



FP2020 THE ARC OF PROGRESS

2019-2020

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THE FP2020 PROGRESS REPORT IS DIGITAL THIS YEAR.

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

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

FP2020

THE ARC OF PROGRESS

2019-2020

Condensed Print Version

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EXECUTIVE SUMMARY

In the eight years of the FP2020 partnership, the family planning community has proven that when we work together, across borders and sectors, we can truly change the course of progress on family planning. Family Planning 2020 was launched with a simple premise: that every woman and girl, no matter where she lives, should have the opportunity to use lifesaving, life-changing modern contraception.

The leaders who gathered at the London Summit in 2012 agreed on an ambitious goal and a tight timeframe for achieving it: to reach an additional 120 million users of modern contraception in the world's 69 lowest-income countries by 2020.

That initial eight-year period is now drawing to a close. We didn't reach 120 million, but we did bend the curve of progress upward. The FP2020 initiative has become a movement, with more than 130 governments, foundations, multilaterals, civil society organizations, youth-led organizations, and private sector partners all collaborating to advance rights-based family planning. Dozens of countries have strengthened and expanded their family planning programs over the past eight years, providing millions of women and girls with access to modern contraception. Together we've cultivated a global community of practice that is grounded in data and evidence, and guided by the principles of human rights.

PHOTO BY
Karlien Truyens/UNFPA Tanzania

That's the story we tell in this final FP2020 Progress Report, The Arc of Progress. We also tell the story of how in the past year the family planning community faced its greatest threat yet—the COVID-19 pandemic—and how partners all over the world worked heroically to maintain health services. And we look ahead to what comes after FP2020: a new partnership that is smarter, stronger, more inclusive, and built to take us to 2030.

REACHING MORE WOMEN AND GIRLS

As of July 2020, the total number of women and girls using a modern method of contraception in the 69 FP2020 focus countries stood at 320 million, up from 260 million when the partnership was launched. Since 2012, an additional 60 million women and girls have chosen to use modern contraception. While this is far short of our original goal, there has been significant progress across many countries, particularly in Africa:

- **The number of modern contraceptive users** in Africa has grown by 66% since 2012, from 40 million to more than 66 million women and girls.
- **In Central and Western Africa**, the number of modern contraceptive users has doubled.
- **In Eastern and Southern Africa**, the number of modern contraceptive users has grown by 70%.
- **In 13 countries** (eight of which are members of the Ouagadougou Partnership), the number of modern contraceptive users has doubled since 2012: Benin, Burkina Faso, Chad, Côte d'Ivoire, the Democratic Republic of the Congo (DR Congo), Guinea, Mali, Mauritania, Mozambique, Niger, Senegal, Sierra Leone, and Somalia.

Across the 69 FP2020 focus countries, modern contraceptive prevalence (MCP)¹ has risen by more than 2 percentage points since 2012. The growth has been fastest in Eastern and Southern Africa, where MCP has risen by approximately 8 percentage points since 2012.

- **Ten FP2020 focus countries** have experienced MCP growth rates greater than 1 percentage point per year since 2012: Burkina Faso, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia, Malawi, Mozambique, Senegal, Sierra Leone, and Uganda.
- **Eleven countries** have achieved or are on track to achieve the MCP goals they established in their FP2020 commitments: Burkina Faso, Egypt, Ghana, India, Kenya, Kyrgyz Republic, Mozambique, Rwanda, Sri Lanka, Viet Nam, and Zimbabwe.

These insights are possible because of the transformation FP2020 partners have brought to the data landscape for family planning. Almost all commitment-making countries now have in place an annual process to review national and subnational data on family planning, and produce estimates of key progress markers (the FP2020 Core Indicators).

Family Planning 2020 was launched with a simple premise: that every woman and girl, no matter where she lives, should have the opportunity to use lifesaving, life-changing modern contraception.

¹ MCP, modern contraceptive prevalence, is a new acronym for the measure of contraceptive prevalence, previously designated as CPR (contraceptive prevalence rate) or mCPR (modern contraceptive prevalence rate). This change has been adopted by the UN Population Division and is recommended by the FP2020 Performance Monitoring & Evidence Working Group as a move toward greater accuracy, since contraceptive prevalence is described by a ratio, not a rate. The measure itself has not changed.

BUILDING BETTER PROGRAMS AND POLICIES

FP2020's measurement framework is one of the initiative's noteworthy successes, but there are many other dimensions of progress. All across commitment-making FP2020 countries, governments, advocates, and partners have done the hard work necessary to expand family planning programs and reach more women and girls:

- **13 countries** have passed laws to improve the enabling environment: legalizing contraception, guaranteeing women's and young people's access to family planning, and creating legal frameworks for family planning programs to operate.
- **29 countries** have adopted policies or measures to help ensure access to family planning during an emergency or humanitarian crisis.
- **35 countries** have invested in logistic management information systems to strengthen their supply chains.
- **38 countries** have adopted measures to expand family planning in the postpartum period, a time when the risk of unintended pregnancy is especially high.
- **41 countries** are using costed implementation plans to design, budget, and implement their family planning programs.
- **45 countries** have introduced, piloted, and/or rolled out the DMPA-SC injectable contraceptive, 27 countries have approved it for self-injection, and 18 have actually begun the process of implementing self-injection programs.

Countries and partners have also invested in expanding service delivery, improving quality of care, training health providers and allowing task-shifting, adding long-acting reversible contraceptives (LARCs) to the method mix, engaging in public outreach

campaigns, cultivating social and behavior change to support women's empowerment and access to contraception, and implementing programs that are especially tailored to the needs of adolescents and youth.

MOBILIZING RESOURCES

The FP2020 initiative has also improved the understanding of resource flows in the family planning sector. Bilateral donor disbursements have been tracked every year by the Kaiser Family Foundation since the 2012 London Summit. After several years of effort to develop the appropriate methodologies, FP2020 began reporting domestic government expenditures in 2018; since then the number of reporting countries has risen from 31 to 54.

This year's report presents the most recent findings from these efforts:

- **Bilateral donor funding** in 2019 totaled US\$1.5 billion, on par with 2018 disbursements of US\$1.5 billion.
- **Donor government funding** for family planning has generally risen since the London Summit, and the funding in 2019 was almost US\$400 million above the 2012 amount (US\$1.1 billion).
- **Domestic government expenditures** in 2018, the most recent year with data for the majority of FP2020 countries, are estimated at US\$1.55 billion. Note that the domestic expenditure estimates lag behind the donor reporting by at least one year, owing to the time required to finalize government accounts and develop estimates.
- **Total expenditures** on family planning in 2018, the most recent year for which domestic government expenditures are available, are estimated at US\$4.4 billion across all FP2020 focus countries. International donors (which include bilateral donors as well as foundations and NGOs) contributed an estimated 48%, domestic governments 35%, and consumers 17%.

With the global commitment to achieving universal health coverage (UHC), it is clear that the future lies in broadly-supported integrated health systems, with family planning as one component. Thirty-five FP2020 focus countries are already partnering with the Global Financing Facility (GFF) to strengthen their programs for reproductive, maternal, newborn, child and adolescent health and nutrition. Nearly all of the countries with GFF investment cases that have been completed and approved (19 out of 21) are prioritizing family planning as part of their strategy.

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





Photo by UNFPA Myanmar

FAMILY PLANNING IN THE TIME OF COVID

The emergence of the COVID-19 pandemic posed an immediate threat to many of the family planning community's hard-won gains. The early months of the pandemic witnessed immense disruption across a range of health services, including family planning. Lockdowns and closures prevented clinics from providing services; fractured supply chains kept contraceptives from reaching the shelves. For many women and girls, reproductive health care was suddenly unobtainable.

But the response of the global family planning community was swift and comprehensive. Partners all around the world—from the largest multilaterals to the smallest grassroots organizations—rallied to protect family planning as an essential service. It's a remarkable story of resilience and adaptation: of countries finding innovative ways to keep family planning programs running, of partners moving to virtual platforms to keep the lines of communication open, of donors pledging to maintain the crucial resources to keep clinics operating and contraceptives on the shelves.

Although the threat from COVID-19 is still very real, the worst—for now—has been averted.

LOOKING AHEAD

Building on the momentum from eight years of FP2020, and strengthened by the difficult trials of the past year, the global family planning community is ready to embark on a new decade of partnership. The 2030 partnership will preserve and expand on the best of FP2020, but shift the balance of power so that countries are in the lead, decision-making is localized, civil society is a full partner in accountability, and commitments are centered on the lived experiences of women and girls in all their complexity and diversity.

The mandate for our next phase has never been clearer. Together we will build on the progress we've made, recover from the impact of COVID-19, and advance toward the FP2030 vision:

Working together for a future where women and girls everywhere have the freedom and ability to lead healthy lives, make their own informed decisions about using contraception and having children, and participate as equals in society and its development.

THE ARC OF PROGRESS

AS OF JULY 2020

320

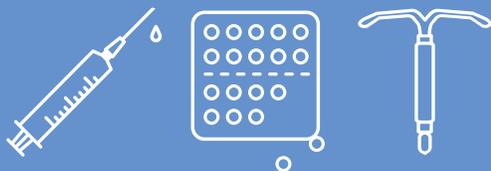
MILLION women and girls are using modern contraception in 69 FP2020 focus countries

+60 

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

AS A RESULT OF MODERN CONTRACEPTIVE USE

from July 2019 to July 2020



121

MILLION unintended pregnancies were averted

21

MILLION unsafe abortions were averted

125

THOUSAND maternal deaths were averted

IN 2019, DONOR GOVERNMENTS PROVIDED

\$1.5

BILLION USD in bilateral funding for family planning

Photo by UNFPA Nepal





बिच्चे (साल जन्मिने) बच्चे



बिच्चे बच्चे



सर्वथा कार्यालयले बिच्चे बच्चे लडाउनुपर्ने



जन्मियारो जन्मो ७ दिन भित्र बिच्चे बच्चे लडाउन जरुरी



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FROM THE FP2020 REFERENCE GROUP CO-CHAIRS

For the past eight years, the FP2020 partnership has served as a global platform to harness innovation and advance progress on family planning. While this is the final FP2020 Progress Report, it is not a farewell but an invitation to continue the journey onward to 2030. This report captures the many accomplishments achieved since 2012 and forges a path to a renewed partnership for the next decade.

We are proud of the accomplishments of this community. Innovations in data systems, supply chains, and contraceptive technologies have transformed the family planning landscape. We implemented new service delivery strategies and elevated the crucial role of human rights and quality of care. When talking about access to contraceptive services and commodities, we expanded the conversation to include all people who want to space, delay, or avoid pregnancy. Most importantly, we built an innovative global network of unprecedented cooperation that spans institutions, bridging sectors and geographies.

We are also proud of how the FP2020 partnership has responded to the COVID-19 pandemic. From government ministries to international NGOs to the smallest grassroots organizations, partners have stepped up with innovative solutions to ensure that any person who wishes to avoid an unintended pregnancy continues to receive the care they need. Some of the solutions that have proven their worth during this pandemic, such as creating access to self-injectable contraception and state-of-the-art supply chain monitoring, are possible only because of the pioneering work of FP2020 partners.

This spirit of innovation and progress directly benefits a world coping with the current pandemic. We have seen consistent progress on reproductive health over the years and that must continue. This will require a collective global response. Family planning is essential, life-saving care that remains crucial, especially in a crisis, for delivering a range of improved outcomes for sexual and reproductive health, maternal and child health, female empowerment, women's economic opportunity, and gender equality.

What we do next matters. We must work together to not only neutralize COVID-19, but to safeguard essential health services so vulnerable members of society are not left behind. As we recalibrate our health systems to meet pressing needs in the post-pandemic era, we must ensure that they are better structured to deliver healthcare for all and universal access to family planning.

The commitment process for FP2030 is starting now, with the launch of this report. We hope you will join us on our continued journey to harness the powers of partnership to build a better future for all.



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



Dr. Natalia Kanem
Executive Director
UNFPA

FROM FP2020'S EXECUTIVE DIRECTOR

FP2020 has always been about people. When I think back over these past years, what I remember most are the conversations. People talking face-to-face about a problem for the first time, and realizing that together, they know how to solve it. People discovering that their counterparts in another country are struggling with the same issues. Civil society partners realizing the challenges that government officials are facing. Senior leaders sitting down with youth colleagues to learn and plan together. People learning from and motivating each other, supporting each other, and finding camaraderie in setbacks as well as success.

So as we wrap up FP2020 and begin the transition to the FP2030 partnership, I'd like to pay tribute to the people who have made this partnership work. The leaders who had the ambition to call the London Summit; the global experts who volunteered their time to lead the FP2020 Working Groups; the government ministers who were bold enough to take the plunge into a new era of rights-based family planning. Our focal points, who have devoted untold time and energy to knitting together new or strengthening existing partnerships, making them work in countries with an eye on reaching everyone who wants and needs family planning services. Young people who stepped forward to inspire us all as leaders, healthcare providers, and educators—within their communities and among global colleagues. Civil society partners, measurement experts, institutional partners, donors, and our colleagues in other initiatives across the global family planning sector. And the many colleagues who have served on the FP2020 Secretariat over the years. Because of you—all of you—FP2020 *worked*.

I also want to take a moment to remember those we've lost.

Valerie DeFillipo, FP2020's founding Executive Director, was a visionary leader who helped FP2020 grow into a flourishing and dynamic global movement.

Dr. Babutunde Osotimehin, the co-chair of the FP2020 Reference Group from the earliest days of FP2020, was a guiding light of the family planning movement and one of the world's greatest champions for the rights of women and girls.

Jennifer Schlecht, who pioneered FP2020's Emergency Preparedness and Response portfolio, devoted her entire career to ensuring that women and girls in crisis situations have access to the medical care they need and deserve, including family planning.

We remember them with love, respect, and enormous gratitude. Their legacies live on in our hearts and in our work.

The FP2020 partnership will transition throughout 2021 into FP2030—becoming more inclusive and transparent at all levels, ensuring equitable power dynamics within our governance structures and accountability processes. The Secretariat will move from being US-based to operating from five regional hubs so the partnership is led from within and among the countries it seeks to serve. Changes we believe will build an ever-stronger partnership over the next decade.

It has been the honor of my life to serve this community. I have been privileged to be a part of this partnership's evolution, and I am filled with optimism for the future—a future you all helped to shape.

Thank you.



Beth Schlachter
Executive Director
Family Planning 2020



SECTION 01

THE ARC OF PROGRESS

The eight years of the FP2020 initiative are just a segment of a much longer arc of progress. Ensuring that every woman and girl has the right and the means to determine if, when, and how often she has children is the work of generations. National and international family planning programs began in the mid-20th century, as soon as modern contraceptive methods became available.

Some of these early programs viewed family planning as a question of top-down population control, in light of what was believed to be a looming “population explosion.” It took decades of activism and a global sea change in sensibilities to reach the Cairo consensus in 1994, when the right of women and girls to use family planning was recognized as central to health and development,² and the Beijing agreements in 1995, acknowledging that “the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality and reproductive health, free of coercion, discrimination, and violence.”³ It was another 20 years before the Sustainable Development Agenda put the right to family planning at the center of the UN’s global goals, essential to both human health and gender equality.

FP2020 was launched in 2012, at a moment when global attention to family planning was at a low point. The idea behind FP2020 was to jumpstart progress, bringing all family planning stakeholders together—countries, donors, manufacturers, the research community, implementing partners, civil society—to break through longstanding barriers in the field and generate expansive new momentum for family planning. The initiative was compressed into a tight timeframe of only eight years, but they were eight years filled with unprecedented progress.

As we prepare to move forward into the next phase of our partnership, it’s time to step back and look at what FP2020 achieved. These accomplishments are the legacy we will build on as we move into the next decade of our partnership, and the next chapter in the arc of progress.

➔ **Our digital report also includes an interactive timeline covering the eight years of the initiative and a brief synopsis for every commitment-making focus country in the FP2020 partnership.**



MORE IN THE DIGITAL REPORT

[Interactive Timeline 2012-2020](#)

[Spotlights on Burkina Faso and Viet Nam](#)

[Progress Summaries for commitment-making focus countries](#)

PHOTO BY
Yagazie Emezi/
Getty Images/Images
of Empowerment

² United Nations Population Fund (UNFPA), *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, 20th Anniversary Edition* (New York: UNFPA, 2014).

³ United Nations, *Beijing Declaration and Platform for Action* (New York: United Nations, 1995; reprinted by UN Women in 2014).

KEY ACHIEVEMENTS

The global family planning movement was already half a century old when world leaders gathered for the London Summit in 2012, but the FP2020 partnership nevertheless represented something new. FP2020 brought together multilateral, bilateral, and private donors on the *same platform* for the first time, side by side with the governments of focus countries and representatives from institutional stakeholders. The partnership continued to expand over the course of the initiative, with growing involvement by civil society organizations, youth-led groups, the private sector, the faith community, feminist and social justice activists, and the humanitarian sector. This unprecedented multilateral, multisectoral approach enabled the community to collaborate on big projects, tackle sector-wide challenges, and build on the global knowledge base created by the first five decades of family planning practitioners.

USING DATA STRATEGICALLY

Before FP2020 was launched, the family planning community relied almost exclusively on periodic national health surveys, typically conducted every five years, to monitor progress. FP2020's measurement agenda, implemented in collaboration with the Performance Monitoring & Evidence Working Group, Track20, and partners, has transformed the data landscape. Instead of waiting five years or longer for new data, the FP2020 Core Indicators are estimated and reported every year, for every country. The process for doing this is country-owned and country-led, so that each commitment-making country now has a strengthened national data system for measuring progress.

Countries can now use data to choose the right mix of investments that are appropriate for their situation, and plan out detailed programs that will help them reach their evidence-based goals. And with a regular annual process in place to collect and analyze data, program managers are able to track how their programs are performing and adjust their strategies as necessary.

The wealth of data now available is also a boon for family planning advocates, who can see clearly where progress is being made, where it isn't, and where more work is needed.

PROTECTING AND FULFILLING HUMAN RIGHTS

Barriers to family planning often have their roots in antiquated policies that prohibit or restrict access to contraception. Since the 2012 London Summit, 13 FP2020 focus countries have passed a variety of landmark laws to remove these barriers: legalizing contraception, guaranteeing women's and young people's access to family planning, and creating legal frameworks for family planning programs to operate.

The FP2020 partnership has also made human rights the lodestar of its approach to family planning programming. The *FP2020 Rights and Empowerment Principles*, published in 2014, drew on and codified the principles enunciated in the ICPD Programme of Action, the Beijing Platform for Action, and the pioneering work done by the World Health Organization, UNFPA, and the Population Council's Evidence Project (funded by USAID). Countries, partners, and the FP2020 Secretariat have worked to build a rights-based focus into family planning programs and continue to explore ways to measure how well rights are being protected and fulfilled.⁴

Instead of waiting five years or longer for new data, the FP2020 Core Indicators are estimated and reported every year, for every country. The process for doing this is country-owned and country-led, so that each commitment-making country now has a strengthened national data system for measuring progress.

⁴ See *Contributions of FP2020 in Advancing Rights-Based Family Planning: Upholding and Advancing the Promise of Cairo*, published in October 2019, for a thorough review of this work and FP2020's impact on rights: http://www.familyplanning2020.org/sites/default/files/Our-Work/RBFP/10.24.19_FP2020_RBFP_Paper.pdf.



Photo by Yagazie Emezi/Getty Images/Images of Empowerment

➔ [See the digital report for The Power of Partnership: Burkina Faso.](#)

EXPANDING THE METHOD MIX

One of FP2020's chief goals has been to expand the range of safe, affordable, high-quality contraceptive methods available to women and girls. The Implant Access Program, launched in 2013, halved the price of contraceptive implants in FP2020 countries, thanks to a public-private volume guarantee. Another public-private agreement allowed DMPA-SC, an all-in-one injectable contraceptive, to be introduced, piloted, and/or rolled out in 45 FP2020 countries. DMPA-SC has also been approved for self-injection in 27 countries, 18 of which are in the process of implementing self-injection programs.

The three-year Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial in Eastern and Southern Africa resolved a longstanding safety question when it determined that DMPA-IM does *not* increase the risk of HIV acquisition in comparison with the copper IUD and the levonorgestrel implant. But it also found that the rate of HIV infection was unexpectedly high for women using all of these methods (almost 4% per year overall), pointing to an urgent need to integrate HIV prevention (including PrEP) with family planning in high-risk regions, and to redouble efforts to provide women and girls with a full range of contraceptive options and thorough counseling. A consortium of HIV and family planning stakeholders are already developing a dual-protection pill that combines PrEP

The Implant Access Program, launched in 2013, halved the price of contraceptive implants in FP2020 countries, thanks to a public-private volume guarantee.



Photo by Jonathan Torgovnik/Getty Images/Images of Empowerment

with contraception, which could be an effective strategy for those who are able to adhere to a daily dosing regimen.⁵

STRENGTHENING SUPPLY CHAINS

Family planning programs rely on secure supply chains, and over the past eight years countries and partners have invested in modernizations and innovations at every level—from local distribution to global procurement. The Informed Push Model pioneered by Senegal, text message-based inventory systems, and other last mile delivery systems have been widely adopted, going a long way toward reducing stockouts. Thirty-five FP2020 countries have invested in logistic management information systems (LMIS), greatly increasing the visibility of supply chain data and enabling program managers to better monitor inventory, manage the commodity pipeline, and forecast needs.

The Coordinated Supply Planning group, a partnership between UNFPA and USAID, was formed in 2012 with the goal of preventing stockouts or overstocking of family planning commodities at the country level. The next generation of supply chain management was announced at the 2017 Family Planning Summit, with the commitment to build a Global Family Planning Visibility Analytics Network (Global FP VAN). Hosted by the Reproductive Health Supplies Coalition, the Global FP VAN links with in-country VANs to enable countries and partners around the world to collaborate virtually on forecasted inventory needs and track progress against those forecasts.

Another breakthrough was the UNFPA Supplies Bridge Funding Mechanism, launched in 2018, which provides a revolving pool of financing that can be used to procure commodities when countries need them—even if the donor funding for the commodities is not yet in hand.

IMPROVING SERVICE DELIVERY

In 2015 the World Health Organization updated its guidance on postpartum family planning (PPFP), approving a wider range of contraceptive methods for use. The subsequent Global PPFP Meeting in Chiang Mai, Thailand, kicked off a global effort to implement these guidelines and ensure that women and girls have access to contraception in the postpartum or post-abortion period—a time when the risk of unintended pregnancy is especially high. A total of 38 FP2020 countries have since adopted measures to strengthen postpartum and post-abortion family planning, and 23 have policies or guidelines in place requiring data on postpartum family planning.

Virtually every commitment-making FP2020 country has adopted some form of task-shifting to enlarge the cadre of health providers who can offer family planning. Most countries that have introduced DMPA-SC allow it to be provided by community health workers, and some countries now allow trained community nurses and midwives to provide implants and IUDs as well. In 2017 the Economic Community of West African States (ECOWAS) adopted a resolution urging member states to mainstream the principle of task-shifting into their national health plans. And WHO's 2019 *Strengthening Quality Midwifery Education for Universal Health Coverage 2030*:

⁵ The HIV Prevention Trials Network study (HPTN 084) found that injectable PrEP is more effective than oral PrEP in preventing HIV acquisition in an intention-to-treat analysis. The World Health Organization notes that “While oral PrEP is highly effective in preventing HIV in women when taken as prescribed, some women find it difficult to take a daily tablet, and inconsistent use of oral PrEP reduces the prevention effect...These results do not contradict evidence showing that consistently using oral PrEP is highly effective as has been demonstrated in several trials. However, adhering to the daily dosing schedule is important. Even short lapses in taking oral PrEP can reduce the protection from HIV acquisition.” <https://www.who.int/news/item/09-11-2020-trial-results-reveal-that-long-acting-injectable-cabotegravir-as-prep-is-highly-effective-in-preventing-hiv-acquisition-in-women#:~:text=While%20both%20methods%20were%20highly,treat%20analysis%20from%20this%20trial.>



Photo by Vicki Francis/DFID/Flickr

Framework for Action identifies midwives as essential frontline workers with the potential to fill numerous gaps in health service delivery, including for family planning—an approach adopted by an increasing number of FP2020 countries.

BUILDING BETTER PROGRAMS

Choosing the right family planning investments has become clearer with the growing number of documented Family Planning High Impact Practices, interventions that have been vetted by experts and shown to work. A total of 20 HIPs have been published as of 2020, along with four Strategic Planning Guides, and are regularly shared with FP2020 countries to assist policymakers in designing their family planning programs.

Another tool is the costed implementation plan (CIP), an operational roadmap describing what interventions a country should implement to achieve its family planning goals and how much these interventions will cost. Under FP2020 the CIP has evolved into a robust, data-driven framework for planning and implementing a fully resourced family planning strategy. When aligned with GFF investment cases, CIPs can help coordinate priorities and financing all across a country's health development framework.⁶ CIPs are also crucial for grounding the family planning program in core principles (human rights, quality of care), establishing benchmarks for accountability, and involving a broad range of stakeholders in the design, implementation, and monitoring of the program. As of 2020, 41 of the 47 commitment-making FP2020 countries have employed CIPs on the national or subnational level.

REACHING ADOLESCENTS AND YOUTH

Only a limited number of commitments made at the 2012 London Summit even mentioned adolescents or youth; today virtually every commitment-making FP2020 country emphasizes young people in their family planning objectives. The family planning community no longer asks *if* or *why* we should be focusing on adolescent and youth needs; we have moved on to *how*. The focus now is on implementing effective approaches that are driven and informed by young people, evidence, and data. In 2017 the FP2020 community pledged to begin collecting sex and age-disaggregated data on adolescents in all family planning and reproductive health programs—critical if the needs of young people are to be seen, understood, and addressed.

The FP2020 community has also endorsed the Global Consensus Statement on Meaningful Adolescent & Youth Engagement, calling for young people to be embraced as full partners in the decisions that shape their lives.⁷ Although “meaningful engagement” is still very much a work in progress, young people are more prominent than ever as participants in knowledge-sharing, decision-making, and agenda-setting within the family planning community.



Photo by Rodnae/Pexels

➔ [See the digital report for Forging a New Path in Viet Nam.](#)

⁶ Elise Lang and Christine Lasway, “Aligning Strategic Documents to Foster a Common Vision for Family Planning,” HP+ Policy Brief, August 2019, http://www.healthpolicyplus.com/ns/pubs/13333-13610_CIPGFFBrief.pdf.

⁷ See <https://www.who.int/pmnch/mye-statement.pdf>.

LEAVING NO ONE BEHIND

Family planning in humanitarian settings emerged as an urgent issue at the 2017 Family Planning Summit, which mobilized global attention to the family planning needs of crisis-affected women and girls. In close collaboration with the humanitarian sector, FP2020 established an Emergency Preparedness and Response portfolio to ensure that family planning programs are prepared and resilient in the face of disasters, epidemics, and man-made crises. To date, 29 commitment-making FP2020 countries have adopted policies or measures to help ensure access to family planning during a time of crisis.

FP2020's work in this area culminated in two groundbreaking publications: *Family Planning in Humanitarian Settings: A Strategic Planning Guide* summarizes best practices for minimizing disruptions in family planning services.⁸ *Ready to Save Lives: Sexual and Reproductive Health Care in Emergencies* is a planning toolkit to ensure that family planning is a part of a country's health system preparedness and resilience plan.⁹ FP2020 has also joined with the RHSC, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), the Women's Refugee Commission (WRC), and other partners in a cross-sectoral effort to strengthen supply chains in humanitarian crises.

LINKING TO OTHER SECTORS

The partnership with the humanitarian sector is just one of several bridges that have been built over the course of FP2020. The ECHO trial brought together the family planning and HIV communities, two sectors that have been siloed for years. The worlds of family planning and maternal health are becoming more tightly integrated through PFPF and the growing participation of midwives as family planning providers. A new consensus has emerged on family planning and environmental conservation, with programs that promise to improve health while protecting biodiversity and fragile ecosystems. The family planning sector and the faith community are increasingly finding ways to collaborate on their shared commitment to safe motherhood and girls' education, while contraception is a core component of women's health and empowerment programs.



Photo by Juan Arredondo/Getty Images/Images of Empowerment

FOSTERING INCLUSIVENESS AND TRANSPARENCY

Finally, FP2020 has made significant headway in the quest to strengthen accountability in the family planning sector, bringing more stakeholders into the decision-making process and enabling more people to see, understand, and use the data. The FP2020 initiative has vastly increased the visibility of data (on financial resource flows as well as family planning indicators), promoted a culture of shared knowledge and evidence, and engaged civil society as leaders, advocates, focal points, and participants in the governance structure. This commitment to inclusiveness and transparency will become one of the cornerstones of FP2030, with an expanded accountability framework designed to ensure that all commitments are grounded in justice, equity, and a culture of collective responsibility.

⁸ See <https://fphighimpactpractices.org/guides/family-planning-in-humanitarian-settings/>.

⁹ See http://familyplanning2020.org/sites/default/files/ready_to_save_lives/SRH_preparedness_toolkit.pdf

COUNTRY COMMITMENTS

The year next to each country indicates its first commitment.

Bangladesh	2012	Senegal	2012	Mali	2015
Burkina Faso	2012	Sierra Leone	2012	Nepal	2015
Cote d'Ivoire	2012	Solomon Islands	2012	Somalia	2015
Ethiopia	2012	Tanzania	2012	Afghanistan	2016
Ghana	2012	Uganda	2012	Lao PDR	2016
India	2012	Zambia	2012	South Sudan	2016
Indonesia	2012	Zimbabwe	2012	Viet Nam	2016
Kenya	2012	Benin	2013	Chad	2017
Liberia	2012	DRC	2013	Egypt	2017
Malawi	2012	Guinea	2013	Haiti	2017
Mozambique	2012	Mauritania	2013	Kyrgyz Republic	2018
Niger	2012	Myanmar	2013	Sri Lanka	2018
Nigeria	2012	Burundi	2014	Angola	2019
Pakistan	2012	Cameroon	2014	CAR	2019
Philippines	2012	Togo	2014	The Gambia	2019
Rwanda	2012	Madagascar	2015		

Learn more about the key events and achievements of the FP2020 partnership in the digital report at familyplanning2020.org/progress





THE ARC OF PROGRESS

2012-2020

An overview of the key events and achievements
of the FP2020 partnership as they happened



**TOTAL USERS
OF MODERN
CONTRACEPTION**
in the 69 FP2020
countries

260
MILLION USERS
AS OF JULY 2012

267
MILLION USERS
AS OF JULY 2013

273
MILLION USERS
AS OF JULY 2014

279
MILLION USERS
AS OF JULY 2015

287
MILLION USERS
AS OF JULY 2016

294
MILLION USERS
AS OF JULY 2017

302
MILLION USERS
AS OF JULY 2018

311
MILLION USERS
AS OF JULY 2019

320
MILLION USERS
AS OF JULY 2020





JULY 2012
The London Summit and establishment of the FP2020 Partnership

World leaders gathered in London to commit to a new goal: reaching 120 million women and girls with modern contraception by 2020. The FP2020 initiative was launched with 70 commitments.

Photo by Russell Watkins/Department for International Development



DECEMBER 2014
FP2020 Rights and Empowerment Principles published

FP2020's Rights and Empowerment Principles for Family Planning articulated the key principles that informed the partnership's rights-based approach to family planning.

Photo by Paula Bronstein/Getty Images/Images of Empowerment



JULY 2015
Global Financing Facility launched

Photo by Yagazie Emezi/Getty Images/Images of Empowerment



JANUARY 2016
FP2020 strengthened country engagement with regional Focal Point Workshops

The FP2020 Secretariat was reorganized to accelerate progress and support countries more directly.

Photo by FP2030



2017
Family Planning Summit

Commitments were revitalized and Global Goods were launched. FP in humanitarian settings was included in commitments for the first time. MISP was launched with prevention of unintended pregnancy as a new pillar.

Photo by Jonathan Torgovnik/Getty Images/Images of Empowerment



2019
Global programs launched to increase collaboration and innovation

The RHSC launched Global VAN to improve supply chains and WHO launched a collaborative mechanism to meet the SRHR needs of adolescents. The Margaret Pyke Trust launched Thriving Together to build partnerships across the health and environment sectors.

Photo by Margaret Pyke Trust



NOVEMBER 2019
Nairobi ICPD+25 Summit

On the 25th anniversary of the International Conference on Population and Development in Cairo, the world gathered to recommit to the Programme of Action and the 2030 Agenda.

Photo by FP2030

FP 2030

THE ARC OF PROGRESS
2012-2020



2013-2014
Critical partnerships and programs launched

The global partnership yielded supporting programs to increase access to long-acting contraceptives, to support national advocacy efforts and to measure progress. These included the Implant Access Program, DMPA-SC pilot projects, the Rapid Response Mechanism, Track20, and Performance Monitoring for Action.

Photo by Jonathan Torgovnik/Getty Images/Images of Empowerment



2015
Critical meetings accelerate progress: First Global Focal Point Workshop and PFPF Global Meeting in Chiang Mai

Focal point workshops became critical meetings where commitment-making countries—and technical experts including from UNFPA and WHO—could collaborate, learn and plan together. Similarly, the Postpartum Family Planning Global Meeting centered creating action plans on WHO's new PFPF MEC guidance.

Photo by FP2030



JULY 2015
The Ouagadougou Partnership exceeded its initial goal

by 20 percent, reaching 1.2 million additional users of contraception.

Photo by Jonathan Torgovnik/Getty Images/Images of Empowerment



2016
Reference Group milestones
 Youth seat established and a meeting was held in Tanzania alongside the GFF.

Photo by FP2030



2018
Fifth International Conference on Family Planning

The Global Consensus Statement on Meaningful Adolescent and Youth Engagement was launched.

Photo by FP2030



JUNE 2019
Results of ECHO trial released

Photo by FP2030



JANUARY 2021
FP2030 transition year launched

FP2020's vision framework led to the launch of 2021 as a transition year to the FP2030 partnership.





SECTION 02

FAMILY PLANNING IN THE TIME OF COVID

As the COVID-19 crisis ricocheted around the world, it quickly became clear that the consequences for women’s reproductive health would be dire. By the early months of 2020 the pandemic was already causing tremendous disruption to family planning programs.

Measures intended to slow the spread of the virus, such as lockdowns and curfews, also impeded access to contraceptive services. While some governments acted quickly to classify family planning as an essential service, others did not. Many clinics were temporarily shuttered; many that stayed open lacked adequate personal protective equipment (PPE) for health care workers to safely provide implants, IUDs, and other clinical methods of contraception. Restrictions on movement and fears about the virus prevented many women and girls from even reaching the clinics, while a widespread lack of clear information and guidelines—especially for young people—served only to deepen the crisis.

Far-reaching disruptions to global supply chains also affected the availability of contraceptive commodities. Production delays, backlogs, crowded shipping lanes, slow customs clearance, and lack of transportation all contributed to a temporary rash of stockouts in the early months of the pandemic. Two-thirds of the 103 countries surveyed by the World Health Organization reported disruptions to family planning and contraceptive services. The pandemic also unleashed a host of corollary effects: a global increase in gender-based violence and child marriage, a global drop in women’s workforce participation and girls’ school enrollment, and a global economic recession.^{10,11}



**MORE IN THE
DIGITAL REPORT**

[Transitioning to a
Virtual World](#)

[Stories from
FP2020 countries](#)

[Impact Report: Early
Findings from the
COVID-19 Family
Planning Task Team](#)

PHOTO BY
Ali Asghar/Pathfinder
International

THE GLOBAL FAMILY PLANNING COMMUNITY RESPONDS

In the face of an unprecedented global crisis, FP2020 partners around the world rapidly mobilized to safeguard family planning as an essential health service.

UNFPA, DKT International, the Guttmacher Institute, and MSI Reproductive Choices (MSI) were among the first partners to sound the alarm about potential disruptions to family planning programs. UNFPA developed a COVID-19 Global Response Plan to maintain continuity of SRH services and protect health workers, address gender-based violence and harmful practices, and ensure the supply of modern contraceptives and reproductive health commodities. Both UNFPA Supplies and the USAID Global Health Supply Chain Program moved quickly to cope with disruptions to the supply chain, working closely with governments and other partners to prioritize supply requests, orders, shipments, production schedules, and other operational aspects of procurement. The Reproductive Health Supplies Coalition (RHSC) brought together all the major players in the commodity space—UNFPA and USAID, manufacturers, procurement experts, and program leaders—to understand the supply chain challenges created by the pandemic and take action to keep products moving. The World Health Organization issued guidance on protecting human rights under the COVID-19 response and published critical guidelines on the safe provision of sexual and reproductive health services in the COVID-19 context, specifically noting that restrictions preventing women and girls from seeking reproductive health care violate their human rights. The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) developed a programmatic guidance specifically adapted to the COVID-19 crisis, and the International Federation of Gynecology and Obstetrics (FIGO) created a COVID-19 resource page on women’s health.

Partners also focused on sharing data and situation reports to keep the global community informed. Both MSI and International Planned Parenthood Federation (IPPF) issued data reports on service impacts from the pandemic. RHSC and Avenir Health developed a new scenario/modeling tool (MICRO) that looks at possible impacts on commodity needs. FP2020, RHSC, and other partners published a joint statement calling for increased family planning data-sharing, drawing upon the power of the Global Family Planning Visibility and Analytics Network (Global FP VAN), a shared platform to increase supply chain data visibility for collective decision making. USAID’s flagship data collection platform, the Demographic and Health Surveys (DHS) Program, developed a “COVID-19 Prevention” tag on STATcompiler so users could easily analyze the data and disaggregate them by region, wealth quintile, and education in more than 90 countries.

Donors stepped up as well—not only to fight the virus and slow the pandemic, but to protect family planning programs during the crisis. The Bill & Melinda Gates Foundation (BMGF), the Foreign, Commonwealth and Development Office (FCDO, formerly the Department for International Development), and USAID all committed hundreds of millions of dollars for programs to respond to the pandemic and protect at-risk populations in the lowest income countries. Other governments also stepped forward, with France helping to expand testing capacity and Sweden protecting access to HIV and family planning care. Thanks to donor support and flexibility, UNFPA Supplies was able to re-program US\$2.5 million toward pandemic response, including US\$1.5 million for personal protective equipment in 25 countries. Private foundations such as BMGF and The David and Lucille Packard Foundation announced that they were standing by their current family planning funding commitments and in some cases converting their grants to operational support—a lifeline for many organizations.

The Reproductive Health Supplies Coalition brought together all the major players in the commodity space—UNFPA and USAID, manufacturers, procurement experts, and program leaders—to understand the supply chain challenges created by the pandemic and take action to keep products moving.



Photo by Fahad Abdullah Kaizer/UN Women

A COVID-19 resource center was established on the FP2020 website to share tools and guidance on family planning in the pandemic, and a weekly community update was launched.

FP2020 RESPONDS

When the FP2020 Reference Group met in March 2020, COVID-19 was top of the agenda. The Secretariat initiated several collaborative efforts to meet the urgent needs of countries and partners and ensure that access to family planning would remain a priority at the global, regional, and local levels. A COVID-19 resource center was established on the FP2020 website to share tools and guidance on family planning in the pandemic, and a weekly community update was launched. Focal points and technical experts were consulted to identify how the partnership could best provide support.

On April 3, FP2020 issued a statement highlighting the need for family planning to be recognized as an essential service in every country, urging steps to ensure that contraceptives remain available, and echoing the UN Secretary General's call for contraception without prescription during the crisis.¹² In partnership with Ouagadougou Partnership Coordination Unit (OPCU), Advance Family Planning (AFP), PAI, Pathfinder International, and Jhpiego, the FP2020 Secretariat created a platform for the advocacy community to share information on the pandemic and align advocacy efforts around COVID-19 response.

In April 2020, FP2020 began convening family planning data partners to better understand how the COVID-19 pandemic was affecting programs and services. A COVID-19 Family Planning Impact Task Team was created to bring together data partners with a wide range of expertise, including MSI, IPPF, Track20, RHSC, Performance Monitoring for Action (PMA), Nivi, and others.

To facilitate the flow of information and resources, FP2020 hosted a series of discussions and webinars with family planning partners and stakeholders around the world. A number of webinars and live Q&A were specifically geared toward addressing the issues facing young people and supporting young leaders in their response to the pandemic. On International Youth Day 2020 (August 12), FP2020 joined the Association of Adolescent Health to issue the Protect Adolescent Health in COVID Response Statement, calling on countries, communities, and clinicians to protect and support the health and wellbeing of adolescents throughout the pandemic response.¹³

➔ [See the digital report for a full list of webinars hosted or co-hosted by FP2020 in response to the COVID pandemic.](#)

COUNTRIES RESPOND

Meanwhile, country partners took bold action and adopted a wide range of innovative solutions to keep services and information available. Governments, civil society, and other partners collaborated to ensure that women and girls would not lose access to contraception during the pandemic.



Photo by Kalu Institute/Flickr

GOVERNMENT GUIDELINES

For many governments, a critical first step was the issuance of guidelines clearly designating family planning as an essential service. Kenya was one of the first countries in Africa to develop COVID-19 guidelines for reproductive health, issuing a guidance document in April 2020 with practical recommendations for the continuation of reproductive, maternal, newborn, and family planning services during the pandemic.



Photo by Liam Blunt/DKT International

PROACTIVELY MANAGING AND MONITORING THE SUPPLY CHAIN

Supply chain issues were a top concern for most FP2020 countries. Government ministries worked closely with UNFPA, USAID, private providers like DKT International, and other commodity partners to forecast issues and forestall shortages.



Photo by Nessma Elaassar

METHOD ADJUSTMENTS: EXTENDED REFILLS, METHOD SUBSTITUTION, AND SELF-CARE

In addition to securing their contraceptive supply chains, countries also implemented policies to allow extended refills on prescriptions, substitute alternate methods when necessary, and promote self-care. In Egypt, the COVID-19 lockdown decree was accompanied by an announcement that the health ministry would be taking special steps to protect women's reproductive health, dispensing a three months' supply of contraceptives along with other essential commodities.



Photo by IPPF Indonesia

SERVICE DELIVERY INNOVATIONS

Countries also leveraged new ways of delivering family planning, through taskshifting, community distribution, mobile outreach, and integration with other services. In Indonesia, with shops and pharmacies closed and women fearful of visiting health facilities, midwives took on an even larger role as frontline providers of health care, including contraception.



Photo by MSI Madagascar

MOBILE CLINICS

Mobile clinics offered another way around lockdowns. In Madagascar, MSI responded to travel restrictions by obtaining government permits to allow MSI buses on the roads, delivering services directly to women by appointment. Each bus was linked with a specific health facility, so women could also be transported to the facility if needed or preferred.



Photo by Barry Pousman/Flickr

TELEHEALTH

Implementing or expanding telehealth options—including hotlines, digital health platforms, mobile apps, and online training—was a key strategy for many FP2020 countries. Several countries shifted to a digital format for training health care providers, such as Pakistan, which established six telemedicine centers to facilitate virtual training.



Photo by Arafat Ahmed/UN Women

COMMUNICATION CAMPAIGNS

To ensure that the public received accurate information about family planning and other essential reproductive health services during the pandemic, countries took to the airwaves, print media, and social networks with carefully designed communications, and conducted mobile campaigns for remote and hard-to-reach populations. Bangladesh was one of several countries to combine family planning communications with messaging about preventing and mitigating gender-based violence during the pandemic.



Photo by Reach A Hand Uganda

YOUTH RESPONSE

Youth-led organizations and youth advocates played an active role in responding to the COVID pandemic, working to ensure that young people were informed about the pandemic, included in the response, and provided with the sexual and reproductive health care they need. In Uganda, youth-led Reach A Hand Uganda organized an e-conference on COVID-19 and Family Planning, televised by Next Media Uganda and supported by UNFPA, PSI, Reproductive Health Uganda, and UK Aid. Reproductive health leaders explained the steps being taken to maintain SRH access during the pandemic, from self-care instructions and digital health platforms to deploying contraceptives through drug shops and even shipping them directly to clients.

CONCLUSION

Because the pandemic also disrupted data gathering—with both the Demographic Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS) temporarily suspended—the full impact of COVID-19 on family planning will not be known for years. The early findings from the Impact Task Team, featured in the digital report, provide a glimpse of what can be gleaned from commodity tracking, service statistics, partner reports, and information from PMA (telephone surveys) and Nivi (digital conversations).

From that perspective, it appears that:

1. Supply chains for contraceptive commodities were seriously disrupted at the start of the pandemic, but have largely recovered thanks to concerted global effort and collaboration.
2. Two of the largest private sector providers—MSI and IPPF—were hit hard early on, but adapted and recovered with mobile services, telehealth, and modified clinic procedures. Neither organization has returned to full capacity, however, and the ongoing service disruptions pose a threat to business operations.
3. Public sector impacts appear to be highly variable across countries and across contraceptive methods, ranging from extreme downturns in service volume to minimal impact. Public sector data probably reflect gaps in reporting as well as changes in service volume, so more time is needed to develop a clearer picture of the pandemic's impacts.
4. Data from both PMA and Nivi point to the wider impacts of the pandemic—including food insecurity and loss of income—as well as the array of concerns and barriers that shape care-seeking behavior. These innovative methods of gathering information have the potential to help fill some of the gaps in data caused by the pandemic.

The next few years will be challenging for family planning data partners as we seek to adapt our systems and methodologies to a world shaped by COVID. FP2020 is committed to continue working with our partners to illuminate the impact of the pandemic on family planning in countries across the globe.

➡ **See the digital report for the full Impact Report from the COVID-19 Family Planning Impact Task Team.**

Learn more about the impact of the COVID-19 pandemic on the family planning community in the digital report at familyplanning2020.org/progress





◀ FOCAL POINT WORKSHOPS

FP2020's last in-person gathering was in Senegal for the Francophone Countries Regional Focal Point Workshop in March 2020. The work continued online, as the rest of the year's workshops were shifted to a virtual format.

Photo by FP2020



◀ RAPID RESPONSE MECHANISM

The FP2020 Rapid Response Mechanism wound down in 2020 after six years as a key element of FP2020's country support, disbursing over US\$11 million and funding 122 projects benefiting more than 21 million people in 49 countries.

Photo by CHIP, RRM Grantee/FP2020

SECTION 03

PARTNERSHIP

For the global family planning community, 2020 was a year of transition. Even as COVID-19 upended normal patterns, FP2020 partners continued to make progress on existing goals and plan ahead for the next phase of partnership. The process of preparing for the 2030 partnership shifted into high gear, with wide-ranging consultations to design the new architecture, draft an accountability framework, develop a measurement agenda, and build commitment and support structures for partners.



◀ EMERGENCY PREPAREDNESS AND RESPONSE

FP2020 and partners published *Ready to Save Lives: Sexual and Reproductive Health Care in Emergencies*, a groundbreaking SRH preparedness toolkit, and *Family Planning in Humanitarian Settings: A Strategic Planning Guide*, an important new addition to the High Impact Practices library.

Photo by Vicki Francis/DFID/Flickr

FAMILY PLANNING AND HIV ▶

FP2020 and AVAC co-hosted an online satellite session for the International AIDS Conference, launched a new joint website on SRH/HIV integration, and issued a *Global Call to Action for the Provision of Rights-Based, Client-Centered Sexual and Reproductive Health (SRH) During and After COVID-19*.

Photo by AIDSvaccine/Flickr



POSTPARTUM AND POST-ABORTION FAMILY PLANNING

FP2020 countries are making rapid progress on PFP/PAFP: scaling up services, incorporating measurement indicators, publishing guidelines, and teaming up for country-to-country learning exchanges.

Photo by Jonathan Torgovnik/Getty Images/Images of Empowerment



ADOLESCENTS AND YOUTH

Youth stakeholders co-developed the Francophone focal point workshop, participated in skill-building webinars and Q&A sessions throughout the year, and collaborated with the Secretariat to propose a new approach to funding youth-led organizations.

Photo by Mimi Thian/Unsplash



In preparation for the new partnership, the FP2020 Secretariat published three reports that were commissioned to assess FP2020's past achievements and anticipate future possibilities. *Faith and Family Planning: Working Together to Drive Progress Post-2020* explores the potential for faith-based partnerships in family planning. *Contributions of FP2020 in Advancing Rights-Based Family Planning: Upholding and Advancing the Promise of Cairo* analyzes FP2020's impact on rights-based programming for family planning. *Strong Alliances, Further Together: Country Engagement at FP2020, 2012-2020* traces the evolution of FP2020's country engagement strategy, chronicling the successes, challenges, and lessons learned along the way.

At the same time, work continued across all of FP2020's existing portfolios—often with heightened urgency and relevance in light of the pandemic.

➤ Our digital report features detailed updates, highlights from the past year, and country spotlights.

FAMILY PLANNING AND UHC

Universal Health Coverage offers great potential to ensure that family planning is accessible to all, and virtually every commitment-making FP2020 country is now in the process of considering, planning, developing, or implementing a UHC scheme.

Photo by Jonathan Torgovnik/Getty Images/Images of Empowerment

ADVOCACY AND ACCOUNTABILITY

The COVID-19 pandemic was a consuming focus for the family planning advocacy community in 2020, alongside conceptualizing a robust new accountability framework for the FP2030 partnership.

Photo by Yagazie Emezi/Getty Images/Images of Empowerment





FP2030: A STRONGER PARTNERSHIP FOR A NEW ERA

Building on the success and momentum of FP2020, the global family planning community is preparing to embark on a new decade of partnership: FP2030.

FP2030 will preserve and expand on the best of FP2020: the convening power of the partnership, the collaborative platform that brings together diverse stakeholders from a wide range of sectors and institutions; the dedication to high-quality data and evidence; and the unswerving commitment to meeting the family planning needs of women and girls.

FP2030 will also feature important changes designed to emphasize country leadership, strengthen accountability, and localize much of the decision-making and support.

THE FP2030 VISION FRAMEWORK

The vision statement, guiding principles, and focus areas for the new partnership were developed through a wide-ranging and in-depth consultation with the global family planning community. More than a thousand stakeholders—representing governments, civil society, donors, implementing partners, women’s rights advocates, youth groups, faith-based organizations, the research community, and the private sector—contributed to the framework, participating through surveys, personal interviews, and working sessions held all over the globe.

»» FP2030 Vision. The vision statement encapsulates the core principles of the new partnership:

Working together for a future where women and girls everywhere have the freedom and ability to lead healthy lives, make their own informed decisions about using contraception and having children, and participate as equals in society and its development.

»» FP2030 Focus Areas. The focus areas define the work the partnership will undertake to realize the vision:

- Expand the narrative and shape the policy agenda.
- Drive data and evidence-informed decision making.
- Increase, diversify, and efficiently use financing.
- Transform social and gender norms.
- Improve system responsiveness to individual rights and needs.

»» FP2030 Guiding Principles. The guiding principles reflect the core values and themes that will govern all decisions, actions, and investments:

- Country-led global partnerships, with shared learning and mutual accountability for commitments and results.
- Voluntary, person-centered, rights-based approaches to family planning, with equity at the core.
- A commitment to gender equality, with support for empowering women and girls and engaging men, boys, and communities.
- Intentional and equitable partnerships with adolescents, youth, and marginalized populations to meet their needs, informed by accurate and disaggregated data collection and use.

THE FP2030 ARCHITECTURE

The global landscape for family planning has evolved significantly since FP2020 was launched in 2012. The FP2030 architecture will be designed to meet these changing circumstances, placing country experience and leadership at the center:

- **Country-defined goals:** Rather than set a numeric goal for the overall initiative, the FP2030 partnership will support countries' individually defined goals for family planning in alignment with their UHC and Sustainable Development Goals.
- **Regional hubs:** Instead of a Secretariat based in Washington, DC, support will be localized in five regional hubs: North, West, and Central Africa; East and Southern Africa; Asia and the Pacific; Latin America and the Caribbean; and North America and Europe.
- **Opt-in model:** The partnership will shift away from a predetermined list of focus countries to a universal opt-in model for commitments, with differentiated levels of support available.
- **Commitments:** The commitment process will be robust and detailed for countries and non-state partners. Countries will move through a consultative, inclusive process with local partners to develop commitments that are actionable and aligned with other national frameworks. Country commitments will be launched nationally before being celebrated globally.
- **Strengthened accountability:** Countries will be invited to establish in-country accountability mechanisms in formal partnership with civil society, with the results feeding into a global accountability network for the entire partnership, including donors, NGOs, and all other partners.
- **Updated measurement framework:** The Core Indicators will be refined and updated to monitor progress in accordance with the new vision framework, with additional indicators to measure individual choice, health system responsiveness, and the policy, financing, and accountability environments for family planning.
- **Transparent governance:** The governance structure will be geared toward transparency and inclusiveness, with clearly defined roles and responsibilities and representation from country governments, civil society, youth, international organizations, and donors.



THE TRANSITION

FP2020 will continue to function smoothly as we gradually transition to FP2030. A Transition Management Team is partnering with the Secretariat to plan and execute all required transition activities. Together they will work with the Transition Oversight Group, which will have primary oversight of the transition through its completion in November 2021.

A detailed architecture for the new model will be developed over the course of 2021, including the operational and governing bodies, the governance structure, and the geographic structure. While the new framework is being designed and operationalized, the FP2020 Secretariat will work with national governments, donors, international NGOs, and civil society and youth-led organizations to mobilize new commitments for the next partnership. These processes will continue in parallel until November 2021, when the global family planning community will celebrate the formal launch of the new partnership.

See the Building 2030 page for updates: www.familyplanning2020.org/Building2030.





SECTION 04

FINANCE

When FP2020 was launched in 2012, the partnership recognized the urgent need for better tracking and monitoring of resource flows in the sector. Over the past eight years, the FP2020 community has engineered a quiet revolution in clarity on key questions: How much of family planning is funded by domestic governments? How much do international donors contribute? What is the total outlay on family planning, including out-of-pocket spending by consumers?

In the wake of the 2012 London Summit, the Kaiser Family Foundation (KFF) agreed to begin tracking donor government disbursements for family planning, adapting the comprehensive methodology it had been using since 2002 to monitor donor spending on HIV/AIDS. A baseline was established of bilateral donor disbursements for family planning in 2012, and KFF has provided estimates using the same methodology for each year since.

The process of tracking domestic government expenditures took longer to establish. After several years of work and a wide-ranging effort to develop the necessary methodologies to collect, analyze, and validate the data, FP2020 began reporting domestic government spending on family planning with the 2018 Progress Report. That first year of reporting included validated expenditure data from 31 FP2020 countries. The next year the number of reporting countries rose to 37. This year's report includes domestic expenditures for 54 of the 69 FP2020 countries—a significant achievement for the family planning sector.

Estimates of out-of-pocket spending have also evolved over the years, and continue to be sharpened as more researchers approach the problem. Better data at all levels—including the number of users in each country, the mix of contraceptive methods, private sector prices and subsidies, and the portion funded by government expenditures—are steadily improving the robustness of the estimates.

This year's report presents the most recent findings from these efforts:

- **Bilateral donor funding** in 2019 totaled US\$1.5 billion, on par with 2018 disbursements of US\$1.5 billion.
- **Domestic government expenditures in 2018**, the most recent year with data for the majority of FP2020 countries, are estimated at US\$1.55 billion. Note that the domestic expenditure estimates lag behind the donor reporting by at least one year, owing to the time required to finalize government accounts and develop estimates.
- **Total expenditures on family planning in 2018**, the most recent year for which domestic government expenditures are available, are estimated at US\$4.4 billion across all FP2020 focus countries. International donors (which include bilateral donors as well as foundations and NGOs) contributed an estimated 48%, domestic governments 35%, and consumers 17%.



MORE IN THE DIGITAL REPORT

Report from the Global Financing Facility

Countdown 2030 Europe analysis

Commodity spending from the Contraceptive Security Indicators Survey

Interactive data graphics

Expenditure graphs for nine individual countries

PHOTO BY
Jonathan Torgovnik,
Getty Images/Images
of Empowerment

Donor government funding for family planning has generally risen since the London Summit, although there have been fluctuations over the period. In 2019, funding was almost US\$400 million above the 2012 amount (US\$1.1 billion).

Reporting on domestic government expenditures is still too new for any trends to be determined; changes from year to year at this point are primarily the result of evolving methodology and an increase in the number of countries reporting. Much the same can be said for out-of-pocket spending and total expenditures.

THE FUTURE OF FINANCE FOR FAMILY PLANNING

As the impact from the COVID-19 pandemic unfolds across the global economy, governments in focus countries and donor countries are adjusting to new realities. Health resources in many countries are being redirected to cope with the pandemic, posing an immediate threat to family planning programs. A pandemic-related global recession will have knock-on effects throughout the world, potentially imperiling family planning resources for years to come.

The outlook for the next decade, even apart from the impact of COVID-19, suggests that international donor funding for family planning will remain essentially stagnant or even shrink. The modest shift to domestic resources in the past eight years—seen in the increasing number of FP2020 countries allocating budget lines for family planning services and commodities—is a positive trend that will need to continue for further progress to be possible. As the RHSC notes in the 2019 Commodity Gap Analysis, it is a mistake to imagine that the private sector will be able to shoulder much more of the burden.¹⁴ Public sector funding is especially critical for LARCs, which are only available in low-resource settings through government subsidies.

Thirty-five FP2020 focus countries are already partnering with the Global Financing Facility (GFF) to strengthen their programs for reproductive, maternal, newborn, child and adolescent health and nutrition (see digital report). Nearly all of the countries with GFF investment cases that have been completed and approved (19 out of 21) prioritized family planning as part of their strategy.

With the global commitment to achieving UHC, it is clear that the future lies in broadly-supported integrated health systems, with family planning as one component. The key going forward will be to ensure that UHC schemes feature a strong focus on primary care, including sexual and reproductive health, and that family planning services are clearly emphasized and funded. The methods and procedures that have been developed over the past eight years of FP2020—in tracking resource flows, as described in this section, as well as in developing costed implementation plans and using data models to identify feasible goals and the necessary investments to reach them—will be essential tools for the next decade of family planning programming.

➔ [See the digital report for Investing in Health: Report from the Global Financing Facility.](#)

Health resources in many countries are being redirected to cope with the pandemic, posing an immediate threat to family planning programs. A pandemic-related global recession will have knock-on effects throughout the world, potentially imperiling family planning resources for years to come.

DONOR GOVERNMENT FUNDING

DONOR GOVERNMENT FUNDING FOR FAMILY PLANNING IN 2019: KFF SUMMARY ANALYSIS

In order to track the role of donor governments in funding family planning, KFF has been collecting and analyzing donor government disbursements on an annual basis since the London Summit on Family Planning in 2012. This year's analysis assesses funding disbursed in 2019 as well as trends over time. It includes both bilateral funding as well as multilateral contributions to UNFPA, and is based on analysis of data from the 30 donor government members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) in 2019 who had reported Official Development Assistance (ODA) to the DAC. Data were collected directly for 10 of these governments, who account for 99% of all donor government funding for family planning (data for the remaining donors were obtained from the OECD Credit Reporting System (CRS)). Key findings are as follows:

BILATERAL FUNDING

- In 2019, bilateral family planning funding from donor governments totaled US\$1.5 billion, on par with 2018 disbursements of US\$1.5 billion (see Figure 1).^{15,16}
- Donor government funding for family planning has generally risen since the London Summit, although there have been fluctuations over the period. In 2019, funding was more than US\$400 million above the 2012 amount (US\$1.1 billion).
- Five of the 10 donors profiled increased their disbursements from 2018 to 2019 in US dollars (Australia, Canada, Norway, Sweden, and the UK)

and half decreased (Denmark, France, Germany, the Netherlands, and the US). These trends were the same after adjusting for inflation and exchange rate fluctuations, except for the Netherlands, which was flat in currency of origin.

- The US was the largest bilateral donor to family planning in 2019, accounting for 39% (US\$592.5 million) of total bilateral funding.¹⁷ The UK was the second largest donor (US\$386.5 million, 25%), followed by the Netherlands (US\$203.3 million, 13%), Sweden (US\$113.1 million, 7%), and Canada (US\$89.4 million, 6%).

DONOR CONTRIBUTIONS TO UNFPA

- In addition to bilateral disbursements for family planning—which may include non-core contributions to UNFPA for specific family planning programs, such as UNFPA Supplies—donors also contribute to UNFPA's core resources, which are meant to be used for both programmatic activities (family planning, population and development, HIV/AIDS, gender, and sexual and reproductive health and rights) as well as operational support.
- In 2019, core contributions from the 10 profiled donor governments totaled US\$367.6 million, essentially flat compared to 2018 (US\$374.1 million).
- Among the 10 donors examined, three increased funding to UNFPA's core resources (Denmark, France, and Germany), five remained flat (Australia, Canada, the Netherlands, Norway, and the UK), and one decreased (Sweden). The US did not provide any funding to UNFPA. Since 2017, the Trump Administration has invoked the Kemp-Kasten Amendment, a provision of US law, to withhold funding—both core and non-core contributions—from UNFPA.¹⁸

¹⁵ For purposes of this analysis, family planning bilateral expenditures represent funding specifically designated by donor governments for family planning as defined by the OECD DAC (see methodology note in the digital report), and include: standalone family planning projects; family planning-specific contributions to multilateral organizations (e.g., contributions to UNFPA Supplies); and, in some cases, projects that include family planning within broader reproductive health activities.

¹⁶ Some of the figures for previous years are different from the data reported last year due to updates after the 2018 report was published. Donor amounts do not exactly sum to total amounts due to rounding.

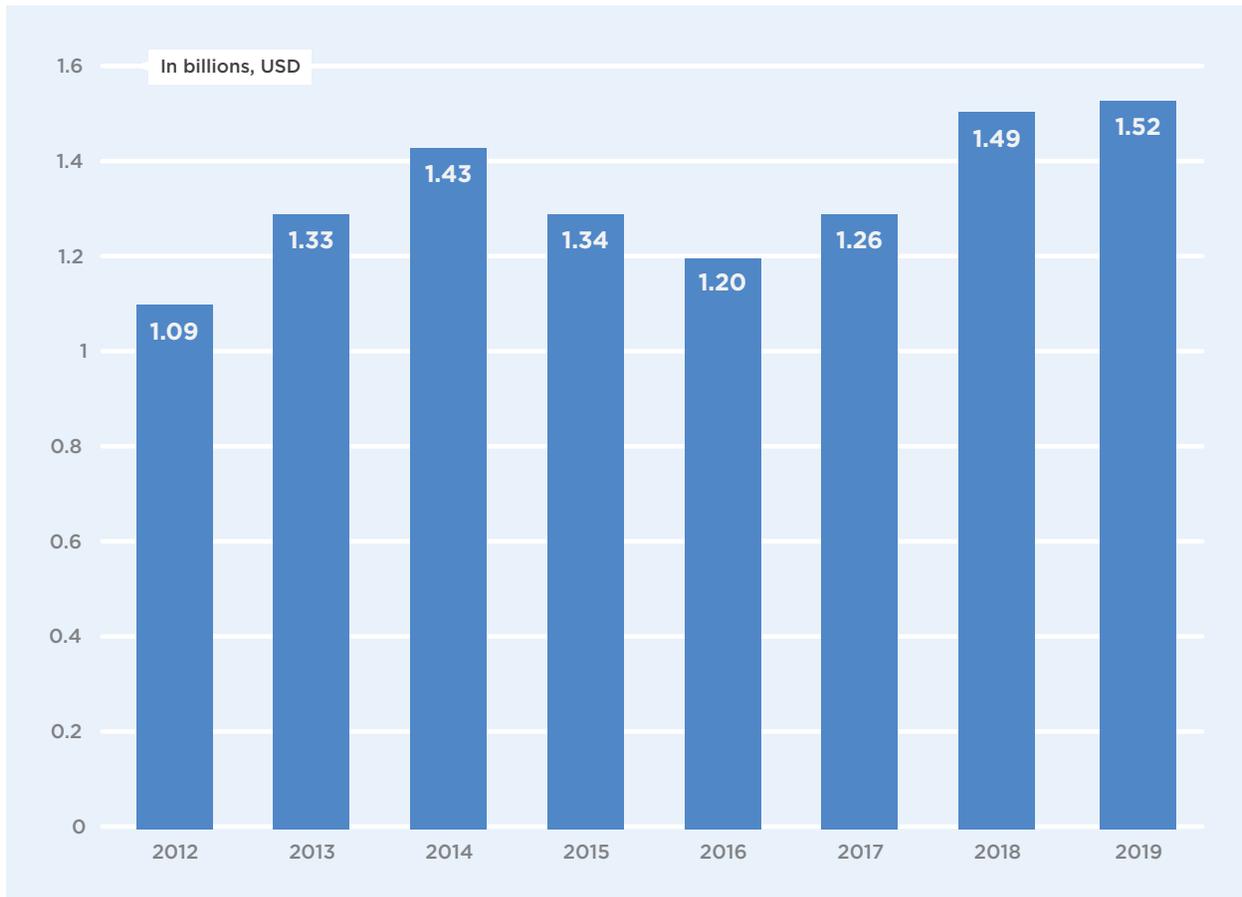
¹⁷ In FY 2019, a comparable figure for funding disbursed was not available due to adjustments made in USAID's accounting system. Instead, the FY 2019 total is based on Congressionally appropriated amounts, which include US\$575.0 million in funding for family planning as well as US\$17.5 million transferred to family planning from the Congressional appropriation to UNFPA (see Donor contributions to UNFPA for additional details). It is important to note that US appropriations for a given year may be disbursed over a multi-year period. Appropriations have remained relatively flat for several years while disbursements have fluctuated largely due to the timing of payments.

¹⁸ In FY 2016, US contributions to UNFPA had totaled US\$69 million, including US\$30.7 million in core resources and an additional US\$38.3 million in non-core resources for other project activities. (See KFF's "UNFPA Funding & Kemp-Kasten: An Explainer.") In FY 2019, the US Congress appropriated US\$32.5 million in core funding for UNFPA. Due to the current administration's decision to invoke the Kemp-Kasten amendment, this funding was transferred to other global activities—per a provision in US law—including US\$17.5 million transferred to family planning.

- Norway and Sweden provided the largest core contributions to UNFPA in 2019 (US\$62.0 million and US\$61.7 million, respectively), followed by Denmark (US\$45.3 million), Germany (US\$37.0 million), and the Netherlands (US\$36.7 million).
- In 2019, UNFPA spent approximately US\$398.5 million (41.7% of UNFPA's total program expenses) on family planning activities (US\$65.7 million from

core resources and US\$332.8 million from non-core resources). This includes US\$267.8 million for family planning-specific activities (such as enabling environments for family planning, contraceptives and related supplies, provision of services, and family planning systems strengthening) and US\$130.7 million for activities with an impact on family planning results in other areas of work under UNFPA's mandate.¹⁹

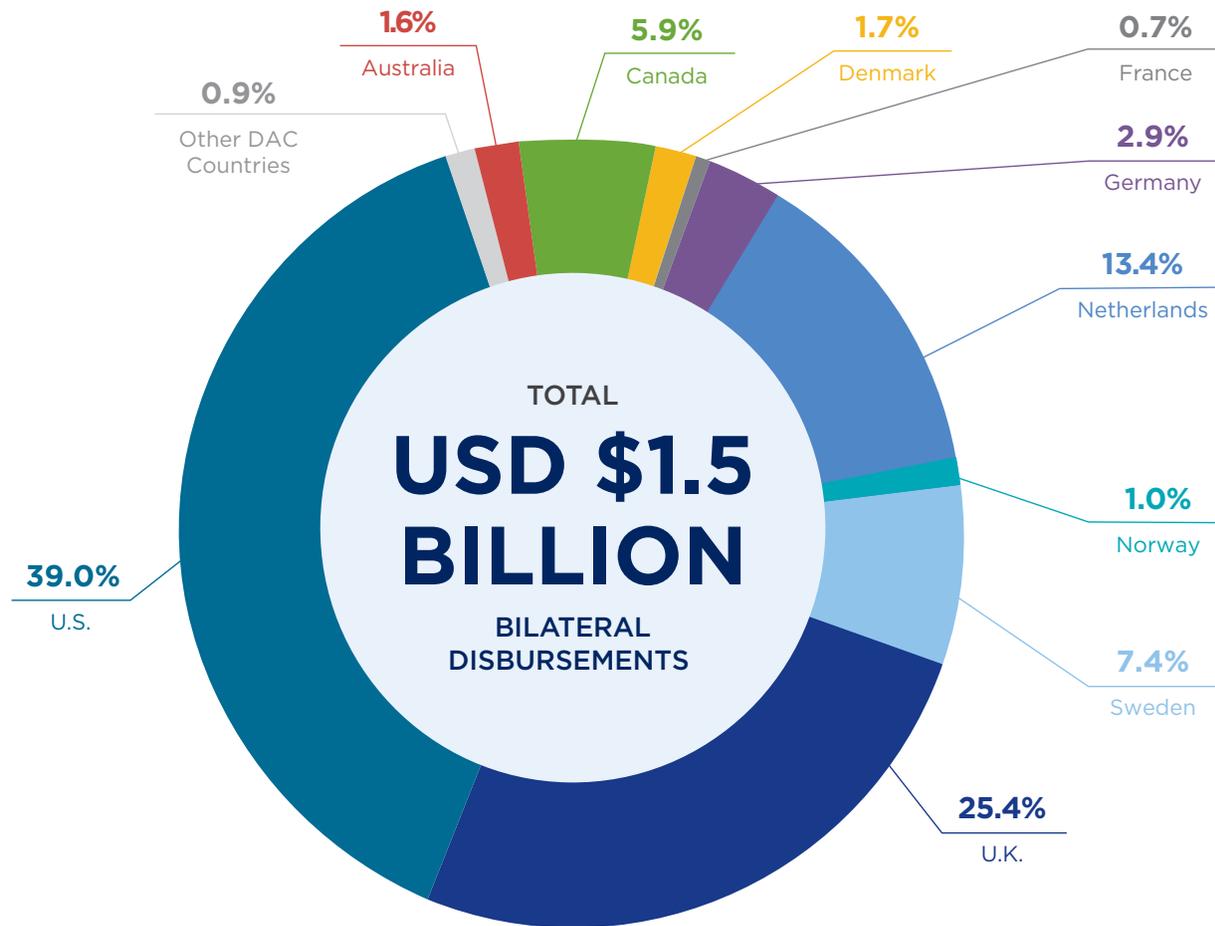
FIGURE 1 DONOR GOVERNMENT BILATERAL ASSISTANCE FOR FAMILY PLANNING, 2012–2019



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

¹⁹ UNFPA Commodity Security Branch, *UNFPA Supplies Annual Report 2019: Reporting on the Performance Monitoring* (New York: UNFPA, 2020), <https://www.unfpa.org/resources/unfpa-supplies-annual-report-2019-reporting-performance-monitoring-framework>.

**FIGURE 2 INTERNATIONAL FAMILY PLANNING ASSISTANCE:
DONOR GOVERNMENTS AS A SHARE OF BILATERAL DISBURSEMENTS, 2019**



➔ See the digital report for notes on methodology.

TABLE 1 DONOR GOVERNMENT BILATERAL ASSISTANCE FOR FAMILY PLANNING, 2012–2019*

In millions, USD

COUNTRY	2012	2013	2014	2015	2016	2017	2018	2019
Australia	\$43.2	\$39.5	\$26.6	\$12.4	\$24.9	\$25.6	\$22.2	\$24.7
Canada	\$41.5	\$45.6	\$48.3	\$43.0	\$43.8	\$69.0	\$81.8	\$89.4
Denmark	\$13.0	\$20.3	\$28.8	\$28.1	\$30.7	\$33.1	\$38.5	\$25.6
France	\$49.6	\$37.2	\$69.8	\$68.6	\$39.9	\$19.2	\$17.0	\$11.1
Germany	\$47.6	\$38.2	\$31.3	\$34.0	\$37.8	\$36.8	\$51.3	\$44.1
Netherlands	\$105.4	\$153.7	\$163.6	\$165.8	\$183.1	\$197.0	\$215.6	\$203.3
Norway	\$3.3	\$20.4	\$20.8	\$8.1	\$5.7	\$2.2	\$12.9	\$15.6
Sweden	\$41.2	\$50.4	\$70.2	\$66.0	\$92.5	\$109.2	\$107.0	\$113.1
United Kingdom	\$252.8	\$305.2	\$327.6	\$269.9	\$204.8	\$279.2	\$286.0	\$386.5
United States	\$485.0	\$585.0	\$636.6	\$638.4	\$532.5	\$474.7	\$630.6	\$592.5
Other DAC Countries**	\$11.0	\$29.5	\$9.0	\$10.1	\$3.3	\$9.6	\$29.6	\$14.4
TOTAL	\$1,093.6	\$1,325.0	\$1,432.7	\$1,344.5	\$1,199.0	\$1,255.5	\$1,492.5	\$1,520.3

NOTES

Australia has identified A\$35.5 million in bilateral FP funding for the 2018-19 fiscal year using the FP2020-agreed methodology, which includes funding from non-FP-specific activities (e.g. RH, maternal health and other sectors) and a percentage of the donor's core contributions to several multilateral organizations (e.g. UNFPA). For this analysis, Australian bilateral FP funding did not include contributions to multilateral institutions. However, it was not possible to identify and adjust for funding to other non-FP-specific activities in most cases.

Bilateral funding is for family planning and reproductive health components of combined projects/ activities in FY19-20. Reproductive health activities without family planning components are not reflected. This is a preliminary estimate. In support of its feminist international agenda, Canada committed to double its funding to sexual and reproductive health and rights (SRHR) from 2017-2020 with an additional CAD 650 million. Canada is taking a comprehensive approach to SRHR. Efforts focus on providing comprehensive sexuality education, strengthening reproductive health services, and investing in family planning and contraceptives. Programs will also help prevent and respond to sexual and gender-based violence, including child early and forced marriage and female genital mutilation and cutting, and support the right to choose safe and legal abortion, as well as access to post-abortion care.

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

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

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

The Netherlands budget provided a total of EUR449 million in 2019 for "Sexual and Reproductive Health & Rights, including HIV/AIDS" of which an estimated EUR181.6 million was disbursed for bilateral family planning and reproductive health activities (not including HIV).

Bilateral funding is for family planning-specific activities, narrowly-defined under the corresponding DAC subsector 13030. Additional Norwegian bilateral family planning activities are for the most part not standalone, but rather are integrated as elements of other activities. In line with Norway's methodology for SRHR monitoring of its FP Summit 2017 pledge, Norwegian SRHR support comprises all projects using DAC Sector 130, 100% of UNFPA and UNAIDS core contributions, 50% of contributions to the Global Fund to Fight Aids, Tuberculosis and Malaria and 28% of contributions to the Global Financing Facility. Using these parameters, Norwegian SRHR funding totaled NOK1.5804 billion in 2018 and NOK1.6055 billion in 2019.

Bilateral funding is for combined family planning and reproductive health activities. None of Sweden's top-magnitude health activities appears to reflect an exclusive family-planning-specific subsector focus, indicative of the integration of FP activities into broader health initiatives in ways similar to those employed by some other governments. It thus may not be possible to identify exact amounts of Swedish bilateral or multi-bi FP financing. More broadly, total Swedish bilateral SRHR activities appear to have accounted for at least SEK1.2 billion in 2019. Of this, at least SEK210 million is estimated to have been related to family planning.

In the financial year 2019/20, total UK spending on family planning was £334.8 million. This is a provisional estimate, based upon the "revised Muskoka Methodology", which includes funding from non-FP-specific activities (e.g., HIV, RH, maternal health and other sectors) and a percentage of the donor's core contributions to several multilateral organizations. For this analysis, UK bilateral FP funding of £304 million was calculated by removing unrestricted core contributions to multilateral organizations. A final estimate will be available after FCDO publishes its annual report for 2019/20 in 2021.

Bilateral funding is for combined family planning and reproductive health activities; while USAID estimates that most funding is for family planning-specific activities only, these cannot be further disaggregated. In FY 2019, a comparable figure for funding disbursed was not available due to adjustments made in USAID's accounting system. Instead, the FY 2019 total is based on Congressionally appropriated amounts, which include US \$575.0 million in funding for family planning as well as US \$17.5 million transferred to family planning from the Congressional appropriation to UNFPA (see Donor contributions to UNFPA for additional details). It is important to note that U.S. appropriations for a given year may be disbursed over a multi-year period. Appropriations have remained relatively flat for several years while disbursements have fluctuated largely due to the timing of payments.

Bilateral funding was obtained from the Organisation for Economic Co-operation and Development (OECD) Credit Reporting System (CRS) database and represents funding provided in the prior year (e.g. data presented for 2019 are the 2018 totals, the most recent year available; 2018 presents 2017 totals; etc.).

* For purposes of this analysis, family planning bilateral expenditures represent funding specifically designated by donor governments for family planning as defined by the OECD DAC (see methodology), and include: stand-alone family planning projects; family planning-specific contributions to multilateral organizations (e.g. contributions to UNFPA Supplies); and, in some cases, projects that include family planning within broader reproductive health activities. During the FP2020 Summit, donors agreed to a revised Muskoka methodology to determine their FP disbursements totals. This methodology includes some funding designated for other health sectors including, HIV, reproductive health (RH), maternal health, and other areas, as well as a percentage of a donor's core contributions to several multilateral organizations including UNFPA, the World Bank, WHO, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Among the donors profiled, Australia and the U.K. reported FP funding using this revised methodology.

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

➔ [See the digital report for Spotlight on European Donors: Report from Countdown 2030 Europe.](#)

DOMESTIC GOVERNMENT EXPENDITURES

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

This is FP2020's third year of reporting domestic expenditures at the country level, with the number of countries for which estimates are available increasing each year. This year's table includes estimates for 54 countries (41 of which are FP2020 commitment makers), amounting to nearly US\$1.6 billion in spending. Most of that figure is attributable to just five countries: India, Indonesia, Bangladesh, Pakistan, and the Philippines. The 54 countries in total represent 96% of the modern method users in FP2020 focus countries.

Each country estimate in the table is for the most recent available fiscal year, in most cases 2017 or 2018. The expenditures reported come from five different sources:

Official government reports. The Government of India prepares a comprehensive assessment of family planning expenditures and furnishes that estimate to FP2020 annually.

WHO/SHA. WHO has been implementing data collection on health expenditures under the System of Health Accounts (SHA) 2011 for several years as part of a joint effort with the Organisation for Economic Co-operation and Development (OECD) and Eurostat. Government approved estimates are published on the WHO Global Health Expenditure Database. Estimates for 2017 were released in December 2019. Estimates for 2018 may become available by December 2020, but are not available in time for publication of this Progress Report.

FPSA (Family Planning Spending Assessment).

Track20 has been collaborating with the Centre for Economic and Social Research (Nairobi, Kenya) to collect data on FP expenditures using a modified version of health accounts that focuses strictly on family planning. These analyses collect information from the main funders and implementing organizations to describe sources and uses of funds. Results are disseminated to governments and other stakeholders.

UNFPA/NIDI. UNFPA and NIDI (Netherlands Interdisciplinary Demographic Institute) have been tracking domestic government expenditures for family planning since 2014. NIDI works with national UNFPA offices to engage local consultants to review records and interview government officials. Results are checked for completeness and quality by NIDI. Final results are approved for release by the organizations contributing data and, in most cases, by appropriate government agencies.

IHME. The Institute for Health Metrics Evaluation (IHME) uses the data from WHO/SHA, UNFPA/NIDI, and Track20 along with other information to fit regression models that estimate expenditures over time for each country, including those without independent estimates. This method is applied to 120 low and middle-income countries. IHME estimates total government expenditures in 2017 at US\$1.65 (range of US\$1.45-US\$1.80) billion. While IHME estimates are not shown for individual countries here, it is an important new resource that will be used as a reference for domestic expenditure tracking efforts.

**TABLE 2 DOMESTIC GOVERNMENT EXPENDITURES ON FAMILY PLANNING
(CORE INDICATOR 12)**

COUNTRY	ESTIMATE	YEAR	SOURCE	COUNTRY	ESTIMATE	YEAR	SOURCE
Afghanistan	\$1,486,850	2017	NCM-NIDI/UNFPA	Liberia	\$7,931,634	2017	WHO-SHA
Bangladesh	\$262,900,000	2019	FPSA	Madagascar	\$1,584,204	2018	NIDI/UNFPA*
Benin	\$345,000	2017	WHO-SHA	Malawi	\$6,622,464	2017	NCM-NIDI/UNFPA
Bhutan	\$1,691,820	2017	WHO-SHA	Mali	\$134,494	2017	WHO-SHA
Bolivia	\$4,236,335	2018	NIDI/UNFPA	Mauritania	\$1,754,519	2017	WHO-SHA
Burkina Faso	\$2,426,213	2018	NIDI/UNFPA	Mozambique	\$1,917,872	2017	FPSA
Burundi	\$2,251,377	2016	WHO-SHA	Myanmar	\$3,570,628	2019	FPSA
Cameroon	\$913,300	2019	FPSA	Nepal	\$1,622,418	2017	WHO-SHA
Comoros	\$64,088	2016	NIDI/UNFPA*	Nicaragua	\$1,088,820	2018	NIDI/UNFPA*
Congo	\$684,000	2017	WHO-SHA	Niger	\$9,693,728	2017	NCM-WHO/SHA
Côte d'Ivoire	\$34,801,185	2017	WHO-SHA	Nigeria	\$1,670,126	2017	WHO-SHA
DR Congo	\$1,484,965	2018	NIDI/UNFPA*	Pakistan	\$149,583,541	2018	NIDI/UNFPA
Djibouti	\$34,311	2016	NIDI/UNFPA	Philippines	\$155,906,592	2018	FPSA
Egypt	\$8,605,751	2018	NIDI/UNFPA*	Sao Tome and Principe	\$182,640	2017	WHO-SHA
Ethiopia	\$40,924,358	2017	WHO-SHA	Senegal	\$4,093,198	2017	FPSA
Gambia	\$303,263	2018	NIDI/UNFPA	Sierra Leone	\$548,250	2016	NIDI/UNFPA*
Ghana	\$26,170	2018	NIDI/UNFPA	South Sudan	\$1,245	2018	NIDI/UNFPA*
Guinea	\$1,411,725	2017	WHO-SHA	Sri Lanka	\$20,707,690	2017	WHO-SHA
Guinea-Bissau	\$31,586	2016	NIDI/UNFPA	Tajikistan	\$2,616,466	2017	WHO-SHA
Haiti	\$114,822	2017	WHO-SHA	Tanzania	\$26,465,669	2017	WHO-SHA
Honduras	\$1,234,047	2016	NIDI/UNFPA	Timor-Leste	\$906,672	2018	NIDI/UNFPA
India	\$335,730,000	2018	Government of India	Togo	\$1,326,405	2017	WHO-SHA
Indonesia	\$366,200,000	2018	NIDI/UNFPA*	Uganda	\$4,696,000	2017	WHO-SHA
Kenya	\$24,035,247	2019	FPSA	Uzbekistan	\$11,821,944	2017	NIDI/UNFPA*
Kyrgyz Republic	\$2,903,747	2018	NIDI/UNFPA	Viet Nam	\$8,904,936	2018	NIDI/UNFPA*
Lao PDR	\$2,418,000	2017	WHO-SHA	Zambia	\$3,941,698	2016	WHO-SHA
Lesotho	\$377,620	2018	NIDI/UNFPA	Zimbabwe	\$20,680,090	2019	FPSA

Notes:

FPSA: Family Planning Spending Assessment

NCM: National Consensus Meeting

NIDI: Netherlands Interdisciplinary Demographic Institute

UNFPA: United Nations Population Fund

WHO-SHA: World Health Organization System of Health Accounts

*Data cleared by contributing organizations but not yet by government

➔ **See the digital report for Commodity Spending:
Contraceptive Security Indicators Report.**

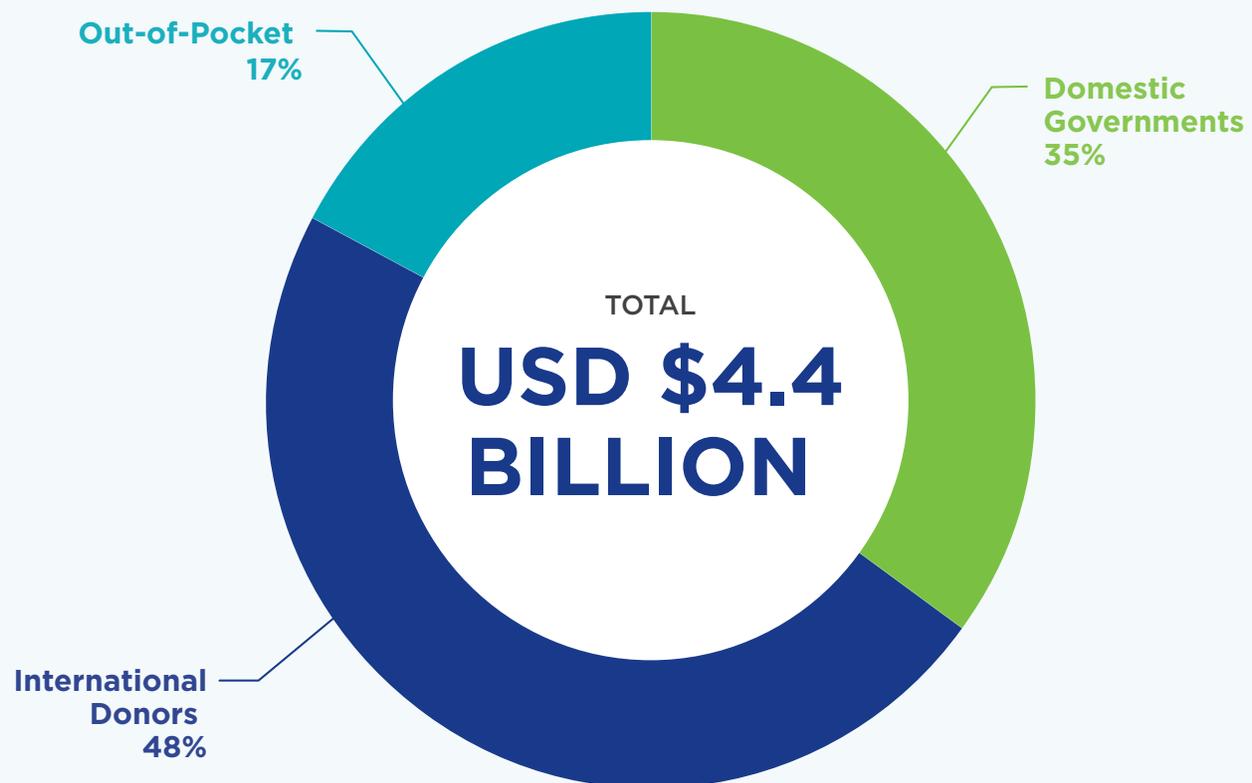
TOTAL EXPENDITURES ON FAMILY PLANNING

Total spending on family planning is comprised of three main segments: domestic government expenditures, international donor contributions, and out-of-pocket spending by consumers who access services in the private sector or pay fees for public sector services.

Total expenditures in 2018, the most recent year for which most domestic government expenditures are available, are estimated at US\$4.4 billion across all FP2020 countries. International donors contributed an estimated 48%, domestic governments 35%, and consumers 17%.

The 2018 estimate for total expenditures is 16% higher than the estimate for 2017, but this may reflect the greater availability of data on domestic expenditures rather than a real increase in expenditures for family planning. Trends over time are only reliable for international donor contributions, which have been tracked and analyzed using the same methodology for many years. Methods to estimate the other segments are continuing to improve and domestic data are becoming available for more countries each year.

FIGURE 3 DISTRIBUTION OF FAMILY PLANNING EXPENDITURES IN 69 FP2020 COUNTRIES BY SOURCE OF FUNDS, 2018



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

Data for each segment are collected and reviewed by the Family Planning Expenditures Expert Advisory Group, which provides guidance on combining the available information into a single estimate.

Domestic Government Expenditures. As described in the previous section, these are now available for 54 of the 69 FP2020 focus countries. Based on this data, the estimated expenditure for 2018 is US\$1.55 billion.

International Donor Contributions. Financial contributions from international donors are tracked by several organizations, each using different methodologies:

- The Kaiser Family Foundation (KFF) tracks bilateral disbursements for family planning by interviewing each of the top 10 donor countries and using the OECD CRS database for all others (see Donor Government Funding). For 2018 they reported donor funding of US\$1.5 billion, the highest level since FP2020 was launched. (The estimate for 2018 is used to align with the estimates for domestic government expenditures and out-of-pocket spending.)
- UNFPA and NIDI collect information on disbursements for 30 DAC countries using the OECD/DAC CRS data base. Project reports are analyzed to determine dedicated family planning expenditures, and the family planning component of combination projects is initially determined by applying standard ratios of FP components to different categories of development assistance. Follow-up conversations are held with selected donors to agree on the allocation to family planning. The resulting estimate for donor disbursements in 2018 is US\$972 million. This differs from the KFF estimate primarily because of different assumptions about the proportion of sexual and reproductive health funding allocated to family planning.
- IHME collects data from a number of sources, including the OECD-DAC CRS, World Bank, regional development banks, USAID-financed NGOs, and UN agencies. Key word searches of project descriptions are used to distinguish family planning funding from other types of Donor Assistance for Health (DAH). Estimates include funding from bilateral donors as well as foundations and NGOs. For 2018, IHME estimates donor disbursements at US\$1.1 billion. This includes US\$460 million from foundations and NGOs that is not included in the KFF estimate, but it also allocates a smaller portion of funds from the US and the Netherlands to family planning than KFF or UNFPA/NIDI.

The Bill & Melinda Gates Foundation reports expenditures directly to FP2020; the amount reported for 2018 was US\$296 million. We combine that figure with the KFF estimate of US\$1.5 billion for bilateral donors; we also use the IHME estimates for other foundations and NGOs (US\$100 million) and other organizations (\$200 million). This results in an estimated total for international donor contributions of US\$2.1 billion in 2018.

Out-of-Pocket Spending. Estimates are now available from three sources:

- The Reproductive Health Supplies Coalition and Avenir Health estimate out-of-pocket (OOP) expenditures on family planning as part of their Commodity Gap Analysis. Estimates are produced separately for married and unmarried contraceptive users, based on the number of modern method users in each country (from Track20 and the UN Population Division), method mix, price points, and the percentage of users getting their services from the private sector (from DHS, MICS, and other national surveys). Total OOP expenditures in 2018 are estimated at US\$727 million in the 69 FP2020 focus countries and US\$2.8 billion in 135 low- and middle-income countries.
- IHME uses price estimates from the RHSC Commodity Gap Analysis and regression analysis to estimate missing data points. This is combined with estimates of the number of women accessing each contraceptive method in the private sector. IHME's total OOP estimate for 2017 is US\$2.17 billion across 120 low and middle-income countries.
- NIDI uses methods similar to RHSC and IHME, but employs a country survey to collect information on prices paid by private sector users. NIDI estimates US\$1.4 billion in OOP expenditures in 64 countries in 2018.

We use the RHSC/Avenir Health estimate of US\$727 million for the 69 FP2020 countries. Total OOP estimates that include all low- and middle-income countries are considerably higher because consumer spending plays a larger role in countries with higher incomes.

➔ **The digital report includes country-specific expenditure graphs for Bangladesh, Cameroon, Indonesia, Kenya, Mozambique, Myanmar, Philippines, Senegal, and Zimbabwe.**



SECTION 05

MEASUREMENT

When FP2020 was launched in 2012, the family planning community relied almost exclusively on periodic national household surveys conducted under the Demographic and Health Surveys (DHS) Project and UNICEF's Multiple Indicator Cluster Surveys (MICS) to monitor progress.

Because DHS and MICS surveys are normally conducted every five years or so, it was not possible to monitor trends with greater frequency.

To provide an annual, global readout of key progress markers that would be applicable and available across countries, FP2020's Performance Monitoring & Evidence Working Group, a group of global measurement experts, established a set of Core Indicators. The Core Indicators were selected with existing country data systems and monitoring efforts in mind, and were designed to capture information on contraceptive use, method choice, quality, availability, and other key aspects of family planning programs. Over the past eight years, FP2020 and its measurement partners have worked to harmonize and align reporting, improve indicators and methodologies, and enhance the infrastructure and capacity to generate and use robust data.

BUILDING COUNTRY CAPACITY

The Track20 program, implemented by Avenir Health, was launched in tandem with FP2020 to assist countries in building the capacity to collect, analyze, use, and report data on family planning. A cadre of Track20-supported Monitoring and Evaluation Officers housed within government family planning units have been trained on new methods and tools, thus increasing country capacity to use sophisticated statistical models of family planning trends and use that information along with survey and service statistics data for decision making.

ENSURING A COUNTRY-LED PROCESS

Each year in FP2020 commitment-making countries, the government family planning program convenes a meeting with in-country stakeholders to review annual family planning data. These data review meetings are critical for ensuring that the process remains country-driven, and that governments and stakeholders dedicate time to review and understand the data, take stock of progress, and adjust their strategies as necessary. This approach also makes transparent the data and methodologies that influence decision-making in-country and internationally.



PHOTO BY
EU Civil Protection
and Humanitarian Aid/
Mallika Panorat/Flickr

MEASURING PROGRESS AND THE LIMITATIONS OF DATA IN 2020

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

At the outset of 2020, we knew it would be a challenge to present a complete picture of progress over the eight years of the partnership. This is because indicator estimates included in each year's report are largely based on data collected in previous years. For the subset of the Core Indicators that are based on models and reported as current year estimates, the most recent year for input data into the models is the year before the report (e.g., 2019 for this 2020 report). A complete accounting of progress from 2012 to 2020 probably will not be possible until a few years after the end of FP2020. Nonetheless, we endeavored in this final FP2020 Progress Report to look at the current year estimates and analyze trends since 2012.

The emergence of COVID-19 in early 2020 further exposed the limitations of this year's Core Indicator data. While we've become accustomed to real-time data on COVID-19, our family planning Core Indicators don't yet reflect the impact of COVID-19. Although data are beginning to emerge on the impacts of COVID-19 on family planning, suspended national-level surveys and the inability of surveys to quickly capture long-term effects on health outcomes means that it may take several years before we've fully captured the impacts of the global pandemic on contraceptive use and related outcomes.

Given these limitations, what can this year's Progress Report reveal about FP2020 progress? The first part of the measurement section reports on Core Indicator estimates prior to the onset of the pandemic, providing insight into the pace of progress on key measures of contraceptive use. The second part uses model data and survey comparisons to assess trends from 2012 to 2020. The analysis examines different aspects of change beyond just expanded contraceptive use, and offers a deeper look at trends. Finally, insights into the impact of COVID-19 on family planning are available in the digital report and will remain a key aspect of measurement work in the year to come.

Learn more about the total and additional users of modern contraception since 2012 in the digital report at familyplanning2020.org/progress



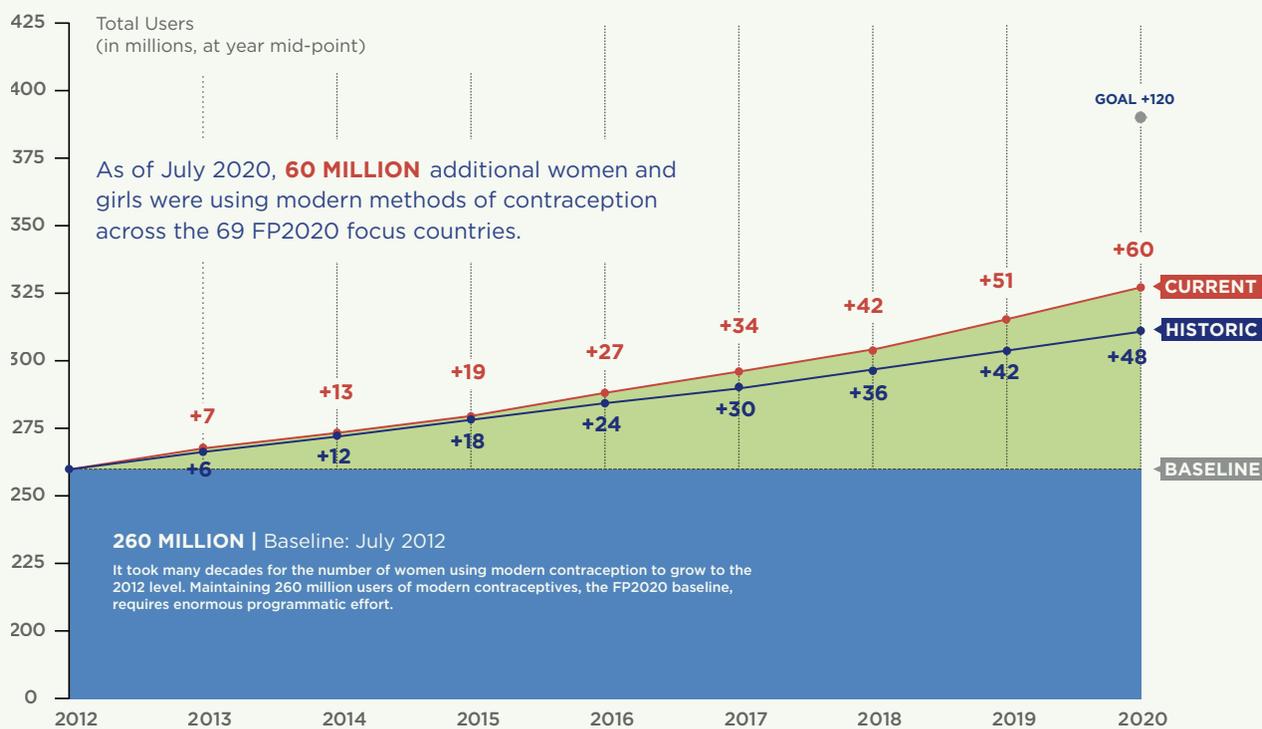
UPDATED CORE INDICATOR ESTIMATES IN 2020

PROGRESS ON CONTRACEPTIVE USE AND NEED

Core Indicator 1, the number of additional users of modern methods of contraception, measures progress toward the FP2020 goal of reaching 120 million additional users of modern contraception by 2020.

As of July 2020, there were 60 million additional users of modern contraception in the 69 FP2020 focus countries as compared to 2012, the time of the London Summit. While the rate of growth over the eight years has been well short of the pace needed to reach 120 million additional users goal, there is progress across many countries, particularly in Africa.

FIGURE 4 TOTAL AND ADDITIONAL USERS OF MODERN CONTRACEPTION, 2012–2020



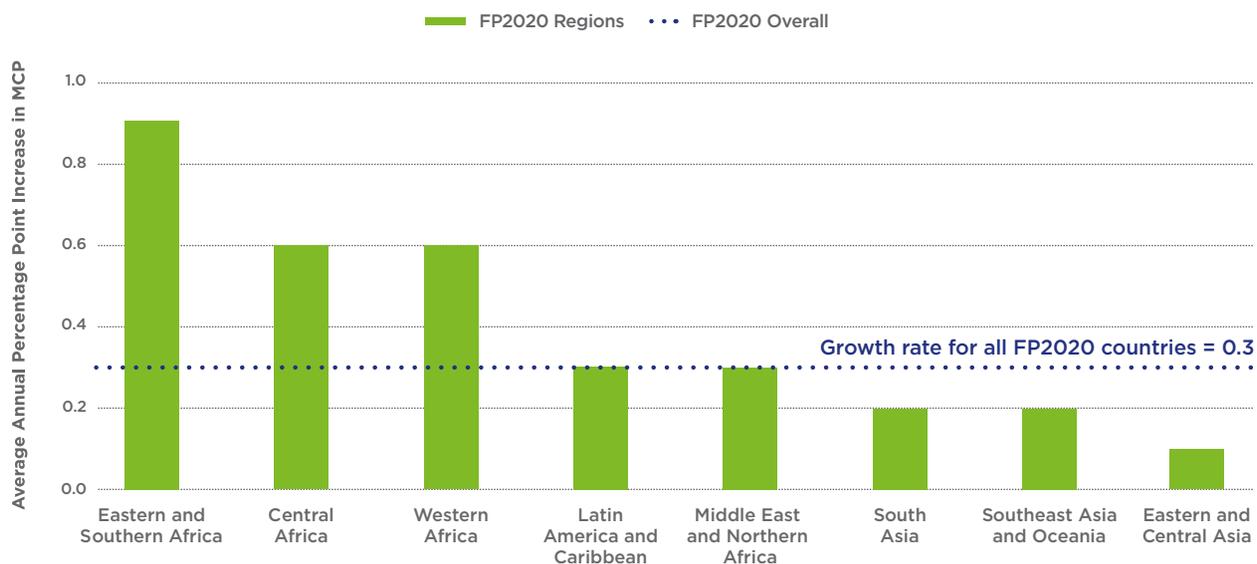
COUNTRIES KEEPING PACE WITH THE GROWING NUMBER OF WOMEN OF REPRODUCTIVE AGE

As of July 2020, there were an estimated 942 million women of reproductive age in the 69 FP2020 focus countries, compared to 822 million in 2012: an increase of approximately 15 million women each year. Just keeping up with this population growth means that many more women and girls need contraceptive services each year just to maintain contraceptive prevalence. But in most FP2020 focus countries, modern contraceptive prevalence among all women

(MCP) is rising. This increase in MCP is an important contributor to the increase in additional users. Across the 69 FP2020 focus countries, MCP among all women of reproductive age, **Core Indicator 2**, has risen by more than 2 percentage points since 2012. This growth has been fastest in Eastern and Southern Africa, where MCP among all women has grown by approximately 8 percentage points since 2012, or about one percentage point per year. Growth in Central and Western Africa has been nearly as fast, despite starting at lower levels of MCP.

FIGURE 5 ANNUAL MCP GROWTH RATE BY REGION

This graphic shows the average annual percentage point increase in MCP (among all women) from 2012–2020, for all FP2020 countries, grouped by region.



Looking at both population growth and increases in MCP, we can see the progress that regions and countries have made in providing services to increasing numbers of women and girls. As of July 2020, the number of users of modern methods of contraception in Africa had grown by 66% since 2012, from 40 million to more than 66 million women and girls. This growth was most pronounced in Central and Western Africa, where the number of modern contraceptive users has doubled in just 8 years, and in Eastern and Southern Africa where the number of users has grown by 70%.

At a country level, 14 countries have each gained more than 1 million additional users of modern contraception since 2012, and another 11 countries have seen the number of additional users grow by between 500,000 to 1 million women and girls. In 13 countries the number of users of modern contraception has doubled since 2012.²⁰ These increases are a sign that health systems and service providers are doing more than just keeping pace; they are also expanding services. As of 2020 there are 10 FP2020 focus countries with MCP growth rates greater than 1 percentage point per year since 2012,²¹ and all but one of these are FP2020 commitment

makers. Mozambique has consistently been the fastest growing country, a testament to the commitment of the government and partners to reach all women, including adolescents, with a range of contraceptive choices. It is one of 11 countries that were on track, before the onset of the COVID-19 pandemic, to achieve the MCP goals they established in their FP2020 commitments.²²

Maintaining these gains in the time of COVID-19 and beyond 2020 is critical. The population of women of reproductive age in the 69 FP2020 focus countries will surpass 1 billion before 2025, and accelerating progress toward the Sustainable Development Goal target 3.7—ensuring universal access to sexual and reproductive health care services—was already going to require increased effort and focus to meet the growing demand for family planning services. Now as countries struggle under the weight of the COVID-19 pandemic, they must ensure that family planning services are an essential service and remain available for all women and girls.

Core Indicator 4, demand satisfied with a modern method of contraception, is an indicator for the Sustainable Development Goals (SDG) target 3.7.

²⁰ Benin, Burkina Faso, Chad, Cote d'Ivoire, DRC, Guinea, Mali, Mauritania, Mozambique, Niger, Senegal, Sierra Leone, and Somalia.

²¹ Burkina Faso, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia, Malawi, Mozambique, Senegal, Sierra Leone, and Uganda.

²² Burkina Faso, Egypt, Ghana, India, Kenya, Kyrgyz Republic, Mozambique, Rwanda, Sri Lanka, Viet Nam, and Zimbabwe.

This indicator assesses the degree to which governments and the broader family planning community are meeting the commitment to make family planning services accessible to all who want them. Total demand is constructed based on the percentage of women of reproductive age using modern methods and the percentage estimated to have an unmet need for modern methods (**Core Indicator 3**), with the proportion of demand that is met with modern methods termed “demand satisfied.” Of the 69 FP2020 countries, 17 were on track to surpass at least 75% of demand satisfied with modern methods among all women by 2030, and 20 countries were on track to surpass this level among married women. Members of the family planning community have established “at least 75% demand satisfied with modern methods” as a benchmark that all countries should strive for both nationally and among population sub-groups. There is great variation across and within countries in terms of progress toward this SDG benchmark, suggesting that most countries needed to accelerate their efforts to achieve SDG target 3.7 by 2030 even before the impact of COVID-19, which is likely to have slowed progress.²³

Core Indicator 5, number of unintended pregnancies, a measure of the work that remains to improve reproductive health, indicates that from July 2019 to July 2020, there were more than 48 million unintended pregnancies across the 69 FP2020 focus countries. Most of these unintended pregnancies were due to women and girls not using contraception despite not wanting to get pregnant, while some were due to women and girls experiencing a contraceptive failure. The number of unintended pregnancies occurring each year has not declined, despite increasing contraceptive use, because the number of women of reproductive age has grown. Increased contraceptive use is, however, having an immense impact on the lives of women and girls. **Core Indicators 6, 7, and 8** (unintended pregnancies, unsafe abortions, and maternal deaths averted) provide estimates of the impact of modern contraceptive use. As a result of contraceptive use by more than 320 million women and girls, more than 121 million unintended pregnancies, 21 million unsafe abortions, and 125,000 maternal deaths were prevented in the last year alone.



Photo by EU Civil Protection and Humanitarian Aid/Mallika Panorat/Flickr

²³ Aisha Dasgupta, Vladimíra Kantorová, and Philipp Ueffing, “The impact of the COVID-19 crisis on meeting needs for family planning: a global scenario by contraceptive methods used” [version 2; peer review: 1 approved, 2 approved with reservations], *Gates Open Research* 2020, 4:102, <https://doi.org/10.12688/gatesopenres.13148.2>.

SPECIAL ANALYSIS: EXAMINING CHANGE FROM 2012 TO 2020

An important achievement of FP2020 is the attention and focus it brought to family planning at the highest levels of government around the world. The initiative spurred ministries of health to assess their current status, set ambitious goals, strengthen monitoring, and identify opportunities to advance progress. The FP2020 goal of reaching 120 million additional users by 2020 is straightforward to measure and assess on its own, but achieving increases in contraceptive use is dependent on many factors, including women's fertility intentions, population dynamics, the availability and quality of services, and existing levels of contraceptive use. This means there are many possible ways to assess if country family planning programs have made progress in meeting the needs of the women and girls they serve. The following special analysis features a few of these approaches, focusing on changes in FP2020 Core Indicators over time: different ways of assessing growth in contraceptive use; changes in equity, including among different wealth groups and among adolescents; and changes related to contraceptive method choice, such as changes in the methods women are using, the type of information they are receiving on family planning, and the availability of methods. These summary pieces are part of a larger effort by the Track20 and FP2020 teams to document changes in different family planning measures over the period of FP2020, and deeper analysis will be published over the coming year in journals and on the Track20 and FP2020 websites.

ASSESSING THE GOAL OF BENDING THE CURVE AND SUPPORTING MORE WOMEN TO USE MODERN CONTRACEPTION

ANNUAL GROWTH IN CONTRACEPTIVE USE ACCORDING TO COUNTRY GROUPINGS

How fast countries grow their MCP depends on many factors, including the current level of use. When countries reach higher levels of MCP, growth typically slows down, as many women are already using contraception. Figure 6 shows the average annual growth in MCP among all women of reproductive age from 2012 to 2020 for countries in Asia and Africa by different levels of MCP (using the 2012 MCP).

Countries are divided into three categories for comparison: FP2020 commitment-making countries (green), FP2020 non-commitment making countries (purple), and non-FP2020 countries (blue). Past progress reports have illustrated that growth differences are associated with where countries lie on the S-Curve,²⁴ with higher growth rates for countries with a starting MCP in 2012 between 10 and 40% (middle of the S-Curve) and lower growth rates for countries at lower and higher levels of MCP. Within each MCP level (Under 10, 10-20, 20-30, 30-40, Over 40), the circle represents the average growth rate and the line represents the range of growth rates for all countries at that level. The country listed at the top of the green line is the fastest-growing FP2020 commitment-making country at that level.

The average growth of MCP in FP2020 commitment-making countries in Africa is faster at all levels of prevalence except the highest, countries with MCP over 40%. This reflects the success African countries have had over the past eight years, with many commitment-making countries increasing their rate of MCP growth and outperforming other countries. Some countries, such as Mozambique and Malawi, have vastly outperformed other countries.

The picture is not as direct in Asia. FP2020 commitment-making countries in Asia are experiencing faster MCP growth than non-commitment and non-focus countries at the 20-30 and 30-40 percent MCP levels, but not at the lowest and highest prevalence ranges. There are certainly success stories, such as Myanmar and Lao PDR, but the results are more varied.

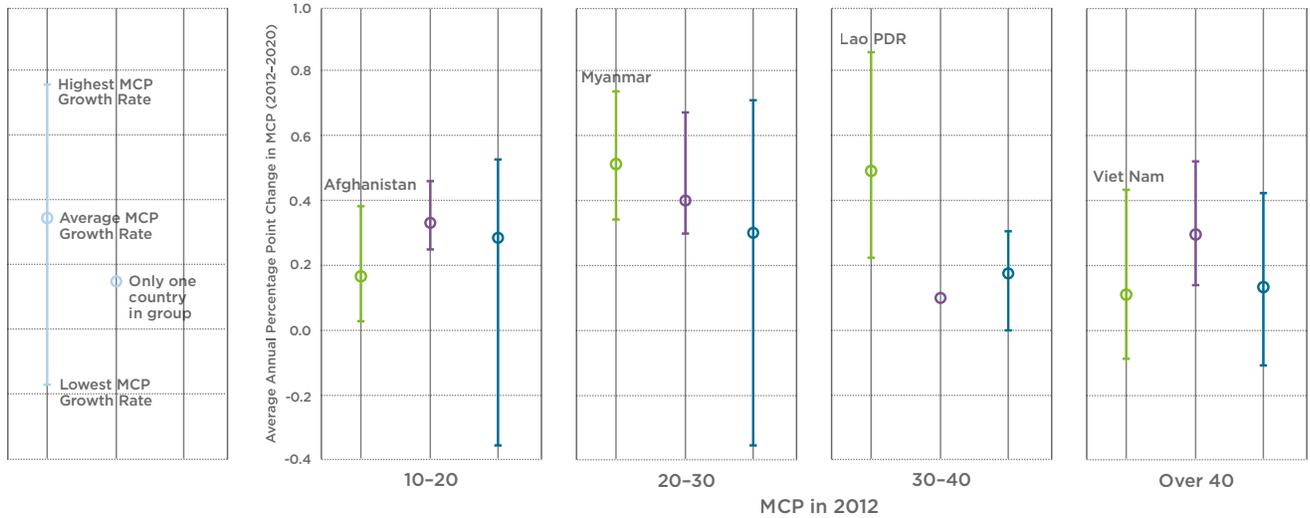
²⁴ See Track20's "The S-Curve: Putting mCPR Growth into Context" at http://www.track20.org/pages/data_analysis/in_depth/mCPR_growth/s_curve.php.

FIGURE 6 ANNUAL CHANGE IN MODERN CONTRACEPTIVE PREVALENCE (MCP) BY MCP IN 2012

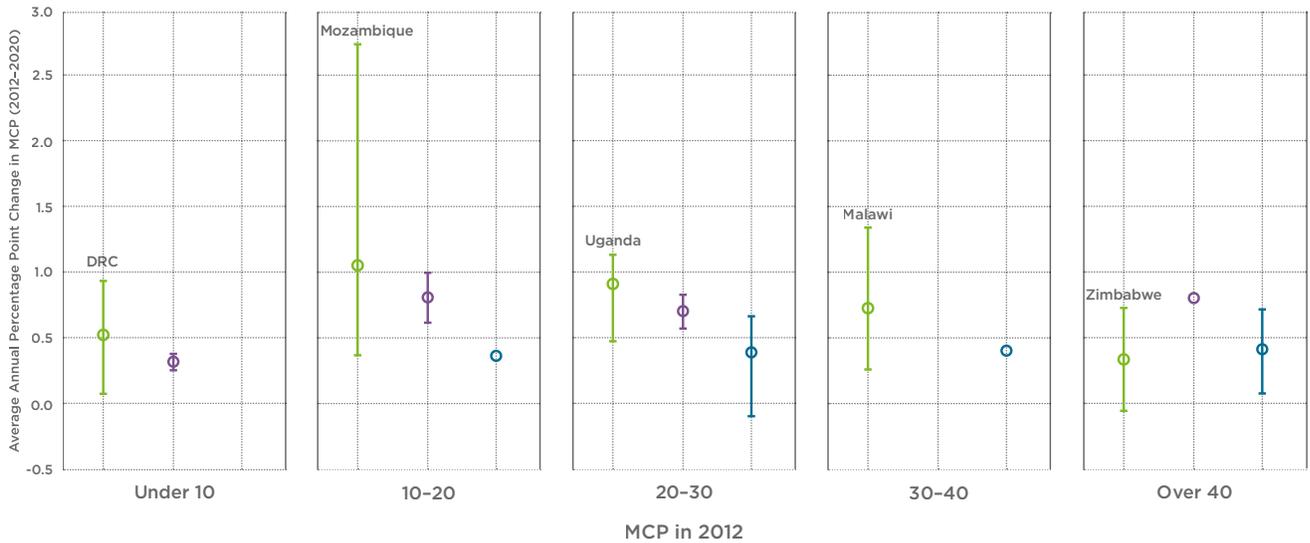
This graphic shows the average annual percentage point change in MCP among all women of reproductive age from 2012 to 2020 for countries in Africa and Asia, based on their MCP in 2012. Countries are divided into three groups: FP2020 commitment-making countries, FP2020 non-commitment making countries, and non-FP2020 countries.

○ FP2020 Commitment-Making Country ○ FP2020 Non-Commitment Making Country ○ Non-FP2020 Country

Asia: Average Annual Percentage Point Change in MCP (2012–2020) by Starting MCP in 2012



Africa: Average Annual Percentage Point Change in MCP (2012–2020) by Starting MCP in 2012



WHAT IS THE PROBABILITY THAT COUNTRIES WOULD HAVE REACHED THEIR CURRENT MCP IN 2020?

Now in 2020, we can compare countries' actual MCP trajectory from 2012 to 2020 with the path they would likely have taken in the absence of FP2020. Looking back at where countries began, and the data available in 2012, how probable is it that their predicted trend would have led them to the MCP they achieved in 2020? How different are the 2020 MCP estimates calculated with pre-2012 data from estimates calculated with current data? Insight into these questions is available through Track20's Family Planning Estimation Tool (FPET), which provides probabilities of MCP estimates.²⁵

Across FP2020 commitment-making countries, the probability of attaining the 2020 estimated MCP based only on the growth trends calculated with pre-2012 data ranges from 0% to 89%. A low probability indicates that contraceptive use grew faster than the trend projected in 2012 (i.e., the likelihood of achieving the actual 2020 level given the context in 2012 was low), while a probability near 50% indicates that growth in contraceptive use has

continued on a similar trend as that predicted in 2012. A high probability indicates that contraceptive use has grown at a slower pace than what was projected in 2012.

In Table 3, column 1 shows the 2012 MCP actual estimate as a gauge for how far these countries have come in eight years. Column 2 shows MCP among married women²⁶ in 2020 estimated using only survey data collected prior to July 2012. Column 3 shows the actual annual MCP calculated in 2020 using all available data, and column 4 shows probabilities for achieving the 2020 MCP given the 2012 trends presented in column 2. The nine countries listed below are those that had only a 1 in 4 chance, or 25% probability, of reaching their estimated 2020 MCP. These countries were able to bend the trend and accelerate progress beyond what was predicted. Six of the nine countries with low probabilities (Mozambique, Senegal, Sierra Leone, Liberia, Burkina Faso, Malawi) greatly exceeded expectations, achieving increases of more than 1 percentage point per year. Again, Mozambique is notable, increasing MCP over the eight-year period from 14 to 36%.

TABLE 3 PROBABILITY OF ATTAINING 2020 MODERN CONTRACEPTIVE PREVALENCE (MCP)

This table shows the probability of each country reaching its 2020 MCP estimate (married women), based on its MCP in 2012.

Commitment-Making Countries with <25% Probability of Attaining 2020 Estimate	2012 MCP Actual Estimate	2020 MCP Estimate (based on pre-2012 data)	2020 MCP Actual Estimate	Probability of Attaining 2020 MCP Actual Estimate (based on pre-2012 data)
Mozambique	14%	17%	36%	0%
Mauritania	12%	10%	19%	4%
Senegal	14%	18%	28%	5%
Sierra Leone	13%	13%	22%	7%
Liberia	17%	17%	25%	15%
Zimbabwe	61%	62%	69%	17%
Burkina Faso	18%	24%	31%	18%
Kenya	50%	50%	58%	20%
Malawi	49%	54%	63%	24%

²⁵ See Track20's "Family Planning Estimation Tool (FPET)" at http://www.track20.org/pages/our_work/innovative_tools/FPET.php.

²⁶ Married women MCP is used for this analysis to align with data reported in countries and the availability of probabilities from FPET.

A GROWING PERCENTAGE OF WOMEN WHO HAVE EVER USED CONTRACEPTION

For countries where fertility intentions remain high and family planning is used primarily for child spacing, looking at the proportion of women of reproductive age who have *ever* used contraception in addition to the proportion *currently* using contraception provides a more complete picture of family planning use. In high-fertility countries where women primarily use contraception to space births on a path to large families, a large percentage of women who are surveyed at any given point have temporarily stopped using contraception in order to get pregnant or are currently pregnant. In this context, an increasing proportion of women who have ever used contraception suggests that more women can

access and use contraceptives when they want and need them, and ultimately suggests that more women are able fulfil their personal fertility intentions through contraceptive use.

Focusing on seven countries²⁷ that have a total fertility rate (TFR) over five, changes among women who have ever used contraception are higher than changes in current use in all countries. Table 3 shows the percentage point change for both married and all women. Particularly important are countries where both current and ever use are growing, which is happening in all seven countries except Nigeria. There have been increases for both married and all women, but the scale of change is much larger for married women. Much of the growth in current use is driven by postpartum family planning.²⁸

TABLE 4 CHANGE IN EVER USE AND CURRENT USE OF MODERN CONTRACEPTION

This table shows the change in the proportion of married and all women of reproductive age who have ever used or are currently using modern contraception. The data show the percentage point change between two surveys for seven FP2020 countries with a total fertility rate greater than 5 and two Demographic and Health Surveys between 2010 and 2020.

	ALL WOMEN		MARRIED WOMEN	
	Change in Ever Use	Change in Current Use	Change in Ever Use	Change in Current Use
Benin	3.3%	0.4%	9.1%	2.6%
Burundi	15.1%	4.5%	21.7%	6.7%
Guinea	5.4%	3.3%	8.2%	5.3%
Mali	10.6%	6.2%	12.4%	6.9%
Nigeria	3.6%	-1.7%	7.5%	1.5%
Senegal	10.1%	6.2%	14.9%	9.1%
Uganda	10.8%	6.6%	13.7%	8.9%

²⁷ Included are FP2020 countries that have a DHS survey pre- and post-2012 that includes the question on ever use of family planning.

²⁸ See Track20's "Trends in the Uptake of Postpartum Family Planning" (http://www.track20.org/pages/data_analysis/in_depth/PPFP/trends.php) and "Assessing Opportunities in Post Partum Family Planning" (http://www.track20.org/pages/data_analysis/in_depth/PPFP/opportunities.php).

ASSESSING EQUITY

HAS THE PURSUIT OF FP2020'S 120 MILLION ADDITIONAL USERS GOAL LEFT SOME WOMEN BEHIND?

An important question is whether FP2020's "120 million additional users" goal exacerbated inequities and led to a prioritization of populations within countries where substantial gains towards the goal could be made. To answer this question, data and policies were examined for signs of inequity in contraceptive gains in 11 commitment-making countries with two comparable DHS surveys from 2012 to 2019: Bangladesh, Burundi, Ethiopia, Haiti, Malawi, Nepal, Pakistan, Senegal, Sierra Leone, Uganda, and Zimbabwe.

In most of these countries, married women MCP increased over the course of the FP2020 partnership. There were statistically significant increases in MCP among married rural women in seven African countries (Burundi, Ethiopia, Malawi, Senegal, Sierra Leone, Uganda, and Zimbabwe). In six countries, MCP gains were statistically significant both among married women with no education (Burundi, Ethiopia, Malawi, Senegal, Sierra Leone, and Uganda) and in the lowest wealth group (Burundi, Ethiopia, Malawi, Senegal, Uganda, and Zimbabwe). Figure 7 illustrates the change in MCP among wealth groups between surveys and shows both the gains among the lowest wealth groups and a narrowing of inequity in contraceptive use among wealth groups. Statistically significant MCP gains were also seen among all young women aged 15–19 and 20–24 in four African countries (Malawi, Senegal, Sierra Leone, and Uganda). Overall, the results highlight that MCP gains were seen among relatively disadvantaged groups, including rural women, the least educated, the poorest, and the youngest (aged 15–24).

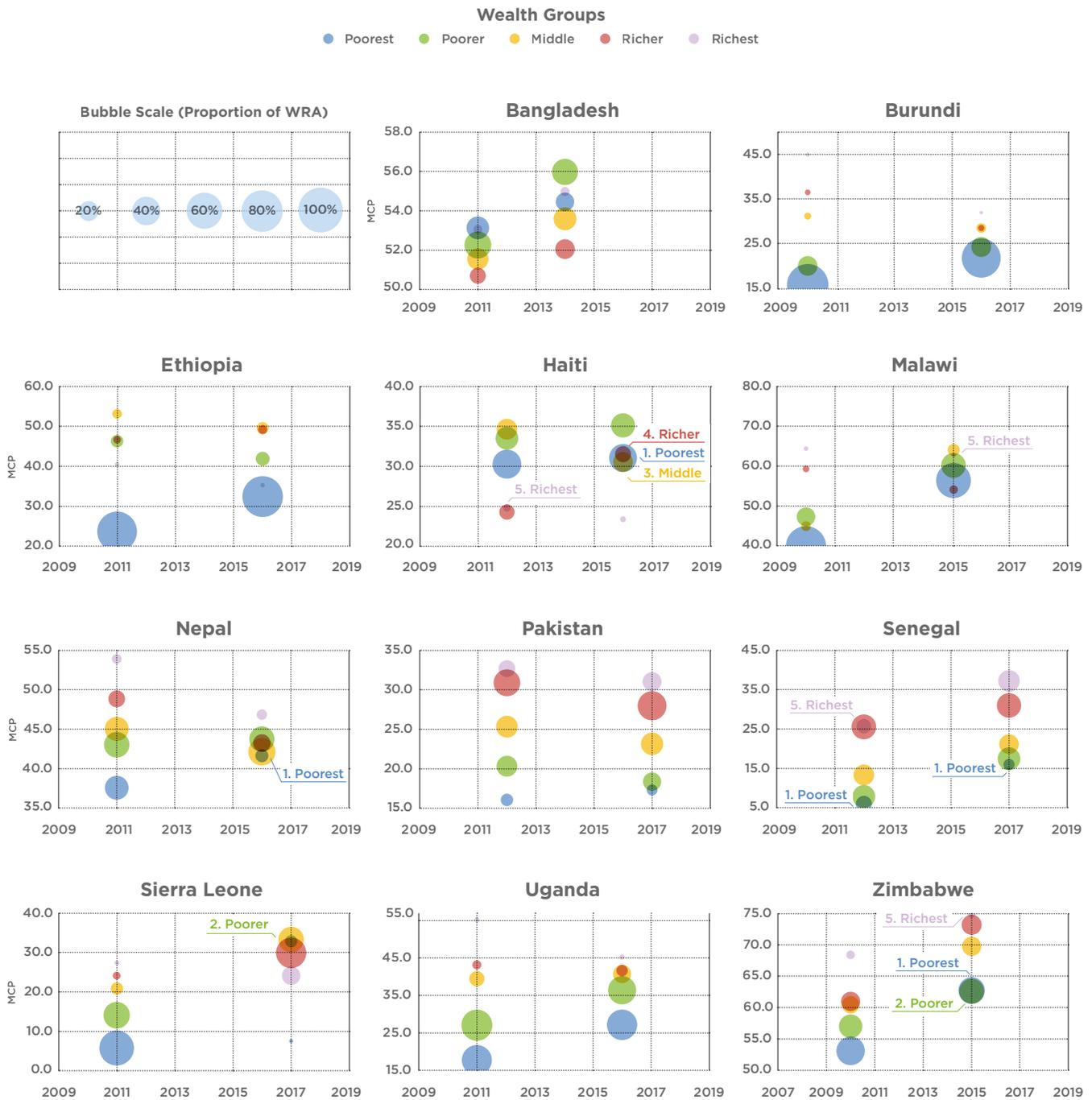
Both Malawi (where MCP gains were significant across multiple equity dimensions) and Bangladesh (where

MCP was maintained despite population growth) had specific policies and programs in place to address inequities in family planning information and services. In Malawi, MCP among all young women aged 15–19 and 20–24 increased significantly between 2011 and 2016. In fact, it is one of the few countries that experienced growth in MCP among this population, and the timing of the growth coincided with the implementation of the revised Youth Friendly Health Services program beginning in 2014. This revised program made reaching young people through education systems and targeted programming a top priority. In Bangladesh, where contraceptive prevalence was already high, the country was able to maintain MCP as the population grew: by 2020 an additional 2.5 million women were using a modern method of contraception as compared to 2012. Bangladesh already had relatively similar levels of MCP across different wealth groups, and further improvements were not seen between its two surveys. Bangladesh did, however, focus its family planning strategy on geographic disparities, providing regional family planning packages in the Sylhet and Chittagong divisions. These regions had the lowest MCP in 2011 and saw statistically significant MCP gains in 2014, with further gains in 2019. Bangladesh was thus able to maintain its base of modern family planning users (even with increasing population growth) and address geographic disparities.

In conclusion, these findings suggest that over the course of the FP2020 partnership, many countries saw MCP gains across different dimensions of equity. Contrary to the early concerns of the family planning community, the impact of the FP2020 partnership on equity appears to be positive or at a minimum neutral, reinforcing the importance of country-specific commitments, policies, and programming that can address country priorities, including reaching underserved populations.

FIGURE 7 MODERN CONTRACEPTIVE PREVALENCE (MCP) BY WEALTH GROUP BETWEEN TWO SURVEYS

This graphic shows the change in MCP (married women) for wealth groups in 11 FP2020 countries with two Demographic and Health Surveys between 2010 and 2020. The color of the bubbles represents different wealth groups and the size indicates the proportion of women of reproductive age (WRA) that each wealth group constitutes.



DOES A FOCUS ON ADOLESCENT CONTRACEPTIVE USE TELL THE WHOLE STORY OF CHANGES IN THE ADOLESCENT BIRTH RATE?

While the adolescent birth rate (ABR) is important for tracking a critical development outcome, it does not on its own help countries understand the different sexual and reproductive health behaviors of young people or their contraceptive needs. Many factors unrelated to family planning services and information, including age at marriage, age at first sex, sexual activity, and girls' education, influence the adolescent birth rate and should also be evaluated closely in each country to better understand adolescent sexual and reproductive health.

Figure 8 shows that, of 21 countries with two DHS surveys between 2010 and 2020, the majority have seen declines in the ABR in their latest survey. In 10 of the 21 countries—Burundi, Guinea, Haiti, India, Indonesia, Malawi, Nigeria, Philippines, Senegal, and Timor-Leste—the declines were significant. Looking more closely at these countries, the change is driven in large part by increasing contraceptive use among married adolescents, as the vast majority of births among adolescents happen within the context of marriage. In Malawi, for example, 23% of women aged 15–19 were married at the time of both the 2010 and 2015–16 DHS, and modern contraceptive use among these women rose from 26% to 37%. Married adolescents in Burundi also saw an increase in MCP of more than 10 percentage points, from 8% to 21%, while in Guinea the MCP grew from 3% to 10%.

Another factor that can affect ABR is contraceptive use among unmarried sexually active adolescents, especially in countries with lower prevalence of early marriage and higher levels of sexual activity before marriage.²⁹ In eight of the 17³⁰ countries with sufficient data on unmarried sexually active adolescents for comparison (Burundi, Ethiopia, Guinea, Malawi, Mali, Uganda, Zambia, and Zimbabwe), MCP among unmarried sexually adolescent women (15–19)

increased between the two surveys. The largest increase was in Guinea, where MCP in this group increased from 22% in 2012 to 51% in 2018. While this change in Guinea is significant, assessing change in contraceptive use among unmarried sexually active adolescents is difficult in many countries due to the small number of adolescent unmarried adolescents who report being sexually active.

Changes in the age at marriage can also have an impact on the ABR in countries where early marriage is common and most of adolescent childbearing happens in the context of marriage. Of the countries with declining ABR, Guinea, India, and Nigeria all saw the share of adolescents who were married decline by at least 5 percentage points between the two surveys. India experienced a historic decline in early marriage. The percentage of women aged 20–24 who reported that they were married before 18 declined by more than 20 percentage points in the decade between the two most recent National Family Health Surveys.

Understanding the lives of young people and their information and service needs is critical for improving sexual and reproductive health. About half of pregnancies among adolescent women aged 15–19 in developing countries remain unintended, and more than half of these end in abortion, most under unsafe conditions.³¹ While gains have been made over the past eight years in reducing ABR, the family planning measurement community continues to work toward more holistic ways of monitoring progress on adolescent sexual and reproductive health needs to better understand the response needed. Understanding the needs of married and unmarried adolescents necessitates examining a range of different indicators at national and sub-national levels. In 2018, FP2020 began aggregating a selection of adolescent and youth indicators on demographics, timing of key life events, sexual activity, and contraceptive use so that partners could better understand the dynamics underlying the ABR, and is continuing to explore ways to make these data more accessible.

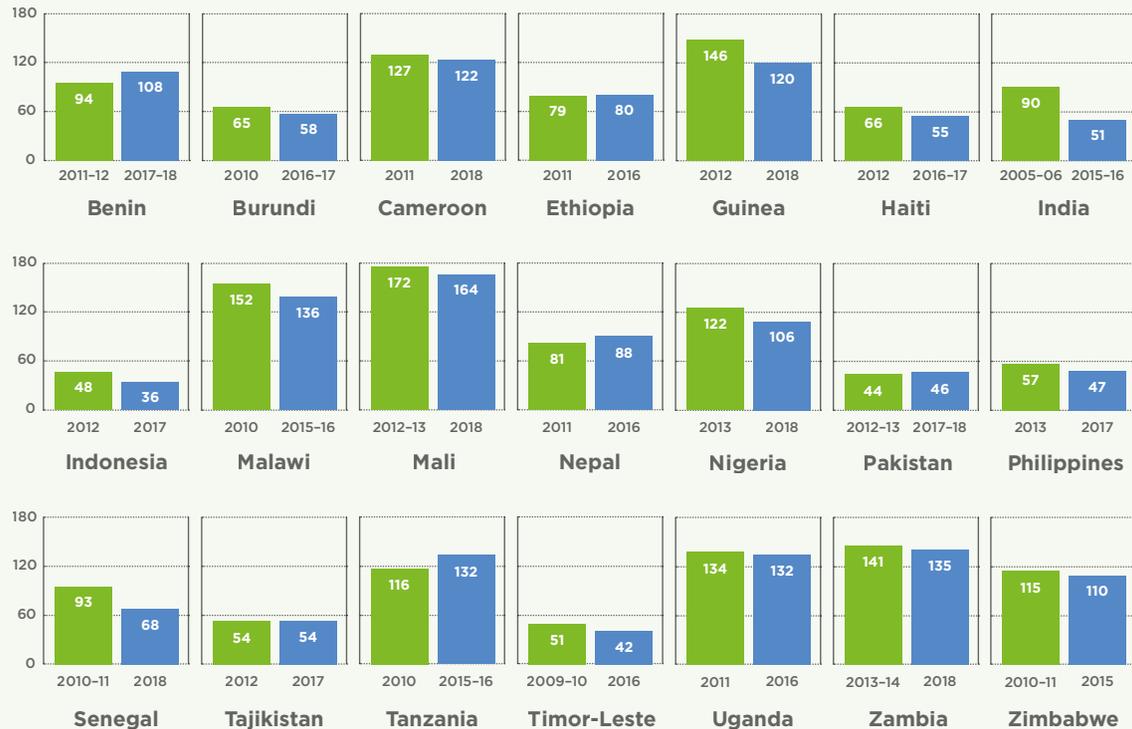
²⁹ Sexually active is defined as those who have engaged in sexual activity in the last 30 days.

³⁰ This excludes Pakistan because the DHS is an ever-married sample. This also excludes Nepal, Tajikistan, and Timor-Leste because the sample sizes for unmarried sexually active adolescents were too small for comparison (N<50).

³¹ Guttmacher Institute, "Adding It Up: Investing in Adolescents' Sexual and Reproductive Health in Low- and Middle-Income Countries Updated," July 2020, <https://www.guttmacher.org/fact-sheet/investing-adolescents-sexual-and-reproductive-health-low-and-middle-income-countries>.

FIGURE 8 CHANGE IN ADOLESCENT BIRTH RATE BETWEEN TWO SURVEYS

This graphic shows the change in Adolescent Birth Rate (Core Indicator 17) for 21 Countries with two Demographic and Health Surveys between 2010 and 2020.



ASSESSING PROGRESS TOWARD EXPANDED CONTRACEPTIVE METHOD CHOICE

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

Since the beginning of the FP2020 initiative, commitment-making countries have made concerted efforts to expand access to a wide range of modern contraceptive methods. Ensuring the availability of a diverse mix of modern methods is essential to providing women, girls, and couples with the ability to choose a contraceptive method that best suits their needs and preferences, increasing both satisfaction with the method and consistent contraceptive use.³² Analysis has shown that when more contraceptive methods are offered, a larger proportion of women choose to use a modern method, contributing to national growth in MCP.

Core Indicator 9, Modern Contraceptive Method Mix, measures the proportion of modern users using each contraceptive method, and is one indicator intended to reflect the extent to which women, girls, and couples are accessing a range of contraceptive

32 John Ross and John Stover, "Use of modern contraception increases when more methods become available: analysis of evidence from 1982-2009," *Global Health: Science and Practice* 1, no. 2 (July 2013): 203-12, <https://doi.org/10.9745/GHSP-D-13-00010>.

methods. Contraceptive method mix, however, is not solely a reflection of the accessibility of methods, but of a broad array of social, economic, and cultural factors that drive millions of individual decisions about contraceptive methods.

Modern contraceptive method mix can be difficult to interpret as a measure of progress as there is no “ideal” or “target” method mix within a rights-based approach to family planning. Method mix can indicate which methods are driving contraceptive use, the extent to which women, girls, and couples are able to access a wide array of methods (based on the number of methods included in the method mix), and shifts in method mix that occur as a result of expanding access to new and underused methods.

In assessing expanded method choice over the course of the FP2020 initiative, one option is to examine changes in modern contraceptive method mix (and method prevalence, the percentage of women of reproductive age currently using each method) across surveys. There are 33 FP2020 countries where surveys (DHS or MICS) were completed prior to or early in the initiative (2009–2013) and a second, matching survey was completed later in the initiative (2015 or later).³³ Data on contraceptive use among all women of reproductive age (as compared to married women alone) was available in 26 of the 33 countries.

Overall, the changes in method mix and method prevalence highlight the continued importance of injectables—often the most common method in use—and the growing role of implants, the fastest growing method. The growth in the use of these two methods generally represents the shift toward longer-acting, more effective methods seen since the launch of the FP2020 initiative.

GROWTH AND DECLINE IN USE OF DIFFERENT METHODS

Across the 33 countries, all but one (Mauritania) saw an increase in implant prevalence between the two surveys. Injectable use and IUD use each increased in 22 countries. In contrast, pills, male condoms, and female sterilization all declined in more countries than they increased (declines in pills: 21 countries; male condoms: 18 countries³⁴; and female sterilization: 17 countries).

Implants and injectables registered the fastest average growth across the 33 countries between the two periods. Implant use increased an average of 0.4 percentage points per year, representing an average total increase in implant prevalence of 2.5 percentage points (based on the average gap of six years between the two surveys). Use of injectables was already far more common and grew more slowly, with an average increase in injectable prevalence of 0.8 percentage points between the periods. The only other method that increased in prevalence between the survey periods was the IUD, which had an average increase in use of 0.3 percentage points between the periods.

The fastest growth in implants was seen in Malawi, Zimbabwe, and Guinea-Bissau, where implant prevalence increased by one percentage point per year, leading to total gains of 9 percentage points in Guinea-Bissau, 8 percentage points in Malawi, and 6 percentage points in Zimbabwe. The fastest growth in injectables was seen in Zambia, Uganda, Malawi, and Mauritania, where prevalence increased by 0.5–0.8 percentage points per year. Notable growth was also seen in pill prevalence in Mauritania (1.2 percentage points per year) and Lao PDR (1 percentage point per year) and in IUD prevalence in Mongolia (0.7 percentage points per year).

MOST COMMON METHOD IN USE

Prior to and early in the initiative, injectables were the most common method in use in around half of the 33 countries (15), followed by pills (in seven countries) and condoms (also in seven countries). Injectables continue to be the most common method in 15 of the 33 countries, although there has been movement within those 15, with two countries shifting from injectables toward longer-acting methods and two countries shifting from shorter-acting methods toward injectables. In Mali and Senegal, where injectables were most common prior to the initiative, implants have become the most common method in use as of 2018. In Togo and Ghana, where previously male condoms and oral contraceptive pills (respectively) were most common, injectables have now become the most common method in use. While pills remain the most common method in six countries (Bangladesh, Iraq, Lao PDR, Mauritania, Philippines, and Zimbabwe), only three countries continue to see the majority of

³³ Bangladesh, Benin, Burundi, Cameroon, DRC, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Indonesia, Iraq, Lao PDR, Liberia, Malawi, Mali, Mauritania, Mongolia, Nepal, Nigeria, Pakistan, Philippines, Rwanda, Senegal, Sierra Leon, Tajikistan, Tanzania, Timor-Leste, Togo, Uganda, Zambia, and Zimbabwe.

³⁴ This analysis suggests a decline in condom use as a primary means of contraception in favor of more effective methods, resulting in fewer unintended pregnancies. This does not necessarily indicate that condom use is declining as a means of prevention of sexually transmitted diseases (STD). Condoms may still be used for dual pregnancy and STD prevention in combination with another method, but only the most effective means of contraception is recorded in surveys. Additional analysis is needed to assess trends in condom use for prevention of STDs.

users relying on male condoms as their primary method of contraception (Cameroon, DR Congo, and Pakistan).

Implants did not appear as the most common method in any of the early surveys of the 33 countries, and represented the second most common method in only one country (Ethiopia). More recently, implants have become the most common method in use in five of the 33 countries (Benin, Guinea-Bissau, Mali, Nigeria, and Senegal), and the second most common method in use in another 13 countries.

Overall, across the 33 countries, only eight saw a change in the most common method in use. In all eight countries, the change represented a shift toward a more effective method (either implants or injectables). Many more saw changes in the second most common method, which also represented a shift toward more effective methods.

Despite the substantial shifts in the modern method mix seen in many countries, there was limited change in the total number of modern methods in use between the two periods. Over the period, while 15 countries saw a change in the number of methods in use (based on methods representing at least 5% of the

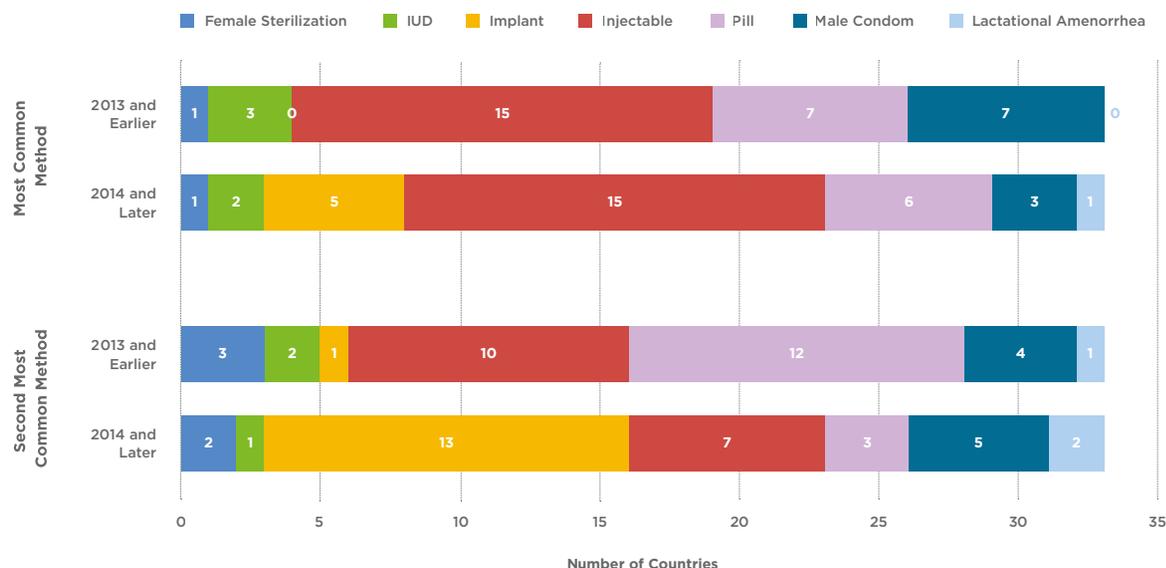
modern method mix), more countries saw no change in the number of methods in use.

IMPROVEMENTS IN COUNSELING AND INFORMATION ON CONTRACEPTIVE METHODS

To ensure that women, girls, and couples can determine the method that best meets their needs, health care providers must provide appropriate information and counseling about the full range of contraceptive options. **Core Indicator 14**, the Method Information Index (MII), measures the extent to which women report receiving specific information on possible side effects and alternative methods when they first started using their current method of contraception. The index is composed of three questions: (1) Were you informed about other methods? (2) Were you informed about side effects of the method? (3) Were you told what to do if you experienced side effects from the method? The reported value for MII is the percentage of women who responded “yes” to all three questions. Research indicates that women who receive more complete counseling about contraception, as measured by the MII, are less likely to discontinue their method.³⁵

FIGURE 9 DISTRIBUTION OF COUNTRIES BY MOST AND SECOND MOST COMMON MODERN METHOD IN USE

This graphic shows the number of countries in which each modern method was the most common one in use, based on surveys conducted before and after 2014.



³⁵ Nirali M. Chakraborty et al., “Association Between the Quality of Contraceptive Counseling and Method Continuation: Findings From a Prospective Cohort Study in Social Franchise Clinics in Pakistan and Uganda,” *Global Health: Science and Practice* 7, no. 1 (March 2019): 87-102, <https://doi.org/10.9745/GHSP-D-18-00407>.

FIGURE 10 CHANGE IN METHOD INFORMATION INDEX BETWEEN TWO SURVEYS

This graphic shows the change in Method Information Index (Core Indicator 14) total scores for 21 countries with two Demographic and Health Surveys between 2010 and 2020.

The Method Information Index measures the extent to which women were given specific information when they received family planning services. It consists of three questions:

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

The total score is the percentage of women who responded yes to all three questions.



Across 21 FP2020 countries³⁶ with two DHS datasets before or around 2012 and after 2015, we measured changes in MII and MII by method. In 15 out of the 21 countries, MII increased between the two surveys. The largest MII increase (32 percentage points) was in

Senegal between 2010 and 2018, and the largest decline was in Haiti between 2012 and 2016-17 (15 percentage points). The average increase in total MII between two surveys was 5 percentage points. For individual questions, the average increase was

³⁶ Benin, Burundi, Cameroon, Ethiopia, Guinea, Haiti, India, Indonesia, Mali, Malawi, Nigeria, Nepal, Pakistan, Philippines, Senegal, Tajikistan, Timor-Leste, Tanzania, Uganda, Zambia, and Zimbabwe. For Pakistan, all data is for married women.

greatest for information related to whether women reported being (1) told of other methods (4.7 percentage points), versus (2) told about side effects (3 percentage points) or (3) told what to do if experiencing side effects (3.2 percentage points).

Figure 10 illustrates the changes in total MII as well as MII by contraceptive method for each of the 21 countries. On average, women using IUD and implants have higher MII in both periods, and on average, MII by method improved between two surveys in the 21 countries. The largest increases were made in MII for women using IUDs (9.9 percentage points), implants (6.9 percentage points), and female sterilization (6.4 percentage points). Modest average increases were seen among injectable and pill users. Generally, countries with the lowest MII in the older survey improved in their more recent survey.

Overall, affirmative answers for the three MII questions and total MII steadily improved over the time span of the FP2020 partnership. This progress highlights that women, girls, and couples generally report receiving more family planning information over time, which likely translates to more informed decisions to use modern contraception. Even with this overall progress, some countries (such as Burundi, Haiti, and Zambia) experienced backsliding on certain components of the MII (on individual questions and/or by methods) and should use this evidence to improve the family planning counseling provided by health care workers.

CHANGES IN THE PROVISION OF FAMILY PLANNING INFORMATION

An important goal of FP2020 has been to support countries in expanding access to and improving the quality of family planning services. **Core Indicator 15**, Family Planning Information, measures if women received information about family planning either from a community health care worker or when they visited a health facility in the last 12 months. The indicator is calculated using DHS and PMA survey data. To ascertain if the communication of family planning information to clients improved during the span of the FP2020 partnership, Core Indicator 15 was analyzed for 20 countries³⁷ with two DHS datasets before or around 2012 and after 2015.

Comparing the average change between surveys across all 20 countries, women's access to family planning information remained stagnant. In both older surveys and more recent surveys, on average only

22% of women received family planning information in their interactions with health facilities or community health workers. In 13 of 20 countries, the percentage of women who visited a health facility or were visited by a health worker and received family planning information increased. In seven countries the proportion of women who reported receiving family planning information was stagnant or declined, including Haiti, Indonesia, Malawi, Pakistan, Philippines, Tanzania, and Zambia.

Overall, this analysis highlights that on average, the percentage of women receiving family planning information in their interaction with health care providers is low. Even in countries reporting the highest proportion of women receiving family planning information, more than 60% are still not receiving FP information during interactions with health facilities and community health workers. And in most countries that proportion is much higher, with three out of four women who visited a health facility or were visited by a community health worker reporting that they did not receive family planning information.

CHANGES IN CONTRACEPTIVE STOCKOUTS AND AVAILABILITY

In response to efforts by RHSC to align on universal stockout indicators, in 2014 the PME Working Group identified two new FP2020 indicators to monitor contraceptive supply availability and stockouts. These included a measure of stockouts (**Core Indicator 10**), defined as the proportion of facilities that are stocked out by method on day of survey or last reporting period for the year,³⁸ and a related measure of contraceptive availability (**Core Indicators 11a and 11b**) that indicates the range of methods in stock at primary care and secondary/tertiary care health facilities.

The decision to include indicators on stock availability expanded the discourse in countries beyond the focus on changes in modern contraceptive use to challenges related to access and disparities in access to supplies. Track20 trainings for Monitoring and Evaluation Officers in FP2020 countries have increasingly included discussion on the sources, quality, and interpretation of stock availability data. Consensus meetings to review annual estimates of Core Indicators now include discussions on a range of issues, including:

³⁷ Benin, Burundi, Cameroon, Ethiopia, Guinea, Haiti, Indonesia, Mali, Malawi, Nigeria, Nepal, Pakistan, Philippines, Senegal, Tajikistan, Timor-Leste, Tanzania, Uganda, Zambia, and Zimbabwe. For Pakistan, all data is for married women.

³⁸ For countries where GHSC_PSM or LMIS data was used as a source, the last reporting period is considered to be October-Dec, to match with the period when UNFPA Service Delivery Point Surveys are collected.

- different signals on stock availability from logistic management information systems (LMIS) versus facility surveys;
- measuring LARC availability against national protocols when trained providers are not available at all facilities; and
- addressing stockouts of methods such as emergency contraception that may be popular with specific subgroups.

FP2020 first began reporting on Core Indicators 10 and 11 in 2015, based on facility surveys conducted by UNFPA Supplies (the Service Delivery Point Surveys). Additional sources for stockout information include other facility surveys, such as the Demographic Health Survey's Service Provision Assessments (SPAs), WHO's Service Availability and Readiness Assessment (SARA), and country logistics systems data or LMIS.

Between 2015 and 2020, a total of 118 facility surveys were conducted across 36 countries. However, these surveys were not implemented in the same countries each year. Only two of these countries have had surveys each year; six countries have had five surveys and ten countries have had four surveys in the past six years. Figure 11 shows the distribution of surveys by region and the number of countries that the surveys covered. Eastern and Southern Africa saw the largest number of surveys implemented (42) during the six-year period and the largest number of countries surveyed. Ten countries were surveyed in Western Africa and five in Central Africa, followed by lower numbers in Asia and Latin American and the Caribbean.

The number of countries using LMIS to report stockouts has increased very slowly over the last six years, starting with one country in 2015 and increasing to five in 2019. Fewer countries held data consensus meetings in 2020, and only three used LMIS data to report on stockouts. When countries use LMIS data to report, they typically report on the last reporting period for the year (October to December), which allows for matching of LMIS data reports with surveys reports, which collect data in the same time period. Most programs continue to focus on monitoring a single commodity in LMIS, often the most common method, as a signal of stockouts, but this is slowly shifting— particularly in East Africa, where stakeholders are working on expanding monitoring of stockouts to more methods. Finally, only three countries have used the SPA or SARA survey for stockout measurement. SPA surveys provide a wealth of facility information but are not regularly implemented in FP2020 countries.

Efforts to understand trends in stockouts and method availability have thus far not revealed consistent patterns over time or across methods. Assessing changes over time in stockout levels and method availability requires more consistent data and reporting, as well as more complete reporting on the methods facilities are meant to offer according to national protocols. Poor data availability and inconsistent monitoring of data are currently constraints on assessing how the FP2020 community is performing on the metric of commodity availability. Comparative analysis is underway in those few countries where LMIS and facility survey data are both available, and over time may help stakeholders better understand stockout data and indicators.

FIGURE 11 NUMBER OF FACILITY SURVEYS

This graphic shows the number of FP2020 countries where facility surveys were conducted and the number of surveys conducted between 2015 and 2020, by region.

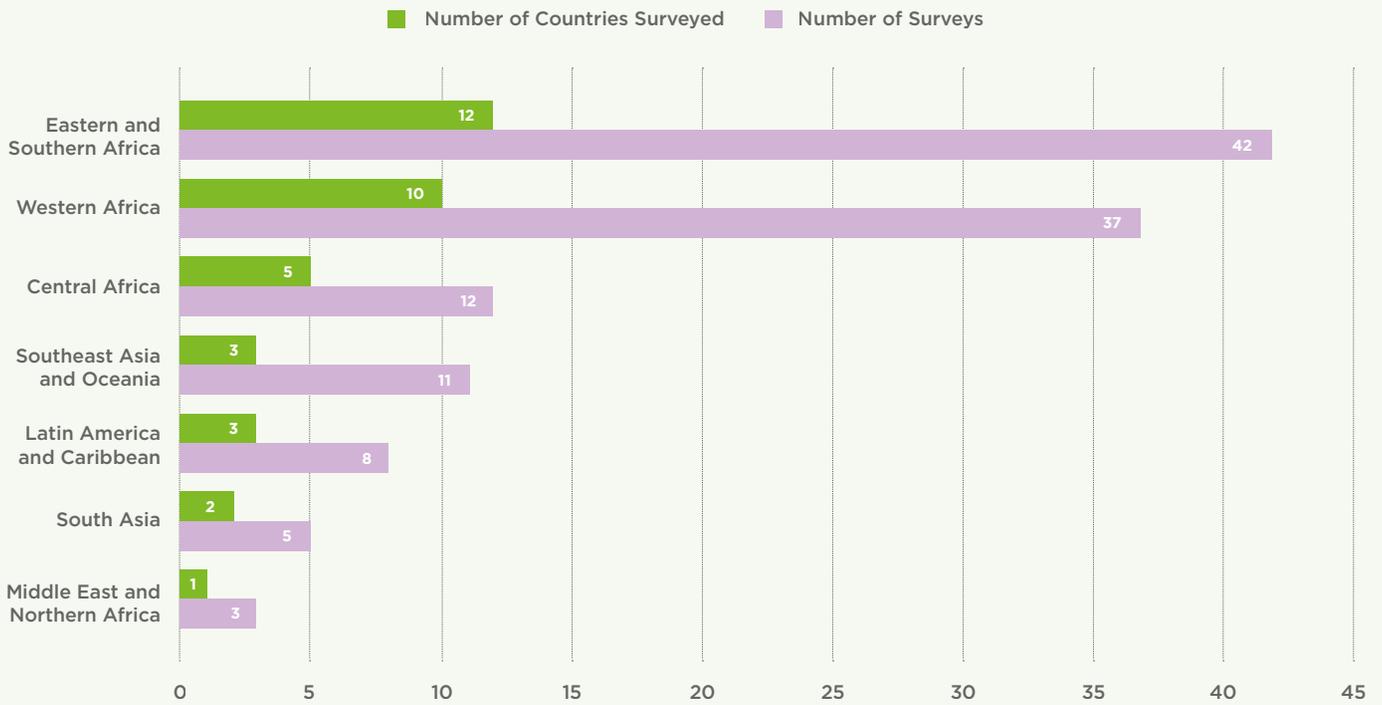


Photo by Yagazie Emezi/Getty Images/Images of Empowerment

ACKNOWLEDGMENTS

FP2020: The Arc of Progress 2019–2020 reflects the support and contributions of numerous organizations and individuals who are the foundation of the FP2020 partnership. Our shared commitment to expanding access to voluntary, rights-based family planning is the engine that has driven these past eight years of progress.

We wish to thank our Core Conveners—the Bill & Melinda Gates Foundation; the UK Foreign, Commonwealth and Development Office (formerly the Department for International Development); the United Nations Population Fund; and the United States Agency for International Development—for their steadfast leadership and support. We also thank our host institution, the United Nations Foundation, for providing a supportive and hospitable home base.

As ever, we are indebted to Emily Sonneveldt and the entire Track20 team for their essential analysis and insight. The expert guidance of the members of the Performance Monitoring & Evidence Working Group is critical to FP2020 measurement efforts, and we thank them for their generous assistance in shaping this report. The Kaiser Family Foundation, Countdown 2030 Europe, the Global Financing Facility, the USAID Global Health Supply Chain Program, and John Stover and Rudolph Chandler of Avenir Health also contributed invaluable data and analysis on family planning financing.

The partners participating in the COVID-19 Family Planning Impact Task Team provided critical insight into the effect of the pandemic on family planning, and we thank them for their illuminating contributions to this report: the International Planned Parenthood Federation, MSI Reproductive Choices, Nivi, Performance Monitoring for Action, the Reproductive Health Supplies Coalition, and Track20.

We also thank Elise Lang at Palladium, Patience Mgoli Mwale of CARE Malawi, and Sono Aibe of the FP2020 Transition Management Team for their contributions, insights, and reflections.

FP2020: The Arc of Progress 2019–2020 was written by Suzanne Scoggins and Jason Bremner, with individual sections authored by Emily Sonneveldt, Jessica Williamson, Kristin Bietsch, Margaret Reeves, Priya Emmart, Rebecca Rosenberg, and Shiza Farid of Track20, John Stover of Avenir Health, and Emma Anderson and Martyn Smith of FP2020. Andrea Goetschius provided project management for the report and Sesi Aliu supervised the data visualization. Yacine Bai, Em Chadband, Amelia Clark, Isha Datta, Guillaume Debar, Onyinye Edeh, Tara Egan, Alison Bodenheimer Gatto, Lorelei Goodyear, Sofia Heffernan, Chonghee Hwang, Cate Lane, Mande Limbu, Krista Newhouse, Laura Raney, Eva Ros, Emma Sampson, Dilly Severin, Emily Sullivan, Hillary J. Varga, Katie Wallner, and Varina Winder provided essential research, analysis, fact-checking, brainstorming, and support. Beth Schlachter and Kirsten Sherk oversaw the creation of the report.

Many thanks to Eighty2degrees—Ambica Prakash for creative direction, Melanie Tingstrom for project management, Amelia von Wolffersdorff for design and data visualization—to PanApps for digital design and development, to Cate Urban for digital site assistance, and to Portland Communications for media support.

FP2020 is a diverse, inclusive, and results-oriented partnership encompassing a range of stakeholders and experts with varying perspectives. As such, the views expressed and language used in the report do not necessarily reflect those of some members of the partnership.



FAMILY PLANNING 2020

www.familyplanning2020.org

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

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

An outcome of the 2012 London Summit on Family Planning, FP2020 is based on the principle that all women, no matter where they live, should have access to lifesaving contraceptives. Achieving the FP2020 goal is a critical milestone to ensuring universal access to sexual and reproductive health services and rights by 2030, as laid out in Sustainable Development Goals 3 and 5. FP2020 is in support of the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health.

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