area in the Philippines that has a majority-Muslim population. Areas of collaboration include strengthening the role of faith-based organizations, sharing lessons on decentralization and local advocacy, and sharing best practices.

A CLOSER LOOK: UGANDA

UGANDA'S COMMITMENT TO FP2020

At the London Summit on Family Planning, Uganda committed to reduce unmet need for family planning from 40% to 10% by 2022. Uganda will increase the annual government allocation for family planning supplies from US\$3.3 million to \$5 million for the next five years and improve accountability for procurement and distribution. The government will develop and implement a campaign for integration of family planning into other services. This will include partnerships with the private sector and scaling up of innovative approaches, such as community-based distribution, social marketing, social franchising, and youth-friendly service provision. Uganda will strengthen the institutional capacity of public and community-based service delivery points to increase choice and quality of care at all levels.

In September 2012, the Ugandan Ministry of Health brought stakeholders together to begin an intensive, collaborative effort to capitalize on President Yoweri Museveni's commitment to FP2020. Partners in Population and Development Africa Regional Office (PPDARO) convened members of parliament to share the President's commitment and devise an action plan to hold the government accountable. The Uganda Family Planning Consortium (UFPC), comprising of all major

private providers of contraceptive services and supplies in the country, strategized a total market approach to coordinate service delivery and increase access to a full range of contraceptive methods. Donors, government, and others assessed the realities of speeding delivery of services and supplies to ensure universal access to quality, voluntary family planning services.

Within a year, the three main pillars of the commitment—increased national government investment in family planning, more donor support, and systems strengthening—had been accomplished. Specifically, the allocation for family planning supplies increased from US\$3.3 million to \$5 million in the current budget. UNFPA, USAID, and DFID exceeded the additional \$5 million called for from donors. Finally, a reproductive health subaccount was established to track reproductive health resource flows and improve the National Medical Stores' capability to distribute reproductive health supplies and commodities.

The government and its partners are now working to create a unified and costed national plan for family planning using the FP2020 commitment as a guide and to firmly ground the plan in Uganda's development priorities. The plan is expected to be completed and implementation underway by the end of 2013.

The UFPC and Advance Family Planning have already begun expanding access to family planning through innovations supported by government

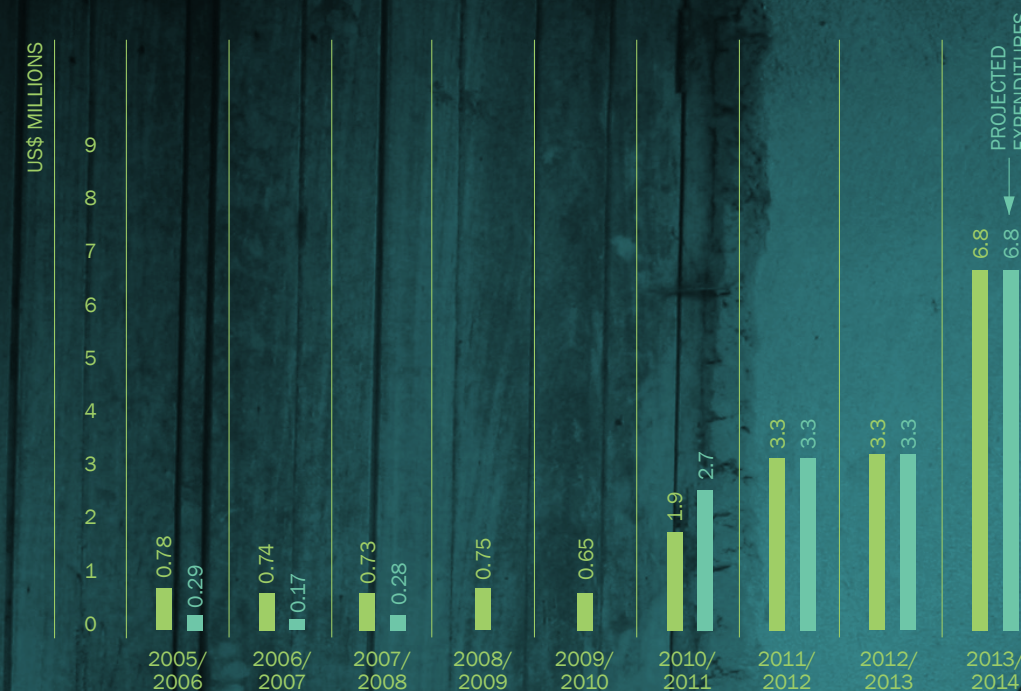
policy. These innovations include task sharing for contraceptive procedures and provision of contraceptive injectables by village health teams, and postpartum availability of IUDs through voucher programs. PPDARO will lead efforts to track the continued fulfillment of the commitment. The first-ever Ugandan family planning conference will take place in December 2013, coordinated by the Ministry of Health, UFPC, and others, with support from UNFPA.

Though Uganda's family planning needs are acute, there is renewed optimism that progress is possible and that health and development prospects will be significantly improved. With gains made toward fulfillment of the FP2020 commitment, universal access to family planning is within reach.

SOURCE
Advance Family Planning,
September 2013.

Government of Uganda Funding for FP/RH Commodities: Allocation Versus Expenditures, 2005/06 – 2013/14 (US\$ Millions)

- Allocated
- Spent



SOURCE
Reproductive Health Financing
for Uganda: Commitment to
Action. Partners in Population
and Development Africa
Regional Office, June 2013.

Uganda's FP2020 commitment presents a great opportunity to move forward on family planning. We have already met the main first-year components of the commitment and now we must work together to see them bear fruit.

DR. COLLINS TUSINGWIRE
ASSISTANT COMMISSIONER FOR
REPRODUCTIVE HEALTH,
UGANDA MINISTRY OF HEALTH

HIGHLIGHT

UNFPA DISBURSEMENTS

At the London Summit on Family Planning, UNFPA committed to increasing the proportion of its resources focused on family planning from 25% to 40%, based on funding levels at that time. It calculates that this will bring new funding for family planning of at least US\$174 million per year from 2013 to 2019. In 2012, UNFPA spent approximately 40% of its total resources on family planning (~US\$272 million) and approximately 70% on sexual and reproductive health (~US\$470 million).⁴

ACCOUNTABILITY: FROM COMMITMENTS TO PROGRESS

Accountability is an aspect of justice: it invokes the expectation that institutions will understand and respect the needs of all the people who are affected by their actions, and will operate in a way that promotes equity and inclusion.

FP2020 will promote accountability by tracking progress on existing and new commitments. There has been a surge of investment as a result of FP2020 to establish mechanisms to monitor the implementation of commitments and elevate civil society voices in debates to shape country-level policies and programs.

While it did not have the infrastructure in place to do so this year, FP2020 does intend to track financial, policy, and service delivery commitments going forward. FP2020's methodology will be informed by feedback from countries, lessons learned from the Partnership for Maternal, Newborn and Child Health's monitoring of commitments to the Global Strategy, and expertise from the Commission on Information and Accountability and the independent Expert Review Group.

This report includes preliminary data on donor expenditures. Early results demonstrate that many donor governments have already budgeted increased levels of funding for family planning in 2013, and indicate progress toward fulfilling financial commitments made at the London Summit on Family Planning. These figures (see chart on page 31) are provisional and for indicative purposes only. The FP2020 tracking methodology will be improved to include, as far as possible, standard definition of family plan-

ning expenditures, consistent data sources, and common reporting periods (see page 90).

TRACKING DONOR EXPENDITURES

Tracking donor expenditures is critical to accountability, yet current financial tracking mechanisms are limited in their ability to provide real-time information specific to family planning assistance and do not fully account for all resource flows.

Beginning in 2014, the Kaiser Family Foundation (KFF) will report annually on global family planning disbursements from all public and private sources. KFF will adapt the comprehensive methodology it uses to monitor global spending on HIV/AIDS to measure family planning financing. This year, KFF began to track donor government disbursements for family planning in an effort to establish the baselines necessary to monitor progress toward meeting FP2020 financial commitments.

While support from all sectors is critical to meeting our goal, donor governments provide a significant share of global funding for family planning services. Preliminary data from KFF's research indicate donor government disbursements for family planning increased in 2013.

⁴ Internal UNFPA analysis from interim FP expense tracking. SRH overall estimates from UNFPA Country Programme Documents approved by UNFPA Executive Board

Donor Government Family Planning Disbursements, 2012

COUNTRY	SUMMIT COMMITMENTS	BILATERAL (US\$ MILLIONS)	MULTILATERAL – UNFPA CORE CONTRIBUTIONS (US\$ MILLIONS) ⁵	TOTAL (US\$ MILLIONS)	NOTES
AUSTRALIA	Plans to spend an additional AU\$58 million over five years on family planning, doubling annual contributions to AU\$53 million by 2016. This commitment will form a part of Australia's broader investments in maternal, reproductive, and child health (at least AU\$1.6 billion over five years to 2015).	\$42.7	\$14.9	\$57.5	Australia identified US\$44.6 in FY11/12 using the FP2020-agreed methodology, which includes a percentage of a donor's core contribution to UNFPA. Australian bilateral funding was determined by adjusting its total funding level to take into account its UNFPA contribution.
CANADA		\$41.5	\$17.4	\$58.9	Bilateral funding is for family planning and reproductive health activities (including life skills education) in FY12.
DENMARK	An additional US\$13 million over eight years	\$13.0	\$44.0	\$57.0	Bilateral funding is family planning-specific in FY11, the most recent year available, and includes a specific contribution (in addition to its core contribution) to UNFPA's Reproductive Health Commodities Fund.
FRANCE	An additional €100 million on family planning within the context of reproductive health through 2015, in nine countries in francophone Africa	\$49.6	\$0.5	\$50.1	Bilateral funding is for a mix of family planning, reproductive health, and maternal/child health activities in FY12.
GERMANY	€400 million to reproductive health and family planning over four years, of which 25% (€100 million) is likely to be dedicated directly to family planning, depending on partner countries' priorities	\$47.6	\$20.7	\$68.3	Bilateral funding is family planning-specific in FY11, the most recent year available.
NETHERLANDS	€370 million in 2012 for sexual and reproductive health and rights, including HIV and health, and [plans] to extend this amount from €381 million in 2013 to €413 million in 2015	\$65.5	\$49.0	\$114.5	The Netherlands provided a total of US\$484.8 million in FY12 for "Sexual and Reproductive Health & Rights, including HIV/AIDS" of which an estimated US\$65.5 million was for family planning-specific activities. In FY13, the Netherlands increased funding for "Sexual and Reproductive Health & Rights, including HIV/AIDS" to US\$504.1 million.
NORWAY	Doubling investment from US\$25 million to US\$50 million over eight years	\$3.3	\$59.4	\$62.7	Bilateral funding is family planning-specific in FY12. For FY13, the Norwegian budget provides an estimated US\$25 million in "new" (additional) family planning funding as well as a slight increase in its UNFPA contributions.
SWEDEN	Increasing spending on contraceptives from 2010 level of US\$32 million per year to US\$40 million per year, totaling an additional US\$40 million between 2011 and 2015	\$41.2	\$66.3	\$107.5	Bilateral funding is for family planning and reproductive health in FY12.
UK	Committing £516 million (US\$800 million) over eight years	\$99.4	\$31.8	\$131.2	Bilateral funding is family planning-specific in FY12/13. Family planning-specific funding is estimated to increase in FY13/14.
U.S.		\$485.0	\$30.2	\$515.2	USAID stipulates that specified bilateral subtotal is family planning-specific in FY12.
OTHER DAC COUNTRIES**		\$11.0	\$98.0	\$109.1	Bilateral funding was obtained from the Organisation for Economic Co-operation and Development (OECD) Credit Reporting System (CRS) database and represents funding provided in 2011, the most recent year available.
TOTAL		\$899.8	\$432.3	\$1,332.1	

KAISER FAMILY FOUNDATION PRELIMINARY ANALYSIS: DONOR GOVERNMENT ASSISTANCE FOR FAMILY PLANNING

This analysis establishes a base-line level of disbursements⁵ in 2012 that can be used to track total international assistance funding levels for family planning⁶ over time, as well as specific donor government progress in meeting London Summit on Family Planning commitments.

It includes an analysis of funding provided by the 24 governments that were members of the Organisation for Economic Co-operation and Development (OECD) and Development Assistance Committee (DAC) in 2012.⁷

Of these, 11 made specific commitments at the Summit to increase funding for family planning: Australia, Denmark, the European Commission, France, Germany, Japan, Korea, the Netherlands, Norway, Sweden, and the United Kingdom. In addition, there are several other donor governments, particularly the United States and Canada, which, while not making specific commitments at the Summit, also provide funding for family planning activities.

* All UNFPA core contributions are for FY2012.
** Austria, Belgium, European Union, Finland, Greece, Ireland, Italy, Japan, Korea, Luxembourg, New Zealand, Portugal, Spain, and Switzerland. Czech Republic, Iceland, and Slovak Republic became DAC members in 2013 and therefore not included in analysis.

⁵ A disbursement is the actual release of funds to, or the purchase of goods or services for, a recipient. Disbursements in any given year may include disbursements of funds committed in prior years, and in some cases, not all funds committed during a government fiscal year are disbursed in that year.

⁶ Family planning services including counseling; information, education, and communication (IEC) activities; delivery of contraceptives; capacity building; and training.

⁷ Since 2012, three other governments have become DAC members: Czech Republic, Iceland, and Slovak Republic.

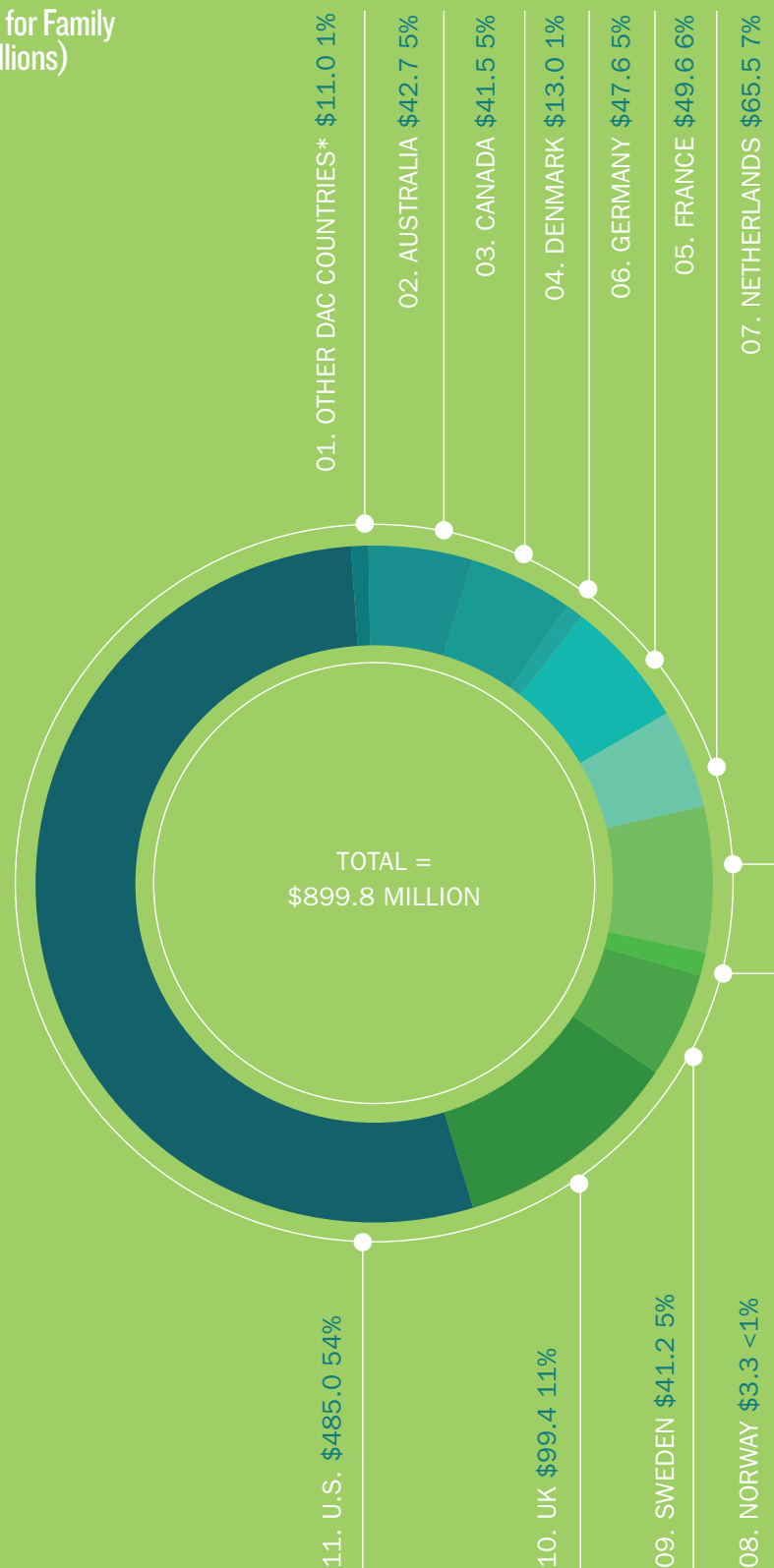
FINDINGS

- In 2012, donor governments provided US\$900 million for bilateral family planning programs and an additional US\$432 million in core contributions to UNFPA.
- The U.S. was the largest bilateral donor, providing US\$485 million and accounting for more than half (54%) of total bilateral funding in 2012. The UK was the second-largest bilateral donor (US\$99.4 million, 11%), followed by the Netherlands (US\$65.5 million, 7%), France (US\$49.6 million, 6%), and Germany (US\$47.6 million, 5%).
- Sweden was the largest donor to UNFPA (US\$66.3 million), followed by Norway (US\$59.4 million), the Netherlands (US\$49.0 million), and Denmark (US\$44.0 million).
- While complete funding data for 2013 is not yet available, two donor governments (Norway and the UK) have already budgeted increased levels of funding for family planning in 2013.
- In addition, while family planning-specific funding is not yet available, the Netherlands increased funding in 2013 for "Sexual and Reproductive Health & Rights, including HIV/AIDS" to US\$504.1 million, fulfilling its summit commitment.

Donor Government Disbursements for Family Planning in 2013 (Totals in US\$ Millions)

01	07
\$11 Other DAC Countries	\$66 Netherlands
02	08
\$43 Australia	\$3 Norway
03	09
\$42 Canada	\$41 Sweden
04	10
\$13 Denmark	\$99 UK
05	11
\$50 France	\$485 U.S.
06	
\$48 Germany	

*Includes the other 14 donor members of the OECD Development Assistance Committee in 2012.



METHODOLOGICAL NOTE

The financial data presented in this analysis represent disbursements and are a significant step forward, in terms both of currency and substance. However, in the wake of the London Summit on Family Planning, tracking financing for family planning in the developing world should be considered a work in progress. The data presented were obtained through direct communication with donor governments, analysis of raw primary data, and from the OECD Creditor Reporting System (CRS). UNFPA core contributions were obtained from United Nations Executive Board documents; however, we were unable to determine what share of these core contributions are attributable to family planning specifically (since such funding is also used to support broader reproductive health and related efforts).

Similarly, it is also difficult in some cases to disaggregate bilateral family planning funding from broader reproductive and maternal health totals, and the two are sometimes represented as integrated totals. In addition, family planning-related activities funded in the context of other official development

assistance sectors (e.g., education, civil society) have remained largely unidentified. For purposes of this analysis, we worked closely with the largest donors to family planning to identify such family planning-specific funding where possible (see Table notes). Going forward, it will be important to efforts to track donor government support for family planning if such funding was more systematically identified within other activity categories by primary financial systems.

ADDITIONAL NOTE

In advance of the London Summit on Family Planning, a number of donors, including the United Kingdom, agreed to use an adapted version of the G8 Muskoka methodology⁸ for tracking donor support to maternal, newborn, and children's health—which takes into account the fact that reproductive health often includes significant spending on family planning as an integrated service—as well as a small percentage of other health codes. The total family planning disbursements reported by donors using this methodology will likely be higher than the figures given here, which are mainly for funds coded to family planning alone. Please see reference on page 30.

⁸ Official G8 Health Working Group Methodology for Calculating Baselines and Commitments: G8 Member Spending on Maternal, Newborn and Child Health.

Bloomberg Philanthropies is pleased to have recently rolled out our first grant from our FP2020 commitment. This grant builds on a maternal health program we have supported in Tanzania since 2006 and will allow for the integration of comprehensive family planning services in some of the country's most remote health facilities.

Establishing health services that promote women's choices and the delivery of high-quality care means fewer maternal complications, fewer maternal deaths and ultimately, healthier households and communities.

DR. KELLY HENNING
DIRECTOR, PUBLIC HEALTH PROGRAMS,
BLOOMBERG PHILANTHROPIES

ALIGNMENT WITH EVERY WOMAN EVERY CHILD

Launched by UN Secretary-General Ban Ki-moon during the Millennium Development Goals Summit in September 2010, *Every Woman Every Child* aims to save the lives of 16 million women and children by 2015. It is an unprecedented global movement of more than 250 partners that mobilizes and intensifies international and national action by governments, multilaterals, the private sector, and civil society to address the major health challenges facing women and children. The effort puts into action the Global Strategy for Women's and Children's Health (Global Strategy), which presents a road map on how to save these lives through the achievement of MDG 4 (Reduce Child Poverty) and MDG 5 (Improve Maternal Health).

FP2020 is proud to be included in this global effort. In the past two years, family planning has gone from being a neglected intervention to receiving the largest number of commitments to the Global Strategy. The London Summit on Family Planning was a major driver of recent gains. Analysis shows that disbursements of both new and additional funds have increased substantially over the past year and that many stakeholders have made significant progress in implementing their commitments. Further, data are emerging that demonstrate that FP2020 is bolstering progress toward the Global Strategy goals of preventing 33 million unintended pregnancies and reaching 43 million new users in 49 countries in 2015. (Source: PMNCH)

FP2020's monitoring and accountability efforts will complement and contribute to *Every Woman Every Child* accountability efforts, through

the Commission on Information & Accountability framework for global reporting, oversight, and accountability on women's and children's health and the independent Expert Review Group. Collaboration with *Every Woman Every Child*, and the Partnership for Maternal, Newborn and Child Health (PMNCH) and alignment with relevant UN mechanisms are fundamental to the success of FP2020.

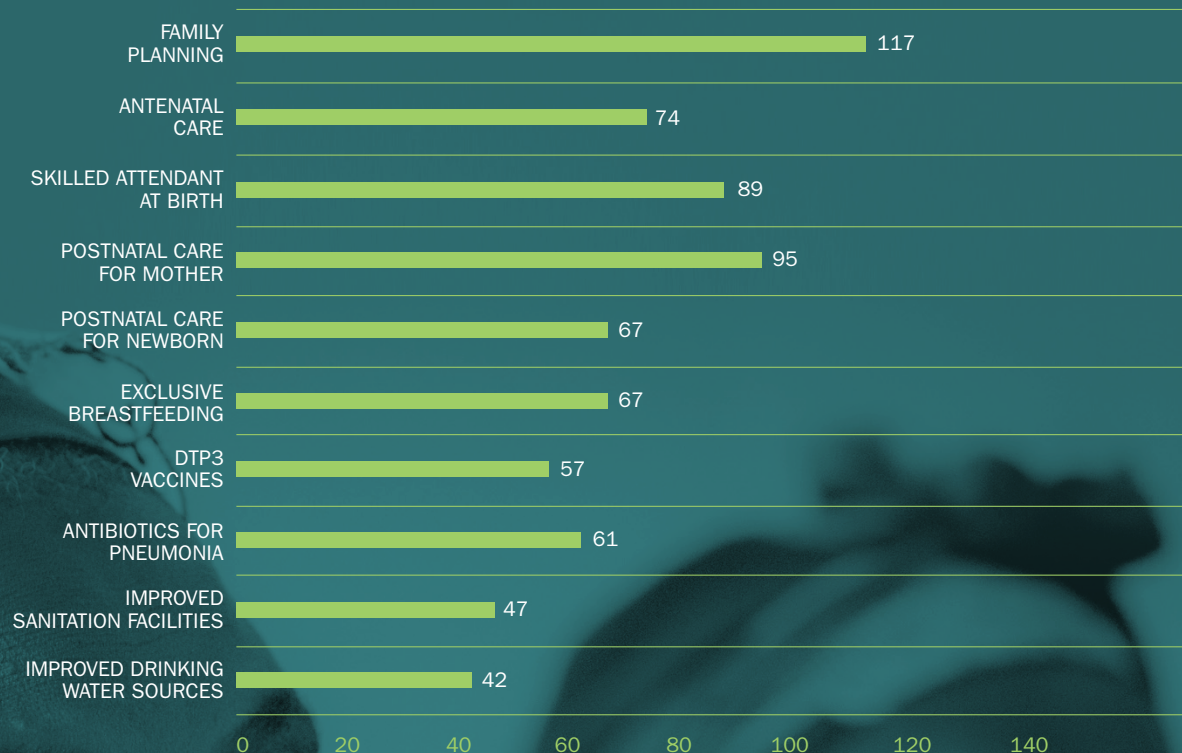
PROMOTING ACCOUNTABILITY

All political leaders have multiple, urgent responsibilities. Despite their best intentions, and regardless of the merits of an issue, if stakeholders do not persistently, visibly, and persuasively hold leaders accountable, the promises they make may never be fulfilled. Commitments serve to inspire; accountability brings results.

Pending ministerial approval, DFID will support an NGO consortium to serve as an accountability secretariat for country-led efforts to hold leaders accountable for their FP2020 commitments. The consortium will coordinate with FP2020's PMA WG and Task Team to complement existing accountability efforts, such as Advance Family Planning.

With support from the Bill & Melinda Gates Foundation, a consortium of European NGOs will advocate funding for family planning as a key element of Official Development Assistance for health. Working in at least eight European countries and at the EU level, it will focus on sustaining and increasing support for family planning above 2012-2013 levels and on honoring FP2020 commitments.

Number of Commitments to the Global Strategy for Women's and Children's Health



SOURCE
PMNCH

Stephanie Freid-Perenchio
photography/SFP STUDIO

02

SECTION 02

Innovation and Partnership

How do we expand access to contraceptives and services for an additional 120 million women and girls in the world's poorest countries? Many live in the least accessible, least developed regions, or they have been displaced by conflict or natural disaster. Some belong to groups who face discrimination or exclusion, and have little, if any, financial or other resources of their own. Too often, these women and girls have been the last to benefit from infrastructure improvements and other development initiatives.

Some barriers have less to do with access to services than with dislike or fear of particular contraceptive methods. Women may experience side effects, or worry that their health or ability to breastfeed may be adversely impacted. When women are unhappy with the contraceptive method available to them, they are less likely to use it consistently or at all.⁹

Using interventions that work elsewhere may not reach these underserved groups. As recommended by the Population Council in its publication *FP2020: A Research Roadmap*, "a clear, accurate accounting of the particular barriers that

still prevent the most disadvantaged women and girls from using family planning services is needed, so that effective interventions can be developed to overcome them."¹⁰ One woman's circumstances and preferences may differ not only from another's, but will most likely change over time. Meeting the needs of all women and girls requires us to adapt and innovate family planning products and service delivery strategies.

FP2020 is predicated on the belief that collaboration is integral to successful innovation. Over the past year, collaborative efforts have produced innovations and price reductions in long-acting reversible contraceptive (LARC) and other methods. Improvements in distribution and service delivery models will make contraceptives available to more women than ever before.

New technology will support the timely and successful collection and reporting of high-quality data. New and renewed partnerships among long-established organizations will facilitate outreach to some of the most vulnerable and underserved populations.

⁹ Darroch JE, Sedgh G and Ball H, *Contraceptive Technologies: Responding to Women's Needs*, New York: Guttmacher Institute, 2011.

¹⁰ Population Council, *FP2020: A Research Roadmap*, New York, 2013. www.popcouncil.org

EXPANDING CONTRACEPTIVE METHOD OPTIONS

Contraceptive implants and injectables are among the most reliable and effective methods for preventing pregnancies. Because they require fewer return visits and do not require users to store supplies, they are more discreet, cost-effective, and convenient than other reversible methods. This is especially true for women who would otherwise have to travel long distances to their nearest health facility or drug dispensary for refills of shorter-acting methods.

Millions of women around the world do not have access to implants or injectables because health facilities offer them inconsistently or not at all. Some women cannot get to a clinic to begin use of one of these methods, while others start but are unable to continue because they cannot return for follow-up visits. Some places have laws that limit which health workers can administer injections or implants; this becomes a barrier when there are staff shortages, particularly in rural areas. Studies have shown that a far greater number of women would choose a long-acting reversible method, such as an implant, if it were consistently available and supported by counseling and clinical services.

CONTRACEPTIVE INJECTIONS

Sayana® Press offers the potential to improve contraceptive access for women worldwide.¹¹ It uses the Uniject™ injection system—a small, prefilled, single-use device to deliver a new, lower-dose formulation of Depo-Provera® via subcutaneous, rather than intramuscular, injection. Like the currently available Depo-Provera®

intramuscular contraceptive, a single dose of Sayana® Press is effective for three months. Its safety and ease of use mean community health workers (CHWs) may be better able to administer injections outside of health facilities. And while Sayana® Press currently is not labeled for home or self-injection, in the future this delivery mode may offer women a convenient, private option for contraception.

At the London Summit on Family Planning, public and private partners announced plans to reach women in sub-Saharan Africa and South Asia with up to 12 million doses of Sayana® Press between 2013 and 2016 and to conduct rigorous evaluations of the product's impact on contraceptive use. The Sayana® Press pilot introduction and evaluation partnership includes the Bill & Melinda Gates Foundation, USAID, DFID, UNFPA, Pfizer Inc., and PATH.

The ultimate success of Sayana® Press hinges on it being affordable and acceptable to family planning clients, providers, and decision makers. With support from the USAID PROGRESS project and PATH, FHI 360 worked with the Ugandan and Senegalese ministries of health and with local partners to assess acceptability of Sayana® Press and offer recommendations for method introduction. The studies, which concluded in 2013, found that most clinic-based providers, CHWs, and clients preferred Sayana® Press over the intramuscular formulation. The studies also found that trained CHWs can safely administer Sayana® Press. The findings suggest that provider recommendations on service delivery, client counseling, and community sensitization should be considered during implementation planning, and

that community-based distribution of either injectable formulation is anticipated to meet more women's family planning needs.

Pilot introduction of Sayana® Press is scheduled to begin in Bangladesh, Burkina Faso, Niger, Senegal, and Uganda in the first quarter of 2014. Over the past year, each country has developed an introduction plan for Sayana® Press. The pilot introduction will evaluate the extent to which Sayana® Press expands access to injectables for new users, improves contraceptive continuation rates, and is cost-effective in various delivery settings, including community-based distribution and social marketing. Evidence generated will enable countries to make informed decisions regarding inclusion of Sayana® Press in the family planning method mix and programs. Whether or not countries provide Sayana® Press after the pilot introduction, the partners will ensure that systems are in place to give women access to other contraceptive methods for continuity of service.

CONTRACEPTIVE IMPLANTS

Contraceptive implants last longer than injections, making them an important option for women who have the greatest difficulty accessing health services or supplies. Unfortunately, access to contraceptive implants in low-resource settings has been relatively limited. Prior to this year, price reduction agreements covered only certain forms of short-acting contraceptive methods.

On January 1, 2013, it was announced that Bayer HealthCare AG would cut the price of its contraceptive implant Jadelle® from US\$18 to \$8.50 per unit. Through

the new Jadelle® Access Initiative, the product is available at this price in more than 50 countries, including those deemed least likely by the UN Secretary-General to meet the targets of MDG 4 and MDG 5 by 2015. The initiative is expected to reach approximately 27 million women. In May 2013, Merck/MSD announced it would reduce by half the price of its contraceptive implants IMPLANON® and IMPLANON NXT® in 69 focus countries identified at the London Summit on Family Planning. Both agreements were developed and supported through partnerships among Bayer HealthCare AG and Merck/MSD; the Bill & Melinda Gates Foundation; the Clinton Health Access Initiative (CHAI); the governments of Norway, the United Kingdom, the United States, and Sweden; the Children's Investment Fund Foundation; and UNFPA.

The Sino-implant (II)® initiative has been at the forefront of helping to reduce the cost of implants in resource-constrained settings. As a result of price ceiling agreements with distribution partners, Sino-implant (II)®, manufactured by Shanghai Dahua Pharmaceutical Co., Ltd., is currently available in the public and NGO sectors for approximately US\$8 per unit.

The Sino-implant initiative, which is led by FHI 360 with support from the Bill & Melinda Gates Foundation and USAID, provides technical assistance to facilitate the global introduction of Sino-implant (II)®. It works in close coordination with a number of organizations, including government officials, distributors, and service delivery groups, to facilitate introductions at the country level. This includes conducting independent quality testing, negotiating public sector price-ceiling agreements, supporting the WHO prequalification application process, and working with distributors to secure national regulatory approvals.¹² Unlike many other contraceptive methods, when an implant reaches the end of its effectiveness period, or a woman

wants to discontinue its use, she must seek help from a medical professional to have it removed. The need for a removal procedure precludes use of an implant by women who either cannot afford it or cannot get to a medical appointment. With funding from USAID, FHI 360 is working with innovators in the field of drug delivery systems to develop a safe, effective, acceptable, and affordable biodegradable contraceptive implant that would not require removal. Proof-of-concept testing by these investigators will be initiated by the end of 2013.

CONTRACEPTIVE VAGINAL RING

Many women assume they do not need to use contraceptives if they are lactating, but research suggests the risk of unintended pregnancy is substantial. Women who are breastfeeding may fear that contraceptives will negatively affect their breast milk or newborn.¹³ For these women, a safe and effective contraceptive method suited to their needs is essential. The Population Council is currently evaluating trial introductions of the Progesterone Vaginal Ring, which is a user-controlled contraceptive method for lactating women. Already proven safe and effective in clinical trials, each progesterone vaginal ring lasts for up to three months, and a woman can use the method for one year. It does not affect breast milk, and contraceptive effectiveness is ensured as long as the woman continues to breastfeed at least four times per day.

To expand contraceptive options for women in low-resource settings, the Population Council is developing a new contraceptive vaginal ring that will provide protection for 13 menstrual cycles and not require refrigeration.

11 Sayana Press and Depo-Provera are registered trademarks of Pfizer, Inc. Uniject is a registered trademark of BD. Country-level regulatory approvals are in place in three of the five pilot introduction countries, with all five expected to be approved in the first quarter of 2014.

12 <http://www.fhi360.org/projects/sino-implant-ii>

13 Darroch JE, Sedgh G and Ball H, *Contraceptive Technologies: Responding to Women's Needs*, New York: Guttmacher Institute, 2011.

NEW MODELS FOR SUPPLIES AND SERVICES

Product improvements and price reductions can create unprecedented levels of consumer demand. This has profound implications for the procurement, movement, and delivery of family planning commodities. A broad group of stakeholders within the reproductive health community is working to ensure that all individuals can obtain and use affordable, quality reproductive health supplies of their choice whenever they need them. Improvements in distribution methods and service delivery are overcoming some of the most persistent barriers to access.

MINIMIZING STOCK-OUTS WITH THE INFORMED PUSH MODEL

Many women have no dependable source of family planning supplies. Unexpected stock-outs of a woman's preferred contraceptive—or all forms of contraceptive—may last for indefinite periods of time and may occur in both public and private health facilities, in rural and urban settings, putting women at risk of unintended pregnancy. Stock-outs can happen for a number of reasons, including poor forecasting and lack of inventory control. They can be minimized only by addressing the root causes of breakdowns in family planning supply-chain management and by establishing systems that respond quickly to short-term disruptions.

The Informed Push Model of distribution uses timely and good-quality information to guide resupply decisions. It was inspired by the commercial sector and looks much like a typical system for vending machines. A driver with a truckful of supplies visits each point of sale on a regular schedule, topping up the stock and recording quantities of products sold. The data collected

by the driver are used to ensure sufficient stock at the warehouse and at each site, to figure out which products and sites are the most popular, and to prepare the manufacturers to keep pace with demand. On the systemic level, the information is used by regional and national decision makers to determine the quantity and types of contraceptives that are requested and dispensed. This is instrumental in optimizing the performance of the health system to provide women with high-quality family planning services and a dependable supply of contraceptives.

INCREASING ACCESS WITH THE CLUSTER MODEL

The “cluster model” is a public-private partnership strategy designed to improve access to family planning and strengthen the continuum of care through integration with other health services. Pioneered by Planned Parenthood Federation of Nigeria, it works by creating a cluster of five health facilities located within a short distance of each other for easy referral. The sites specialize in different aspects of health, and range in size from small health post to hospital. One of the five provides integrated reproductive health and family planning services. The clusters include government and private sector providers, community-based distributors, faith-based organizations, and Planned Parenthood Federation of Nigeria. Traditional, religious, and social institutions play a role in generating demand for services in their communities. The cluster model holds great promise for reaching underserved populations. Evaluations of the impact of the cluster model show an increase in the utilization of family planning and related services.

HIGHLIGHT


THE GLOBAL PROGRAMME TO ENHANCE REPRODUCTIVE HEALTH COMMODITY SECURITY

UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) works with countries to develop sustained approaches for securing essential reproductive health supplies. GPRHCS develops countries' capacity to strengthen national health systems, and assists in procuring reproductive health commodities. Over five years, this flagship thematic fund mobilized US\$565 million in donor support and helped governments procure contraceptives in 46 priority countries. As a result, GPRHCS has contributed to higher contraceptive prevalence rates, more service delivery points, fewer stock-outs, more choices of contraceptives in more health centers, and a greater prioritization of family planning in country governments.



SENEGAL

The unmet need for family planning in Senegal is one of the highest in the world. At the London Summit on Family Planning, Senegal committed to improving the family planning supply chain and to reducing contraceptive stock-outs. A six-month collaborative effort led by the Reproductive Health Department of the Ministry of Health tested the Informed Push Model of distribution at select sites. The results were impressive, and it has now been launched nationwide.



In Senegal, we are bringing women greater contraceptive choices through the innovative Informed Push Model of product distribution. Now more women can trust that the contraceptive method that best meets her needs will be available every time she needs it.

DR. AWA MARIE COLL-SECK
MINISTER OF HEALTH, SENEGAL

MEETING THE NEEDS OF UNDERSERVED COMMUNITIES IN SIERRA LEONE

The 25,000 residents of the fishing communities of the Sherbro Islands live just a short distance off the coast of Freetown, Sierra Leone, but until recently they were isolated from basic social services such as health care.

The 40 Sherbro Islands are located in a wide estuary, accessible only through turbulent waterways, creeks, and mangrove swamps. Despite a distance of only 145 kilometers, the journey from the mainland to the largest and most accessible of the islands, Bonthe, could take anywhere from nine hours in the dry season to two days in the wet season.

That changed when Marie Stopes Sierra Leone launched its own speedboat for the purpose of bringing family planning and maternal health services to these remote communities. The speedboat was acquired with assistance from DFID and the European Commission.

The speedboat took to the water in December 2012. In the first three months of the boat's use, health care workers provided services to more than 3,000 women and men—nearly 10% of the entire population of the island chain.

MARIE AND BAINDU TAKE CONTROL

Two of the women who have been able to access family planning for the first time are Marie (30) and Baindu (34). They both live on Benducha Island with their husbands and children (Marie has

eight children, and Baindu has six), and none of their children has been able to attend secondary school.

Neither Marie nor Baindu wanted such a big family. With the arrival of the Marie Stopes speedboat and the vital services that its outreach team provides, both women are now able to decide whether and when to have more children.

They received counseling with their husbands on different methods of contraception. Both women opted for a contraceptive implant. It will provide three years' protection against pregnancy and will mean that they can focus on caring for the children that they already have.

STILL MORE TO DO

Despite the early successes of the Marie Stopes Sierra Leone speedboat, there are still challenges inherent to providing services in such remote communities, and there is always more to be done.

The physical demands on the outreach team are enormous: they travel by boat under the blazing sun, then trek along dirt tracks to reach the furthest communities. When bad weather strikes, as it frequently does in this coastal region, the journey to the most remote islands becomes even more treacherous.

But like all of Marie Stopes International's 8,500 team members across the globe, the speedboat outreach team remains dedicated to overcoming these challenges in order to bring family planning services where they are needed most.

HIGHLIGHT

PARTNERSHIP ACCELERATES PROGRESS IN ZAMBIA

Zambia has one of the highest maternal mortality ratios in the world: 591 per 100,000 live births. The loss of life and the impact on families and communities are devastating. At the London Summit on Family Planning, Zambia took an important step toward improving maternal health when it pledged to increase the prevalence rate for modern contraceptive methods from 33% in 2007 to 58% by 2020.

With support from partners including DFID, FHI360, MSI, Planned Parenthood Association of Zambia, UNFPA Zambia, and the USAID-funded Health Policy Project, the Zambian Ministry of Community Development, Mother and Child Health, developed and launched the Costed Eight-Year Integrated Family Planning Scale-up Plan 2013-2020.

It is projected that the implementation of Zambia's plan will avert 3.5 million unintended pregnancies, more than 100,000 child deaths, and nearly 10,000 maternal deaths. It is expected that the plan will save Zambia 1,492 million ZMW.

Zambia's national family planning strategy is very ambitious, but it is also achievable. We are on track to better serve the needs of the hardest to reach communities. The women and girls of Zambia will benefit from the renewed commitment to expand family planning services.

DR. CAROLINE PHIRI
DIRECTOR OF MOTHER CHILD HEALTH
MINISTRY OF COMMUNITY DEVELOPMENT
MOTHER CHILD HEALTH, ZAMBIA

SOURCE
Marie Stopes International.
March, 2013. Author: Shumon
Sengupta, Country Director,
MSI Sierra Leone <http://www.mariestopes.org/news/launching-family-planning-sierra-leone%E2%80%99s-fishing-communities>

PMA2020

By harnessing innovations in and widespread expansion of technology, PMA2020 promotes the use of accurate, timely, accessible information to facilitate annual progress reporting in 10 FP2020 countries across Africa and Asia. The project, led by the Bill & Melinda Gates Institute of Population and Reproduction at the Johns Hopkins Bloomberg School of Public Health, leverages a mobile Assisted Data and Dissemination System (mADDs) to produce new analyses automatically and rapidly to better inform family planning programs and policy.

PMA2020 will deliver data from nationally representative household and facility surveys, in real-time using mobile phone technologies, fielded through a cadre of resident enumerators who are recruited, trained, and deployed on a regular

basis to conduct successive survey rounds. In addition to replicating questions included in the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS), PMA2020 introduces new questions that address access, equity, quality, and choice. These questions generate a broader set of family planning data, allowing for more in-depth monitoring and analysis across a subset of countries, and are critical to tracking whether rights are respected, protected, and fulfilled. At the time of preparing this report, data was being collected in Ghana and surveys were about to begin in Democratic Republic of Congo, Ethiopia, Kenya, and Uganda. Data collected from these surveys will feed into FP2020 core indicators and be presented in future FP2020 progress reports.

PMA2020 has trained more than 100 female resident enumerators in Ghana. Each was recruited from

her community, where data are collected. Together, they comprise a sentinel network that is activated to conduct repeated rounds of the survey, interviewing approximately 40 households and three service delivery points each time. Each enumerator is equipped with a smartphone, supported by a regional supervisor, and compensated for her work. Through training, equipping, and supporting this network of sentinel resident enumerators, PMA2020 is building local skills for generating meaningful and timely data for program improvement. Enumerators commented on what they liked best about the training: “It gave us the opportunity to build self-confidence,” “The belief that we can do it,” and “The training has brought improvement to my life.” In addition, the project strengthens the capacity of local university partners to manage all aspects of survey implementation.



Courtesy PMA2020

Family planning services are a means through which women and girls exercise self-determination. Therefore, the ultimate metric for judging a family planning program is the degree to which it empowers women and girls. On an operational level, family planning programs that do not respect and reflect the agency of women and girls are inherently flawed and destined to fail.

The new framework for *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights*¹⁴ was drafted by Futures Group, EngenderHealth, and the Bill & Melinda Gates Foundation as a tool to elucidate what a rights-based family planning program should include and how it should be implemented. The Framework was reviewed by more than 150 people from 25+ countries through a series of in-person and web-based consultations and the WHO consultation on rights-based family planning held in April 2013.

The Framework describes four domains in which the rights implications of family planning programs should be considered:

- Policy level: the conditions of governance (especially political commitment) and accountability

(especially to the community) support family planning programs that respect, protect, and fulfill rights (especially in the areas of information, supplies, and services)

- Service level: the elements of quality of care (quality, accessibility, availability, and acceptability) guide programming to adhere to the highest standard of care and thus protect inherent human rights principles (especially in the areas of method mix, technical competence, and service integration)
- Community level: the political, financial, and social environments are supported by the effective participation of diverse community groups (especially youth) in all aspects of family planning policy and program development, implementation, and monitoring (especially in the areas of policy making, funding, and societal norms and equity)
- Individual level: the various contexts in which an individual lives allow him or her to exercise rights (especially in the areas of behavior, knowledge, access to information and services, and empowerment)

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

As the world's largest bilateral donor of family planning, USAID is proud to be a core partner in Family Planning 2020 and work alongside country governments and other donors to increase access to voluntary family planning information, products, and services.

Family Planning 2020 has brought together the comparative advantages of multiple stakeholders and united the global community under a clear and shared vision. This is crucial as we know that family planning is essential for promoting health, economic growth, and development across the globe.

DR. ARIEL PABLOS-MÉNDEZ
ASSISTANT ADMINISTRATOR FOR
GLOBAL HEALTH AT USAID

EDUCATING AND ENGAGING YOUNG PEOPLE

Pregnancy and childbirth can have a devastating impact on a young girl's health. New initiatives are encouraging young people to wait until they are age 18 before marrying and giving birth, to allow two years between pregnancies, and to utilize reproductive health services.

The government of Burkina Faso and Pathfinder International have introduced youth-friendly services in health facilities in Diapaga and Ouga, and initiated a peer education program to support the use of these services complemented by ongoing involvement of religious leaders. This effort is part of a West Africa initiative launched by Pathfinder to work with local partners to build their capacity to implement an evidence-based, scalable program to serve young married women and their partners.

In Sierra Leone, a youth-led organization called YES Salone is leading a multisector program that includes five government ministries, UNFPA and other UN agencies, and NGOs. The acronym YES stands for "Young, Empowered and Safe." The program will scale up demand for family planning and health services for young people. Activities this year included the development of

minimum standards for services; a mobile minibus outreach effort, including music, drama, debate, and discussion; and a peer-to-peer education program in 13 districts.

The *It Takes Two* campaign was founded by the Global Poverty Project and Women Deliver with the goal of promoting gender equality, especially in health and education. Using an online platform and mobile application, it makes advocacy both fun and relevant to young people's social lives by tracking activities and awarding points that translate into entertainment events. *It Takes Two* demonstrates that the nexus of digital entertainment, grassroots organizing, and social media opens up tremendous opportunities for young people to gain vital information and participate in civil society.

Currently in its first phase of implementation, the campaign is aimed at youth living in urban centers in five African countries, starting with Uganda, but has already generated 60,000 actions from people in 27 countries. To engage young people and raise awareness, campaign activities include customizing condom wrappers online and voicing support for family planning programs.



NEW AND RENEWED PARTNERSHIPS

Four of the world's largest organizations devoted to improving the health of women and girls are core partners in FP2020:

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID)

DFID is the ministerial department that leads the UK's work to end extreme poverty. Its responsibilities include honoring the UK's international commitments and taking action to achieve the MDGs, and improving the lives of girls and women through better education and a greater choice on family planning.

THE BILL & MELINDA GATES FOUNDATION

Guided by the belief that every life has equal value, the Bill & Melinda Gates Foundation works to help all people lead healthy, productive lives. In developing countries, it focuses on improving people's health and giving them the chance to lift themselves out of hunger and extreme poverty.

UNITED NATIONS POPULATION FUND (UNFPA)

UNFPA delivers a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled. UNFPA is the longest-serving multilateral agency leading in the field of family planning, and currently supports family planning progress in more than 150 countries. UNFPA promotes family planning as part of a comprehensive approach to sexual and reproductive health and reproductive rights. This includes not only essential supplies but also training midwives, eliminating barriers to access, making family planning available to adolescents

and unmarried people, empowering women and girls, engaging men and boys, responding in humanitarian emergencies, and mobilizing national and global commitment.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

USAID is the United States federal government agency primarily responsible for administering civilian foreign aid. USAID seeks to extend a helping hand to those people overseas struggling to make a better life, recover from a disaster, or striving to live in a free and democratic country. USAID has been the leading donor in international family planning for more than 40 years— both in terms of financial resources (in most years making up 40%–50% of all donor funds) and technical leadership (advancing new technologies and supporting program innovation, implementation, and evaluation).

THE NEEDS OF WOMEN AND GIRLS WHO LIVE IN OR MUST FLEE FROM CONFLICT ZONES, OR WHO ARE DISPLACED BY NATURAL DISASTERS, ARE ESPECIALLY ACUTE.

Providing family planning services in an environment where basic infrastructure is severely compromised, overloaded, or nonexistent is extraordinarily difficult. A new level of partnership between seven International Planned Parenthood Federation (IPPF) Member Associations and UNFPA will focus on providing services to vulnerable groups, including refugees and migrants as well as youth and unmarried people. The new approach will vary according to context and needs. The collaboration between IPPF and UNFPA builds upon the

institutions' long-standing history of cooperation on family planning and reproductive health.

In 2013, USAID and UNFPA renewed their commitment to collaboration on global initiatives, including FP2020, Committing to Child Survival: A Promise Renewed, *Every Woman Every Child*, and the UN Commission on Life-Saving Commodities for Women and Children. Their priorities include coordinating supply planning, filling critical funding and technical assistance gaps, and improving program monitoring and evaluation.

Together with DFID, AusAID, and the Bill & Melinda Gates Foundation, USAID is a member of the Alliance for Reproductive, Maternal, and Newborn Health. The Alliance promotes the cost-effective use of resources, leverages resources to fill funding gaps, reduces duplication, and encourages the sharing of best practices among partners to accelerate progress in achieving MDG 4 and MDG 5. Alliance partners work together at headquarters level and in 10 high-need countries in sub-Saharan Africa and Asia. To promote alignment and leverage existing relationships, the Alliance is represented on the FP2020 Country Engagement Working Group.

In support of FP2020, the Alliance and WHO hosted the first Family Planning Implementation Research Donor Meeting in December 2012. The meeting brought together more than 40 representatives from 21 funding agencies to identify research gaps that could be addressed through collective action, and outlined the initial strategies for doing so.

OUAGADOUGOU PARTNERSHIP AND FP2020

Launched in February 2011, the Ouagadougou Partnership is dedicated to improving access to family planning in nine countries in French-speaking West Africa. It is led by the governments of Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo. At the London Summit on Family Planning, members of the Ouagadougou Partnership pledged to accelerate progress toward their goal.

In 2012, the Ouagadougou Partnership established a Coordination Unit to provide support to countries and facilitate relationships among donors, governments, and other stakeholders. Agence Française de Développement, the Bill & Melinda Gates Foundation, the William and Flora Hewlett Foundation, the French Ministry of Foreign Affairs, and USAID provide core support to the Ouagadougou Partnership. UNFPA, WHO, and WAHO also provide important assistance on the global and country levels.

The development and implementation of national, broad-based, costed implementation plans for family planning (FP CIPs) are a crucial part of countries' reproductive, maternal, newborn, and child health efforts. FP CIPs serve to clarify a country's strategies by articulating its priorities for family

planning. They describe activities and include an implementation road map and detailed budget. They estimate the demographic, health, and economic impacts of a program, and prescribe a monitoring strategy to accurately measure and evaluate those impacts going forward. Crucially, FP CIPs are needed to identify funding gaps, secure donor commitments, increase political support, and promote accountability. In collaboration with USAID and other partners, the Health Policy Project is assisting the countries of the Ouagadougou Partnership to develop and augment their FP CIPs.

The Ouagadougou Partnership and FP2020 work together to support the efforts of Ouagadougou Partnership countries to develop and fully implement their family planning plans. To facilitate the seamless sharing of information, the director of Ouagadougou Partnership's Coordination Unit is a member of FP2020's Country Engagement Working Group. To minimize administrative burdens on countries, FP2020 and the Ouagadougou Partnership have agreed to accept and share the same country action plans (countries are not asked to submit a different plan to each entity). FP2020 and the Ouagadougou Partnership will work together to seek funding for countries' plans and to share information and best practices with the global family planning community.

**Collaboration
multiplies our power
to change the world.**
Working together, we
will accelerate progress
globally, creating a brighter
future for women,
families, and communities
everywhere.

KATHY CALVIN
PRESIDENT AND CHIEF EXECUTIVE OFFICER,
UNITED NATIONS FOUNDATION



Progress is the result
of dedication combined
with knowledge.
The stakeholders in
FP2020 are dedicated
to a common goal;
now, with the foundation
of a strong platform
for measurement and
evaluation, we'll have the
knowledge we need to
guide us toward success.

VALERIE DEFILLIPO
DIRECTOR, FP2020

Stephanie Freid-Perenchio
photography/SFP STUDIO

03

SECTION 03

Measuring Progress

Approximately 260 million women in the world's 69 poorest countries currently use a modern method of contraception. Sustaining this level of use between 2012 and 2020 will cost roughly US\$10 billion through resources principally provided by country governments' health budgets, supported by individuals' out-of-pocket expenditures and external donor contributions. At the London Summit on Family Planning, the global community took a significant step to expand the availability of voluntary family planning information, services, and supplies. The goal is to enable a total of 380 million women and girls to choose and use contraception by 2020 through the commitment of resources equivalent to US\$4.3 billion, above and beyond the level of funding provided for family planning in 2010.¹⁵

This unprecedented declaration of support marks a significant step toward realizing the FP2020 vision that women and girls should have the same access to lifesaving contraceptives and services no matter where they live. With such an ambitious goal, it is clear that FP2020 must have an equally ambitious performance monitoring and accountability system devoted to improving the quality and availability of information for progress reporting, planning, evaluation, decision making, and advocacy at the community, country, and global levels.

FP2020 is predicated on the belief that measurement and results are necessary to drive change. In the first year, FP2020 initiated activities to establish systems and infrastructure to monitor progress toward the FP2020 goal, to ensure that girls' and women's rights to voluntary contraception are respected and promoted, and to strengthen accountability for implementing financial, policy, and programming commitments made by country governments, donors, the UN, civil society, and others. Building accountability is at the heart of FP2020: we are all accountable to women and girls.

These activities, detailed throughout this report, included selecting core indicators and collating corresponding baseline data, improving the way in which family planning expenditures are tracked, and launching electronic collection of data in select countries. Importantly, FP2020 partners also came together to lay the groundwork for further developing and implementing a transformative measurement agenda over the life of FP2020 that will elevate the role of service statistics, identify innovations in data collection, find new ways to leverage these tools to impact the poorest and hardest-to-reach, and enhance capacity to measure rights-based programming.

¹⁵ Family Planning Summit 2012 data sources and methodology for calculating 2012 baseline, 2020 objectives, impacts, and costings by Family Planning Summit Metrics Group.

It is my distinct pleasure to be part of the global Family Planning 2020 movement, which has brought fresh energy to cross-sector and cross-border innovation and collaboration. Together, we will surely change the lives of millions of women and girls.

ANURADHA GUPTA
JOINT SECRETARY, MINISTRY OF HEALTH
AND FAMILY WELFARE, INDIA

MEASURES OF SUCCESS

FP2020 CORE INDICATORS

A set of 15 core indicators has been selected through a systematic process over the past 18 months to determine whether countries are on track to reach their goals, to assess strategies and inform decision making, to provide the tools to answer fundamental questions concerning the overall performance of FP2020, and, importantly, to measure how well individual needs are met. Ten will be reported annually for 69 countries. Data sources and methodology for the indicators will necessarily vary between countries that make a commitment to FP2020 and those that do not, although this distinction is ameliorated as new measurement grants are awarded that relate to FP2020 monitoring, such as the Track20 project.¹⁶ Many of these indicators will be modeled, since

the data needed is not collected on an annual basis. Therefore, many of the indicators do not reflect direct measurement.

The process of developing FP2020 core indicators began in early 2012 with the creation of a Metrics Working Group that set out to estimate the overall parameters of the FP2020 initiative and establish a baseline for the number of contraceptive users in the 69 FP2020 priority countries. The Metrics Working Group also updated a conceptual framework (see chart on next page) from which indicators would be derived. The framework includes 10 conceptual domains, organized by the standard measurement sequence of enabling environment, process, output, outcome, and impact. Adjustments may be made to this framework upon further review by the Performance Monitoring & Accountability Working Group.

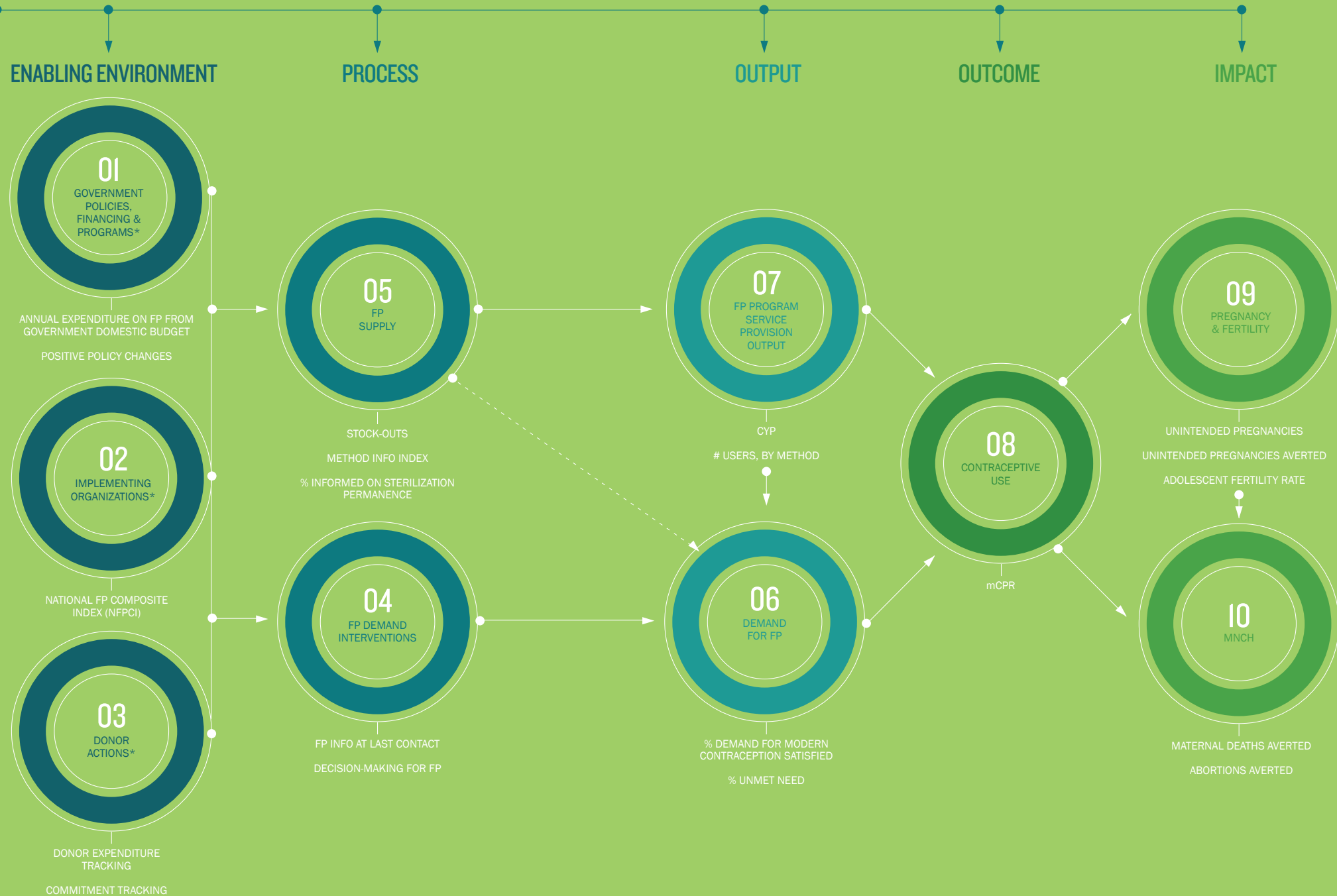
¹⁶ Track20 efforts will be concentrated mainly in countries that make a commitment to FP2020, though some technical support will be provided to all 69 FP2020 countries.

FP2020 PMA Conceptual Framework with Core Indicators

Country-level conceptual framework: results chain for family planning inputs, outputs, outcomes, and impacts

Enabling environment wider health system and services (including RMNCH)

*Including Summit commitments



Societal and structural characteristics (e.g., gender, equity, social and cultural norms, girls' and women's empowerment)

Following the London Summit on Family Planning and upon the establishment of the FP2020 governance structure, the work of finalizing the indicators was transferred to the FP2020 Reference Group, Task Team, and Working Groups. The Performance Monitoring & Accountability Working Group played a leadership role throughout the execution of this process, with substantial input from the Rights & Empowerment Working Group.

The intent of constructing a core set of FP2020 indicators was to provide an annual, global readout of key progress markers that would be applicable to and available from all 69 countries. The indicators were selected with country M&E and data systems in mind to avoid creating a parallel indicator capture and reporting process at the country level. The list was kept short to allow FP2020 to focus on indicators with global relevance, while leaving space for countries to identify indicators that are aligned with their family planning strategies and priorities. For example, if a country is focusing on community-based distribution or the introduction of long-acting reversible contraceptives, it will be important to include indicators relevant to those programs in the annual monitoring and reporting.

Attention was paid to linking indicators with important global platforms in order to foster collaboration with partners and avoid duplication of efforts. FP2020 aligns with *Every Woman Every Child*, spearheaded by United Nations Secretary-General Ban ki-Moon. Partnerships and initiatives taken into consideration by FP2020 include but are not limited to the International Conference on Population and

Development's Programme of Action, the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights, the Partnership on Maternal, Newborn and Child Health (PMNCH), and the World Health Organization's Indicators development process on Health and Rights.

Graphics that demonstrate growth rates for contraceptive prevalence, levels of unmet need, and analysis of method mix in FP2020 countries are presented in this first report. In the future, progress reports will display graphics that highlight changes in key indicators as the FP2020 global initiative progresses. The analyses behind these graphics will focus on core indicators, and, where appropriate, additional information relevant to the progress of FP2020 will be incorporated into the analyses. Where comparisons are appropriate, analyses of multiple indicators together may also be presented.

REPORTED ANNUALLY FOR 69 COUNTRIES

1. Contraceptive prevalence rate, modern methods (mCPR) (modeled)
2. Total number of contraceptive users by method (modeled)
3. Percent of women whose demand for modern contraception is satisfied (modeled)
4. Percentage of women with unmet need for contraception (modeled)
5. Annual expenditure on family planning from government domestic budget
6. Couple-Year of Protection (CYP)

7. Number of unintended pregnancies (estimated)
8. Number of unintended pregnancies averted due to contraceptive use (estimated)
9. Number of maternal deaths averted due to contraceptive use (estimated)
10. Number of unsafe abortions averted due to contraceptive use (estimated)

REPORTED ANNUALLY FOR A SUBSET OF 10 COUNTRIES AND FOR THE SUBSET OF THE 69 FP2020 COUNTRIES IN YEARS WITH A DHS¹⁷

11. Percentage of women who were provided with information on family planning during their last visit with a health service provider
12. Mean score on Method Information Index¹⁸
13. Percent of women who make family planning decisions alone or jointly with their husbands/partners or jointly with a health service provider
14. Adolescent birth rate
15. Percent informed of the permanence of sterilization

CRITERIA USED TO IDENTIFY CORE INDICATORS:

(1) Progress under each of the five domains of the Family Planning Summit Monitoring & Accountability Conceptual Framework's is tracked by at least one indicator (the five domains are enabling environment, process, output, outcome, and impact); (2) indicator is relevant to the domain and methodologically sound (e.g., based to the greatest extent possible on existing definitions and standards and with documentation readily available); and (3) indicators for which data are most readily available across FP2020 countries¹⁹. Additionally, special consideration was given to (4) indicators proposed by the

Rights and Empowerment Working Group, in line where possible with the WHO Indicators on Health and Rights (to ensure dimensions of availability, accessibility, quality, and informed decision making were reflected) and (5) indicators already used by countries to monitor other initiatives or goals (e.g., The Global Strategy for Women's and Children's Health and MDG 5).

THE CORE INDICATOR TABLE IS SEPARATED INTO THREE CATEGORIES:

1. Indicators that will be reported annually for all 69 FP2020 countries. Data sources and methodology will vary between countries that make a commitment to FP2020 and those that do not, based on presence of Track20 project.²⁰ Indicators 5 and 6 will not have data in year one. Mechanisms to collect this information will be established within the first year.
2. Indicators that are estimates of impact of family planning, using modeling based on real-time data from the last DHS or similar national survey and not based on directly collected data.
3. Indicators that will be reported annually in a subset of countries and based on the PMA2020 survey or countries that have DHS surveys in the reporting year. PMA2020 will collect data in 10 countries²¹, which will be available in two years. In years when there is a DHS in one of these countries, indicators for the country (with disaggregated figures) will be utilized in progress reporting.

¹⁷ Five countries had a DHS in 2012: Côte d'Ivoire, Haiti, Honduras, Indonesia, and Laos.

¹⁸ Method Information Index is a new index developed by FP2020 to measure the extent to which women were made aware of alternative methods of contraception and provided adequate information about them, drawing on three questions from DHS/PMA2020 surveys.

¹⁹ Most of the indicators referenced in this category are based on modeling of assumptions about past trends or past points of real-time data, such as the last DHS, and therefore may not pick up any recent change in annual trends.

²⁰ Track20 efforts will be concentrated for the most part in countries that make a commitment to FP2020. However, some technical support will be provided to all 69 FP2020 countries.

²¹ PMA2020 countries: Phase 1—Ghana, Ethiopia, Uganda, Democratic Republic of Congo, and Kenya. Phase 2—Nigeria, Senegal, Burkina Faso, India, and Indonesia.

Indicators that Will Be Reported Annually for All 69 FP2020 Countries

INDICATOR NAME	DEFINITION	DATA SOURCE & AVAILABILITY	CONCEPTUAL FRAMEWORK CATEGORY	DISAGGREGATION	LINKS TO OTHER INITIATIVES
01 CONTRACEPTIVE PREVALENCE RATE, MODERN METHODS (mCPR)	The proportion of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.	Surveys such as the Demographic and Health Surveys (DHS), the CDC-assisted Reproductive Health Surveys (RHS), MICS and other nationally sponsored surveys. Service statistics.	Outcome	When possible (in years with a DHS) by: wealth quintile, age, marital status, urban/rural, ethnicity, region, etc.	Contraceptive prevalence rate (any method) is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health. Included in WHO indicators on health and rights list
02 TOTAL NUMBER OF CONTRACEPTIVE USERS BY METHOD	The number of women (or their partners) of reproductive age currently using a contraceptive method.	Modeled using various data sources, including DHS and service statistics.	Output	Type of method, source	
03 PERCENT OF WOMEN WHOSE DEMAND FOR MODERN CONTRACEPTION IS SATISFIED (MET NEED FOR CONTRACEPTION)	The percent of women (or their partners) who desire either to have no more children or to postpone having the next child, who are currently using a modern contraceptive method.	Surveys such as DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics.	Outcome	When possible (in years with a DHS) by: wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.	The proportion of demand for family planning that is satisfied (any method) is a tracking indicator for the Global Strategy for Women's and Children's Health.
04 PERCENTAGE OF WOMEN WITH AN UNMET NEED FOR CONTRACEPTION	The percentage of fecund women of reproductive age who want no children or to postpone having the next child, but are not using a contraceptive method.	Surveys such as DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics.	Output	When possible (in years with a DHS) by: method, wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.	The proportion of women (married/union) with an unmet need for family planning is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health. Included in WHO indicators on health and rights list
05 ANNUAL EXPENDITURE ON FAMILY PLANNING FROM GOVERNMENT DOMESTIC BUDGET	Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.	Estimate will be derived through contributions from Kaiser Family Foundation, UNFPA/NIDI, WHO/COIA and the DELIVER project. Country availability will depend on COIA and NIDI implementation. All 69 countries are expected to be available at some point.	Enabling environment		Proportion of SRH budget allocated to FP is a tracking indicator for the Maputo Plan of Action.
06 COUPLE-YEAR OF PROTECTION (CYP)	The estimated protection provided by family planning services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method.	Service statistics	Output	By method	CYP was developed by USAID, and most FP donors, international agencies, and service providers report CYPs.

Indicators that Model Impact for All 69 FP2020 Countries

INDICATOR NAME	DEFINITION	DATA SOURCE & AVAILABILITY	CONCEPTUAL FRAMEWORK CATEGORY	DISAGGREGATION	LINKS TO OTHER INITIATIVES
07 NUMBER OF UNINTENDED PREGNANCIES	The number of pregnancies that occurred at a time when women (and their partners) either did not want (additional) children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies, including current pregnancies	Estimated using modeling and the last DHS or similar survey as the base	Impact		
08 NUMBER OF UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE	The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period	Estimated using modeling and the last DHS or similar survey as the base	Impact		
09 NUMBER OF MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE	The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period	Estimated using modeling and the last DHS or similar survey as the base	Impact		This indicator is tracked in the ICPD Program of Action in a slightly different formulation as follows: "countries should strive to effect significant reductions in maternal mortality by 2015."
10 NUMBER OF UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE	The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period	Estimated using modeling and the last DHS or similar survey as the base	Impact		

Indicators that Will Be Reported Annually for a Subset of 10 Countries and for the Subset of the 69 FP2020 Countries in Years with a DHS

INDICATOR NAME	DEFINITION	DATA SOURCE & AVAILABILITY	CONCEPTUAL FRAMEWORK CATEGORY	DISAGGREGATION	LINKS TO OTHER INITIATIVES
11 PERCENT OF WOMEN WHO WERE PROVIDED WITH INFORMATION ON FAMILY PLANNING DURING THEIR LAST VISIT WITH A HEALTH SERVICE PROVIDER	The percent of women who were provided information on FP in some form at the time of their last contact with a health service provider. The contact could occur in either a clinic or community setting. Information could have been provided via a number of mechanisms, including counseling, IEC materials or talks/conversations about FP.	PMA2020 Survey DHS in select years	Process		
12 MEAN SCORE ON METHOD INFORMATION INDEX	An index measuring the extent to which women were made aware of alternative methods of contraception and were provided adequate information about them. The index is constructed from three questions (Were you informed about other methods? Were you informed about side effects? Were you told what to do if you experienced side effects?) Information will also be available for each indicator independently.	PMA2020 Survey DHS in select years	Process		Included in WHO indicators on health and rights list
13 PERCENT OF WOMEN WHO MAKE FAMILY PLANNING DECISIONS ALONE OR JOINTLY WITH THEIR HUSBANDS/PARTNERS OR JOINTLY WITH PROVIDER	The percent of women who make decisions on matters, such as whether and when to initiate and terminate contraceptive use and choice of contraceptive method, either by themselves or based upon consensus joint decision-making with their husband/partner/provider	PMA2020 Survey DHS in select years	Process		
14 ADOLESCENT BIRTH RATE	The number of births to adolescent females, aged 15-19 occurring during a given reference period per 1,000 adolescent females	PMA2020 Survey DHS, MICS, RHS in select years	Impact		The adolescent (ages 15-19) birth rate is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health.
15 PERCENT INFORMED OF PERMANENCE OF STERILIZATION	Among women who said they were using male or female sterilization, the percent who were informed by the provider that the method was permanent	PMA2020 Survey DHS in select years (and select countries). Not a standard question.	Process		

NEW INDICATORS

An important area of contribution of the FP2020 partnership is and will continue to be the identification of new indicators that better measure concepts of informed choice, autonomy, and the extent to which family planning programs are implemented in accordance with human rights principles. Currently, data that are routinely collected through existing mechanisms arguably do not adequately measure these concepts. Both the Rights & Empowerment and Performance Monitoring & Accountability Working Groups have identified indicators that are not routinely collected in all countries through existing data collection mechanisms, and would require facility-level measures and/or do not have an existing data source that would allow comparison of such indicators on an annual basis among all 69 countries. This work has benefited from collaboration with WHO, and FP2020 will align where possible with WHO's upcoming guidance and recommendations on optimizing human rights in the provision of contraceptive information and services.

Many of these indicators are designed to reflect whether and how national family planning programs and services are provided in an atmosphere that respects choice, autonomy, and the principles of human rights. FP2020 Working Groups are committed to building capacity over time by

strengthening existing systems and working with countries through a variety of mechanisms to encourage the exploration of new indicators. This kind of indicator work might involve, for example, use of existing data in new ways, including disaggregation of data as a way to investigate differentials in family planning program performance and outcomes by population subgroups.

Indicators that are currently being explored include:

- Percent of individuals in community/facility catchment area reporting awareness of, access to, and satisfaction with reproductive health services
- Percent of facilities reliably offering at least one long-term reversible method, at least one short-term method, permanent methods (in place or referral), and emergency contraception
- Percent of facilities equipped to provide easy access for removal of implants and IUDs

FP2020 also intends to add an indicator to monitor contraceptive availability/stock-outs to the core list. The selection of this indicator will be informed by a process led by the DELIVER Project and the Reproductive Health Supplies Coalition (RHSC) Systems Strengthening Working Group Stock-out Indicator Work Stream to identify standard indicators and recommend standard definitions to reduce confusion in the field due to organizations defining

contraceptive availability and stock-outs differently, with varying lengths in reporting systems (six months, 12 months, day of visit) and in whether stock-outs are reported for individual methods or types of methods. See chart on next page.

NATIONAL FAMILY PLANNING COMPOSITE INDEX

FP2020 plans to develop a National Family Planning Composite Index (NFPCI) as a comprehensive measurement tool to monitor the enabling environment in a manner that takes into account not merely the existence of policies and guidelines but also the extent to which family planning program implementation includes measurable dimensions of quality service provision. Future progress reports will contain index findings and country-specific information.

The index will be constructed using a modified version of the Family Planning Effort Index (FPE),²² government policies and protocols, and input from key stakeholders (i.e., government, partners, donors, civil society). Potential indicators that may be included in the index are:

- The existence of a comprehensive, costed action plan for achieving national family planning goals
- Family planning service guidelines and SOPs that reflect latest, updated WHO medical guidelines
- The existence, coverage, and effectiveness of a quality-of-care monitoring system

²² Ross, John and Ellen Smith. 2010. The Family Planning Effort Index: 1999, 2004, and 2009. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Service Delivery Points (SDPs)

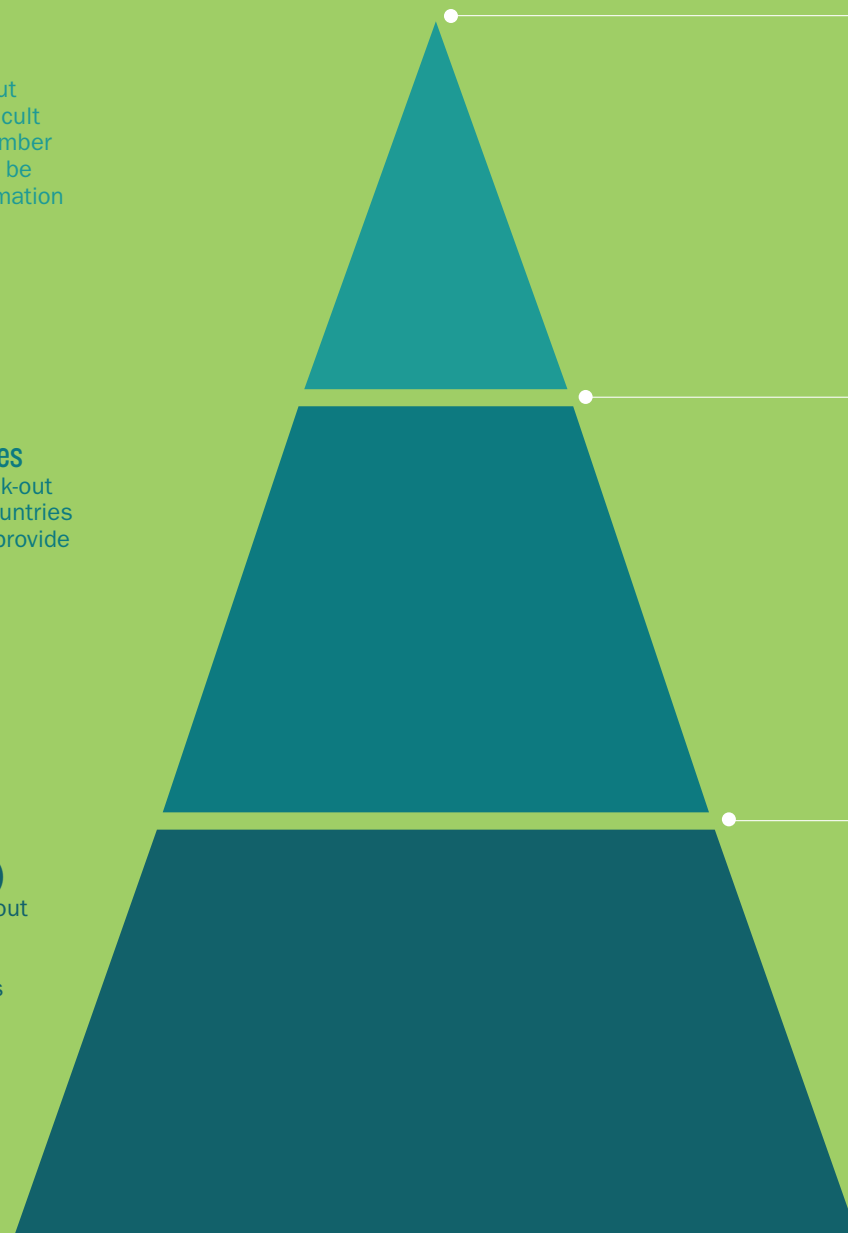
Most robust stock-out indicators, most difficult to collect, fewest number of countries likely to be able to provide information

Regional/ District Warehouses

Medium-robust stock-out indicators, some countries likely to be able to provide information

Central Warehouse (CMS)

Least robust stock-out indicators, simplest to collect, greatest number of countries likely to be able to provide information



BY FP METHOD OFFERED:

Percent of SDPs stocked out on day of visit or most recent LMIS report (determined via physical inspection)

Average number of stock-outs over the year (determined via stock records)

On average, total number of days stocked out over the year (determined via stock records)

BY FP METHOD OFFERED:

Percent of regional/district warehouses stocked out on day of visit or most recent LMIS report (determined via physical inspection)

Average number of stock-outs over the year (determined via stock records)

On average, total number of days stocked out over the year (determined via records)

BY FP METHOD OFFERED:

Whether central warehouse (CMS) stocked out on day of visit or most recent LMIS report (determined via physical inspection)

Number of stock-outs over the year (determined via stock records)

Total number of days stocked out over the year (determined via records)

INDICATOR REGARDING CHOICE OF FAMILY PLANNING METHOD

DELIVER/RHSC recommends the following availability indicator to provide an indication of choice:

Percent of SDPs with at least five modern FP methods in stock on day of visit or day of report.

INDICATOR FORMULA

(Number of SDPs with at least five modern FP methods in stock on day of visit or report)



(Total number of SDPs) × 100

STOCK-OUT INDICATOR CALCULATIONS

If any usable (unexpired, undamaged) stock of the method exists, the method is not considered stocked out. If there is stock anywhere in the facility—whether in the facility's storeroom or dispensing area—the facility should not be considered stocked out.

Along with reporting the percentages, it is recommended that countries include the numerators and denominators used; this will provide more transparency for the calculations and enable a better understanding of changes in the percentages and reporting rates over time.

The denominator for the stock-out calculations should be the number of facilities that offer the method.

Most of the indicators can be measured by brand (e.g., Depo-Provera®) or by method type (e.g., injectable contraceptive). We recommend choosing one of these ways and reporting consistently across countries.

Indicators on the frequency and duration of stock-outs (measured over the course of the year) can only be collected if records are accurately and consistently kept. Many facilities (especially SDPs) will not have accurate and complete records kept throughout the year. Where calculated, these two indicators can be averaged across facilities of that type, at that level of the supply chain, or within a region or district.

MEASUREMENT ISSUES TO CONSIDER FOR SDP-LEVEL INDICATORS

The availability of contraceptives at SDPs is based both on:

- The number of facilities that offer the FP method in the first place
- Of the facilities that offer the method, those that have the method in stock

For this reason, DELIVER and RHSC included an SDP-level service provision indicator (regarding the percent of SDPs that offer each method) along with the stock-out indicators.

Along with being reported across all SDPs, the SDP-level indicators can also be reported by type of SDP.

INDICATORS THAT WILL BE REPORTED ANNUALLY FOR ALL 69 FP2020 COUNTRIES

**Indicator 1
Contraceptive Prevalence Rate, Modern Methods (mCPR)**

There are two data points displayed in the table for Indicator 1.

1. The first data point is the mCPR from the most recent survey completed in the country. The source for this information is most often a Demographic and Health Survey (DHS) with additional inputs from Multiple Indicator Cluster Survey (MICS), Reproductive Health Survey (RHS), and/or national surveys. The year of the survey can be found at the bottom of the table. The cell has been left blank in countries where the mCPR rate is only available for married or in-union women.
2. The second data point is the 2012 baseline mCPR for each country. The value included for countries with a 2012 DHS survey is derived from the preliminary or final DHS report. For all other countries, the value represents an estimate derived from the Guttmacher Institute and Futures Institute through a past-trend analysis by linear extrapolation from the last survey using the rate of change between the last two (or more) surveys. The mCPR estimates are based on multiple sources, including tabulations of all available DHS country datasets provided by ICF International²³; Guttmacher Institute tabulations of other national surveys,

including MICS and RHS datasets; published reports; and a database of contraceptive use information for married women, compiled from all available sources by the UN.²⁴

The final column for the mCPR indicator is blank and serves as a placeholder for countries to adjust their baseline numbers if desired. Track20 will work with FP2020 pledging countries in the upcoming year to either validate or adjust their 2012 baseline mCPR values in order to be more useful for performance monitoring against national plan objectives. Any changes will be reported in the next progress report. When available, data represents mCPR among all women aged 15-49. When surveys only reported on mCPR among married women, a methodology from the Guttmacher Institute was used to estimate contraceptive use among unmarried women that was then added to the number of married women in order to calculate prevalence among all women aged 15-49. In order to perform this calculation, the proportion of married women, among women of reproductive age, was required. The total number of women aged 15-49 by five-year age groups in each country in 2012 was taken from the UN Population Division's *World Population Prospects: the 2012 Revision*.

For most countries, the proportions of women who were currently married or in union, formerly married, or never married (for each five-year age group within ages 15-49) were taken from a UN compilation of information from national censuses and surveys.²⁵ These

proportions were assumed to apply to 2012, regardless of the year of the relevant census or survey. Age-specific proportions in each marital status group were applied to 2012 age-specific numbers of women and added to estimate the total number of women aged 15-49 in 2012 in each developing country who were currently married. For countries with more recent survey information than included in the UN database, marital status proportions of women aged 15-49 were updated, and regional estimates or estimates from a similar nearby country were used for the few countries with no available information on marital status.

**Indicator 2
Total Number of Contraceptive Users by Method**

Data for this indicator were obtained by multiplying the modern contraceptive prevalence estimate for all women for 2012 by the number of women aged 15-49. The original analysis prepared for the London Summit on Family Planning estimated there were approximately 260 million modern method users in the 69 poorest countries. New estimates made possible by the release of data following July 2012 show that there was a slight increase in modern method users (263 million) in 2012. This figure does not include South Sudan, where data were not available, and it does not include South Africa, since it is not one of the 69 poorest countries. This increase in the number of estimated users reflects small revisions to mCPR estimates and revised population projections in some FP2020 countries.

²³ Special tabulations of unmet need using revised definition, for all DHS surveys, produced by Trevor N. Croft and Sarah E. K. Bradley, MEASURE DHS, ICF International, February 2012.

²⁴ United Nations Department of Economic and Social Affairs, Population Division, World Contraceptive Use 2010 (POP/DB/CP/Rev2010), 2011.

²⁵ United Nations, Department of Economic and Social Affairs, Population Division, World Marriage Data 2008 (POP/DB/Marr/Rev2008).



GROWTH RATES

The figure here displays countries grouped by their growth rates for contraceptive prevalence. This chart indicates whether progress is being accelerated over time. If FP2020 is successful over the next eight years, the number of countries that fall in the higher-growth categories will increase.

The growth rates were estimated by calculating the annual rate of change between the last two data points. The sources of the data include DHS, MICS, RHS, and national surveys (the same data points that were used to estimate the 2012 mCPR were used to produce this graphic). Western Sahara is not included due to lack of data.

The majority of FP2020 Focus Countries (38) fall in the lowest-growth category, while only six fall in the highest (Rwanda and Djibouti). Over time, this graph will visually represent progress toward the overall achievement of FP2020 demonstrated by a shift toward the higher-growth-rate categories by a majority of the countries. Countries with smaller population sizes will achieve accelerated growth rates more easily than those with larger populations.

SOURCES
 Afghanistan (National survey 2010 and 2007/8), Bangladesh (DHS 2011 and 2007), Benin (DHS 2011/12 and 2006), Bhutan (MICS 2010 and National Survey 2000), Bolivia (DHS 2008 and 2003), Burkina Faso (DHS 2010 and 2003), Burundi (DHS 2010 and 1987), Cambodia (DHS 2010 and 2005), Cameroon (DHS 2011 and 2004), Central African Republic (MICS 2010 and 2006), Chad (MICS 2010 and DHS 2004), Comoros (DHS 2012 and 1996), Congo (DHS 2012 and 2005), Côte d'Ivoire (DHS 2012 and 1998/99), Democratic Republic of Congo (MICS 2010 and DHS 2001), Djibouti (MICS 2006 and PapFam 2001), Egypt (DHS 2008 and 2005), Eritrea (DHS 2011 and 2005), Ethiopia (DHS 2011 and 2005), Gambia (MICS 2010 and 2000), Ghana (MICS 2011 and DHS 2008), Guinea (DHS 2012 and 2005), Guinea-Bissau (MICS 2010 and 2006), Haiti, (DHS 2012 and 2005/6), Honduras (DHS 2011/12 and 2005/6), India (DHS 2006/7 and 1998/99), Indonesia (DHS 2012 and 2007), Iraq (MICS 2011 and 2006), Kenya (DHS 2008/9 and 2003), Kyrgyzstan (DHS 2012 and MICS 2006), Laos (MICS 2011/12 and National Survey 2000, Lesotho (DHS 2009 and 2004), Liberia (DHS 2007 and 1996), Madagascar (DHS 2008/9 and 2003/4), Malawi (DHS 2010 and 2004), Mali (DHS 2006 and 2004/2), Mauritania (MICS 2007 and DHS 2001), Mongolia (MICS 2010 and 2005), Mozambique (DHS 2011 and 2003), Myanmar (MICS 2010 and National Survey 2007), Nepal (DHS 2011 and 2006),

Nicaragua (RHS 2006/7 and DHS 2001), Niger (DHS 2012 and 2006), Nigeria (MICS 2011 and DHS 2008), North Korea (National Survey 2002 and 1997), Occupied Palestinian Territories (MICS 2010 and Family Health Survey 2006), Pakistan (DHS 2012/12 and 2006/7), Papua New Guinea (National Survey 2006 and 1996), Philippines (National Family Survey 2011 and DHS 2008), Rwanda (DHS 2010 and 2007/8), Sao Tome and Principe (DHS 2008/9 and MICS 2006), Senegal (DHS 2010/11 and 2006), Sierra Leone (MICS 2010 and DHS 2008), Somalia (MICS 2006 and WCU 1999), South Africa (DHS 2003 and 1998), Sri Lanka (DHS 2007 and 1987), Sudan (MICS 2006), Tajikistan (DHS 2012 and MICS 2005), Timor-Leste (DHS 2009/10 and LSMS 2007), Togo (MICS 2010 and 2006), Uganda (DHS 2011 and 2006), Tanzania (DHS 2010 and 2005), Uzbekistan (MICS 2006 and DHS 2002), Vietnam (MICS 2011 and 2006), Yemen (MICS 2006 and PapFam 2003), Zambia (DHS 2007 and 2001/2), Zimbabwe (DHS 2010/11 and 2005/6), Solomon Islands, South Sudan, and Western Sahara are not included because they have only one or no data points. Analysis was done using both mCPR among all women and married women, depending on which data were available for each country. However, the two data points for each country are based on the same population, either all women or married women. If estimates for all women and married women available for both data points, all women was used for the analysis.

Country Categories

0 - 0.5

Afghanistan
 Benin
 Bolivia
 Burundi
 Cameroon
 Central African Republic
 Chad
 Comoros
 Côte d'Ivoire
 Egypt
 Eritrea
 Gambia
 Guinea
 Indonesia
 Iraq
 Kyrgyzstan
 Liberia
 Mali
 Mauritania
 Mongolia
 Mozambique
 Nepal
 North Korea
 Papua New Guinea
 Sao Tome and Principe
 Senegal
 Somalia

South Africa
 Sudan
 Tajikistan
 Togo
 Uzbekistan
 Vietnam
 Zimbabwe

Ethiopia
 Laos
 Lesotho
 Niger
 Tanzania
 Uganda
 Zambia

0.5 - 1.0

Burkina Faso
 Democratic Republic of Congo
 Haiti
 Honduras
 India
 Kenya
 Nicaragua
 Nigeria
 Occupied Palestinian Territories
 Pakistan
 Philippines
 Sri Lanka

1.0 - 1.5

Bangladesh
 Cambodia
 Congo

1.5 - 2.0

Madagascar
 Malawi
 Sierra Leone

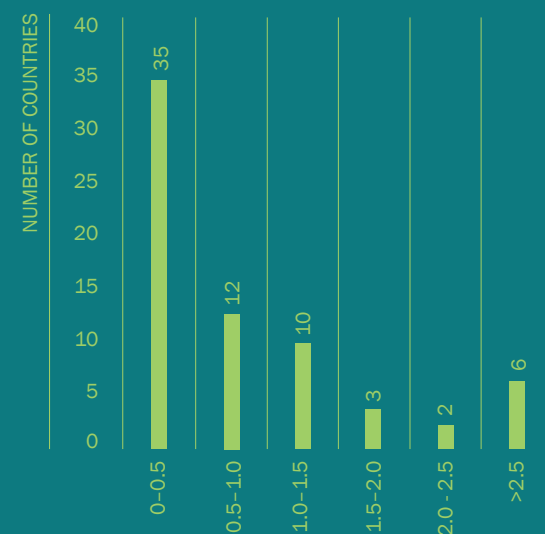
2.0 - 2.5

Myanmar
 Timor-Leste

>2.5

Bhutan
 Djibouti
 Ghana
 Guinea-Bissau
 Rwanda
 Yemen

Past Annual Growth Rates in mCPR



Indicator 3 Percent of married women whose demand for modern contraception is satisfied

Indicator 4 Percentage of married women with an unmet need

The data for indicators 3 and 4 were provided by the United Nations Population Division.²⁶ These indicators are traditionally reported for women who are married or in union, so estimates reflect demand and unmet need among married/in-union women and are therefore not strictly comparable with the mCPR and number of users reported in the table. Going forward, FP2020 intends to report these indicators for all women.

In 11 countries, 20% or less of the current demand for family planning among married women was met. Of these 11 countries, seven are in West Africa, a region where indicators of family planning performance tend to fall below the overall averages for other regions of Africa and for western and south-central Asia. Between 25% and 50% of demand among married women was met. The countries that fall into this category are more regionally diverse and include 22 African countries, with the remainder from the Middle East, Central Asia, and South America.

Percentages for an unmet need are harder to translate because these can reflect both a need for contraception as well as high desired rates of fertility. For example, Chad had the lowest estimated mCPR in 2012 (1.6) and an estimated unmet need that is lower than the median for the FP2020 countries (Chad is 26, and the median is 31). In contrast, South Africa had the highest mCPR and the lowest unmet

need, representing the expected mCPR unmet need relationship for a location further along the demographic transition.

The methodology used to estimate the 2012 modern contraceptive prevalence rates, unmet need, and percent of demand satisfied (Indicators 1, 3, and 4) will be modified for the next report. The new methodology will modify the Bayesian hierarchical model, currently used by the UN Population Division, that produces country-specific contraceptive prevalence.²⁷ The modifications will allow for the inclusion of country-produced data, such as service statistics and commodity data, with data already included from cross-sectional surveys. In addition to a modification of the methodology, the process of applying the model will be introduced in FP2020 pledging countries to increase transparency and allow countries to make decisions about which country-level data are included in the analysis.

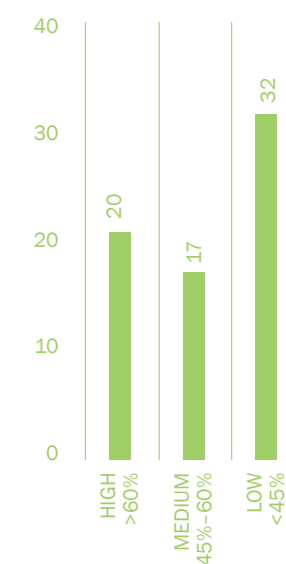
The final two core indicators that will be reported every year include:

Indicator 5 Annual expenditure on family planning from the government domestic budget

Indicator 6 Couple-year of protection (CYP)

These indicators are not included in this report because the processes necessary for data collection are currently being developed and implemented. CYP data will be collected by service statistics from both the public and private sector. The process under development for estimating family planning expenditures is described later in the report, but data on country expenditures are not yet available.

Number of Countries with Low, Medium, and High Percent of Demand Satisfied



²⁶ United Nations, Department of Economic and Social Affairs, Population Division (2013). *Model-based Estimates and Projections of Family Planning Indicators: 2013 Revision*. New York: United Nations.

²⁷ Alkema, L., Kantorova, V., Menozzi, C. and Biddlecom, A. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *The Lancet*. www.thelancet.com.

Table I Indicators that Will Be Reported Annually for All 69 FP2020 Countries (Pledging Countries)

PLEDGING COUNTRIES	mCPR (ALL WOMEN AGED 15-49)			# USERS OF MODERN CONTRACEPTION (2012 ESTIMATE)	% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)	% WOMEN WITH UNMET NEED FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)
	MOST RECENT ESTIMATE (%)	2012 ESTIMATE (%)	ADJUST BASELINE FOR 2012 COUNTRY INPUT			
BANGLADESH	N/A	42.2		17,965,000	70	22.6
BURKINA FASO	14.3	15.6		642,000	38	27.0
CÔTE D'IVOIRE	13.9	13.9		676,000	27	35.9
DEMOCRATIC REPUBLIC OF CONGO	6.7	10.8		1,713,000	14	42.8
ETHIOPIA	18.7	20.2		4,317,000	50	28.6
GHANA	13.5	22.5		1,409,000	32	40.7
INDIA	38.0	42.5		137,860,000	71	20.8
INDONESIA	42.7	42.7		12,175,000	79	15.1
KENYA	28.0	31.4		3,241,000	59	29.4
MALAWI	32.6	36.0		1,269,000	61	28.1
MOZAMBIQUE	12.1	12.1		689,000	34	25.9
NIGER	N/A	10.8		391,000	35	22.5
NIGERIA	10.5	14.2		5,435,000	26	27.4
PAKISTAN	N/A	18.1		8,482,000	43	33.9
PHILIPPINES	21.8	24.3		6,020,000	51	35.6
RWANDA	25.2	32.3		891,000	60	29.0
SENEGAL	8.9	9.3		298,000	30	31.5
SIERRA LEONE	8.2	17.6		268,000	23	31.0
SOLOMON ISLANDS	N/A	19.1		26,000	51	28.6
SOUTH AFRICA	50.1	51.5		6,953,000	82	13.2
UGANDA	20.7	21.8		1,705,000	42	37.6
ZAMBIA	24.6	30.1		921,000	48	35.5
ZIMBABWE	40.5	40.9		1,373,000	79	15.4

N/A = Not available.



Stephanie Freid-Perenchio
photography/SFP STUDIO

Indicators that Will Be Reported Annually for All 69 FP2020 Countries (Nonpledging Countries)

NONPLEDGING COUNTRIES	mCPR (ALL WOMEN AGED 15-49)			# USERS OF MODERN CONTRACEPTION (2012 ESTIMATE)	% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)	% WOMEN WITH UNMET NEED FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)
	MOST RECENT ESTIMATE (%)	2012 ESTIMATE (%)	ADJUST BASELINE FOR 2012 COUNTRY INPUT			
AFGHANISTAN	N/A	15.6		1,148,000	35	35.2
BENIN	N/A	9.3		206,000	20	35.2
BHUTAN	N/A	52.8		104,000	82	13.4
BOLIVIA	24.0	24.2		629,000	47	41.9
BURUNDI	11.0	11.9		273,000	35	35.8
CAMBODIA	21.7	23.8		962,000	55	31.5
CAMEROON	N/A	16.5		822,000	31	33.9
CENTRAL AFRICAN REPUBLIC	3.5	13.5		151,000	25	37.7
CHAD	1.5	5.0		135,000	8	25.9
COMOROS	N/A	9.8		18,000	49	33.9
CONGO (BRAZZAVILLE)	N/A	21.9		224,000	31	44.7
DJIBOUTI	N/A	24.9		61,000	41	32.0
EGYPT	N/A	39.5		8,603,000	80	14.4
ERITREA	5.2	8.2		116,000	27	34.2
GAMBIA	N/A	7.4		34,000	25	32.9
GUINEA	7.0	7.0		169,000	16	26.5
GUINEA-BISSAU	N/A	66.3		251,000	29	26.7
HAITI	21.6	21.6		579,000	45	38.8
HONDURAS	42.9	43.3		896,000	71	23.2
IRAQ	N/A	22.3		1,741,000	51	33.1
KYRGYZSTAN	N/A	21.8		331,000	72	19.2
LAOS	N/A	29.6		516,000	63	25.5
LESOTHO	34.9	39.3		224,000	68	23.2
LIBERIA	11.7	12.8		127,000	27	35.2

N/A = Not available.

NONPLEDGING COUNTRIES	mCPR (ALL WOMEN AGED 15-49)			# USERS OF MODERN CONTRACEPTION (2012 ESTIMATE)	% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)	% WOMEN WITH UNMET NEED FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)
	MOST RECENT ESTIMATE (%)	2012 ESTIMATE (%)	ADJUST BASELINE FOR 2012 COUNTRY INPUT			
MADAGASCAR	23.0	29.3		1,528,000	52	29.3
MALI	6.2	6.7		249,000	23	30.1
MAURITANIA	3.1	6.3		57,000	25	33.6
MONGOLIA	N/A	36.4		278,000	71	20.9
MYANMAR	N/A	31.4		4,406,000	68	21.2
NEPAL	33.2	33.2		2,707,000	59	31.1
NICARAGUA	46.9	49.9		806,000	82	14.6
NORTH KOREA	N/A	50.2		3,269,000	75	19.3
OCCUPIED PALESTINIAN TERRITORIES	N/A	26.4		274,000	58	30.3
PAPUA NEW GUINEA	N/A	20.0		356,000	45	33.7
SAO TOME AND PRINCIPE	N/A	22.4		9,000	47	38.9
SOMALIA	N/A	3.6		82,000	7	47.4
SOUTH SUDAN	N/A	2.0		49,000	6	33.7
SRI LANKA	N/A	38.6		2,102,000	69	23.6
SUDAN	N/A	8.6		772,000	26	31.5
TAJIKISTAN	N/A	16.0		305,000	48	29.9
TANZANIA	23.6	25.8		2,787,000	49	31.4
TIMOR-LESTE	12.8	17.4		45,000	43	30.7
TOGO	7.9	16.4		262,000	28	40.0
UZBEKISTAN	36.6	41.3		3,139,000	79	16.0
VIETNAM	N/A	40.1		10,399,000	80	16.6
WESTERN SAHARA	N/A	N/A		N/A	N/A	N/A
YEMEN	N/A	31.5		1,906,000	37	43.1

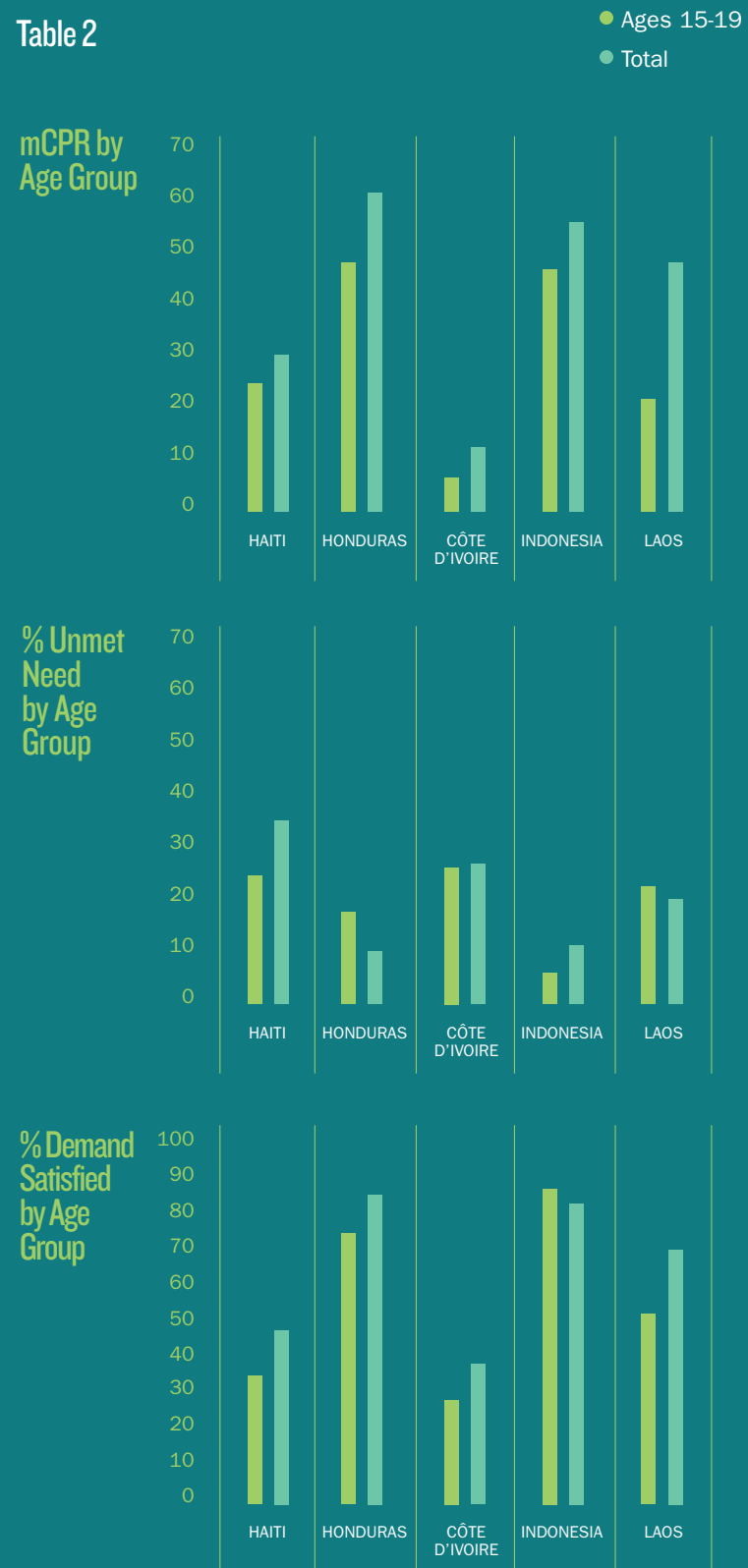
N/A = Not available.

For most recent estimates, the year of the last survey—1995: Central African Republic; 1996: Uzbekistan; 1998: Togo; 2001: Mauritania; 2002: Eritrea; 2003: South Africa; 2004: Chad; 2006: India, Mali; 2007: Democratic Republic of Congo, Liberia, Nicaragua, Zambia; 2008: Bolivia, Nigeria, Philippines, Sierra Leone; 2009: Ghana, Kenya, Lesotho, Madagascar; 2010: Burkina Faso, Burundi, Cambodia, Malawi, Rwanda, Tanzania, Timor-Leste; 2011: Cameroon, Ethiopia, Mozambique, Nepal, Senegal, Uganda, Zimbabwe; 2012: Côte d'Ivoire, Guinea, Haiti, Honduras, Indonesia

Table 2 presents data on Indicators 1, 3, and 4 in the five countries with a DHS survey in 2012 disaggregated by age. The figures for unmet need and demand in this table differ from those in Table 1 (pages 77-80) as they come directly from a DHS and allow for further analysis within each country by providing the ability to disaggregate by important socioeconomic factors, such as wealth quintile and urban/rural status. The figures in Table 1 are derived from UNPD data to allow a common methodology to be used across countries, since there are a limited number of countries that have a DHS in any given year. In addition, the mCPR estimates in Table 2 are for married women only, rather than for all women (Table 1), as a DHS publishes only the breakdowns of CPR by characteristic for married women.

Data on the four indicators—mCPR, number of users of modern methods, unmet need, and satisfied demand presented in subsequent progress reports will be obtained directly from countries, in some cases with the assistance of Monitoring & Evaluation officers in country and in some cases through electronic methods (see Track20 and PMA2020 Highlight on page 86). Annual figures will be estimated through two FP2020 innovations: one that utilizes technology for annual data collection and analysis (PMA2020) and one that is introducing country-specific processes that analyze and model available data in making estimates (Track20). The presence of these activities is limited to FP2020 pledging countries, or a subset of pledging countries, so methodologies will differ for nonpledging countries. These processes will provide the data to complete Tables 1 and 2 in subsequent years.

Table 2



Stephanie Freid-Perenchio
photography/SFP STUDIO

Table 3 Indicators that Model Impact for All 69 FP2020 Countries (Pledging Countries)

Estimated number (000s) of unintended pregnancies in 2012, numbers (000s) of unintended pregnancies and unsafe abortions averted by modern contraceptive

use in 2012, and number of maternal deaths averted by modern contraceptive use in 2012, for 69 poorest countries.

PLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000s)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000s)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000s)	# MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE	PLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000s)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000s)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000s)	# MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE
BANGLADESH	3,518	5,069	1,508	366	NIGER	77	110	31	366
BURKINA FASO	126	181	51	5,436	NIGERIA	1,064	1,533	429	5,436
CÔTE D'IVOIRE	132	191	53	3,501	PAKISTAN	1,661	2,393	712	3,501
DEMOCRATIC REP. OF CONGO	335	48	152	946	PHILIPPINES	1,179	1,698	832	946
ETHIOPIA	845	1,218	171	481	RWANDA	174	251	88	481
GHANA	276	398	111	175	SENEGAL	58	84	24	175
INDIA	26,993	38,895	11,571	379	SIERRA LEONE	52	76	21	379
INDONESIA	2,384	3,435	1,683	4	SOLOMON ISLANDS	5	7	0	4
KENYA	635	914	320	839	UGANDA	334	481	168	839
MALAWI	248	358	125	643	ZAMBIA	180	260	91	643
MOZAMBIQUE	135	194	68	1,242	ZIMBABWE	269	387	136	1,242

INDICATORS THAT MODEL IMPACT FOR ALL 69 FP2020 COUNTRIES

The second category includes **Indicators 7-10**, which will be modeled to produce annual estimates. For this report, these estimates are based on analysis done by the Guttmacher Institute. Its analysis found that in 2012, there were 51.3 million unintended pregnancies in the 69 FP2020 countries. In addition, the impact of modern contraceptive use was estimated at 73.9 million unintended pregnancies averted, 23.8 million unsafe abortions averted, and 92,715 maternal deaths averted.²⁹

The numbers were estimated using two scenarios.

Scenario one is the current situation, in terms of modern contraceptive use by women aged 15-49. In scenario two, none of these women were using contraception, and then remained at risk of unintended pregnancy.

To produce country-specific estimates, the Guttmacher Institute totals for the 69 countries were proportioned to each country. For the first two indicators—number of unintended pregnancies and number of unintended pregnancies averted due to contraceptive use—the totals were distributed to each country based on the number of users in each country (reported in Table 1). Numbers are reported in thousands and are influenced by

the contraceptive prevalence in each country as well as by the number of women who are of reproductive age. The highest numbers were reported for India, which has the largest population and very high contraceptive prevalence. The third indicator—number of unsafe abortions averted due to contraceptive use—was based on distributing the total for the 69 countries according to both the number of users and the WHO 2008 regional abortion rates. The fourth indicator—number of maternal deaths averted due to contraceptive use—was calculated by distributing the total for the 69 countries according to both the number of users and the UN 2010 maternal mortality ratios.

Indicators that Model Impact for All 69 FP2020 Countries (Nonpledging Countries)

NONPLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000s)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000s)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000s)	# MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE	NONPLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000s)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000s)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000s)	# MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE
AFGHANISTAN	225	324	96	838	MADAGASCAR	299	431	151	582
BENIN	40	58	16	114	MALI	49	70	20	213
BHUTAN	20	29	9	30	MAURITANIA	11	16	5	46
BOLIVIA	123	177	134	190	MONGOLIA	54	78	0	28
BURUNDI	53	77	27	347	MYANMAR	863	1,243	609	1,399
CAMBODIA	188	271	133	382	NEPAL	530	764	227	731
CAMEROON	161	232	73	900	NICARAGUA	158	227	135	122
CENTRAL AFRICAN REPUBLIC	30	43	13	213	NORTH KOREA	640	922	0	420
CHAD	26	38	12	236	OCCUPIED PALESTINIAN TERRITORIES	54	77	22	28
COMOROS	4	5	2	8	PAPUA NEW GUINEA	70	100	5	130
CONGO (BRAZZAVILLE)	44	63	20	199	SAO TOME AND PRINCIPE	2	3	1	1
DJIBOUTI	12	17	6	19	SOMALIA	16	23	8	130
EGYPT	1,684	2,427	765	901	SOUTH SUDAN	N/A	N/A	N/A	N/A
ERITREA	23	33	11	44	SRI LANKA	412	593	176	117
GAMBIA	7	10	3	19	SUDAN	151	218	69	895
GUINEA	33	48	13	164	TAJIKISTAN	60	86	26	31
GUINEA-BISSAU	49	71	20	315	TANZANIA	546	786	275	2,035
HAITI	113	163	63	322	TIMOR-LESTE	9	13	6	21
HONDURAS	175	253	150	142	TOGO	51	74	21	125
IRAQ	341	491	138	174	UZBEKISTAN	615	886	263	140
KYRGYZSTAN	65	93	28	37	VIETNAM	2,036	2,934	1,438	974
LAOS	101	146	71	385	WESTERN SAHARA	3	4	1	2
LESOTHO	44	63	11	220	YEMEN	373	538	151	605
LIBERIA	25	36	10	155					

N/A = Not available.

²⁹ Guttmacher Institute, 2013, tabulations for data by Singh S and Darroch JE, *Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012*, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012.

SOURCES
1. Number of users taken from Table 1.
2. Guttmacher Institute, 2013, tabulations for data by Singh S and Darroch JE, *Adding It Up: Costs and Benefits of Contraceptive Services—Estimates*

for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012.
3. Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA, and World Bank estimates.

4. Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition, World Health Organization.

INDICATORS THAT WILL BE REPORTED ANNUALLY IN 10 COUNTRIES AND FOR A SUBSET OF THE 69 FP2020 COUNTRIES IN YEARS WITH A DHS

Indicators 11-15 will be reported annually in the 10 countries in which PMA2020 collects data³⁰ and in any country with a DHS in the reporting year. These indicators measure whether women are receiving information on family planning, women's roles in decision making, and fertility rates among adolescents.

PMA2020 data were not available in time for this report, but efforts are under way to make these innovative survey findings available for countries in the future. For this report, only countries with a fully released DHS are included because the information is not included in preliminary DHS reports. Age-specific fertility rates are included in preliminary reports, and this information is reflected here. These data show the age pattern of fertility and are reported per 1,000 women. For example, there were 94 births per 1,000 women aged 15-19 in Benin.

The percent of women who were provided with family planning information during their last health provider visit are among those who visited a health facility, for a variety of reasons, within the last 12 months. This information is important for measurement of integration of services, but it cannot be assumed that all of these women should have been provided with family planning information, so the maximum should not be seen as 100. For the Method Information Index, three variables were included in the analysis: (1) whether women were informed about other methods, (2) whether women were told of side effects, and (3) whether they were told what to do if experiencing side effects. The value in the table represents the percentage of women who responded yes to all three of these questions.

Indicators To Be Reported Annually in 10 Countries and for Subset of 69 FP2020 Countries in Years with a DHS

COUNTRIES	% WOMEN PROVIDED WITH PLANING DURING LAST PROVIDER VISIT	MEAN SCORE ON METHOD INFORMATION INDEX	% WOMEN MAKING FP DECISIONS ALONE OR WITH PARTNER	ADOLESCENT AGE-SPECIFIC FERTILITY RATE (15-19)	% INFORMED OF PERFORMANCE OF STERILIZATION
BENIN				94	
COMOROS				70	
CONGO (BRAZZAVILLE)				147	
CÔTE D'IVOIRE	19	31	81.6	129	
GUINEA				146	
HAITI	40	55	91.4	66	
HONDURAS	35	30	88.0	101	87
INDONESIA	23	24	91.5	48	87
KYRGYZSTAN				44	
LAOS				94	
NIGER				206	

³⁰ PMA2020 Countries/Partners: Ghana (Kwame Nkrumah University of Science & Technology), Ethiopia (Addis Ababa University School of Public Health), Uganda (Makerere University School of Public Health), Nigeria (Obademi Awolowo University and University of Ibadan), Democratic Republic of Congo (University of Kinshasa School of Public Health), Kenya (TBD), Senegal (TBD), Burkina Faso (TBD), India (TBD), Indonesia (TBD).

HIGHLIGHT

TRACK20

Implemented by Futures Institute, the Track20 Project supports national efforts to collect, analyze, and use data to track progress in family planning and to develop effective program strategies and plans. The project works with governments to transform practices that rely heavily on large, national household surveys every few years to a system in which data collected by governments are used to produce annual estimates for key indicators, including modern contraceptive prevalence, commodity security, choice, quality, and family planning expenditures. This approach will make greater use of service statistics and other data collected through the public and private sectors, taking into account their limitations, and will work with governments to install an annual process that reviews the data and issues official estimates.

PERFORMANCE MONITORING AND ACCOUNTABILITY 2020 (PMA2020)

Implemented by the Bill & Melinda Gates Institute of Population and Reproduction at the Johns Hopkins Bloomberg School of Public Health, PMA2020 is designed to facilitate annual progress reporting in support of the goals and principles of FP2020 across 10 countries in Africa and Asia, using an innovative mobile-Assisted Data and Dissemination System (mADDs) that:

- Employs innovative mobile technology
- Supports low-cost, rapid-turnaround surveys
- Generates annual (or semiannual) indicators
- Is expandable to other health sectors
- Provides consistency with DHS measures
- Introduces new indicators of quality, choice, and access
- Creates community feedback loops to prompt program improvement
- Strengthens local capacity



METHOD MIX

The graphic to the right shows the FP2020 countries in which 20% or more of the method mix (both modern and traditional) is attributed to 0 or 1 modern method, 2 modern methods, or 3 modern methods. The left side of the graphic shows that there is relatively low method mix in many of the FP2020 countries. In almost all countries, only one or two methods represent more than 20% of the method mix. In many of these countries, more than 25% of method use is attributed to a composite of traditional methods. Five of the FP2020 countries have three methods that each represents more than 20% of the method mix. This graphic suggests a possible association between modern method mix and traditional method use: countries with high rates of traditional method use are in higher proportion among the countries with limited modern method mix.

The right side of the graphic shows countries with a large proportion

of users using only one method. In this figure, the composite of traditional methods is included in the analysis. The right side of the graphic shows 28 countries (two-fifths of all FP2020 countries) in which 40%–60% percent of contraceptive users rely on one method. For four of those countries, that method is traditional, not modern. The second column on the right side of the graphic lists the 11 countries in which 60% or more of all users rely on only one method of contraception.

There are many different reasons why a few methods dominate the method mix in so many FP2020 countries, including access, availability, and preferences. Further research at the country level can help FP2020 countries better understand the needs of women and why some methods are being chosen more than others. By ensuring the availability of a full range of modern family planning methods, FP2020 will play an important role in diversifying the method mix in places where access is limited.

Countries with ≥20% of the Method Mix (All Users, Both Modern and Traditional Methods) Attributed to 1, 2, or 3 Modern Methods

Countries where traditional method use is ≥25% of the method mix are highlighted in white.

≤ 1 Method

Bangladesh
Benin
Bhutan
Bolivia
Burundi
Cameroon
Central African Republic
Chad
Comoros
Congo (Brazzaville)
Democratic Republic of Congo
Djibouti
Egypt
Ethiopia
Guinea
India
Iraq
Kenya
Madagascar
Mauritania
Nepal
Nigeria
North Korea
Occupied Palestinian Territories
Rwanda
Somalia
South Africa
Tajikistan
Tanzania
Timor-Leste
Togo
Uganda
Uzbekistan
Vietnam
Zimbabwe

2 Methods

Afghanistan
Burkina Faso
Cambodia
Côte d'Ivoire
Eritrea
Gambia
Ghana
Guinea-Bissau
Haiti
Honduras
Indonesia
Kyrgyzstan
Laos
Malawi
Mongolia
Myanmar
Nicaragua
Niger
Pakistan
Senegal
Sierra Leone
Solomon Islands
Sri Lanka
Yemen
Zambia

3 Methods

Lesotho
Liberia
Mali
Mozambique
Sao Tome and Principe

Countries with Indicated % of Method Mix (All Users: Modern and Traditional Methods) Composed of Only 1 Method

Countries highlighted in white indicate that this one method is the composite of traditional methods.

40% - 60%

Afghanistan
Bangladesh
Bhutan
Bolivia
Burundi
Cameroon
Chad
Congo (Brazzaville)
Democratic Republic of Congo
Egypt
Gambia
Haiti
Indonesia
Kenya
Laos
Madagascar
Malawi
Mongolia
Myanmar
Niger
Occupied Palestinian Territories
Philippines
Rwanda
Sierra Leone
South Africa
South Sudan
Togo
Uganda

≥ 60%

Djibouti
Ethiopia
India
Kyrgyzstan
Mauritania
North Korea
Somalia
Tajikistan
Timor-Leste
Uzbekistan
Zimbabwe

SOURCES
Method mix data were unavailable for Papua New Guinea, Sudan, and Western Sahara. For countries where method mix data for all women were unavailable, data for women married/in union was used. Method mix data sources were the same as for the most recent mCPR estimates in Table 1, with the following exceptions: Afghanistan (MICS 2011), Bangladesh (DHS 2011), Benin (DHS 2012), Bhutan (MICS 2010), Central African Republic (MICS 2010), Chad (MICS 2010), Comoros (DHS 2012), Congo-Brazzaville (DHS 2012), Democratic Republic of Congo (MICS 2010), Djibouti (MICS 2008), Egypt (DHS 2008), Gambia (DHS 2013), Ghana (MICS 2011), Guinea-Bissau (MICS 2010), India (DLHS 2008), Iraq (MICS 2011), Kyrgyzstan

(DHS 2012), Laos (MICS/DHS 2012), Mali (DHS 2013), Mauritania, (MICS 2007), Mongolia (MICS 2010), Myanmar (MICS 2010), Niger (DHS 2012), Nigeria (MICS 2011), Occupied Palestinian Territories (FHS 2006), Pakistan (DHS 2013), Philippines (FHS 2011), Sierra Leone (MICS 2010), Sao Tome and Principe (DHS 2009), Solomon Islands (National Survey 2007), Somalia (MICS 2006), South Sudan (SHHS2 2010), Sri Lanka (DHS 2007), Tajikistan (DHS 2012), Timor-Leste (DHS 2010), Togo (MICS 2010), Uzbekistan (MICS 2006), Vietnam (MICS 2011), Yemen (MICS 2006). Original sources for North Korea and Solomon Islands could not be located; for these two countries, method mix data was obtained from the *UN Population Division World Contraceptive Use 2012*.



MONITORING FAMILY PLANNING EXPENDITURES

Monitoring family planning expenditures is an important means of holding stakeholders accountable for their commitments and to measure progress in mobilizing sufficient resources to achieve FP2020 goals. Historically, family planning expenditures have been estimated periodically through special expenditure studies and national health accounts applications.

There has not yet been a unified process to comprehensively and consistently track all resource flows for family planning, including sometimes overlooked sources such as out-of-pocket consumer spending, subnational governments, and the private sector.

NEW COLLABORATIVE TO TRACK EXPENDITURES

Building upon successful approaches for tracking expenditures in the fields of HIV/AIDS, malaria, and other infectious diseases, a collaborative effort by Track20, the Kaiser Family Foundation, UNFPA and the Netherlands Interdisciplinary Demographic Institute, WHO and COIA, and the DELIVER project established a process to comprehensively collect, consolidate, and analyze data that, when taken as a whole, will provide the best possible estimate of family planning expenditures by country on an annual basis. This effort has already generated some new information in 2013, and estimates in 2014 and onward will be even more comprehensive.

For more information about the role of the **Kaiser Family Foundation**, please refer to page 30.

UNFPA/NIDI

UNFPA and the Netherlands Demographic Institute (NIDI) have been tracking financial flows for population activities since 1997 through the Resource Flows Project. The project monitors spending disaggregated by the four components of the costed population package specified in the ICPD Programme of Action: family planning service, basic reproductive health services, STD/HIV/AIDS prevention program, and basic research, data, and population and development policy analysis.

The Track20 project is now working with UNFPA and NIDI to add even more family planning-specific information to their data collection efforts. These efforts are focused on adding elements such as out-of-pocket expenditures to the standard questionnaire. National consultants will be used to implement the questionnaire in each country. Pilot tests are being conducted in late 2013 in Ethiopia and Tanzania. Based on the results of the pilot test, the revised questionnaire can be used in the 2014 round of data collection. This should produce estimates of family planning expenditures from international donors and most developing countries. Major challenges to be addressed include developing new approaches to estimating out-of-pocket expenditures and properly allocating shared expenditures to family planning.

WHO/COIA

The World Health Organization (WHO), as part of the implementation of the Commission on Information and Accountability (COIA) recommendations, is supporting the enhancement of member states' tracking of health expenditures. WHO promotes the use of health accounts software, which collects and maps all expenditures following the standard System of Health Accounts (SHA) 2011 categories.

Program-specific expenditures are estimated by collecting earmarked flow-of-funds data and distributing non-earmarked spending using allocation algorithms, based on information such as number of health visits. The collection of family planning-specific expenditure data has been incorporated into WHO overall work on tracking of expenditures. Unrolling of training and technical assistance started in 2013 with applications in about 20 countries. Ultimately, this should expand in the next few years to a total of about 70 low- and middle-income countries.

DELIVER

The USAID-funded DELIVER project has developed a tool to assist countries in tracking the financing for contraceptive commodities. The Contraceptive Finance Tracking Guide has been piloted in Ghana and Uganda. DELIVER is also developing a training curriculum and a web-based guide. Track20 will work with DELIVER to provide training in the use of the tool to family planning M&E officers. This should ensure that financing for family planning commodities is tracked carefully in key countries.



It is inspiring to see
Tanzania's growing
commitment to
family planning.

The government and
the private sector are
working together to meet
the unmet need for family
planning. The future looks
bright for women and
girls in my country.

HALIMA SHARIFF
COUNTRY DIRECTOR, TANZANIA,
ADVANCE FAMILY PLANNING,
JOHNS HOPKINS BLOOMBERG SCHOOL
OF PUBLIC HEALTH
CENTER FOR COMMUNICATIONS PROGRAM

Stephanie Freid-Perenchio
photography/SFP STUDIO

04

SECTION 04

Annexes
FP2020 Reference Group & Working Group Members
FP2020 Commitment Makers
69 Focus Countries
Acronyms

ANNEX I
Reference Group &
Working Group
Members
As of October, 2013

REFERENCE GROUP

The Reference Group's purpose is to provide strategic direction and oversight of FP2020.

**CO-CHAIR -
DR. CHRIS ELIAS**
Bill & Melinda Gates Foundation

**CO-CHAIR -
DR. BABATUNDE OSOTIMEHIN**
UNFPA

DR. WAPADA BALAMI
Ministry of Health, Nigeria

DR. TEWODROS BEKELE
Ministry of Health, Ethiopia

DR. FLAVIA BUSTREO
World Health Organization

KATHY CALVIN
United Nations Foundation

DR. AWA MARIE COLL-SECK
Ministry of Health, Senegal

JANE EDMONDSON
UK Department for International
Development

DR. TORE GODAL
Ministry of Foreign Affairs, Norway

ANURADHA GUPTA
Ministry of Health and
Family Welfare, India

DR. KELLY HENNING
Bloomberg Philanthropies

JANE WAMBUI KIRAGU
Satima Consultants, Ltd., Kenya

TEWODROS MELESSE
International Planned
Parenthood Federation

POONAM MUTTREJA
Population Foundation of India

DR. ARIEL PABLOS-MENDEZ
USAID

DR. CAROLE PRESERN
Partnership for Maternal, Newborn
and Child Health

JOHN SKIBIAK
Reproductive Health
Supplies Coalition

DR. JULIANTO WITJAKSONO
National Population Family Planning
Agency, Indonesia

**COUNTRY ENGAGEMENT
WORKING GROUP (CE WG)**
The Country Engagement
Working Group will
facilitate access to funding,
technical assistance, and
country-to-country support
for transformational, country-
owned family planning programs.

**CO-LEAD -
DR. KECHI OGBUAGU**
United Nations Population Fund

**CO-LEAD -
ELLEN STARBIRD**
USAID

DR. ABOSEDE ADENIRAN
Federal Health Ministry, Nigeria

DR. MUHAMMED ASLAM
Bayer

**DR. ARTHUMAN BAKER
NDUGGA MAGGWA**
FHI 360

DR. RITA COLUMBIA
United Nations Population Fund

DR. BOCAR DAFF
Ministry of Health, Senegal

DR. ABU JAMIL FAISEL
EngenderHealth

DR. SITI FATHONAH
National Population and Family
Planning Coordinating Board,
Indonesia

MONICA KERRIGAN
Bill & Melinda Gates Foundation

DR. ABDISSA KURKIE
Ministry of Health, Ethiopia

DR. JEAN-PIERRE MANSHANDE
MSD/Merck

DR. JOTHAM MUSINGUZI
Partners in Population
and Development

GRETHE PETERSEN
Marie Stopes International

SARA RUSLING
UK Department for International
Development

HALIMA SHARIFF
Johns Hopkins University Center
for Communications Programs

DR. S K SIKDAR
Ministry of Health and
Family Welfare, India

VINCENT SNIJDERS
Government of the Netherlands

FATIMATA SY
IntraHealth International

**MARKET DYNAMICS
WORKING GROUP (MD WG)**
The Market Dynamics
Working Group will improve
the availability, affordability,
and variety of quality family
planning methods.

**CO-LEAD -
JOHN SKIBIAK**
Reproductive Health
Supplies Coalition

**CO-LEAD -
ALAN STAPLE**
Clinton Health Access Initiative

SHARAD AGARWAL
Hindustan Latex Family Planning
Promotion Trust, India

FRANCOISE ARMAND
Abt Associates

WOLFGANG BECKER JEZUITA
Bayer Pharma AG

KRISHNA JAJA BHUSHAN
Population Services International

TRACEY BRETT
Marie Stopes International

FABIO CASTANO
Management Sciences for Health

LESTER CHINERY
Concept Foundation

LESTER COUTINHO
David & Lucile
Packard Foundation

JAMES DROOP
UK Department for
International Development

IMANOL ECHEVARRIA
Pfizer

MARCEL HENDRICKS
I+ Solutions

THOMAS HOW
International Planned
Parenthood Federation

VENKATESWARAN IYER
Famy Care Limited

YONG LI
Zizhu Pharmaceuticals

BEATRICE MUTALI
Merck

NORA QUESADA
John Snow Inc.

SANGEETA RAJA
World Bank

MARK RILLING
USAID

TRISHA WOODS SANTOS
Bill & Melinda Gates Foundation

JOE THOMAS
Partners in Population
and Development

JANET VAIL
PATH

RENEE VAN DE WEERDT
United Nations Population Fund

**PERFORMANCE MONITORING
& ACCOUNTABILITY
WORKING GROUP (PMA WG)**
The Performance Monitoring
& Accountability Working Group
will enable the data collection
and analysis necessary to
bolster accountability for
implementing financial, policy,
and programming commitments.

**CO-LEAD -
DR. ZEB SATHAR**
Population Council, Pakistan

**CO-LEAD -
DR. MARLEEN TEMMERMAN**
World Health Organization

**DR. LUIS ANDRES
DE FRANCISCO SERPA**
Partnership for Maternal, Newborn
and Child Health

DR. IAN ASKEW
Population Council

ANN BIDDLECOM
United Nations Population Division

DR. WIN BROWN
Bill & Melinda Gates Foundation

JULIA BUNTING
International Planned
Parenthood Federation

ABHIJIT DAS
Centre for Health and
Social Justice

NEL DRUCE
UK Department for International
Development

THOMAS DUBOIS
Ministry of Foreign Affairs, France

SARAH HARBISON
USAID

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International HIV/AIDS Alliance

DR. ROY TJIONG
Indonesian Planned Parenthood
Association

MICHELLE WEINBERGER
Marie Stopes International

DR. ELIYA ZULU
African Institute for
Development Policy

**RIGHTS & EMPOWERMENT
WORKING GROUP (RE WG)**
The Rights & Empowerment
Working Group will provide
guidance and support to all
FP2020 Working Groups on
rights-based approaches to
family planning.

**CO-LEAD -
SUZANNE EHLERS**
Population Action International

**CO-LEAD -
SIVANANTHI THANENTHIRAN**
Asia-Pacific Resource and Research
Center for Women

BRIDGET ANYAFULU
International Centre for Women's
Empowerment & Child Development

MUHAMMAD BUN BIDA
Muslim Family Counseling Services

JACQUELINE BRYLD
Danish Family Planning Association

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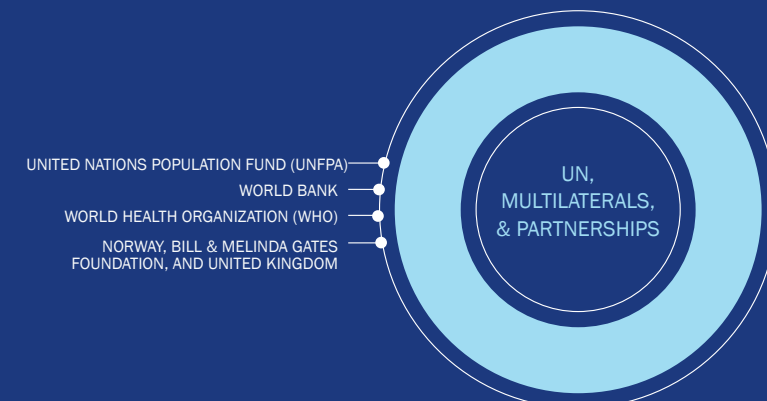
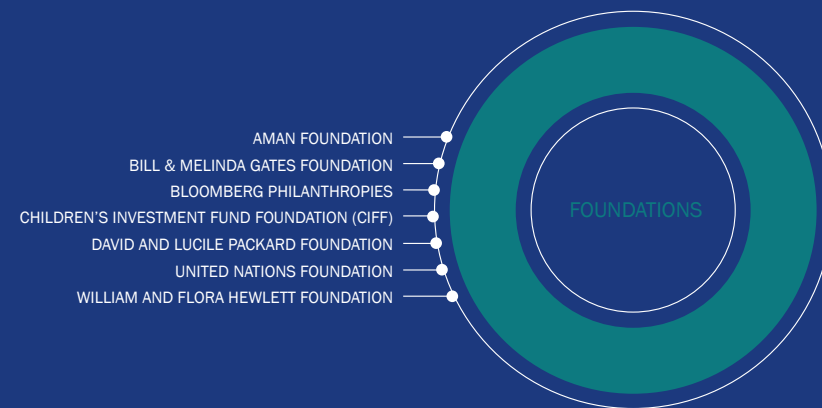
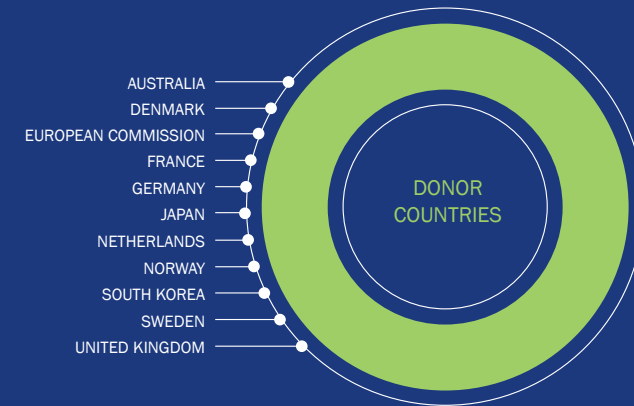
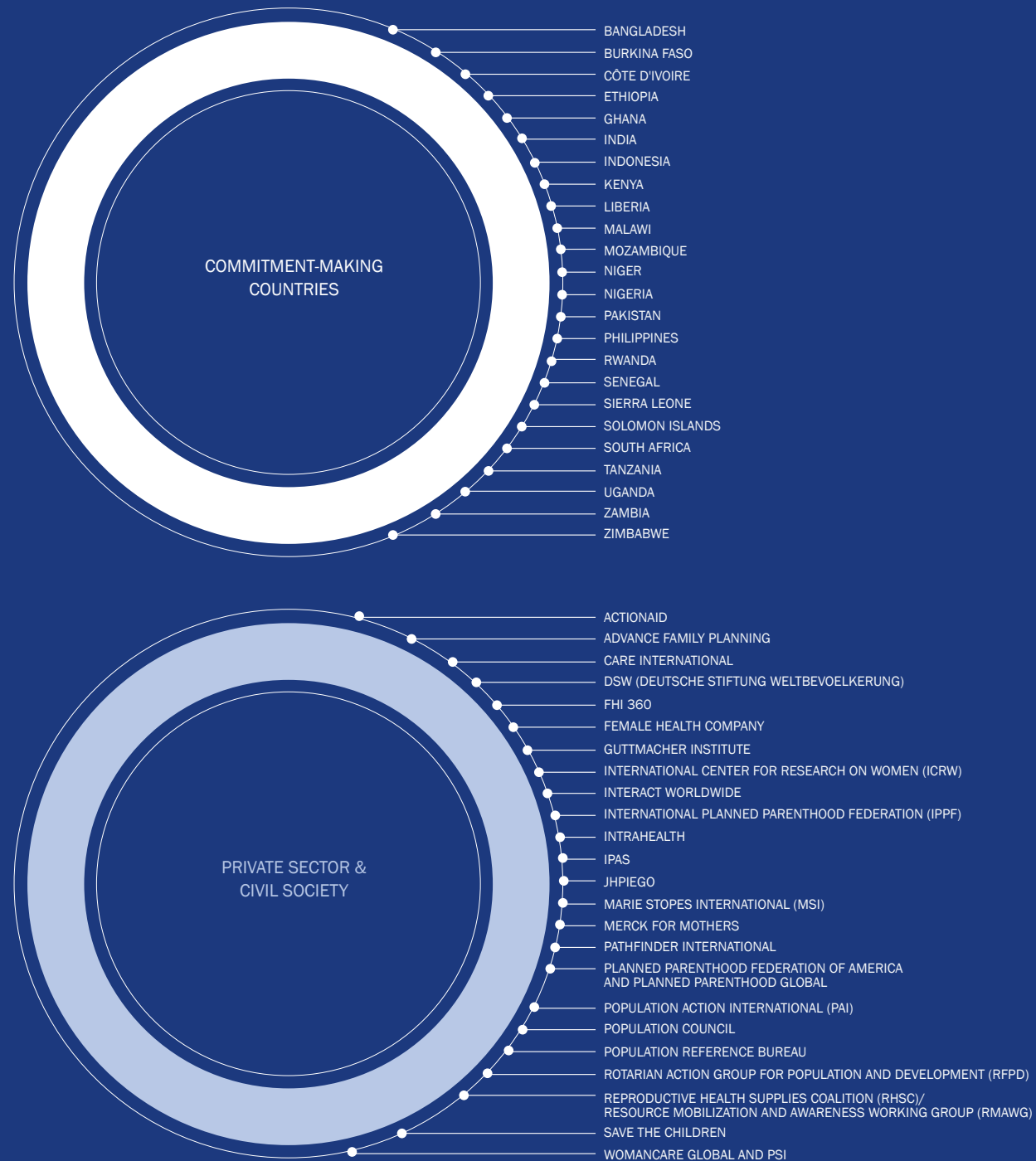
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ANNEX 2 COMMITMENT MAKERS

As of October 2013



ANNEX 3 69 Focus Countries

List of the 69 poorest countries in the developing world by region and subregion (with 2010 gross national per-capita annual income less than or equal to US\$2,500)

EASTERN AFRICA

Burundi
Comoros
Djibouti
Eritrea
Ethiopia
Kenya
Madagascar
Malawi
Mozambique
Rwanda
Somalia
Tanzania
Uganda
Zambia
Zimbabwe

CENTRAL AFRICA

Cameroon
Central African Republic
Chad
Congo (Brazzaville)
Democratic Republic of Congo
Sao Tome and Principe

NORTHERN AFRICA

Egypt
South Sudan
Sudan
Western Sahara

SOUTHERN AFRICA

Lesotho

WESTERN AFRICA

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

CENTRAL ASIA

Kyrgyzstan
Tajikistan
Uzbekistan

EASTERN ASIA

Mongolia
North Korea

SOUTH ASIA

Afghanistan
Bangladesh
Bhutan
India
Nepal
Pakistan
Sri Lanka

SOUTHEAST ASIA

Cambodia
Indonesia
Laos
Myanmar
Philippines
Timor-Leste
Vietnam

WESTERN ASIA

Iraq
Occupied Palestinian Territories
Yemen

CARIBBEAN

Haiti

CENTRAL AMERICA

Honduras
Nicaragua

SOUTH AMERICA

Bolivia

OCEANIA

Papua New Guinea
Solomon Islands

ACRONYMS

AUSAID	Australian Agency for International Development
AFP	Advance Family Planning
BMGF	Bill & Melinda Gates Foundation
CE WG	Country Engagement Working Group (FP2020)
CH	Child Health
CHW	Community Health Worker
COIA	Commission on Information and Accountability
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CYP	Couple-Year of Protection
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EWEC	Every Woman Every Child
FP	Family Planning
FP2020	Family Planning 2020 initiative
FPEI	Family Planning Effort Index
ICPD	International Conference on Population and Development
IERG	Independent Expert Review Group
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
IPPF	International Planned Parenthood Federation
KFF	Kaiser Family Foundation
LARC	Long-Acting Reversible Contraceptive
mADDS	Mobile-Assisted Data and Dissemination System
MAF	MDG Acceleration Framework
mCPR	Contraceptive Prevalence Rate, Modern Methods
MDG	Millennium Development Goals
MD WG	Market Dynamics Working Group (FP2020)
M&E	Measurement and Evaluation
MH	Maternal Health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NFPCI	National Family Planning Composite Index
NGO	Non-Governmental Organization
NHA	National Health Account
NIDI	Netherlands Interdisciplinary Demographic Institute
ODA	Official Development Assistance
OECD DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
PMA WG	Performance Monitoring & Accountability Working Group (FP2020)
PMA2020	Performance Monitoring & Accountability 2020 (Project)
PMNCH	Partnership for Maternal, Newborn, and Child Health
RH	Reproductive Health
RHS	Reproductive Health Survey
RHSC	Reproductive Health Supplies Coalition
RG	Reference Group (FP2020)
RMNCH+A	Reproductive, Maternal, Newborn, and Child Health plus Adolescents
RE WG	Rights & Empowerment Working Group (FP2020)
SHA	System of Health Accounts
SOP	Standards of Practice
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
UN	United Nations
UNF	United Nations Foundation
UNPD	United Nations Population Division
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization



FP2020

WWW.FAMILYPLANNING2020.ORG

Family Planning 2020 (FP2020) is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multilateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. FP2020 is an outcome of the 2012 London Summit on Family Planning, where more than 20 governments made commitments to address the policy, financing, delivery, and sociocultural barriers to women accessing contraceptive information, services, and supplies. Donors also pledged an additional US\$2.6 billion in funding.

Led by an 18-member Reference Group, guided technically by Working Groups, operated daily by a Task Team, and hosted by the United Nations Foundation, FP2020 is based on the principle that all women, no matter where they live, should have access to lifesaving contraceptives. FP2020 is in support of the UN Secretary-General's global effort for women and children's health, *Every Woman Every Child*.



UNITED NATIONS FOUNDATION

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

CORE PARTNERS

BILL & MELINDA GATES foundation



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Special thanks to Advance Family Planning, Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health, Futures Institute, International Planned Parenthood Federation, Kaiser Family Foundation, Marie Stopes International, Pathfinder International, and Women Deliver for providing the insights and research that helped us to more clearly depict the global family planning landscape.

Additionally, we are grateful to humanitarian documentary photographer Stephanie Freid-Perenchio for generously donating her photographs for use in this report. In the course of her career, Stephanie has explored Africa's tribal cultures and its endangered wildlife, has borne witness to the impact of war on women and children in Afghanistan, and has honored U.S. Navy SEALs and their families in her published book of photographs, *SEAL: The Unspoken Sacrifice*. To view more of Stephanie's work, please visit www.stephaniefreidperenchio.com.

Finally and fundamentally, our deep appreciation goes to the women who shared details of their lives to inform this research, and to the countries that strive to better the lives of women, girls, and families by advancing access to family planning worldwide.

FEEDBACK

FP2020 holds the strong belief that the family planning community's biggest asset is the energy and passion of its leaders, experts, advocates, and implementers. This progress report documents only a portion of the incredible work being done by partners. If you have any questions or comments about the contents of this report, we welcome your feedback via email at info@familyplanning2020.org.

We also strongly encourage partners to share their progress stories with us so we may promote them to the family planning community through the FP2020 website, newsletters, and social networks.

