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www.FAMILYPLANNING2020.ORG
FP2020 is a global partnership that supports the right of women and girls to decide, freely and for themselves, whether, when and how many children they want to have. FP2020 is a global partnership that supports the right of women and girls to decide, freely and for themselves, whether, when and how many children they want to have. FP2020 carries forward the momentum of the 2012 London Summit on Family Planning and promises to make lifesaving contraceptives accessible to an additional 120 million women and girls in the world’s 69 poorest countries1 by 2020. To achieve this ambitious goal, the initiative partners with governments, donors, foundations, civil society organizations, the private sector and the research and development community to address the policy, financial, service delivery and sociocultural barriers to women accessing family planning information, services and supplies.

FP2020 is in support of and contributes to the UN Secretary General’s Global Strategy for Women’s and Children’s Health, Every Woman Every Child. In addition to promoting progress towards the Millennium Development Goals (MDG4 and MDG5), family planning can dramatically change how women can seek education, empowerment and economic activity. In the past two years, family planning has gone from being a neglected intervention to receiving the highest number of commitments of any category in the Global Strategy.2 FP2020—and the momentum catalyzed by the 2012 London Summit on Family Planning—has been a major driver of these recent gains.

FP2020 spurs action on these commitments by engaging with the family planning community to ensure that donors come through

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1 These countries—69 in total—are defined as those with a Gross National Income (GNI) of $2,500 per year or less (based on World Bank 2010 classification using the Atlas method). For the full list of these countries, please see Annex 1.

with funding, countries come through with their policy, financial and programmatic commitments and all commitment makers are accountable for high-impact, rights-based outcomes.

FP2020 is not a new NGO, nor is it a vertical fund or a complex bureaucracy. It is a new and different way of working together towards a common and shared goal. It is a network of cooperation that revolves around a hub to promote knowledge sharing and emergent thinking. The initiative encourages partners to align their agendas, pool their talents and utilize existing structures in innovative and complementary ways (see page 11 for specific examples).

FP2020 is pleased to submit this report to the Independent Expert Review Group (iERG). The report is structured around the iERG’s astute recommendations in 2013 and the information presented supplements the achievements outlined in FP2020’s first progress report, Partnership in Action,3 published and submitted in November 2013. This report also details developments which occurred from November 2013 to April 2014. Additional progress on FP2020 commitments will be reported on by the Partnership for Maternal, Newborn & Child Health (PMNCH) as part of its tracking of Every Woman Every Child financial commitments and submitted in its 2014 report to the iERG.

To build synergies and avoid duplication of efforts, FP2020 and PMNCH collaborated on gathering data to report on the progress of commitments made by a subset of 21 commitment makers, 10 of which FP2020 has funded the research for and had direct input on questionnaires.4 As agreed previously with PMNCH, FP2020’s progress report is strategically released after theirs and is expected to be launched in November 2014. This year, FP2020 expects to report on progress against the 2013 baseline and will release estimates on the number of additional new users of contraception.

This report shows how the FP2020 partnership engages in cross-institutional collaboration5 and works together to promote transformative change in the family planning sphere by providing tailored support to countries to develop, implement and monitor national family planning strategies, creating the space for innovation and collaboration, and improving the quality and availability of data for use at the community, national and global levels. The progress documented in this report demonstrates that the collaboration is moving forward toward a future where all women and girls, no matter what their circumstances, will have the information, services and supplies they need to make decisions about their own bodies, their families and their futures.

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3 See Annex 2 for the FP2020, Partnership in Action, progress report.

4 FP2020 provided direct input on questionnaires to Ghana, Nigeria, Pakistan, Senegal, Zambia, Tanzania, Niger, Indonesia, the World Bank and Merck.

5 See Annex 3 for more information on FP2020’s cross-institutional collaboration efforts.
In November 2013, five countries made new commitments to FP2020, bringing the total number of country pledges up to 29.

At the 2012 London Summit on Family Planning, leaders from 150 countries, multilateral agencies, civil society organizations, foundations, the research and development community, and the private sector endorsed the goal of expanding access to contraceptive information, services, and supplies to an additional 120 million women and girls in the world’s poorest countries by 2020. 24 countries made commitments and donors pledged $2.6 billion in funding. FP2020 is an outcome of this global momentum and works with its partners to help commitment-makers fulfill their commitments and uphold their promise to millions of women and girls.

FP2020 is led by an 18-member Reference Group, operated daily by a Task Team, and hosted by the United Nations Foundation. FP2020 consists of four core Working Groups which provide technical guidance in the areas of Country Engagement, Rights & Empowerment, Market Dynamics, and Performance Monitoring & Accountability. Each Working Group has an affiliated Consultative Network of stakeholders who are engaged periodically on Working Group activities. FP2020 intends to streamline the Consultative Networks, which currently number over 1,000 individuals, into a broad-based stakeholder group.

The intent behind FP2020’s governance model was to create a structure that is at once broadly inclusive of the many stakeholders crucial to the family planning movement – while still being sufficiently nimble to fulfill its charge of accelerating progress in a short timeframe.

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6 South Africa made a commitment in London, however its GNI does not qualify the country as one of the world’s poorest, based on the World Bank 2010 classification using the Atlas method.

7 Decision made at FP2020 Reference Group meeting, April 2014.
FP2020 was established with a set of principles that underpin the efforts of the partnership.\(^8\) The consistent thread that runs through all FP2020 activities is that the rights and perspectives of women and girls are observed and their agency is respected. FP2020 recognizes the importance of integrating family planning within the overall continuum of care for women and children (including HIV-related services), as well as equity in policies, program design, and implementation, so that the poorest and most vulnerable women and girls have ready access to a broad range of affordable, high-quality contraceptives.

FP2020 operates on the understanding that strong partnerships and high-impact interventions spring from the participatory convening of key stakeholders. FP2020 strives for results, transparency and accountability to ensure countries and the global community have the information needed to track progress and inform programming and planning.

Key achievements are as follows:

In November 2013, five countries made new commitments to FP2020, bringing the total number of country pledges up to 29. The governments of Benin, the Democratic Republic of Congo, Guinea, Mauritania and Myanmar announced major new national family planning commitments. With the addition of these five countries, FP2020 commitments now represent 40% of the world’s 69 poorest countries, which in turn represents 80% of the total women of reproductive age who have an unmet need for contraception.

The 75 commitments made by seven constituency groups across three functional areas (financial, program and policy/political) have been standardized, analyzed and documented on FP2020’s website. Core indicators on each of the 69 poorest countries are also being tracked and made available on the FP2020 website. This information and analysis will form the baseline to promote monitoring and accountability.

A rigorous measurement and evaluation agenda has been established as a means of guiding progress in delivering on the promise set forth in London. Over the past year, FP2020 established the systems and infrastructure necessary to monitor the impact of family planning programs and to strengthen accountability for implementing financial, policy, and programming commitments. This undertaking included the selection of 10 core indicators,\(^9\) collating corresponding baseline data, improving the way in which family planning expenditures are tracked, and launching electronic data collection in select countries. In November 2014, FP2020 will release new estimates on the number of additional new users of contraception.

FP2020 continues to accelerate action on existing commitments and worked closely with Bloomberg Philanthropies to realize its commitment through country investments and the establishment of a Rapid Response Mechanism to fill urgent gaps and unforeseen time-bound opportunities to accelerate progress towards FP2020’s goal. The Rapid Response Mechanism was announced in March 2014 and will be administered by FP2020.\(^{10}\)

\(^8\) http://www.familyplanning2020.org/images/content/old_site_files/London-Summit-Family-PlanningOverview_V1-14June.pdf

\(^9\) See Annex 2 for a listing of FP2020 core indicators.

Analysis by PMNCH in its report to the iERG shows that disbursements of family planning funds have increased substantially over the past year and that commitment-makers have made significant progress in implementing their commitments. The Kaiser Family Foundation also reports an increase in overall donor disbursements on family planning, a prime indication that donors are delivering on their funding promises.

The FP2020 Working Groups are operational and members are ramping up efforts to implement the activities outlined in their work plans11 whether it be through consultations with governments to identify and fill resource gaps, outreach to experts working to refine and standardize measurement methodologies, packaging and disseminating high-impact practices (including for rights-based programming) or working with private sector manufacturers to improve global market forecasts.

FP2020 has played a strong convening role, reaching out to all stakeholders and including them in the conversation around family planning. In February of 2014, the Task Team conducted a Global Stakeholder Meeting that drew 700 RSVPs worldwide, with simultaneous in-person events in Jakarta, London, New York, Seattle and Washington, D.C. FP2020 received nearly 200 questions from stakeholders via the website, email and Twitter. In response, FP2020 initiated a “Global Stakeholder Q&A” series through which the Task Team and Working Groups collectively continue to respond to these important questions via thematic emails and website posts.12 The FP2020 partnership has made significant progress in uniting the family planning community: more than 25,000 individuals and organizations have expressed interest in joining the initiative and the constellation of stakeholders who are vested in improving women’s and girls’ lives continues to grow.

Over the past year, FP2020 established the systems and infrastructure necessary to monitor the impact of family planning programs and to strengthen accountability for implementing financial, policy, and programming commitments.

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11 See Annex 4 for complete work plans for all the FP2020 Working Groups, endorsed by the Reference Group in April 2014.
Myanmar committed to implementing a monitoring system to strengthen quality of care and ensure women have a full range of contraceptive options. The country is hosting a Best Practices Conference in Naypyitaw in June 2014 to meet maternal and child health goals, including accelerating progress in family planning.

India held a national conference focused on the importance of family planning, specifically postpartum issues.

In Nigeria, the critical role of family planning in achieving the MDGs and other development goals was emphasized at a national conference. To extend its reach into communities that previously lacked access, the Planned Parenthood Federation of Nigeria pioneered a cluster model that increases geographic coverage of service provision.

Senegal’s goal is to increase the number of women using modern contraceptives from 12 to 27 percent between 2012 and 2015. To reach this goal, the country pledged to increase its commodity budget by 200 percent and to double the overall budget for its family planning program. Senegal has stepped up to improve its contraceptive supply chain and eliminate stock-outs.

Zambia launched its Costed Eight-Year Integrated Family Planning Scale-up Plan. The country’s goal is to reduce unmet contraceptive need from 22 to 19 percent and increase the contraceptive prevalence rate from 33 to 58 percent.
In keeping with its FP2020 commitment, Bloomberg Philanthropies announced the launch of a multi-faceted $50 million reproductive health program to prevent maternal deaths and help more women freely and safely make decisions about when to have children.

The full allocation of this commitment includes:
• Advocacy grants to PPFA Global to strengthen reproductive health rights for women in Burkina Faso, Nicaragua, Senegal and Uganda.
• A Rapid Response Mechanism to fill urgent gaps and unforeseen time-bound opportunities to accelerate progress towards FP2020’s goal (more information on page 13)
• Support and complement existing interventions to integrate family planning services in comprehensive emergency obstetric care and post-abortion care in 20 existing and newly-renovated health centers in Tanzania, where a woman dies from complications of pregnancy or childbirth almost every hour.

To ensure the commitments made at the 2012 London Summit on Family Planning are met, the UK Department for International Development (DFID) is developing a program to strengthen monitoring and accountability for FP2020 at two levels, with global and country level components. This will inform wider accountability processes of the UN Secretary General’s Global Strategy for Women’s and Children’s Health and the iERG. The UN Foundation will host the global component (managed by the FP2020 Task Team).

DFID intends to appoint a civil society-led consortium to deliver the country component. The consortium will support national and local accountability mechanisms to accelerate the full implementation of countries’ commitments. Civil society coalitions will independently monitor governments’ progress and ensure that programming respects and promotes the human rights of all women and girls. Furthermore, they will build capacity for stakeholders and others to unite in advocating for meeting the goals of the London Summit. As of April 2014, DFID had not yet released its tender, though it is expected to do so soon.
Accurate, timely, accessible information is the lifeblood of this initiative. That’s why FP2020 is committed to expanding participation in the practices of measurement, evaluation, and adjustment, which for many countries are in their infancy.

DR. CHRIS ELIAS
FP2020 Co-Chair
President, Global Development
Bill & Melinda Gates Foundation

DR. BABATUNDE OSOTIMEHIN
FP2020 Co-Chair
Executive Director
United Nations Population Fund
To ensure countries continue to drive progress, FP2020 promotes, facilitates and supports new country commitments and the development of costed national plans that accelerate voluntary access to family planning.

FP2020 works through its Country Engagement Working Group (CE WG) to help governments develop, implement and monitor the progress of their transformational family planning plans.

In order to support a responsive country engagement strategy, the CE WG is vested in developing a process that is grounded in country-level perspectives and needs. The process is comprised of three components: monitoring country progress, identifying and filling technical assistance and funding needs, and disseminating best practices/innovations. FP2020 is driven at the country level by donor and government focal points. UNFPA Country Representatives, USAID Health Officers and DFID staff serve as donor focal points. Government focal points are designated by ministries of health. All focal points play a key role in supporting governments and facilitating communication with the FP2020 CE WG.

The CE WG identifies existing resources and mobilizes technical assistance and funding to support countries’ family planning strategies by:

- Mapping family planning funding resources at country, regional and global levels using the newly developed Brokering Resources: Process Algorithm
- Reviewing country plans against baseline criteria and analyzing resource gaps
- Facilitating access to assistance for developing, strengthening, reviewing or costing plans as well as for implementing them
- Developing a methodology protocol to support brokering assistance

13 See Annex 5 for the Brokering Resources: Process Algorithm
The CE WG monitors countries’ family planning progress by completing landscape questionnaires based on countries’ own plans and data from partners, by working with focal points to track implementation of family planning plans, and developing implementation reports for countries without country plans.

FP2020 has made important strides in consulting with technical experts and strengthening mechanisms to determine whether country plans contain supply, demand and quality best practices. FP2020 has begun defining what “supply, demand, and quality practices in family planning plans” means in concrete terms in order to create a diagnostic tool for use by countries in identifying and incorporating these elements in plans.

Out of the 28 FP2020 commitment countries, progress is already underway in most to accelerate implementation of the plans: 15 countries have family planning plans, 13 plans incorporate some elements of costing and eight countries have already begun identifying funding gaps within the plans.

In January 2014, the DRC followed through on its commitment to FP2020 by instituting its first family planning Costed Implementation Plan (CIP), the 2014-2020 National Strategic Plan for Family Planning. This CIP aims to increase modern contraceptive use across the country from 6.5% to at least 19% by 2020 and to ensure access to modern contraceptive methods to at least 2.1 million women by 2020 (up from 700,000). Other goals include reforming laws that pose barriers to responsible family planning and protecting adolescent girls from early marriage.

The DRC’s government, for the first time, has made an initial allocation of US$1 million in its national budget for the purchase of contraceptives.
FP2020 is developing a Country Resource Kit14 — consisting of evidence-based, technically reviewed high-impact practices — to be disseminated to countries and posted on the FP2020 website for stakeholder use. The CE WG is currently consulting with ministries and technical experts on its content. Once finished, this consensus-based tool will be shared with governments, donors and consultants, contributing to a universal standard for CIPs.

In addition, FP2020 is collaborating with technical experts and countries to identify needs and funding gaps. In Zambia, FP2020 is supporting development partners and the government to identify and quantify funding gaps in Zambia’s country plan, which has already been developed and budgeted. FP2020 has also held consultations with the governments of India, Indonesia, Nigeria, Ethiopia and Senegal to identify priority needs for funding.

FP2020 will continue to support the iERG’s recommendation to promote accountability at the country level by using the same methodologies and consultation process for other focus countries. FP2020 will share results of this process with countries, donors and other stakeholders. Donor focal points within each country will receive these gap analyses in order to promote progress towards realizing the ambitious goals of the country plans with governments and other donors.

14 See Annex 6 for a complete list of the Country Engagement tools in development

Progress at the country level will be further bolstered by FP2020’s Rapid Response Mechanism (RRM). The RRM supports rapid response grants and technical consultancies that fill urgent gaps and unforeseen time-bound opportunities to accelerate progress toward FP2020’s goal of expanding access to family planning.

The RRM is anchored in principles of voluntarism, informed choice, participation, protection against coercion and accountability, and it focuses on action-oriented projects intended to widen method mix. FP2020’s core partners have the resources to implement major, game-changing initiatives, though they have longer planning cycles. The RRM will complement these investments by providing fast and flexible resources to act on unanticipated opportunities or critical emergencies that have high-impact potential for the short-term. Grant requests may cover supply, demand, advocacy and enabling environment related activities at the regional, national, state and district levels.

FP2020 will deploy funds quickly to be expended within one year. Grants will range from US$25,000 to $250,000.
The Performance Monitoring & Accountability Working Group (PMA WG) provides technical advice and guidance in (a) measuring and monitoring progress toward the FP2020 goal, and (b) utilizing evidence to inform decision-making.

The PMA WG collaborates with other FP2020 Working Groups, especially the Rights & Empowerment Working Group (RE WG) to ensure the measurement and evaluation agenda captures data on RE principles. In 2013, the PMA WG identified and recommended a set of 10 core indicators that will be monitored and reported on an annual basis for the 69 focus countries. It also reviewed methodologies and estimates for baseline data for the 10 core indicators published in FP2020’s 2012-2013 progress report. An additional five indicators will be reported on for a subset of countries.

FP2020 submitted the initiative’s first annual progress report to the iERG in November 2013 which was informed in part by PMNCH commitment-tracking data. In an effort to map the existing family planning accountability and reporting architecture, FP2020 is conducting a thorough audit of global family planning accountability, which will be shared when completed and vetted by the FP2020 Reference Group. This analysis is identifying gaps, opportunities for coordination and includes next steps for strengthening accountability. To reduce reporting burdens on commitment-makers, as mentioned earlier, FP2020 is working with PMNCH to integrate FP2020-specific questions where relevant into the PMNCH annual survey being administered to a subset of commitment-makers.

The PMA WG has also provided technical advice in the creation of a set of questions for the 2014 round of the 80-country Family Planning Effort Score (FPE) questionnaire. Data from these questions will form the basis of FP2020’s National Composite Index on Family Planning, which will combine information on the implementation and functionality of programs, policies and systems, including: components of country family planning plans, use of data for programmatic decision-making, quality of care, equity and discrimination, and accountability and participation. Using the existing FPE questionnaire as a source of data will allow FP2020 to access important and timely information without duplicating efforts.

Implementing the Track20 Project supports national efforts to collect, analyze and use data to track progress in family planning and to develop effective program strategies and plans.

The project, currently underway in most FP2020 commitment countries, works with governments to transform practices that rely heavily on large, national household surveys every few years to a system in which data collected by governments are used to produce annual estimates for key indicators, including modern contraceptive prevalence, commodity security, choice, quality and family planning expenditures. This approach will make greater use of service statistics and other data collected through the public and private sectors, taking into account their limitations, and will work with governments to install an annual process that reviews the data and issues official estimates.
In Ghana, recent survey results demonstrate that progress is being made on select family planning indicators such as the modern contraceptive prevalence rate (mCPR) and demand satisfied by modern method. However, the results also imply inequity in meeting contraceptive needs. The data derived through disaggregation is an important contribution to FP2020’s effort to monitor progress towards important measures of rights and empowerment for national, regional and community action.

Key Findings

• Modern Contraceptive Prevalence Rate (married women, age 15-49) increased from 16.6% in 2008 to 18.4% in 2013
• Demand satisfied is highest for the wealthiest females and lowest for the poorest females
• For women from the poorest households, 43.5% reported their last pregnancy was unintended (mistimed or unwanted), as compared to 20.5% of women from the wealthiest households
• Unmarried and rural women are more likely to pay for family planning than those women in higher wealth quintiles or urban areas
• Women in lowest quintiles are the least likely to make family planning decisions on their own (for 10.2% of women, the final decision on the method received was made by the partner alone/provider alone/other)

15 http://www.pma2020.org/
Adolescents, particularly young girls, are a critical group in FP2020. 16 out of 28 commitment-making countries have made specific commitments to expanding outreach or services for youth. FP2020 has adapted an indicator specifically related to adolescents – the adolescent fertility rate – within the performance monitoring and accountability framework. When possible, in years with a DHS, FP2020 core indicators will be disaggregated by age to provide a clearer picture of the contraceptive needs of young people.

In recognition of the importance of bringing young people’s voices to the forefront, in April 2014, the FP2020 Reference Group endorsed a champions framework. The framework details plans to identify youth champions for family planning who will help ensure that young people’s voices are heard and represented throughout FP2020 platforms.

In line with its commitment to FP2020, Sierra Leone has formed strong partnerships with organizations that work with young people, like Marie Stopes International (MSI). MSI’s youth-orientated behavior-change communications have led to an upsurge in the number of young women choosing to access contraception. A quarter of MSI’s clients in Sierra Leone in 2012 were young people, many of them first-time users.

In Malawi, the goal is “no parenthood before adulthood.” In embracing its FP2020 commitment, the country seeks to raise the contraceptive prevalence rate to 60% by 2020, focusing on women and girls aged 15 to 24. Malawi will create a family planning budget line in the main drug budget by 2013/2014 and will raise the age of marriage to 18. In addition, it plans to develop a comprehensive sexual and reproductive health program to meet the needs of its young people and will work to strengthen effective policy leadership for family planning.
Quality care is the route to equity and dignity for women and girls. FP2020 prioritizes quality in its human rights-based approach to women’s and girls’ health to a) support the development of products and implementation of best and high-impact practices that put quality at the center of family planning programming and b) track progress against indicators that best measure quality to ensure accountability.17

While all FP2020 entities are critical to this effort, the Rights & Empowerment Working Group (RE WG) was established to specifically address these issues. The RE WG provides technical advice and support to all FP2020 Working Groups and ensures that all activities are grounded in rights-based approaches to family planning.

MEASURING QUALITY AND HUMAN RIGHTS

The RE WG is producing a set of foundational materials to determine a unified understanding of rights-based programming to underpin the work of all FP2020 Working Groups. These materials will be informed by emerging and existing resources and tools on how to ensure that human rights are at the center of family planning service provision, including the World Health Organization’s (WHO) guidance, the United Nations Population Fund’s (UNFPA) operational guide on human rights in contraceptive services (forthcoming), as well as the conceptual framework and corresponding user’s guide on voluntary family planning programs that respect, protect and fulfill human rights produced by Futures Group and EngenderHealth.19

These products will include a Statement of Universal Principles, a resource document that links to several fully developed frameworks from across sectors (including those that prioritize quality of care), and a messaging memo that conveys FP2020’s position on rights and empowerment to stakeholders. These are currently under development and will undergo a consultation phase in the coming months.

FP2020 is also exploring its position on responding to human rights violations. In this regard, the RE WG will soon begin holding consultations with grassroots women’s groups in South Asia and potentially Africa to seek input on a strategy for how, if and when FP2020, as a global collaboration, will respond to human rights violations, should they occur. This consultation builds upon FP2020’s collaborative spirit, engages country stakeholders and ensures that any forthcoming strategy is being developed from the ground up.

One of the most successful collaborations to date was with the PMA WG to ensure that the FP2020 measurement agenda reflects principles of rights and empowerment, including quality of care (for example, quality and human rights-based approaches are reflected in the FP2020 core indicators and the National Composite Index on Family Planning).

In April 2014, Track20 held an orientation for monitoring and evaluation (M&E) officers from a number of commitment-making countries to help orient them on tracking the FP2020 core indicators. This training included RE WG-led sessions to get feedback on rights and empowerment-related indicators that could bolster the FP2020 measurement agenda. The RE WG is also considering the development of a training module on the intersection of rights and empowerment principles and measurement that could be used during Track20’s country consultations.

Additionally, the RE WG developed a set of recommendations in response

16 See Annex 6: Key Resources Under Development by the FP2020 Country Engagement Working Group
17 http://progress.familyplanning2020.org/measuring-progress
to the call for the identification of new indicators that better measure concepts of informed choice, autonomy and the extent to which family planning programs are implemented in accordance with human rights principles. These were submitted for review and feedback during the PMA WG in-person meeting in Brussels from May 7-8, 2014. The PMA WG agreed to move forward with the recommendations outlined by the RE WG. These recommendations are to:

• further disaggregate core indicators as a way to track non-discrimination among other rights principles;
• elevate components derived from the National Composite Index on Family Planning related to equity, accountability and participation to promote better understanding of the implications of implementing (or not) these aspects of the national strategic plan;
• work in partnership with the RE WG to develop RE-related indicators by conducting an indicator review including those recommended by the WHO framework entitled *Ensuring human rights in the provision of contraceptive information and services – Guidance and recommendations*;
• explore additional ways of measuring rights and empowerment as part of the PMA WG learning agenda.

### QUALITY SUPPLIES

The Market Dynamics Working Group (MD WG) plays a key role in quality care by improving global markets to ensure a sustainable supply and equitable access to a broad range of high-quality, affordable contraceptive methods in FP2020’s focus countries. Contraceptive implants last longer than injections making them an important option for women who have the greatest difficulty accessing health services or supplies. On January 1, 2013, it was announced that Bayer HealthCare AG would cut the price of its contraceptive implant Jadelle from US$18 to $8.50 per unit. Through the new Jadelle Access Initiative, the product is available at this price in more than 50 countries, including those deemed least likely by the UN Secretary General to meet the targets of MDG 4 and MDG 5 by 2015. The initiative is expected to reach approximately 27 million women.

In May 2013, Merck/MSD announced it would reduce by half the price of its contraceptive implants IMPLANON® and IMPLANON NXT® in 69 focus countries identified at the London Summit on Family Planning. Both agreements were developed and supported through partnerships among Bayer HealthCare AG and Merck/MSD; the Bill & Melinda Gates Foundation; the Clinton Health Access Initiative (CHAI); the governments of Norway, the United Kingdom, the United States and Sweden; the Children’s Investment Fund Foundation; and UNFPA.

### GLOBAL MARKETS VISIBILITY PROJECT

In cooperation with FP2020’s Market Dynamics Working Group, the Reproductive Health Supplies Coalition (RHSC) and Clinton Health Access Initiative (CHAI) have launched a global markets visibility project, which will help FP2020 meet its goals and ensure long-term availability of critical family planning supplies. The project will address information gaps in the reproductive health commodities market by consolidating and analyzing consumption and shipment data. It will highlight gaps between supply and demand and monitor and report current market trends by product.

CHAI will collect and manage supplier shipment data at the global level, inviting suppliers to submit shipment data bi-annually for consolidation and aggregation. A standardized data template will provide consistency and ease of recording. Supplier data will be kept confidential.

Key metrics include shipments by country/region (Africa, Asia Pacific, Latin America, etc.), shipments by organization (UNFPA, USAID) and shipments by product (implants, injectables, oral contraceptives, etc.)

The RHSC and CHAI will publish reports on the family planning market so that partners, countries and suppliers can monitor and evaluate needs.

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20 FP2020 is committed to ensuring that all women have access to the full family planning method mix, which includes the three overlooked life-saving reproductive health commodities identified and endorsed by the UN Commission on Life-Saving Commodities.
FP2020 strongly upholds a participatory, country-driven process to deliver on commitments. To this end, the initiative also recognizes that commitments are made at a singular moment in time. Real progress is only achieved when a commitment moves from a public statement to a concrete implementation plan to the execution of these plans.

FP2020 will continue to work closely with governments and focal points to identify and match country needs to resources, coordinate with existing mechanisms, disseminate high-impact practices and innovations, strengthen the capture of data, track and report on indicators to ensure information is as accurate, accessible and as timely as possible. FP2020 remains confident that the family planning needs of 120 million more women and girls will be met by 2020 and the initiative looks forward to continuing to support and contribute to Every Woman Every Child. Together, we are accountable to the millions of women and girls who depend on the success of this collaboration.

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

Led by an 18-member Reference Group, guided technically by Working Groups, operated daily by a Task Team, and hosted by the United Nations Foundation, FP2020 is based on the principle that all women, no matter where they live, should have access to lifesaving contraceptives. FP2020 is in support of the UN Secretary-General’s global effort for women and children’s health, Every Woman Every Child.
Annex 1
FP2020 Focus Countries

Annex 2
FP2020 Core Indicators

Annex 3
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List of the 69 poorest countries in the developing world by region and subregion (with 2010 gross national per-capita annual income less than or equal to US$2,500)

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<thead>
<tr>
<th>EASTERN AFRICA</th>
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<td>Congo (Brazzaville)</td>
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<td>Democratic Republic of Congo</td>
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<td>Sao Tome and Principe</td>
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ANNEX 2
FP2020 CORE INDICATORS
### Indicators that Will Be Reported Annually for All 69 FP2020 Countries

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Definition</th>
<th>Data Source &amp; Availability</th>
<th>Conceptual Framework Category</th>
<th>Disaggregation</th>
<th>Links to Other Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>01</strong> Contraceptive Prevalence Rate, Modern Methods (CPR)</td>
<td>The proportion of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.</td>
<td>Surveys such as the Demographic and Health Surveys (DHS), the CDC-assisted Reproductive Health Surveys (RHS), MICS and other nationally sponsored surveys, Service statistics.</td>
<td>Outcome</td>
<td>When possible (in years with a DHS) by: wealth quintile, age, marital status, urban/rural, ethnicity, region, etc.</td>
<td>Contraceptive prevalence rate (any method) is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health. Included in WHO indicators on health and rights list.</td>
</tr>
<tr>
<td><strong>02</strong> Total Number of Contraceptive Users by Method</td>
<td>The number of women (or their partners) of reproductive age currently using a contraceptive method.</td>
<td>Modeled using various data sources, including DHS and service statistics.</td>
<td>Output</td>
<td>Type of method, source</td>
<td></td>
</tr>
<tr>
<td><strong>03</strong> Percent of Women whose Demand for Modern Contraception is Satisfied (MET NEED FOR CONTRACEPTION)</td>
<td>The percent of women (or their partners) who desire either to have no more children or to postpone having the next child, who are currently using a modern contraceptive method.</td>
<td>Surveys such as DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics.</td>
<td>Outcome</td>
<td>When possible (in years with a DHS) by: wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.</td>
<td>The proportion of demand for family planning that is satisfied (any method) is a tracking indicator for the Global Strategy for Women’s and Children’s Health.</td>
</tr>
<tr>
<td><strong>04</strong> Percentage of Women with an Unmet Need for Contraception</td>
<td>The percentage of fecund women of reproductive age who want no children or to postpone having the next child, but are not using a contraceptive method.</td>
<td>Surveys such as DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics.</td>
<td>Output</td>
<td>When possible (in years with a DHS) by: wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.</td>
<td>The proportion of women (married/union) with an unmet need for family planning is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health. Included in WHO indicators on health and rights list.</td>
</tr>
<tr>
<td><strong>05</strong> Annual Expenditure on Family Planning from Government Domestic Budget</td>
<td>Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.</td>
<td>Estimate will be derived through contributions from Kaiser Family Foundation, UNFPA/ NDI, WHO/COIA and the DELIVER project. Country availability will depend on COIA and NDI implementation. All 69 countries are expected to be available at some point.</td>
<td>Enabling environment</td>
<td></td>
<td>Proportion of SRH budget allocated to FP is a tracking indicator for the Maputo Plan of Action.</td>
</tr>
<tr>
<td><strong>06</strong> Couple-Year of Protection (CYP)</td>
<td>The estimated protection provided by family planning services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method.</td>
<td>Service statistics</td>
<td>Output</td>
<td>By method</td>
<td>CYP was developed by USAID, and most FP donors, international agencies, and service providers report CYPs.</td>
</tr>
</tbody>
</table>
## Indicators that Model Impact for All 69 FP2020 Countries

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Definition</th>
<th>Data Source &amp; Availability</th>
<th>Conceptual Framework Category</th>
<th>Disaggregation</th>
<th>Links to Other Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>07 Number of Unintended Pregnancies</td>
<td>The number of pregnancies that occurred at a time when women (and their partners) either did not want additional children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
<td></td>
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</tr>
<tr>
<td>08 Number of Unintended Pregnancies Averted Due to Contraceptive Use</td>
<td>The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09 Number of Maternal Deaths Averted Due to Contraceptive Use</td>
<td>The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
<td></td>
<td>This indicator is tracked in the ICPD Program of Action in a slightly different formulation as follows: “countries should strive to effect significant reductions in maternal mortality by 2015.”</td>
</tr>
<tr>
<td>10 Number of Unsafe Abortions Averted Due to Contraceptive Use</td>
<td>The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
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ANNEX 3
FP2020 PROGRESS REPORT 2012-2013:
PARTNERSHIP IN ACTION
When women have the tools they need to plan their families—information, access to contraceptives, and high-quality health care—they are much more likely to finish their education. That gives them the opportunity to do what they do best: build thriving families, communities, and nations.

MELINDA GATES
CO-CHAIR, BILL & MELINDA GATES FOUNDATION
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EXECUTIVE SUMMARY

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

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

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

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

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

A rigorous measurement and evaluation agenda has been established as a means of guiding progress in delivering on the promise set forth in London. Over the past year, FP2020 initiated a number of activities to establish the systems and infrastructure necessary to monitor the impact of family planning programs and to strengthen accountability for implementing financial, policy, and programming commitments. This undertaking included the selection of core indicators, collating corresponding baseline data, improving the way in which family planning expenditures are tracked, and launching electronic data collection in select countries.

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

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

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

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

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

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

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

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

We believe that the family planning community’s greatest resource is the human energy of our diverse leaders, experts, advocates, and implementers. Some of the most exciting progress of the past year came from innovative partnerships that harnessed market incentives to solve formerly intractable problems. Millions of women in the world’s poorest countries will now have access to long-acting, reversible contraceptive methods thanks to the vision and dedication of colleagues representing governments, NGOs, pharmaceutical companies, donors, and multilateral organizations.

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

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

Insufficient funding is just one reason family planning programs may fail to reach women and girls. Social and cultural factors such as gender inequality, discrimina-
tion, and a lack of appreciation for cultural sensitivities and personal preferences are all formidable barriers. Family planning strategies will not succeed unless they are embedded in a continuum of care, protect human rights, and promote gender equality. No plan can be said to serve the needs of women and girls if it does not respect their agency.

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

DR. CHRIS ELIAS
PRESIDENT, GLOBAL DEVELOPMENT
BILL & MELINDA GATES FOUNDATION

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

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

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

12.12
- Responsible Parenthood and Reproductive Health Act signed, Philippines
- Malawi approves National Population Policy
- FP2020 Reference Group meets for the first time, New York
| 02.13 | • Niger launches costed national family planning plan  
|       | • FP2020 Stakeholders meet  
|       | • Agreement to reduce price of Jadelle® contraceptive implant |
| 03.13 | • FP2020 Reference Group meets for the second time, Washington, D.C. |
| 05.13 | • FP2020 commitment makers at Women Deliver Third Global Conference, Kuala Lumpur  
|       | • PMA 2020 and Track 20 projects launch  
|       | • Agreement to reduce price of IMPLANON® and IMPLANON NXT® contraceptive implants  
|       | • FP2020 Reference Group meets for the third time, Kuala Lumpur |
| 06.13 | • Burkina Faso launches national family planning plan  
|       | • Memberships of FP2020 Country Engagement, Performance Monitoring & Accountability, and Rights & Empowerment Working Groups announced |
| 07.13 | • Uganda’s Parliament approves the National Population Council Bill  
|       | • One-year anniversary of the London Summit on Family Planning  
|       | • FP2020 Country Engagement Working Group convenes for first full meeting, Washington, D.C.  
|       | • FP2020 Performance Monitoring & Accountability Working Group convenes for first full meeting, Geneva |
| 08.13 | • FP2020 Rights & Empowerment Working Group convenes for first full meeting, Washington, D.C.  
|       | • Burkina Faso launches Consolidated Action Plan for Family Planning |
| 09.13 | • Indonesia holds National Family Planning Summit, Jakarta  
|       | • Senegal launches nationwide scale-up of Informed Push Model of distribution for contraceptive commodities  
|       | • Zambia launches Costed Eight-Year Integrated Family Planning Scale-up Plan  
|       | • FP2020 Reference Group Meeting, New York  
|       | • Family Planning Association of Pakistan holds Towards Realizing Family Planning Vision 2020 seminar |
| 10.13 | • Tanzania holds national family planning conference, Dar-es-Salaam  
|       | • FP2020 Market Dynamics Working Group membership announced |
| 11.13 | • Third International Conference on Family Planning, Addis Ababa. New FP2020 commitments announced |
| 12.13 | • Uganda to hold national family planning conference |
Family planning programs have had a profound impact in a relatively short period of time. In the developing world, the contraceptive prevalence rate (modern methods) rose from negligible levels in the 1960s to 55% in 2000.\(^1\) Although many groups were underserved, steady progress was manifest.

But the gains stopped, and the contraceptive prevalence rate leveled off. Support for family planning and reproductive health remained high, but the sense of urgency had waned. For far too many decision makers, funding and implementing these programs were no longer priorities.

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

---

Women and Girls at the Heart of FP2020

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

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

The local women didn’t see it that way.

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

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

If a woman could get to a hospital, she could get access to contraceptives. But getting there was only part of the problem. By taking contraceptives, a wife was usurping her husband’s authority. If she was caught taking a pill, his wrath, and the wrath of his family, could be formidable.

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

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

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

When Bridget saw what had happened, she knew the problem was neither the pipes nor the women. She understood that the root of the trouble was the husbands’ attitude toward family planning, and the cultural norms that kept women disempowered.

She also knew that if this was a problem in one village, it was likely a problem in other Delta District communities.

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

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

It took many years of hard work, but today, attitudes in Delta District have changed. Family size is smaller, and there are fewer maternal and newborn deaths. There is still a long road ahead, but the lessons are clear. Services should never be implemented without a deep understanding of the needs of all members of a community. Building a pipeline is not enough. For change to take root, we must place women’s empowerment at the center of the development agenda.
The 2012 London Summit on Family Planning was intended to reenergize the global family planning community, but the enthusiasm it unleashed far exceeded expectations. Leaders from 150 donor and developing countries, international agencies, civil society organizations, foundations, and the private sector joined together to endorse the goal of expanding access to contraceptives to an additional 120 million women and girls in the world’s poorest countries.

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

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

Equally important are the things FP2020 does not do. It does not create bottlenecks by funneling all participants into one-size-fits-all strategies. In recognition that duplicative reporting structures create significant administrative burdens, FP2020 does not require countries to adhere to a new reporting regime. FP2020 does not divert attention from its constituent stakeholders, but rather magnifies their ability to mobilize resources and deliver life-saving services.

**FP2020 STRUCTURE**

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

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

FP2020 has a Task Team responsible for the implementation of day-to-day activities. It is led by Valerie DeFillipo, reports to the Reference Group, and is hosted by the UN Foundation. The Task Team monitors overall progress for reporting to countries and to the Reference Group, coordinates across other entities and external groups, and supports Working Group strategies and implementation.
The imperatives of human rights and public health are not merely compatible; they are indivisible. FP2020 has four Working Groups that mirror the lateral, organic interrelation of the forces that contribute to rights-based family planning programs.

• Countries vary in the type of support they need to develop, implement, and monitor transformational national family planning strategies. The Country Engagement Working Group (CE WG) works with partners to provide support to accelerate the implementation of country plans within the context of their reproductive, maternal, newborn, and children’s health strategies. CE WG facilitates access to technical, funding, and other assistance, and coordinates information sharing and peer-to-peer support. CE WG works with the Performance Monitoring & Accountability Working Group (PMA WG) to measure the impact of family planning programs and to strengthen countries’ efforts to collect and utilize data on an ongoing basis to inform decision making.

• Substantial and consistent monitoring and evaluation efforts are central to FP2020’s efforts to track advances, identify gaps and challenges, and promote accountability. The PMA WG strives to improve the quality and availability of information for use at the community, country, and global levels and to further explore methodologies to measure service quality, encourage the use of data in program management and policy development, and embed human-rights approaches recommended by the Rights & Empowerment Working Group (RE WG).

• FP2020 envisions a world where the right of women and girls, no matter where they live, to decide whether and when to have children is respected, protected, and fulfilled. The RE WG acts as a resource for expertise, guidance, best practices, and tools to ensure that a rights-based approach underpins the design, implementation, monitoring, and evaluation of family planning programs. RE WG will collaborate with other Working Groups and partners to address the full range of barriers that limit or prevent many women from using family planning information, services, and supplies, and to prioritize human rights principles such as participation, accountability, non-discrimination, empowerment, transparency, and sustainability in all FP2020 activities.

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

Each Working Group has an affiliated Consultative Network of stakeholders who will be engaged periodically for input on Working Group activities. The Consultative Networks provide additional expertise and are instrumental in identifying critical resources and materials that highlight success stories, high-impact practices, and innovations to share with decision makers at the country level.
The London Summit on Family Planning last year was a starting point for determined global action on family planning. Public, private and civil society partners from around the world agreed to a goal of giving an additional 120 million girls and women in the world’s poorest countries access to voluntary family planning by 2020.

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

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

THE RIGHT HONOURABLE JUSTINE GREENING
MP, SECRETARY OF STATE FOR INTERNATIONAL DEVELOPMENT, UNITED KINGDOM
The enthusiasm that emerged at the London Summit on Family Planning is yielding tangible results, and it is clear that countries are leading the way. As of July 2013, countries comprised one-third of the 70 commitment makers to FP2020.

**THE FP2020 COMMITMENT-MAKING COUNTRIES ARE:**

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

**FP2020 Commitment Makers**

- Low- and Middle Income Countries (24): 34%
- Civil Society Organizations (23): 33%
- Donor Countries, Foundations, Private Sector (19): 27%
- Multilaterals and Partnerships (4): 6%

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

3. South Africa’s GNI does not qualify as one of the world’s poorest based on the World Bank 2010 classification using the Atlas Method.
Progress is driven by the governments of these countries, in collaboration with civil society organizations, service providers, advocates, industry leaders, and experts. Multilateral organizations, foundations, and other members of the global family planning community provide support and technical assistance.

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

**Snapshot of Country-Led Progress**

**BURKINA FASO**
- National family planning plan launched
- Introduction plan for Sayana® Press approved

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

**GHANA**
- National Family Planning Conference

**INDIA**
- National Review Meeting on Family Planning

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

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

**MALAWI**
- National Population Policy approved

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

**NIGERIA**
- *National Family Planning Conference* organized
- National budget for family planning commodities and services increased
- Gombe State plan to expand access to family planning launched
- Policy change to allow community health workers to provide injectable contraceptives
- Cluster model of integrated services implemented by Nigeria Planned Parenthood
- President launched Saving One Million Lives initiative
- Family planning trainings scaled up
- Trainings of community health workers on injectable contraceptives begin
- Distribution of contraceptives to the last mile using review-resupply meeting model
- BCC and media campaign to increase knowledge and awareness of female condoms
- Detailed implementation plan to expand use of modern contraception developed
PAKISTAN
National budget for family planning increased for fiscal years 2012-2013
Provinces currently developing budget frameworks for financing of family planning

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

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

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

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

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

ZAMBIA
Costed Eight-Year Integrated FP Scale-up Plan 2013-2020 launched
Pilot study on allowing community health workers to provide contraceptive injections
Implementing scale-up of mobile health services
Family planning is not a privilege, but a basic human right. By enabling women, particularly the most disadvantaged and hardest to reach, to make informed choices about the number, timing and spacing of their children, we help them exercise this right.

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

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

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

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

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

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

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

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

In the coming months and years, the Planned Parenthood of Ghana clinic will help Afia keep herself and her baby healthy, and will give her the information and contraceptives she needs to plan her family and her future.
The London Summit on Family Planning was a defining event for Indonesia’s family planning program. Our commitment there crystallized actions we were considering for revitalizing our program. FP2020 continues to be a catalyst, as was evident during Indonesia’s Summit on Family Planning.

DR. JULIANTO WITJAKSONO
DEPUTY OF FAMILY PLANNING AND REPRODUCTIVE HEALTH OF INDONESIA’S NATIONAL POPULATION AND FAMILY PLANNING BOARD (BKKBN)
INDONESIA’S COMMITMENT TO FP2020

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

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

Dr. Juliarto Witjaksono, Deputy of Family Planning and Reproductive Health of Indonesia’s National Population and Family Planning Board (BKKBN), serves on the FP2020 Reference Group. BKKBN’s Dr. Siti Fathonah serves on FP2020’s CE WG, and Dr. Roy Tjong of the Indonesian Planned Parenthood Association serves on PMA WG. All three played an active role in designing and executing the Indonesia summit.

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

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

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

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

Another high point was the announcement that BKKBN and the Population Commission of the Philippines had signed a memorandum of understanding to support south-to-south collaboration, with a focus on Mindanao Island, a conflict area in the Philippines that has a majority-Muslim population. Areas of collaboration include strengthening the role of faith-based organizations, sharing lessons on decentralization and local advocacy, and sharing best practices.
private providers of contraceptive services and supplies in the country, strategized a total market approach to coordinate service delivery and increase access to a full range of contraceptive methods. Donors, government, and others assessed the realities of speeding delivery of services and supplies to ensure universal access to quality, voluntary family planning services.

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

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

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

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

<table>
<thead>
<tr>
<th>YEAR/PERIOD</th>
<th>ALLOCATED</th>
<th>SPENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/2006</td>
<td>0.78</td>
<td>0.29</td>
</tr>
<tr>
<td>2006/2007</td>
<td>0.74</td>
<td>0.47</td>
</tr>
<tr>
<td>2007/2008</td>
<td>0.73</td>
<td>0.28</td>
</tr>
<tr>
<td>2008/2009</td>
<td>0.75</td>
<td>0.65</td>
</tr>
<tr>
<td>2009/2010</td>
<td>0.65</td>
<td>1.9</td>
</tr>
<tr>
<td>2010/2011</td>
<td>2.7</td>
<td>3.3</td>
</tr>
<tr>
<td>2011/2012</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>2012/2013</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>2013/2014</td>
<td>6.8</td>
<td>6.8</td>
</tr>
</tbody>
</table>

PROJECTED EXPENDITURES

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

DR. COLLINS TUSINGWIRE
ASSISTANT COMMISSIONER FOR REPRODUCTIVE HEALTH, UGANDA MINISTRY OF HEALTH
Accountability is an aspect of justice: it invokes the expectation that institutions will understand and respect the needs of all the people who are affected by their actions, and will operate in a way that promotes equity and inclusion.

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

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

This report includes preliminary data on donor expenditures. Early results demonstrate that many donor governments have already budgeted increased levels of funding for family planning in 2013, and indicate progress toward fulfilling financial commitments made at the London Summit on Family Planning. These figures (see chart on page 31) are provisional and for indicative purposes only. The FP2020 tracking methodology will be improved to include, as far as possible, standard definition of family planning expenditures, consistent data sources, and common reporting periods (see page 90).

**TRACKING DONOR EXPENDITURES**

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

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

While support from all sectors is critical to meeting our goal, donor governments provide a significant share of global funding for family planning services. Preliminary data from KFF’s research indicate donor government disbursements for family planning increased in 2013.
<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>SUMMIT COMMITMENTS</th>
<th>BILATERAL (US$ MILLIONS)</th>
<th>MULTILATERAL - UNFPA CORE CONTRIBUTIONS (US$ MILLIONS)</th>
<th>TOTAL (US$ MILLIONS)</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUSTRALIA</td>
<td>Plans to spend an additional AU$58 million over five years on family planning, doubling annual contributions to AU$53 million by 2016. This commitment will form a part of Australia’s broader investments in maternal, reproductive, and child health (at least AU$1.6 billion over five years to 2015).</td>
<td>$42.7</td>
<td>$14.9</td>
<td>$57.5</td>
<td>Australia identified US$44.6 in FY11/12 using the FP2020 agreed methodology, which includes a percentage of a donor’s core contribution to UNFPA. Australian bilateral funding was determined by adjusting its total funding level to take into account its UNFPA contribution.</td>
</tr>
<tr>
<td>CANADA</td>
<td></td>
<td>$41.5</td>
<td>$17.4</td>
<td>$58.9</td>
<td>Bilateral funding is for family planning and reproductive health activities (including life skills education) in FY12.</td>
</tr>
<tr>
<td>DENMARK</td>
<td>An additional US$13 million over eight years</td>
<td>$13.0</td>
<td>$44.0</td>
<td>$57.0</td>
<td>Bilateral funding is family planning–specific in FY11, the most recent year available, and includes a specific contribution (in addition to its core contribution) to UNFPA’s Reproductive Health Commodities Fund.</td>
</tr>
<tr>
<td>FRANCE</td>
<td>An additional €100 million on family planning within the context of reproductive health through 2015, in nine countries in francophone Africa</td>
<td>$49.6</td>
<td>$0.5</td>
<td>$50.1</td>
<td>Bilateral funding is for a mix of family planning, reproductive health, and maternal/child health activities in FY12.</td>
</tr>
<tr>
<td>GERMANY</td>
<td>€400 million to reproductive health and family planning over four years, of which 25% (€100 million) is likely to be dedicated directly to family planning, depending on partner countries’ priorities</td>
<td>$47.6</td>
<td>$20.7</td>
<td>$68.3</td>
<td>Bilateral funding is family planning–specific in FY11, the most recent year available.</td>
</tr>
<tr>
<td>NETHERLANDS</td>
<td>€370 million in 2012 for sexual and reproductive health and rights, including HIV and health, and [plans] to extend this amount from €381 million in 2013 to €413 million in 2015.</td>
<td>$65.5</td>
<td>$49.0</td>
<td>$114.5</td>
<td>The Netherlands provided a total of US$484.8 million in FY12 for “Sexual and Reproductive Health &amp; Rights, including HIV/AIDS” of which an estimated US$65.5 million was for family planning–specific activities. In FY13, the Netherlands increased funding for “Sexual and Reproductive Health &amp; Rights, including HIV/AIDS” to US$504.1 million.</td>
</tr>
<tr>
<td>NORWAY</td>
<td>Doubling investment from US$25 million to US$50 million over eight years</td>
<td>$3.3</td>
<td>$59.4</td>
<td>$62.7</td>
<td>Bilateral funding is family planning–specific in FY12. For FY13, the Norwegian budget provides an estimated US$25 million in &quot;new&quot; (additional) family planning funding as well as a slight increase in its UNFPA contributions.</td>
</tr>
<tr>
<td>SWEDEN</td>
<td>Increasing spending on contraceptives from 2010 level of US$32 million per year to US$40 million per year; totaling an additional US$40 million between 2011 and 2015.</td>
<td>$41.2</td>
<td>$66.3</td>
<td>$107.5</td>
<td>Bilateral funding is for family planning and reproductive health in FY12.</td>
</tr>
<tr>
<td>UK</td>
<td>Committing £516 million (US$800 million) over eight years</td>
<td>$99.4</td>
<td>$31.8</td>
<td>$131.2</td>
<td>Bilateral funding is family planning–specific in FY12/13. Family planning–specific funding is estimated to increase in FY13/14.</td>
</tr>
<tr>
<td>U.S.</td>
<td></td>
<td>$485.0</td>
<td>$30.2</td>
<td>$515.2</td>
<td>USAID stipulates that specified bilateral subtotal is family planning–specific in FY12.</td>
</tr>
<tr>
<td>OTHER DAC COUNTRIES**</td>
<td></td>
<td>$11.0</td>
<td>$98.0</td>
<td>$109.1</td>
<td>Bilateral funding was obtained from the Organisation for Economic Co-operation and Development (OECD) Credit Reporting System (CRS) database and represents funding provided in 2011, the most recent year available.</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$899.8</td>
<td>$432.3</td>
<td>$1,332.1</td>
<td></td>
</tr>
</tbody>
</table>
This analysis establishes a baseline level of disbursements\(^5\) in 2012 that can be used to track total international assistance funding levels for family planning\(^6\) over time, as well as specific donor government progress in meeting London Summit on Family Planning commitments.

It includes an analysis of funding provided by the 24 governments that were members of the Organisation for Economic Co-operation and Development (OECD) and Development Assistance Committee (DAC) in 2012.\(^7\)

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

**FINDINGS**

- In 2012, donor governments provided US$900 million for bilateral family planning programs and an additional US$432 million in core contributions to UNFPA.

- The U.S. was the largest bilateral donor, providing US$485 million and accounting for more than half (54%) of total bilateral funding in 2012. The UK was the second-largest bilateral donor (US$99.4 million, 11%), followed by the Netherlands (US$65.5 million, 7%), France (US$49.6 million, 6%), and Germany (US$47.6 million, 5%).

- Sweden was the largest donor to UNFPA (US$66.3 million), followed by Norway (US$59.4 million), the Netherlands (US$49.0 million), and Denmark (US$44.0 million).

- While complete funding data for 2013 is not yet available, two donor governments (Norway and the UK) have already budgeted increased levels of funding for family planning in 2013.

- In addition, while family planning-specific funding is not yet available, the Netherlands increased funding in 2013 for “Sexual and Reproductive Health & Rights, including HIV/AIDS” to US$504.1 million, fulfilling its summit commitment.

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

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

\(^7\) Since 2012, three other governments have become DAC members: Czech Republic, Iceland, and Slovak Republic.
Donor Government Disbursements for Family Planning in 2013 (Totals in US$ Millions)

<table>
<thead>
<tr>
<th>Country</th>
<th>Disbursement (US$ Millions)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>$66</td>
<td>7%</td>
</tr>
<tr>
<td>Australia</td>
<td>$42</td>
<td>5%</td>
</tr>
<tr>
<td>Canada</td>
<td>$41</td>
<td>5%</td>
</tr>
<tr>
<td>Denmark</td>
<td>$13</td>
<td>1%</td>
</tr>
<tr>
<td>France</td>
<td>$99</td>
<td>11%</td>
</tr>
<tr>
<td>Germany</td>
<td>$50</td>
<td>5%</td>
</tr>
<tr>
<td>U.S.</td>
<td>$485</td>
<td>54%</td>
</tr>
<tr>
<td>Norway</td>
<td>$3</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

TOTAL = $899.8 MILLION

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

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

Similarly, it is also difficult in some cases to disaggregate bilateral family planning funding from broader reproductive and maternal health totals, and the two are sometimes represented as integrated totals. In addition, family planning–related activities funded in the context of other official development assistance sectors (e.g., education, civil society) have remained largely unidentified. For purposes of this analysis, we worked closely with the largest donors to family planning to identify such family planning–specific funding where possible (see Table notes). Going forward, it will be important to efforts to track donor government support for family planning if such funding was more systematically identified within other activity categories by primary financial systems.

ADDITIONAL NOTE

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

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Bloomberg Philanthropies is pleased to have recently rolled out our first grant from our FP2020 commitment. This grant builds on a maternal health program we have supported in Tanzania since 2006 and will allow for the integration of comprehensive family planning services in some of the country’s most remote health facilities.
Establishing health services that promote women’s choices and the delivery of high-quality care means fewer maternal complications, fewer maternal deaths and ultimately, healthier households and communities.

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

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

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

**PROMOTING ACCOUNTABILITY**

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

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>117</td>
</tr>
<tr>
<td>Antenatal Care</td>
<td>74</td>
</tr>
<tr>
<td>Skilled Attendant At Birth</td>
<td>89</td>
</tr>
<tr>
<td>Postnatal Care For Mother</td>
<td>95</td>
</tr>
<tr>
<td>Postnatal Care For Newborn</td>
<td>67</td>
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<tr>
<td>Exclusive Breastfeeding</td>
<td>67</td>
</tr>
<tr>
<td>DTP3 Vaccines</td>
<td>57</td>
</tr>
<tr>
<td>Antibiotics For Pneumonia</td>
<td>61</td>
</tr>
<tr>
<td>Improved Sanitation Facilities</td>
<td>47</td>
</tr>
<tr>
<td>Improved Drinking Water Sources</td>
<td>42</td>
</tr>
</tbody>
</table>

**Source**
PMNCH

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

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

Using interventions that work elsewhere may not reach these underserved groups. As recommended by the Population Council in its publication *FP2020: A Research Roadmap*, “a clear, accurate accounting of the particular barriers that still prevent the most disadvantaged women and girls from using family planning services is needed, so that effective interventions can be developed to overcome them.”10 One woman’s circumstances and preferences may differ not only from another’s, but will most likely change over time. Meeting the needs of all women and girls requires us to adapt and innovate family planning products and service delivery strategies.

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

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

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EXPANDING CONTRACEPTIVE METHOD OPTIONS

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

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

CONTRACEPTIVE INJECTIONS

Sayana® Press offers the potential to improve contraceptive access for women worldwide. It uses the Uniject™ injection system—a small, prefilled, single-use device to deliver a new, lower-dose formulation of Depo-Provera® via subcutaneous, rather than intramuscular, injection. Like the currently available Depo-Provera® intramuscular contraceptive, a single dose of Sayana® Press is effective for three months. Its safety and ease of use mean community health workers (CHWs) may be better able to administer injections outside of health facilities. And while Sayana® Press currently is not labeled for home or self-injection, in the future this delivery mode may offer women a convenient, private option for contraception.

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

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

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

CONTRACEPTIVE IMPLANTS

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

On January 1, 2013, it was announced that Bayer HealthCare AG would cut the price of its contraceptive implant Jadelle® from US$18 to $8.50 per unit. Through
the new Jadelle® Access Initiative, the product is available at this price in more than 50 countries, including those deemed least likely by the UN Secretary-General to meet the targets of MDG 4 and MDG 5 by 2015. The initiative is expected to reach approximately 27 million women. In May 2013, Merck/MSD announced it would reduce by half the price of its contraceptive implants IMPLANON® and IMPLANON NXT® in 69 focus countries identified at the London Summit on Family Planning. Both agreements were developed and supported through partnerships among Bayer HealthCare AG and Merck/MSD; the Bill & Melinda Gates Foundation; the Clinton Health Access Initiative (CHAI); the governments of Norway, the United Kingdom, the United States, and Sweden; the Children's Investment Fund Foundation; and UNFPA.

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

The Sino-implant initiative, which is led by FHI 360 with support from the Bill & Melinda Gates Foundation and USAID, provides technical assistance to facilitate the global introduction of Sino-implant (II)®. It works in close coordination with a number of organizations, including government officials, distributors, and service delivery groups, to facilitate introductions at the country level. This includes conducting independent quality testing, negotiating public sector price-ceiling agreements, supporting the WHO prequalification application process, and working with distributors to secure national regulatory approvals. Unlike many other contraceptive methods, when an implant reaches the end of its effectiveness period, or a woman wants to discontinue its use, she must seek help from a medical professional to have it removed. The need for a removal procedure precludes use of an implant by women who either cannot afford it or cannot get to a medical appointment. With funding from USAID, FHI 360 is working with innovators in the field of drug delivery systems to develop a safe, effective, acceptable, and affordable biodegradable contraceptive implant that would not require removal. Proof-of-concept testing by these investigators will be initiated by the end of 2013.

CONTRACEPTIVE VAGINAL RING

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

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

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

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

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

MINIMIZING STOCK-OUTS WITH THE INFORMED PUSH MODEL

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

The Informed Push Model of distribution uses timely and good-quality information to guide resupply decisions. It was inspired by the commercial sector and looks much like a typical system for vending machines. A driver with a truckful of supplies visits each point of sale on a regular schedule, topping up the stock and recording quantities of products sold. The data collected by the driver are used to ensure sufficient stock at the warehouse and at each site, to figure out which products and sites are the most popular, and to prepare the manufacturers to keep pace with demand. On the systemic level, the information is used by regional and national decision makers to determine the quantity and types of contraceptives that are requested and dispensed. This is instrumental in optimizing the performance of the health system to provide women with high-quality family planning services and a dependable supply of contraceptives.

INCREASING ACCESS WITH THE CLUSTER MODEL

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

The unmet need for family planning in Senegal is one of the highest in the world. At the London Summit on Family Planning, Senegal committed to improving the family planning supply chain and to reducing contraceptive stock-outs. A six-month collaborative effort led by the Reproductive Health Department of the Ministry of Health tested the Informed Push Model of distribution at select sites. The results were impressive, and it has now been launched nationwide.
In Senegal, we are bringing women greater contraceptive choices through the innovative Informed Push Model of product distribution. Now more women can trust that the contraceptive method that best meets her needs will be available every time she needs it.

DR. AWA MARIE COLL-SECK
MINISTER OF HEALTH, SENEGAL
MEETING THE NEEDS OF UNDERSERVED COMMUNITIES IN SIERRA LEONE

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

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

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

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

MARIE AND BAINDU TAKE CONTROL

Two of the women who have been able to access family planning for the first time are Marie (30) and Baindu (34). They both live on Benducha Island with their husbands and children (Marie has eight children, and Baindu has six), and none of their children has been able to attend secondary school.

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

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

STILL MORE TO DO

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

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

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

SOURCE
Marie Stopes International.
March, 2013. Author: Shumon Sengupta, Country Director, MSI Sierra Leone

PARTNERSHIP ACCELERATES PROGRESS IN ZAMBIA

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

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

It is projected that the implementation of Zambia’s plan will avert 3.5 million unintended pregnancies, more than 100,000 child deaths, and nearly 10,000 maternal deaths. It is expected that the plan will save Zambia 1.492 million ZMW.
Zambia’s national family planning strategy is very ambitious, but it is also achievable. We are on track to better serve the needs of the hardest to reach communities. The women and girls of Zambia will benefit from the renewed commitment to expand family planning services.

DR. CAROLINE PHIRI
DIRECTOR OF MOTHER CHILD HEALTH
MINISTRY OF COMMUNITY DEVELOPMENT
MOTHER CHILD HEALTH, ZAMBIA
PMA2020

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

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

PMA2020 has trained more than 100 female resident enumerators in Ghana. Each was recruited from her community, where data are collected. Together, they comprise a sentinel network that is activated to conduct repeated rounds of the survey, interviewing approximately 40 households and three service delivery points each time. Each enumerator is equipped with a smartphone, supported by a regional supervisor, and compensated for her work. Through training, equipping, and supporting this network of sentinel resident enumerators, PMA2020 is building local skills for generating meaningful and timely data for program improvement. Enumerators commented on what they liked best about the training: “It gave us the opportunity to build self-confidence,” “The belief that we can do it,” and “The training has brought improvement to my life.” In addition, the project strengthens the capacity of local university partners to manage all aspects of survey implementation.
Family planning services are a means through which women and girls exercise self-determination. Therefore, the ultimate metric for judging a family planning program is the degree to which it empowers women and girls. On an operational level, family planning programs that do not respect and reflect the agency of women and girls are inherently flawed and destined to fail.

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

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

- Policy level: the conditions of governance (especially political commitment) and accountability (especially to the community) support family planning programs that respect, protect, and fulfill rights (especially in the areas of information, supplies, and services)

- Service level: the elements of quality of care (quality, accessibility, availability, and acceptability) guide programming to adhere to the highest standard of care and thus protect inherent human rights principles (especially in the areas of method mix, technical competence, and service integration)

- Community level: the political, financial, and social environments are supported by the effective participation of diverse community groups (especially youth) in all aspects of family planning policy and program development, implementation, and monitoring (especially in the areas of policy making, funding, and societal norms and equity)

- Individual level: the various contexts in which an individual lives allow him or her to exercise rights (especially in the areas of behavior, knowledge, access to information and services, and empowerment)

As the world’s largest bilateral donor of family planning, USAID is proud to be a core partner in Family Planning 2020 and work alongside country governments and other donors to increase access to voluntary family planning information, products, and services.
Family Planning 2020 has brought together the comparative advantages of multiple stakeholders and united the global community under a clear and shared vision. This is crucial as we know that family planning is essential for promoting health, economic growth, and development across the globe.

DR. ARIEL PABLOS-MÉNDEZ
ASSISTANT ADMINISTRATOR FOR GLOBAL HEALTH AT USAID
Pregnancy and childbirth can have a devastating impact on a young girl’s health. New initiatives are encouraging young people to wait until they are age 18 before marrying and giving birth, to allow two years between pregnancies, and to utilize reproductive health services.

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

In Sierra Leone, a youth-led organization called YES Salone is leading a multisector program that includes five government ministries, UNFPA and other UN agencies, and NGOs. The acronym YES stands for “Young, Empowered and Safe.” The program will scale up demand for family planning and health services for young people. Activities this year included the development of minimum standards for services; a mobile minibus outreach effort, including music, drama, debate, and discussion; and a peer-to-peer education program in 13 districts.

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

Currently in its first phase of implementation, the campaign is aimed at youth living in urban centers in five African countries, starting with Uganda, but has already generated 60,000 actions from people in 27 countries. To engage young people and raise awareness, campaign activities include customizing condom wrappers online and voicing support for family planning programs.
Four of the world’s largest organizations devoted to improving the health of women and girls are core partners in FP2020:

**DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID)**

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

**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)**

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

**THE BILL & MELINDA GATES FOUNDATION**

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

**UNITED NATIONS POPULATION FUND (UNFPA)**

UNFPA delivers a world where every pregnancy is wanted, every birth is safe, and every young person’s potential is fulfilled. UNFPA is the longest-serving multilateral agency leading in the field of family planning, and currently supports family planning progress in more than 150 countries. UNFPA promotes family planning as part of a comprehensive approach to sexual and reproductive health and reproductive rights. This includes not only essential supplies but also training midwives, eliminating barriers to access, making family planning available to adolescents and unmarried people, empowering women and girls, engaging men and boys, responding in humanitarian emergencies, and mobilizing national and global commitment.

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

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

In support of FP2020, the Alliance and WHO hosted the first Family Planning Implementation Research Donor Meeting in December 2012. The meeting brought together more than 40 representatives from 21 funding agencies to identify research gaps that could be addressed through collective action, and outlined the initial strategies for doing so.
Launched in February 2011, the Ouagadougou Partnership is dedicated to improving access to family planning in nine countries in French-speaking West Africa. It is led by the governments of Benin, Burkina Faso, Côte d’Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo. At the London Summit on Family Planning, members of the Ouagadougou Partnership pledged to accelerate progress toward their goal.

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

The development and implementation of national, broad-based costed implementation plans for family planning (FP CIPs) are a crucial part of countries’ reproductive, maternal, newborn, and child health efforts. FP CIPs serve to clarify a country’s strategies by articulating its priorities for family planning. They describe activities and include an implementation road map and detailed budget. They estimate the demographic, health, and economic impacts of a program, and prescribe a monitoring strategy to accurately measure and evaluate those impacts going forward. Crucially, FP CIPs are needed to identify funding gaps, secure donor commitments, increase political support, and promote accountability. In collaboration with USAID and other partners, the Health Policy Project is assisting the countries of the Ouagadougou Partnership to develop and augment their FP CIPs.

The Ouagadougou Partnership and FP2020 work together to support the efforts of Ouagadougou Partnership countries to develop and fully implement their family planning plans. To facilitate the seamless sharing of information, the director of Ouagadougou Partnership’s Coordination Unit is a member of FP2020’s Country Engagement Working Group. To minimize administrative burdens on countries, FP2020 and the Ouagadougou Partnership have agreed to accept and share the same country action plans (countries are not asked to submit a different plan to each entity). FP2020 and the Ouagadougou Partnership will work together to seek funding for countries’ plans and to share information and best practices with the global family planning community.
Collaboration multiplies our power to change the world. Working together, we will accelerate progress globally, creating a brighter future for women, families, and communities everywhere.

KATHY CALVIN
PRESIDENT AND CHIEF EXECUTIVE OFFICER, UNITED NATIONS FOUNDATION
Progress is the result of dedication combined with knowledge. The stakeholders in FP2020 are dedicated to a common goal; now, with the foundation of a strong platform for measurement and evaluation, we’ll have the knowledge we need to guide us toward success.

VALERIE DEFillipo
DIRECTOR, FP2020
Approximately 260 million women in the world’s 69 poorest countries currently use a modern method of contraception. Sustaining this level of use between 2012 and 2020 will cost roughly US$10 billion through resources principally provided by country governments’ health budgets, supported by individuals’ out-of-pocket expenditures and external donor contributions. At the London Summit on Family Planning, the global community took a significant step to expand the availability of voluntary family planning information, services, and supplies. The goal is to enable a total of 380 million women and girls to choose and use contraception by 2020 through the commitment of resources equivalent to US$4.3 billion, above and beyond the level of funding provided for family planning in 2010.15

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

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

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

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

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

FP2020 CORE INDICATORS

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

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

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

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

Enabling environment wider health system and services (including RMNCH)

*Including Summit commitments

Societal and structural characteristics (e.g., gender, equity, social and cultural norms, girls’ and women’s empowerment)
Following the London Summit on Family Planning and upon the establishment of the FP2020 governance structure, the work of finalizing the indicators was transferred to the FP2020 Reference Group, Task Team, and Working Groups. The Performance Monitoring & Accountability Working Group played a leadership role throughout the execution of this process, with substantial input from the Rights & Empowerment Working Group.

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

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

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

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

**REPORTED ANNUALLY FOR 69 COUNTRIES**

1. Contraceptive prevalence rate, modern methods (mCPR) (modeled)
2. Total number of contraceptive users by method (modeled)
3. Percent of women whose demand for modern contraception is satisfied (modeled)
4. Percentage of women with unmet need for contraception (modeled)
5. Annual expenditure on family planning from government domestic budget
6. Couple-Year of Protection (CYP)
7. Number of unintended pregnancies (estimated)
8. Number of unintended pregnancies averted due to contraceptive use (estimated)
9. Number of maternal deaths averted due to contraceptive use (estimated)
10. Number of unsafe abortions averted due to contraceptive use (estimated)

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

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

CRITERIA USED TO IDENTIFY CORE INDICATORS:

(1) Progress under each of the five domains of the Family Planning Summit Monitoring & Accountability Conceptual Framework’s is tracked by at least one indicator (the five domains are enabling environment, process, output, outcome, and impact); (2) indicator is relevant to the domain and methodologically sound (e.g., based to the greatest extent possible on existing definitions and standards and with documentation readily available); and (3) indicators for which data are most readily available across FP2020 countries. Additionally, special consideration was given to (4) indicators proposed by the Rights and Empowerment Working Group, in line where possible with the WHO Indicators on Health and Rights (to ensure dimensions of availability, accessibility, quality, and informed decision making were reflected) and (5) indicators already used by countries to monitor other initiatives or goals (e.g., The Global Strategy for Women’s and Children's Health and MDG 5).

THE CORE INDICATOR TABLE IS SEPARATED INTO THREE CATEGORIES:

1. Indicators that will be reported annually for all 69 FP2020 countries. Data sources and methodology will vary between countries that make a commitment to FP2020 and those that do not, based on presence of Track20 project. Indicators 5 and 6 will not have data in year one. Mechanisms to collect this information will be established within the first year.
2. Indicators that are estimates of impact of family planning, using modeling based on real-time data from the last DHS or similar national survey and not based on directly collected data.
3. Indicators that will be reported annually in a subset of countries and based on the PMA2020 survey or countries that have DHS surveys in the reporting year. PMA2020 will collect data in 10 countries, which will be available in two years. In years when there is a DHS in one of these countries, indicators for the country (with disaggregated figures) will be utilized in progress reporting.
<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Definition</th>
<th>Data Source &amp; Availability</th>
<th>Conceptual Framework Category</th>
<th>Disaggregation</th>
<th>Links to Other Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Contraceptive Prevalence Rate, Modern Methods (mCPR)</td>
<td>The proportion of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.</td>
<td>Surveys such as the Demographic and Health Surveys (DHS), the CDC-assisted Reproductive Health Surveys (RHS), MICS and other nationally sponsored surveys. Service statistics.</td>
<td>Outcome</td>
<td>When possible (in years with a DHS) by: wealth quintile, age, marital status, urban/rural, ethnicity, region, etc.</td>
<td>Contraceptive prevalence rate (any method) is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health. Included in WHO indicators on health and rights list.</td>
</tr>
<tr>
<td>02 Total Number of Contraceptive Users by Method</td>
<td>The number of women (or their partners) of reproductive age currently using a contraceptive method.</td>
<td>Modeled using various data sources, including DHS and service statistics.</td>
<td>Output</td>
<td>Type of method, source</td>
<td></td>
</tr>
<tr>
<td>03 Percent of Women Whose Demand for Modern Contraception is Satisfied (met need for contraception)</td>
<td>The percent of women (or their partners) who desire either to have no more children or to postpone having the next child, who are currently using a modern contraceptive method.</td>
<td>Surveys such as DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics.</td>
<td>Outcome</td>
<td>When possible (in years with a DHS) by: wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.</td>
<td>The proportion of demand for family planning that is satisfied (any method) is a tracking indicator for the Global Strategy for Women’s and Children’s Health.</td>
</tr>
<tr>
<td>04 Percentage of Women with an Unmet Need for Contraception</td>
<td>The percentage of fecund women of reproductive age who want no children or to postpone having the next child, but are not using a contraceptive method.</td>
<td>Surveys such as DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics.</td>
<td>Output</td>
<td>When possible (in years with a DHS) by: method, wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.</td>
<td>The proportion of women (married/union) with an unmet need for family planning is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health. Included in WHO indicators on health and rights list.</td>
</tr>
<tr>
<td>05 Annual Expenditure on Family Planning from Government Domestic Budget</td>
<td>Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.</td>
<td>Estimate will be derived through contributions from Kaiser Family Foundation, UNFPA/ NIDI, WHO/COIA and the DELIVER project. Country availability will depend on COIA and NIDI implementation. All 69 countries are expected to be available at some point.</td>
<td>Enabling environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06 Couple-Year of Protection (CYP)</td>
<td>The estimated protection provided by family planning services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method.</td>
<td>Service statistics</td>
<td>Output</td>
<td>By method</td>
<td>Proportion of SRH budget allocated to FP is a tracking indicator for the Maputo Plan of Action. CYP was developed by USAID, and most FP donors, international agencies, and service providers report CYPs.</td>
</tr>
</tbody>
</table>
## Indicators that Model Impact for All 69 FP2020 Countries

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Definition</th>
<th>Data Source &amp; Availability</th>
<th>Conceptual Framework Category</th>
<th>Disaggregation</th>
<th>Links to Other Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>07 Number of Unintended Pregnancies</td>
<td>The number of pregnancies that occurred at a time when women (and their partners) either did not want (additional) children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08 Number of Unintended Pregnancies Averted Due to Contraceptive Use</td>
<td>The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09 Number of Maternal Deaths Averted Due to Contraceptive Use</td>
<td>The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
<td>This indicator is tracked in the ICPD Program of Action in a slightly different formulation as follows: &quot;countries should strive to effect significant reductions in maternal mortality by 2015.&quot;</td>
<td></td>
</tr>
<tr>
<td>10 Number of Unsafe Abortions Averted Due to Contraceptive Use</td>
<td>The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.</td>
<td>Estimated using modeling and the last DHS or similar survey as the base</td>
<td>Impact</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Indicators that Will Be Reported Annually for a Subset of 10 Countries and for the Subset of the 69 FP2020 Countries in Years with a DHS

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Definition</th>
<th>Data Source &amp; Availability</th>
<th>Conceptual Framework Category</th>
<th>Disaggregation</th>
<th>Links to Other Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 PERCENT OF WOMEN WHO WERE PROVIDED WITH INFORMATION ON FAMILY PLANNING DURING THEIR LAST VISIT WITH A HEALTH SERVICE PROVIDER</td>
<td>The percent of women who were provided information on FP in some form at the time of their last contact with a health service provider. The contact could occur in either a clinic or community setting. Information could have been provided via a number of mechanisms, including counseling, IEC materials or talks/conversations about FP.</td>
<td>PMA2020 Survey, DHS in select years</td>
<td>Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 MEAN SCORE ON METHOD INFORMATION INDEX</td>
<td>An index measuring the extent to which women were made aware of alternative methods of contraception and were provided adequate information about them. The index is constructed from three questions (Were you informed about other methods? Were you informed about side effects? Were you told what to do if you experienced side effects?) Information will also be available for each indicator independently.</td>
<td>PMA2020 Survey, DHS in select years</td>
<td>Process</td>
<td></td>
<td>Included in WHO indicators on health and rights list</td>
</tr>
<tr>
<td>13 PERCENT OF WOMEN WHO MAKE FAMILY PLANNING DECISIONS ALONE OR JOINTLY WITH THEIR HUSBANDS/PARTNERS OR JOINTLY WITH PROVIDER</td>
<td>The percent of women who make decisions on matters, such as whether and when to initiate and terminate contraceptive use and choice of contraceptive method, either by themselves or based upon consensus joint decision-making with their husband/partner/provider.</td>
<td>PMA2020 Survey, DHS in select years</td>
<td>Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 ADOLESCENT BIRTH RATE</td>
<td>The number of births to adolescent females, aged 15-19 occurring during a given reference period per 1,000 adolescent females.</td>
<td>PMA2020 Survey, DHS, MICS, RHS in select years</td>
<td>Impact</td>
<td></td>
<td>The adolescent (ages 15-19) birth rate is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health.</td>
</tr>
<tr>
<td>15 PERCENT INFORMED OF PERMANENCE OF STERILIZATION</td>
<td>Among women who said they were using male or female sterilization, the percent who were informed by the provider that the method was permanent.</td>
<td>PMA2020 Survey, DHS in select years</td>
<td>Process</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NEW INDICATORS

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

Many of these indicators are designed to reflect whether and how national family planning programs and services are provided in an atmosphere that respects choice, autonomy, and the principles of human rights. FP2020 Working Groups are committed to building capacity over time by strengthening existing systems and working with countries through a variety of mechanisms to encourage the exploration of new indicators. This kind of indicator work might involve, for example, use of existing data in new ways, including disaggregation of data as a way to investigate differentials in family planning program performance and outcomes by population subgroups.

Indicators that are currently being explored include:

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

FP2020 also intends to add an indicator to monitor contraceptive availability/stock-outs to the core list. The selection of this indicator will be informed by a process led by the DELIVER Project and the Reproductive Health Supplies Coalition (RHSC) Systems Strengthening Working Group Stock-out Indicator Work Stream to identify standard indicators and recommend standard definitions to reduce confusion in the field due to organizations defining contraceptive availability and stock-outs differently, with varying lengths in reporting systems (six months, 12 months, day of visit) and in whether stock-outs are reported for individual methods or types of methods. See chart on next page.

NATIONAL FAMILY PLANNING COMPOSITE INDEX

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

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

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

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USAID | DELIVER Project and RHSC Systems
Strengthening Working Group Stock-Out Indicator Work Stream, September 2013

Service Delivery Points (SDPs)
Most robust stock-out indicators, most difficult to collect, fewest number of countries likely to be able to provide information

Regional/District Warehouses
Medium-robust stock-out indicators, some countries likely to be able to provide information

Central Warehouse (CMS)
Least robust stock-out indicators, simplest to collect, greatest number of countries likely to be able to provide information

SOURCE
USAID | DELIVER Project, 2013
INDICATOR REGARDING CHOICE OF FAMILY PLANNING METHOD

DELIVER/RHSC recommends the following availability indicator to provide an indication of choice:
Percent of SDPs with at least five modern FP methods in stock on day of visit or day of report.

INDICATOR FORMULA
\[
\frac{\text{(Number of SDPs with at least five modern FP methods in stock on day of visit or report)}}{\text{(Total number of SDPs) \times 100}}
\]

STOCK-OUT INDICATOR CALCULATIONS

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

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

The denominator for the stock-out calculations should be the number of facilities that offer the method. Most of the indicators can be measured by brand (e.g., Depo-Provera®) or by method type (e.g., injectable contraceptive). We recommend choosing one of these ways and reporting consistently across countries.

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

MEASUREMENT ISSUES TO CONSIDER FOR SDP-LEVEL INDICATORS

The availability of contraceptives at SDPs is based on:

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

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

Along with being reported across all SDPs, the SDP-level indicators can also be reported by type of SDP.
INDICATORS THAT WILL BE REPORTED ANNUALLY FOR ALL 69 FP2020 COUNTRIES

Indicator 1
Contraceptive Prevalence Rate, Modern Methods (mCPR)

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

1. The first data point is the mCPR from the most recent survey completed in the country. The source for this information is most often a Demographic and Health Survey (DHS) with additional inputs from Multiple Indicator Cluster Survey (MICS), Reproductive Health Survey (RHS), and/or national surveys. The year of the survey can be found at the bottom of the table. The cell has been left blank in countries where the mCPR rate is only available for married or in-union women.

2. The second data point is the 2012 baseline mCPR for each country. The value included for countries with a 2012 DHS survey is derived from the preliminary or final DHS report. For all other countries, the value represents an estimate derived from the Guttmacher Institute was used to estimate contraceptive use among unmarried women that was then added to the number of married women in order to calculate prevalence among all women aged 15-49. In order to perform this calculation, the proportion of married women, among women of reproductive age, was required. The total number of women aged 15-49 by five-year age groups in each country in 2012 was taken from the UN Population Division’s World Population Prospects: the 2012 Revision.

For most countries, the proportions of women who were currently married or in union, formerly married, or never married (for each five-year age group within ages 15-49) were taken from a UN compilation of information from national censuses and surveys. These proportions were assumed to apply to 2012, regardless of the year of the relevant census or survey. Age-specific proportions in each marital status group were applied to 2012 age-specific numbers of women and added to estimate the total number of women aged 15-49 in 2012 in each developing country who were currently married. For countries with more recent survey information than included in the UN database, marital status proportions of women aged 15-49 were updated, and regional estimates or estimates from a similar nearby country were used for the few countries with no available information on marital status.

Indicator 2
Total Number of Contraceptive Users by Method

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


GROWTH RATES

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

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

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

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

Indicator 4
Percentage of married women with an unmet need

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

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

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

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

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

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

Indicator 6
Couple-year of protection (CYP)

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


Number of Married Women Aged 15-49 with Unmet Need for Family Planning

SOURCE
Percent of women with an unmet need is from United Nations Population Division data. This percentage was multiplied by the number of women aged 15-49 from the 2012 UN Population Prospects, and the percent of women married was taken from the 2008 UN marriage database and DHS.
FP2020 countries have high levels of unmet need, with more than 140 million married women estimated to have had an unmet need for family planning in 2012. These are married women who are not currently using family planning but who have expressed that either they do not wish to have additional children or they wish to wait at least two years before having a child. While there are different methodologies used to produce estimates of unmet need, this number is derived from the UN Population Division’s methodology because it produces country-specific estimates as opposed to regional estimates.

The figure to the left shows the number of women with an unmet need in 67 of the 69 FP2020 countries (South Sudan and Western Sahara are omitted due to lack of data). The circle representing India has been reduced in size so that it does not obscure surrounding countries. It should be noted that the FP2020 pledge to reach 120 million additional women with modern methods also aims to increase access among these 140 million women, as well as among unmarried women with an unmet need and women currently using traditional methods who may want to change to a modern form of contraception.

28 Calculated from United Nations Population Division Data on Unmet Need among Married Women and Married Women of Reproductive Age, 15-49.
<table>
<thead>
<tr>
<th>PLEDGING COUNTRY</th>
<th>mCPR (ALL WOMEN AGED 15-49)</th>
<th>MOST RECENT ESTIMATE (%)</th>
<th>2020 ESTIMATE (%)</th>
<th>ADJUST BASELINE FOR 2012 COUNTRY INPUT</th>
<th>% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE)</th>
<th>% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED IN UNION)</th>
<th># USERS OF MODERN CONTRACEPTION (2012 ESTIMATE)</th>
<th>% WOMEN WITH UNMET NEED FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED IN UNION)</th>
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N/A = Not available.
Indicators that Will Be Reported Annually for All 69 FP2020 Countries (Nonpledging Countries)

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N/A = Not available.
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<th>Non-Pledging Countries</th>
<th>2012 Estimate (%)</th>
<th>Most Recent Estimate (%)</th>
<th>% Women with Satisfied Demand for Modern Contraception (2012 Estimate)</th>
<th>% Women with Unmet Need for Modern Contraception (2012 Estimate)</th>
<th>mCPR (All Women Aged 15-49)</th>
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N/A = Not available.

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

Data on the four indicators—mCPR, number of users of modern methods, unmet need, and satisfied demand presented in subsequent progress reports will be obtained directly from countries, in some cases with the assistance of Monitoring & Evaluation officers in country and in some cases through electronic methods (see Track20 and PMA2020 Highlight on page 86). Annual figures will be estimated through two FP2020 innovations: one that utilizes technology for annual data collection and analysis (PMA2020) and one that is introducing country-specific processes that analyze and model available data in making estimates (Track20). The presence of these activities is limited to FP2020 pledging countries, or a subset of pledging countries, so methodologies will differ for nonpledging countries. These processes will provide the data to complete Tables 1 and 2 in subsequent years.
## Table 3 Indicators that Model Impact for All 69 FP2020 Countries (Pledging Countries)

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<th>Pledging Countries</th>
<th># Unintended Preg. (000s)</th>
<th># Unintended Preg. Averted Due to Contraceptive Use (000s)</th>
<th># Maternal Deaths Averted Due to Contraceptive Use</th>
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<td>BANGLADESH</td>
<td>3,518</td>
<td>5,069</td>
<td>1,508</td>
</tr>
<tr>
<td>BURKINA FASO</td>
<td>126</td>
<td>181</td>
<td>51</td>
</tr>
<tr>
<td>CÔTE D’IVOIRE</td>
<td>335</td>
<td>48</td>
<td>152</td>
</tr>
<tr>
<td>DEMOCRATIC REP. OF CONGO</td>
<td>845</td>
<td>1,218</td>
<td>171</td>
</tr>
<tr>
<td>ETHIOPIA</td>
<td>276</td>
<td>398</td>
<td>111</td>
</tr>
<tr>
<td>GHANA</td>
<td>26,993</td>
<td>38,895</td>
<td>11,571</td>
</tr>
<tr>
<td>INDIA</td>
<td>2,384</td>
<td>3,435</td>
<td>1,683</td>
</tr>
<tr>
<td>INDONESIA</td>
<td>635</td>
<td>914</td>
<td>320</td>
</tr>
<tr>
<td>KENYA</td>
<td>248</td>
<td>358</td>
<td>125</td>
</tr>
<tr>
<td>MALAWI</td>
<td>135</td>
<td>194</td>
<td>68</td>
</tr>
<tr>
<td>MOZAMBIQUE</td>
<td></td>
<td></td>
<td>1,242</td>
</tr>
<tr>
<td>NIGER</td>
<td>77</td>
<td>1,064</td>
<td>1,661</td>
</tr>
<tr>
<td>NIGERIA</td>
<td></td>
<td>1,533</td>
<td>2,393</td>
</tr>
<tr>
<td>PAKISTAN</td>
<td></td>
<td>1,179</td>
<td>1,698</td>
</tr>
<tr>
<td>PHILIPPINES</td>
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<td>1,74</td>
<td>251</td>
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<td>RWANDA</td>
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<td>58</td>
<td>84</td>
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<td></td>
<td>52</td>
<td>76</td>
</tr>
<tr>
<td>SIERRA LEONE</td>
<td></td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>SOLOMON ISLANDS</td>
<td></td>
<td>334</td>
<td>481</td>
</tr>
<tr>
<td>UGANDA</td>
<td></td>
<td>180</td>
<td>260</td>
</tr>
<tr>
<td>ZAMBIA</td>
<td></td>
<td>269</td>
<td>387</td>
</tr>
<tr>
<td>ZIMBABWE</td>
<td></td>
<td></td>
<td>136</td>
</tr>
</tbody>
</table>

### Indicators That Model Impact for All 69 FP2020 Countries

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

The numbers were estimated using two scenarios.

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

To produce country-specific estimates, the Guttmacher Institute totals for the 69 countries were proportioned to each country. For the first two indicators—number of unintended pregnancies and number of unintended pregnancies averted due to contraceptive use—the totals were distributed to each country based on the number of users in each country (reported in Table 1). Numbers are reported in thousands and are influenced by the contraceptive prevalence in each country as well as by the number of women who are of reproductive age. The highest numbers were reported for India, which has the largest population and very high contraceptive prevalence. The third indicator—number of unsafe abortions averted due to contraceptive use—was based on distributing the total for the 69 countries according to both the number of users and the WHO 2008 regional abortion rates. The fourth indicator—number of maternal deaths averted due to contraceptive use—was calculated by distributing the total for the 69 countries according to both the number of users and the UN 2010 maternal mortality ratios.
## Indicators that Model Impact for All 69 FP2020 Countries (Nonpledging Countries)

<table>
<thead>
<tr>
<th>Nonpledging Country</th>
<th># Unintended Pregnancies (000s)</th>
<th># Unique Abortions/Averted due to Contraceptive Use (000s)</th>
<th># Maternal Deaths Averted due to Contraceptive Use</th>
<th># Unsafe Abortions Averted due to Contraceptive Use (000s)</th>
<th># Maternal Deaths Contraceptive Use (000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFGHANISTAN</td>
<td>225</td>
<td>324</td>
<td>96</td>
<td>838</td>
<td>151</td>
</tr>
<tr>
<td>BENIN</td>
<td>40</td>
<td>58</td>
<td>16</td>
<td>114</td>
<td>20</td>
</tr>
<tr>
<td>BHUTAN</td>
<td>20</td>
<td>29</td>
<td>9</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td>BOLIVIA</td>
<td>123</td>
<td>177</td>
<td>134</td>
<td>190</td>
<td>0</td>
</tr>
<tr>
<td>BURUNDI</td>
<td>53</td>
<td>77</td>
<td>27</td>
<td>347</td>
<td>0</td>
</tr>
<tr>
<td>CAMBODIA</td>
<td>188</td>
<td>271</td>
<td>133</td>
<td>382</td>
<td>227</td>
</tr>
<tr>
<td>CAMEROON</td>
<td>161</td>
<td>232</td>
<td>73</td>
<td>900</td>
<td>135</td>
</tr>
<tr>
<td>CENTRAL AFRICAN REPUBLIC</td>
<td>30</td>
<td>43</td>
<td>13</td>
<td>213</td>
<td>0</td>
</tr>
<tr>
<td>CHAD</td>
<td>26</td>
<td>38</td>
<td>12</td>
<td>236</td>
<td>22</td>
</tr>
<tr>
<td>COMORES</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>199</td>
<td>8</td>
</tr>
<tr>
<td>CONGO (BRAZZAVILLE)</td>
<td>44</td>
<td>63</td>
<td>20</td>
<td>19</td>
<td>N/A</td>
</tr>
<tr>
<td>DJIBOUTI</td>
<td>12</td>
<td>17</td>
<td>6</td>
<td>19</td>
<td>N/A</td>
</tr>
<tr>
<td>EGYPT</td>
<td>1,684</td>
<td>2,427</td>
<td>765</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>ERITREA</td>
<td>23</td>
<td>33</td>
<td>11</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>GAMBIA</td>
<td>7</td>
<td>10</td>
<td>3</td>
<td>19</td>
<td>N/A</td>
</tr>
<tr>
<td>GUINEA</td>
<td>33</td>
<td>48</td>
<td>13</td>
<td>164</td>
<td>8</td>
</tr>
<tr>
<td>GUINEA-BISSAU</td>
<td>49</td>
<td>71</td>
<td>20</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>HAITI</td>
<td>113</td>
<td>163</td>
<td>20</td>
<td>164</td>
<td>0</td>
</tr>
<tr>
<td>HONDURAS</td>
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<td>322</td>
<td>315</td>
<td>1</td>
</tr>
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<td>IRAQ</td>
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<td>491</td>
<td>142</td>
<td>142</td>
<td>3</td>
</tr>
<tr>
<td>KYRGYZSTAN</td>
<td>65</td>
<td>93</td>
<td>37</td>
<td>37</td>
<td>1</td>
</tr>
<tr>
<td>LAOS</td>
<td>101</td>
<td>146</td>
<td>385</td>
<td>385</td>
<td>4</td>
</tr>
<tr>
<td>LESOTHO</td>
<td>44</td>
<td>63</td>
<td>220</td>
<td>220</td>
<td>5</td>
</tr>
<tr>
<td>LIBERIA</td>
<td>25</td>
<td>36</td>
<td>10</td>
<td>155</td>
<td>1</td>
</tr>
</tbody>
</table>

N/A = Not available.

**Sources:**
1. Number of users taken from Table 1.
INDICATORS THAT WILL BE REPORTED ANNUALLY IN 10 COUNTRIES AND FOR A SUBSET OF THE 69 FP2020 COUNTRIES IN YEARS WITH A DHS

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

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

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

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>% WOMEN PROVIDED WITH FP INFO DURING LAST PROVIDER VISIT</th>
<th>MEAN SCORE ON METHOD INFORMATION INDEX</th>
<th>% WOMEN MAKING FP DECISIONS ALONE OR WITH PARTNER</th>
<th>AGE-ADJUSTED FERTILITY RATE (15-19)</th>
<th>% INFORMED OF PERMANENCE OF STERILIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comoros</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congo (Brazzaville)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>19</td>
<td>31</td>
<td>81.6</td>
<td>94</td>
<td>70</td>
</tr>
<tr>
<td>Guinea</td>
<td></td>
<td></td>
<td></td>
<td>147</td>
<td>129</td>
</tr>
<tr>
<td>Haiti</td>
<td>40</td>
<td>55</td>
<td>91.4</td>
<td>146</td>
<td>86</td>
</tr>
<tr>
<td>Honduras</td>
<td>35</td>
<td>30</td>
<td>88.0</td>
<td>101</td>
<td>87</td>
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<tr>
<td>Indonesia</td>
<td>23</td>
<td>24</td>
<td>91.5</td>
<td>48</td>
<td>87</td>
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<tr>
<td>Kyrgyzstan</td>
<td></td>
<td></td>
<td></td>
<td>44</td>
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</tr>
<tr>
<td>Laos</td>
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<td></td>
<td></td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Niger</td>
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<td>206</td>
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</tr>
</tbody>
</table>

PMA2020 Countries/Partners: Ghana (Kwame Nkrumah University of Science & Technology), Ethiopia (Addis Ababa University School of Public Health), Uganda (Makerere University School of Public Health), Nigeria (Obafemi Awolowo University and University of Ibadan), Democratic Republic of Congo (University of Kinshasa School of Public Health), Kenya (TBD), Senegal (TBD), Burkina Faso (TBD), India (TBD), Indonesia (TBD).
**TRACK20**

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

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**PERFORMANCE MONITORING AND ACCOUNTABILITY 2020 (PMA2020)**

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

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

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

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

There are many different reasons why a few methods dominate the method mix in so many FP2020 countries, including access, availability, and preferences. Further research at the country level can help FP2020 countries better understand the needs of women and why some methods are being chosen more than others. By ensuring the availability of a full range of modern family planning methods, FP2020 will play an important role in diversifying the method mix in places where access is limited.
Countries with \( \geq 20\% \) of the Method Mix (All Users, Both Modern and Traditional Methods) Attributed to 1, 2, or 3 Modern Methods

Countries where traditional method use is \( \geq 25\% \) of the method mix are highlighted in white.

<table>
<thead>
<tr>
<th>( \leq 1 ) Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
</tr>
<tr>
<td>Benin</td>
</tr>
<tr>
<td>Bhutan</td>
</tr>
<tr>
<td>Bolivia</td>
</tr>
<tr>
<td>Burundi</td>
</tr>
<tr>
<td>Cameroon</td>
</tr>
<tr>
<td>Central African Republic</td>
</tr>
<tr>
<td>Chad</td>
</tr>
<tr>
<td>Comoros</td>
</tr>
<tr>
<td>Congo (Brazzaville)</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>Djibouti</td>
</tr>
<tr>
<td>Egypt</td>
</tr>
<tr>
<td>Ethiopia</td>
</tr>
<tr>
<td>Guinea</td>
</tr>
<tr>
<td>India</td>
</tr>
<tr>
<td>Iraq</td>
</tr>
<tr>
<td>Kenya</td>
</tr>
<tr>
<td>Madagascar</td>
</tr>
<tr>
<td>Mauritania</td>
</tr>
<tr>
<td>Nepal</td>
</tr>
<tr>
<td>Nigeria</td>
</tr>
<tr>
<td>North Korea</td>
</tr>
<tr>
<td>Occupied Palestinian Territories</td>
</tr>
<tr>
<td>Rwanda</td>
</tr>
<tr>
<td>Somalia</td>
</tr>
<tr>
<td>South Africa</td>
</tr>
<tr>
<td>Tajikistan</td>
</tr>
<tr>
<td>Tanzania</td>
</tr>
<tr>
<td>Timor-Leste</td>
</tr>
<tr>
<td>Togo</td>
</tr>
<tr>
<td>Uganda</td>
</tr>
<tr>
<td>Uzbekistan</td>
</tr>
<tr>
<td>Vietnam</td>
</tr>
<tr>
<td>Zimbabwe</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>2 Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
</tr>
<tr>
<td>Burkina Faso</td>
</tr>
<tr>
<td>Cambodia</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
</tr>
<tr>
<td>Eritrea</td>
</tr>
<tr>
<td>Gambia</td>
</tr>
<tr>
<td>Ghana</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
</tr>
<tr>
<td>Haiti</td>
</tr>
<tr>
<td>Honduras</td>
</tr>
<tr>
<td>Indonesia</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
</tr>
<tr>
<td>Laos</td>
</tr>
<tr>
<td>Malawi</td>
</tr>
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<td>Mongolia</td>
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<tr>
<td>Myanmar</td>
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<td>Nicaragua</td>
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<td>Niger</td>
</tr>
<tr>
<td>Pakistan</td>
</tr>
<tr>
<td>Senegal</td>
</tr>
<tr>
<td>Sierra Leone</td>
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<td>Solomon Islands</td>
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<td>Sri Lanka</td>
</tr>
<tr>
<td>Yemen</td>
</tr>
<tr>
<td>Zambia</td>
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<table>
<thead>
<tr>
<th>3 Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho</td>
</tr>
<tr>
<td>Liberia</td>
</tr>
<tr>
<td>Mali</td>
</tr>
<tr>
<td>Mozambique</td>
</tr>
<tr>
<td>Sao Tome and Principe</td>
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</table>

<table>
<thead>
<tr>
<th>40% - 60%</th>
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<tbody>
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</tr>
<tr>
<td>Bangladesh</td>
</tr>
<tr>
<td>Bhutan</td>
</tr>
<tr>
<td>Bolivia</td>
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<tr>
<td>Burundi</td>
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<tr>
<td>Cameroon</td>
</tr>
<tr>
<td>Chad</td>
</tr>
<tr>
<td>Congo (Brazzaville)</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
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<tr>
<td>Egypt</td>
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<tr>
<td>Gambia</td>
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<td>Haiti</td>
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<tr>
<td>Indonesia</td>
</tr>
<tr>
<td>Kenya</td>
</tr>
<tr>
<td>Laos</td>
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<td>Madagascar</td>
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<td>Myanmar</td>
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<tr>
<td>Niger</td>
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<tr>
<td>Occupied Palestinian Territories</td>
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<td>Philippines</td>
</tr>
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<td>Rwanda</td>
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<td>Sierra Leone</td>
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<td>South Sudan</td>
</tr>
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<td>Togo</td>
</tr>
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<td>Uganda</td>
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</table>

<table>
<thead>
<tr>
<th>( \geq 60% )</th>
</tr>
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<tbody>
<tr>
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<td>Ethiopia</td>
</tr>
<tr>
<td>India</td>
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<tr>
<td>Kyrgyzstan</td>
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<td>Mauritania</td>
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<td>Tajikistan</td>
</tr>
<tr>
<td>Timor-Leste</td>
</tr>
<tr>
<td>Uzbekistan</td>
</tr>
</tbody>
</table>

**Sources**

Method mix data were unavailable for Papua New Guinea, Sudan, and Western Sahara. For countries where method mix data for all women were unavailable, data for women married/in union was used. Method mix data sources were the same as for the most recent mCPR estimates in Table 1, with the following exceptions:

- Afghanistan (MICS 2011), Bangladesh (DHS 2011), Benin (DHS 2012), Bhutan (MICS 2010), Central African Republic (MICS 2010), Chad (MICS 2010), Comoros (DHS 2012), Congo-Brazzaville (DHS 2012), Democratic Republic of Congo (MICS 2010), Djibouti (MICS 2008), Egypt (DHS 2008), Gambia (DHS 2013), Ghana (MICS 2011), Guinea-Bissau (MICS 2010), India (DHS 2008), Iraq (MICS 2011), Kyrgyzstan (DHS 2012), Laos (MICS/DHS 2012), Mali (DHS 2013), Mauritania, (MICS 2007), Mongolia (MICS 2010), Myanmar (MICS 2010), Niger (DHS 2012), Nigeria (MICS 2011), Occupied Palestinian Territories (FHS 2006), Pakistan (DHS 2013), Philippines (FHS 2011), Sierra Leone (MICS 2010), Sao Tome and Principe (DHS 2009), Solomon Islands (National Survey 2007), Somalia (MICS 2006), South-Sudan (BHHS2 2010), Sri Lanka (DHS 2007), Tajikistan (DHS 2012), Timor-Leste (DHS 2010), Togo (MICS 2011), Yemen (MICS 2006). Original sources for North Korea and Solomon Islands could not be located for these two countries, method mix data was obtained from the UN Population Division World Contraceptive Use 2012.
Monitoring family planning expenditures is an important means of holding stakeholders accountable for their commitments and to measure progress in mobilizing sufficient resources to achieve FP2020 goals. Historically, family planning expenditures have been estimated periodically through special expenditure studies and national health accounts applications.

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

NEW COLLABORATIVE TO TRACK EXPENDITURES

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

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

UNFPA/NIDI

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

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

WHO/COIA

The World Health Organization (WHO), as part of the implementation of the Commission on Information and Accountability (COIA) recommendations, is supporting the enhancement of member states' tracking of health expenditures. WHO promotes the use of health accounts software, which collects and maps all expenditures following the standard System of Health Accounts (SHA) 2011 categories. Program-specific expenditures are estimated by collecting earmarked flow-of-funds data and distributing non-earmarked spending using allocation algorithms, based on information such as number of health visits. The collection of family planning–specific expenditure data has been incorporated into WHO overall work on tracking of expenditures. Unrolling of training and technical assistance started in 2013 with applications in about 20 countries. Ultimately, this should expand in the next few years to a total of about 70 low- and middle-income countries.

DELIVER

The USAID-funded DELIVER project has developed a tool to assist countries in tracking the financing for contraceptive commodities. The Contraceptive Finance Tracking Guide has been piloted in Ghana and Uganda. DELIVER is also developing a training curriculum and a web-based guide. Track20 will work with DELIVER to provide training in the use of the tool to family planning M&E officers. This should ensure that financing for family planning commodities is tracked carefully in key countries.
It is inspiring to see Tanzania’s growing commitment to family planning. The government and the private sector are working together to meet the unmet need for family planning. The future looks bright for women and girls in my country.

HALIMA SHARIFF
COUNTRY DIRECTOR, TANZANIA, ADVANCE FAMILY PLANNING, JOHN HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH CENTER FOR COMMUNICATIONS PROGRAM
REFERENCE GROUP
The Reference Group’s purpose is to provide strategic direction and oversight of FP2020.

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

CO-CHAIR -
DR. BABATUNDE OSOTIMEHIN
UNFPA

DR. WAPADA BALAMI
Ministry of Health, Nigeria

DR. TEWODROS BEKELE
Ministry of Health, Ethiopia

DR. FLAVIA BUSTREO
World Health Organization

KATHY CALVIN
United Nations Foundation

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

JANE EDMONDSON
UK Department for International Development

DR. TORE GODAL
Ministry of Foreign Affairs, Norway

ANURADHA GUPTA
Ministry of Health and Family Welfare, India

DR. KELLY HENNING
Bloomberg Philanthropies

JANE WAMBUI KIRAGU
Satima Consultants, Ltd., Kenya

TEWODROS MELESSE
International Planned Parenthood Federation

POONAM MUTTREJA
Population Foundation of India

DR. ARIEL PABLOS-MENDEZ
USAID

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

JOHN SKIBIAK
Reproductive Health Supplies Coalition

DR. JULIANTO WITJAKSONO
National Population Family Planning Agency, Indonesia

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

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

CO-LEAD -
ELLEN STARBIRD
USAID

DR. ABOSEDE ADENIRAN
Federal Health Ministry, Nigeria

DR. MUHAMMED ASLAM
Bayer

DR. ARTHUMAN BAKER
NDUGGA MAGGWA
FHI 360

DR. RITA COLUMBIA
United Nations Population Fund

DR. BOCAR DAFF
Ministry of Health, Senegal

DR. ABU JAMIL FAISEL
EngenderHealth

DR. SITI FATHONAH
National Population and Family Planning Coordinating Board, Indonesia
The Market Dynamics Working Group will improve the availability, affordability, and variety of quality family planning methods.

CO-LEAD - JOHN SKIBIAK
Reproductive Health Supplies Coalition

CO-LEAD - ALAN STAPLE
Clinton Health Access Initiative

SHARAD AGARWAL
Hindustan Latex Family Planning Promotion Trust, India

FRANCOISE ARMAND
Abt Associates

WOLFGANG BECKER JEZUITA
Bayer Pharma AG

KRISHNA JAFAR BHUSHAN
Population Services International

TRACEY BRETT
Marie Stopes International

FABIO CASTANO
Management Sciences for Health

LESTER CHINERY
Concept Foundation

LESTER COUTINHO
David & Lucile Packard Foundation

JAMES DROOP
UK Department for International Development

IMANOL ECHEVARRIA
Pfizer

MARCEL HENDRICKS
I+ Solutions

THOMAS HOW
International Planned Parenthood Federation

VENKATESWARAN IYER
Famy Care Limited

YONG LI
Zizhu Pharmaceuticals

BEATRICE MUTALI
Merck

NORA QUESADA
John Snow Inc.

SANGEETA RAJA
World Bank

MARK RILLING
USAID

TRISHA WOODS SANTOS
Bill & Melinda Gates Foundation

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

CO-LEAD - DR. Zeba Sathar
Population Council, Pakistan

CO-LEAD - DR. MARLEEN TEMMERMAN
World Health Organization

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

DR. IAN ASKEW
Population Council

ANN BIDDLECOM
United Nations Population Division

DR. WIN BROWN
Bill & Melinda Gates Foundation

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

CO-LEAD - SUZANNE EHLERS
Population Action International

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

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

MUHOMMAD BUN BIDA
Muslim Family Counseling Services

JACQUELINE BRYLD
Danish Family Planning Association

ELIZABETH TYLER CRONE
ATHENA Network

RADIO DIALLO
Population Services International

DR. CHRISTINE GALAVOTTI
CARE

NOMUHLE GOLA
Restless Development

JANE HOBSON
UK Department for International Development

SANDRA JORDAN
USAID

JAMES KITYO
International HIV/AIDS Alliance

ELLY LEEMHUIS-DE REGT
Ministry of Foreign Affairs, Netherlands

LUIS MORA
United Nations Population Fund

KAREN NEWMAN
Population and Sustainability Network

KINYANUI NYAMBURA
Health Rights Advocacy Forum

FAUSTINA FYNN NYAME
Marie Stopes International

DR. JOHN TOWNSEND
Population Council

DR. RAVI VERMA
International Center for Research on Women

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VALERIE DEFILLIPO
Director

ZAHRA AZIZ
Senior Communications Officer

RATI BISHNOI
Knowledge Management and Innovations Manager

KELLY DUDINE
Communications Associate

MABINTY KOROMA
Working Group Manager

NINA MILLER
Working Group Manager

KATE PETERS
Administrative Assistant

JESSICA SCHWARTZMAN
Working Group Manager

EMILY SMITH
Program Associate

ERIKA STUDT
Working Group Associate

ALISA WONG
Working Group Manager
ANNEX 2 COMMITMENT MAKERS
As of October 2013

COMMITMENT-MAKING COUNTRIES

- BANGLADESH
- BURKINA FASO
- CÔTE D’IVOIRE
- ETHIOPIA
- GHANA
- INDIA
- INDONESIA
- KENYA
- LIBERIA
- MALAWI
- MOZAMBIQUE
- NIGER
- NIGERIA
- PAKISTAN
- PHILIPPINES
- RWANDA
- SENEGAL
- SIERRA LEONE
- SOLOMON ISLANDS
- SOUTH AFRICA
- TANZANIA
- UGANDA
- ZAMBIA
- ZIMBABWE

PRIVATE SECTOR & CIVIL SOCIETY

- ACTIONAID
- ADVANCE FAMILY PLANNING
- CARE INTERNATIONAL
- DSW (DEUTSCHE STIFTUNG WELTBEVÖLKERUNG)
- FHI 360
- FEMALE HEALTH COMPANY
- GUTTMACHER INSTITUTE
- INTERNATIONAL CENTER FOR RESEARCH ON WOMEN (ICRW)
- INTERACT WORLDWIDE
- INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF)
- INTRAHEALTH
- IPAS
- JHPIEGO
- MARIE STOPES INTERNATIONAL (MSI)
- MERCK FOR MOTHERS
- PATHFINDER INTERNATIONAL
- PLANNED PARENTHOOD FEDERATION OF AMERICA AND PLANNED PARENTHOOD GLOBAL
- POPULATION ACTION INTERNATIONAL (PAI)
- POPULATION COUNCIL
- POPULATION REFERENCES BUREAU
- ROTARIAN ACTION GROUP FOR POPULATION AND DEVELOPMENT (RFPD)
- REPRODUCTIVE HEALTH SUPPLIES COALITION (RHSC)/RESOURCE MOBILIZATION AND AWARENESS WORKING GROUP (RMAWG)
- SAVE THE CHILDREN
- WOMANCARE GLOBAL AND PSI
DONOR COUNTRIES

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

COMMITMENT-MAKING COUNTRIES

- Australia
- Denmark
- European Commission
- France
- Germany
- Japan
- Netherlands
- Norway
- South Korea
- Sweden
- United Kingdom

FOUNDATIONS

- Aman Foundation
- Bill & Melinda Gates Foundation
- Bloomberg Philanthropies
- Children’s Investment Fund Foundation (CIFF)
- David and Lucile Packard Foundation
- United Nations Foundation
- William and Flora Hewlett Foundation

UN, MULTILATERALS, & PARTNERSHIPS

- United Nations Population Fund (UNFPA)
- World Bank
- World Health Organization (WHO)
- Norway, Bill & Melinda Gates Foundation, and United Kingdom
List of the 69 poorest countries in the developing world by region and subregion (with 2010 gross national per-capita annual income less than or equal to US$2,500)

**EASTERN AFRICA**
- Burundi
- Comoros
- Djibouti
- Eritrea
- Ethiopia
- Kenya
- Madagascar
- Malawi
- Mozambique
- Rwanda
- Somalia
- Tanzania
- Uganda
- Zambia
- Zimbabwe

**CENTRAL AFRICA**
- Cameroon
- Central African Republic
- Chad
- Congo (Brazzaville)
- Democratic Republic of Congo
- Sao Tome and Principe

**NORTHERN AFRICA**
- Egypt
- South Sudan
- Sudan
- Western Sahara

**SOUTHERN AFRICA**
- Lesotho

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

**CENTRAL ASIA**
- Kyrgyzstan
- Tajikistan
- Uzbekistan

**EASTERN ASIA**
- Mongolia
- North Korea

**SOUTH ASIA**
- Afghanistan
- Bangladesh
- Bhutan
- India
- Nepal
- Pakistan
- Sri Lanka

**SOUTHEAST ASIA**
- Cambodia
- Indonesia
- Laos
- Myanmar
- Philippines
- Timor-Leste
- Vietnam

**WESTERN ASIA**
- Iraq
- Occupied Palestinian Territories
- Yemen

**CARIBBEAN**
- Haiti

**CENTRAL AMERICA**
- Honduras
- Nicaragua

**SOUTH AMERICA**
- Bolivia

**OCEANIA**
- Papua New Guinea
- Solomon Islands
### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUSAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>AFP</td>
<td>Advance Family Planning</td>
</tr>
<tr>
<td>BMGF</td>
<td>Bill &amp; Melinda Gates Foundation</td>
</tr>
<tr>
<td>CEWG</td>
<td>Country Engagement Working Group (FP2020)</td>
</tr>
<tr>
<td>CH</td>
<td>Child Health</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>COIA</td>
<td>Commission on Information and Accountability</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>CYP</td>
<td>Couple-Year of Protection</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development (United Kingdom)</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>EWEC</td>
<td>Every Woman Every Child</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<td>FP2020</td>
<td>Family Planning 2020 initiative</td>
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<tr>
<td>FPEI</td>
<td>Family Planning Effort Index</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IERG</td>
<td>Independent Expert Review Group</td>
</tr>
<tr>
<td>JHPIEGO</td>
<td>Johns Hopkins Program for International Education in Gynecology and Obstetrics</td>
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<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>KFF</td>
<td>Kaiser Family Foundation</td>
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<tr>
<td>LARC</td>
<td>Long-Acting Reversible Contraceptive</td>
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<tr>
<td>mADDs</td>
<td>Mobile-Assisted Data and Dissemination System</td>
</tr>
<tr>
<td>MAF</td>
<td>MDG Acceleration Framework</td>
</tr>
<tr>
<td>mCPR</td>
<td>Contraceptive Prevalence Rate, Modern Methods</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MD WG</td>
<td>Market Dynamics Working Group (FP2020)</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Measurement and Evaluation</td>
</tr>
<tr>
<td>MH</td>
<td>Maternal Health</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>NFPCI</td>
<td>National Family Planning Composite Index</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NHA</td>
<td>National Health Account</td>
</tr>
<tr>
<td>NIDI</td>
<td>Netherlands Interdisciplinary Demographic Institute</td>
</tr>
<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
</tr>
<tr>
<td>OECD DAC</td>
<td>Organisation for Economic Co-operation and Development’s Development Assistance Committee</td>
</tr>
<tr>
<td>PMA WG</td>
<td>Performance Monitoring &amp; Accountability Working Group (FP2020)</td>
</tr>
<tr>
<td>PMA2020</td>
<td>Performance Monitoring &amp; Accountability 2020 (Project)</td>
</tr>
<tr>
<td>PMNCH</td>
<td>Partnership for Maternal, Newborn, and Child Health</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>RHS</td>
<td>Reproductive Health Survey</td>
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<tr>
<td>RHSC</td>
<td>Reproductive Health Supplies Coalition</td>
</tr>
<tr>
<td>RG</td>
<td>Reference Group (FP2020)</td>
</tr>
<tr>
<td>RMNCH+A</td>
<td>Reproductive, Maternal, Newborn, and Child Health plus Adolescents</td>
</tr>
<tr>
<td>RE WG</td>
<td>Rights &amp; Empowerment Working Group (FP2020)</td>
</tr>
<tr>
<td>SHA</td>
<td>System of Health Accounts</td>
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<tr>
<td>SOP</td>
<td>Standards of Practice</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNF</td>
<td>United Nations Foundation</td>
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<tr>
<td>UNPD</td>
<td>United Nations Population Division</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Family Planning 2020 (FP2020) is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multilateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. FP2020 is an outcome of the 2012 London Summit on Family Planning, where more than 20 governments made commitments to address the policy, financing, delivery, and sociocultural barriers to women accessing contraceptive information, services, and supplies. Donors also pledged an additional US$2.6 billion in funding.

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

The United Nations Foundation builds public-private partnerships to address the world’s most pressing problems, and broadens support for the United Nations through advocacy and public outreach. Through innovative campaigns and initiatives, the Foundation connects people, ideas, and resources to help the UN solve global problems. The Foundation was created in 1998 as a U.S. public charity by entrepreneur and philanthropist Ted Turner and now is supported by global corporations, foundations, governments, and individuals.
FP2020 Partnership in Action
benefited from many individuals and
organizations whose assistance
proved invaluable in creating this
report. We are deeply grateful for
the guidance and support of our
partners at the UK Department
for International Development, the
Bill & Melinda Gates Foundation,
the United Nations Population Fund,
and the United States Agency for
International Development. We
wish to acknowledge in particular
the Performance Monitoring &
Accountability Working Group
(PMA WG) co-leads Zeba Sathar
(Population Council) and Marleen
Temmerman (World Health Organi-
zation), as well as the focal points
of the PMA WG subgroup on indica-
tors, Win Brown (Bill & Melinda Gates
Foundation) and Michelle Weinberger
(Marie Stopes International), for
their substantive inputs and review
of the measurement section of this
report. Tremendous thanks to Bridget
Anyafulu of the International Centre
for Women’s Empowerment and
Child Development and member of
the Rights & Empowerment Working
Group for reminding us why women
need to remain at the heart of
global development.

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

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

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

FEEDBACK

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

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

Suggested citation:
FP2020 Progress Report
2012-2013: Partnership in
ANNEX 4
CROSS-INSTITUTIONAL COLLABORATION
There are several concrete examples of cross-institutional collaboration with FP2020. For example, FP2020 has shared countries’ costed implementation plans (CIPs) with the UN Special Envoy’s Office, in support of its efforts to achieve MDG5 through the creation of an MDG5 roadmap.

FP2020 also collaborates with the RMNCH Steering Committee and corresponding Strategy and Coordination Team to ensure that family planning plans are integrated within RMNCH plans during RMNCH’s resource alignment and mobilization exercises. Through this process, RMNCH should be able to support FP2020 efforts to close funding gaps where they exist in costed national family planning plans.

FP2020 now serves on the RMNCH Steering Committee as a meeting observer. FP2020 invited RMNCH to participate in the March 2014 CE WG meeting. FP2020 shared CIPs with RMNCH — including Senegal, Malawi and Ouagadougou Partnership FP plans — to ensure national family planning plans are part of the RMNCH country engagement process. And FP2020 provides updates and information to RMNCH as requested in advance of country visits (e.g., Nigeria).

As noted earlier, FP2020 is collaborating with PMNCH on data gathering for the tracking of a subset of FP2020 commitments. The initiative is also collaborating on a working group with the Executive Office of the UN Secretary General on the development of future online accountability platforms. In addition, FP2020’s Reference Group and Working Group membership comprises of individuals from a wide-range of organizations that bring diverse perspectives and entry points for cross-institutional collaboration. For a complete list of the Reference Group and Working Group members, please see Annex 8.
ANNEX 5
WORKING GROUP WORK PLANS
THE PURPOSE OF THE RIGHTS & EMPOWERMENT WORKING GROUP (RE WG) IS TO PROVIDE TECHNICAL ADVICE AND SUPPORT TO FP2020 TO: A.) ENSURE THAT ALL ACTIVITIES OF FP2020 ARE UNDERPINNED BY A RIGHTS-BASED APPROACH AND THAT WOMEN’S AND GIRLS’ PERSPECTIVES AND RIGHTS ARE OBSERVED IN ALL PROGRAMS AND ACTIVITIES B.) SUPPORT THE DEVELOPMENT OF APPROACHES TO ADDRESS THE FULL RANGE OF BARRIERS THAT PREVENT AND LIMIT WOMEN’S AND GIRLS’ ABILITY TO MAKE REPRODUCTIVE DECISIONS/CHOICES FOR MODERN METHODS OF FAMILY PLANNING (FP) AND TO ACT ON THESE DECISIONS ON THE BASIS OF FULL, FREE AND INFORMED CONSENT AND, C.) PERFORMANCE MONITORING AND ACCOUNTABILITY (PMA), MARKET DYNAMICS (MD) AND COUNTRY ENGAGEMENT (CE) WORKING GROUPS WITH MATERIALS, INFORMATION, RESEARCH, BEST PRACTICES AND PROPOSALS FOR INDICATORS THAT WILL STRENGTHEN THEIR WORK.

OBJECTIVES

The specific objectives of the RE WG are to:

- Establish the rights-based frame that will underpin and inform FP2020
- Serve as the focal point for rights and empowerment expertise and support implementation of good practices and indicators explicitly incorporated into program design, implementation and evaluation that will assure Family Planning 2020 is successful and promotes, respects, protects and fulfills the rights of women and girls, men and boys
- Serve as the body that will gather and review multisectoral approaches, global definitions and principles that are consistent with a human rights approach
- Propose the related goals and indicators for FP2020 success in achieving rights-based results
- Work with and provide support to all working groups to ensure their work advances human rights principles of participation, accountability, non-discrimination and empowerment to improve the ability of all working groups to achieve their objectives
- Stimulate wide ranging discussion — and shared understanding — at global, regional and country levels on rights-based approaches to family planning and lessons learned from existing multisectoral approaches that are being utilized to provide a human rights, gendered, and youth sensitive frame to rights-based family planning programs
- Through a wider R&E consultative group (see following pages), engage with CSOs and other stakeholders in the North and South on a regular basis to provide updates on progress, solicit input and information, and to continue the dialogue around rights and empowerment in family planning
### Task 1: Determine a unified understanding of rights-based programming to underpin the work of all FP2020 working groups

<table>
<thead>
<tr>
<th>Activities</th>
<th>Deliverables</th>
<th>Timeframe</th>
<th>Persons Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 COLLECT AND ANALYZE RELEVANT FRAMEWORKS, INCLUDING: VOLUNTARY FAMILY PLANNING PROGRAMS THAT RESPECT, PROTECT AND FULFILL HUMAN RIGHTS; OPTIMIZING HUMAN RIGHTS IN THE PROVISION OF CONTRACEPTIVE INFORMATION AND SERVICES: GUIDANCE AND RECOMMENDATIONS (WHO)</td>
<td>One page analysis identifying/comparing key characteristics of frameworks including audience</td>
<td>Activities 1-3 completed by end of Q2</td>
<td>Activities 1-3: Suzanne (Lead) with support from WS1 members/Task Team Endorsement by full RE WG</td>
</tr>
<tr>
<td>02 PRODUCE A DRAFT SUITE OF FOUNDATIONAL MATERIALS STATING FP2020’S POSITION ON RIGHTS AND RIGHTS-BASED FRAMEWORKS FOR FAMILY PLANNING INCLUDING A STATEMENT OF UNIVERSAL PRINCIPLES, RELATED RESOURCE DOCUMENT AND A MESSAGING MEMO.</td>
<td>Presentation including materials and rationale to full RE WG</td>
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</table>

### Task 2: Translate product developed in Task 1 into practical tools to inform human rights-based approaches to family planning programming

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<thead>
<tr>
<th>Activities</th>
<th>Deliverables</th>
<th>Timeframe</th>
<th>Persons Responsible</th>
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<tbody>
<tr>
<td>01 COLLATE AND ANALYZE EXISTING PRACTICAL TOOLS FOR USE IN PROGRAMMING FOR COUNTRIES AND IMPLEMENTERS</td>
<td>Compendium of identified practical tools</td>
<td>Activities 1-2 completed by Q2</td>
<td>Activity 1-3: Suzanne (Lead) with WS1 members/RE WG Manager and Associate Coordination with CE WG to determine needs so that deliverables are aligned with CE WG goals and timelines</td>
</tr>
<tr>
<td>02 REVIEW, IDENTIFY, ADDRESS GAPS</td>
<td>Gap analysis</td>
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<tr>
<td>ACTIVITIES</td>
<td>DELIVERABLES</td>
<td>TIMEFRAME</td>
<td>PERSONS RESPONSIBLE</td>
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<tr>
<td>03</td>
<td>Develop best practices and practical guidance/tools for countries and conduct country-level test of concepts (in partnership with CE WG) for FP2020 resource kit</td>
<td>First draft of easy-to-use tool to ensure best practices are incorporated in FP planning</td>
<td>Activity 3 completed by Q3</td>
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</tbody>
</table>

**Task 3: Strategic Communications**

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
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<th>PERSONS RESPONSIBLE</th>
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</thead>
<tbody>
<tr>
<td>01</td>
<td>Identify strategic opportunities to profile countries as models of the gold standard of promoting and protecting human rights, including countries that have made progress (e.g., through peer to peer learning to establish resonance at national level)</td>
<td>External communications, official statements, meetings, etc.</td>
<td>Activity 1: As needed</td>
</tr>
<tr>
<td>02</td>
<td>Develop a CSO/NGO guide to rights-based contraceptive and family planning services, based on WHO guidelines</td>
<td>Strategy for FP2020's response to human rights violations</td>
<td>Activities 2-4 completed by end of Q3</td>
</tr>
<tr>
<td>03</td>
<td>Develop guideline for adaptation and implement a course of adaptation with national partners</td>
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<tr>
<td>04</td>
<td>Determine a strategy on how and if FP2020 will respond in the event that a human rights violation occurs</td>
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<tr>
<td>ACTIVITIES</td>
<td>DELIVERABLES</td>
<td>TIMEFRAME</td>
<td>PERSONS RESPONSIBLE</td>
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<tr>
<td>05 ASSESS AND MODIFY RE WG TOOLS AND PRODUCTS AND ENSURE INFORMED BY UNIFIED UNDERSTANDING OF FP2020 RIGHTS-BASED PROGRAMMING.</td>
<td>Strategy to engage consultative network (e.g. webinars, most targeted sub-lists, electronic communication)</td>
<td>Activity 5: Ongoing</td>
<td>Activity 5: RE WG/RE WG Manager and Associate</td>
</tr>
<tr>
<td>06 DEVELOP STRATEGY TO ENGAGE BROADER COMMUNITY (CONSULTATIVE NETWORK)</td>
<td></td>
<td>Activity 6 completed by end of Q2</td>
<td>Activity 6: Task Team with RE WG</td>
</tr>
<tr>
<td>07 PROVIDE TECHNICAL ASSISTANCE TO ENSURE RIGHTS AND EMPOWERMENT REPRESENTED IN OTHER WG PRODUCTS/PROGRAMMING (AND AS A RESOURCE FOR “EXTERNAL” PARTNERS WHERE APPROPRIATE)</td>
<td></td>
<td>Activity 7: Ongoing</td>
<td>Activity 7: RE WG/RE WG Manager and Associate</td>
</tr>
</tbody>
</table>
## WORK STREAM 2 (WS2): RIGHTS & EMPOWERMENT AT THE COUNTRY LEVEL

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>DELIVERABLES</th>
<th>TIMEFRAME</th>
<th>PERSONS RESPONSIBLE/DEPENDENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task 1: Country Plans</strong></td>
<td></td>
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<tr>
<td>01</td>
<td>REVIEW EXISTING COUNTRY PLANS AND ASSESSMENT TOOLS TO INFORM CRITERIA FOR DEVELOPING/ASSESSING COUNTRY PLANS FROM R&amp;E PERSPECTIVE</td>
<td>Agreed first draft of criteria for assessing country plans</td>
<td>Activity 1: January 15, 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indicators for developing/assessing country plans</td>
<td>Activity 2: February 15, 2014</td>
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<td></td>
<td>Final guidance for developing/assessing country plans</td>
<td>Activity 3: February 21, 2014 (and then review final draft in line with CE WG timeline)</td>
</tr>
<tr>
<td><strong>04</strong></td>
<td>AUDIT OF EXISTING FP2020 COUNTRY PLANS AND MAKE RECOMMENDATIONS TO STRENGTHEN RIGHTS-BASED PROGRAMMING</td>
<td>All FP2020 country plans reviewed using guidance template</td>
<td>Activity 4: 5 plans reviewed by end of Q2 and then ongoing</td>
</tr>
</tbody>
</table>

*country plans to shared
<table>
<thead>
<tr>
<th>Activities</th>
<th>Deliverables</th>
<th>Timeframe</th>
<th>Persons Responsible/Dependencies</th>
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</thead>
<tbody>
<tr>
<td><strong>Task 2: Technical Assistance</strong></td>
<td></td>
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<tr>
<td>01</td>
<td>Package training tools and best practices for dissemination</td>
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<td></td>
<td>Tools available to countries</td>
<td>Activity 1: Q2 to Q4</td>
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<td></td>
<td></td>
<td></td>
<td>Persons Responsible: Luis Mora, Faustina Fynn-Nyame, Nomuhle Gola</td>
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<td></td>
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<td></td>
<td>Dependencies: Funding for training, Collaboration with CE WG</td>
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<tr>
<td><strong>Task 3: Participate in related CE WG subgroup</strong></td>
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</tr>
<tr>
<td>01</td>
<td>Participate in relevant CE WG subgroup meetings and provide input from RE WG perspective</td>
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<tr>
<td>02</td>
<td>Share information with full RE WG</td>
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<td></td>
<td>RE WG Manager/Associate, RE WG delegates</td>
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<td></td>
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<td>*pending further discussion with WG members</td>
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</table>
### WORK STREAM 3 (WS3): RIGHTS & EMPOWERMENT IN THE FIELD OF MARKET DYNAMICS

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>DELIVERABLES</th>
<th>TIMEFRAME</th>
<th>PERSONS RESPONSIBLE/DEPENDENCIES</th>
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</thead>
<tbody>
<tr>
<td><strong>Task 1: Landscaping</strong></td>
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</tr>
<tr>
<td>01 DEPLOY SHORT PAPER SETTING OUT KEY ISSUES AND POSSIBLE ENTRY POINTS</td>
<td>Complete Landscaping to inform 2014-2015 work plan</td>
<td>January 15</td>
<td>Persons responsible: John Townsend and Jane Hobson</td>
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<tr>
<td>02 DISCUSS WITH KEY MEMBERS IN THE FIELD</td>
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<tr>
<td>03 CONDUCT A PRELIMINARY RISK ASSESSMENT</td>
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<tr>
<td><strong>Task 2: Operationalize landscaping/determine key issues to work on in depth</strong></td>
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<tr>
<td>01 DETERMINE ONE-PAGE REVIEW OF KEY ISSUES TO WORK ON IN DEPTH</td>
<td>Recommendations to inform updated 2014 Work Plan</td>
<td>January 30</td>
<td>Persons responsible: John Townsend (Lead) with RE Manager and Associate and select WG members</td>
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<tr>
<td>• One-page review of each of the key issues</td>
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<td>• Pre-test key recommendations</td>
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<td>• Identify target audiences</td>
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<td>• Specify ideal format and channels for distribution</td>
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<tr>
<td>• Harmonize output of this work and other work streams</td>
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<tr>
<td>• Dissemination of these briefs to key audiences within the working group and as part of the social communication strategy of the working group to others</td>
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</tbody>
</table>
## Activities

### Task 4: Update and Complete 2014 Work Plan

- **Timeframe**: January 30
- **Deliverables**:
  - Recommendations to inform updated 2014 Work Plan
  - COMMUNICATION WITHIN THE R&E WORKING GROUP
  - Frame communication within the R&E Working Group
  - Communicate recommendations for Reference Group and other working groups.
  - Follow-up on indicators of R&E in Market Dynamics
  - Integrate with R&E framework
  - Determine if we need additional human resources for the work stream
- **Persons Responsible/Dependencies**:
  - Persons responsible: John Townsend (Lead) with RE Manager and Associate and select WG members
  - Dependencies: Based on results of landscaping, consultation and final analysis

### Task 5: Participate in related MD WG sub-group

- **Timeframe**: Ongoing
- **Deliverables**:
  - Particpate in related MD WG sub-group meetings and provide input from RE WG perspective
  - Share information with full RE WG
- **Persons Responsible/Dependencies**:
  - RE WG Manager/Associate, RE WG delegates
  - *pending further discussion with WG members

### Task 6: Updated and Complete 2014 Work Plan

- **Timeframe**: Ongoing (report during quarterly RE WG calls)
- **Deliverables**:
  - Task 4: Update and Complete 2014 Work Plan
  - Task 5: Participate in related MD WG sub-group
  - Recommendations to inform updated 2014 Work Plan
- **Persons Responsible/Dependencies**:
  - John Townsend (Lead) with RE Manager and Associate and select WG members
  - Based on results of landscaping, consultation and final analysis
  - RE WG Manager/Associate, RE WG delegates
  - *pending further discussion with WG members
## WORK STREAM 4 (WS4): RIGHTS & EMPOWERMENT AND MEASUREMENT

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>DELIVERABLES</th>
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<th>PERSONS RESPONSIBLE/DEPENDENCIES</th>
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</thead>
<tbody>
<tr>
<td>01 PROVIDE FEEDBACK TO PMA (COMPLETE)</td>
<td>Agreed upon indicators and recommendation on R&amp;E measurement for submission to Reference Group</td>
<td>Activities 1-4: Completed mid-September 2013 *Initial thoughts submitted with indicators</td>
<td>Persons Responsible: Activities 1-5: Chris G (Lead), RE WG Manager/Associate, R&amp;E measurement work stream</td>
</tr>
<tr>
<td>02 MEET WITH PMA SUBGROUP ON INDICATORS AND DATA SOURCES (COMPLETE)</td>
<td></td>
<td></td>
<td>Dependencies: PMA WG and WHO</td>
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<tr>
<td>03 MEET WITH WHO IAG ON HR INDICATORS (COMPLETE)</td>
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<tr>
<td>04 FINALIZE CORE INDICATORS MATRIX FOR SUBMISSION TO THE RG (COMPLETE)</td>
<td>Activity 5: Ongoing</td>
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<tr>
<td>05 MAKE FURTHER RECOMMENDATIONS BEYOND EXISTING FP2020 CORE INDICATORS</td>
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### Task 2: FP2020 R&E Measurement Development Agenda

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
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<th>PERSONS RESPONSIBLE/DEPENDENCIES</th>
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<tbody>
<tr>
<td>01 FULLY CONCEPTUALIZE MODEL AND IDENTIFY CRITICAL PIECES OF WORK THAT MAY NEED FUNDING</td>
<td>R&amp;E measurement/research agenda</td>
<td>Activity 1 by end of Q2</td>
<td>Persons Responsible: Activities 1-3: WS4, R&amp;E WG, Consultative Group</td>
</tr>
<tr>
<td>02 GET CRITICAL PIECES OF WORK FUNDED AND UNDERWAY</td>
<td>Analysis of studies to collect qualitative and quantitative data underway to advance field in measuring whether rights are being respected, protected, and fulfilled in FP programs</td>
<td>Activity 2 by end of Q4</td>
<td>Dependencies: Researchers/evaluators, funders</td>
</tr>
<tr>
<td>03 REVIEW/ANALYZE RANGE OF STUDIES TO COLLECT QUALITATIVE AND QUANTITATIVE DATA UNDERWAY TO ADVANCE THE FIELD IN MEASURING WHETHER RIGHTS ARE BEING RESPECTED, PROTECTED AND FULFILLED IN FP PROGRAMS</td>
<td>Activity 3 by end of Q2</td>
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<tr>
<td>ACTIVITIES</td>
<td>DELIVERABLES</td>
<td>TIMEFRAME</td>
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<tr>
<td><strong>Task 3: Innovation in presenting data to encourage utilization</strong></td>
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<td>Recommendations for evaluation of improvements in data utilization</td>
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<td>Recommendations for evaluation of impact on various stakeholders</td>
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<tr>
<td><strong>Task 4: Influence and participate in Track20 M&amp;E Officer Trainings and Country Consultations</strong></td>
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<tr>
<td><strong>01</strong></td>
<td>DEVELOP R&amp;E SESSIONS FOR M&amp;E OFFICER TRAININGS AND COUNTRY CONSULTATIONS</td>
<td>R&amp;E session program and corresponding materials</td>
<td>Activity 1: Q2 and ongoing</td>
</tr>
<tr>
<td><strong>02</strong></td>
<td>ATTEND TRAININGS AND COUNTRY CONSULTATIONS AND IMPLEMENT R&amp;E SESSIONS (CONDUCT BRIEF ANALYSIS OF IMPACT OF TRAINING)</td>
<td>Analysis of impact/evaluation</td>
<td>Activity 2: Q2 and ongoing</td>
</tr>
<tr>
<td><strong>03</strong></td>
<td>REVIEW AND UPDATE PROGRAM AND MATERIALS AS NEEDED</td>
<td></td>
<td>Activity 3: Q2 and ongoing</td>
</tr>
<tr>
<td><strong>Task 5: Participate in related PMA WG subgroup</strong></td>
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<tr>
<td><strong>01</strong></td>
<td>PARTICIPATE IN RELEVANT PMA WG SUBGROUP MEETINGS AND PROVIDE INPUT FROM RE WG PERSPECTIVE</td>
<td></td>
<td>Persons responsible: RE WG Manager/Associate, RE WG delegates. *pending further discussion with WG members.</td>
</tr>
<tr>
<td><strong>02</strong></td>
<td>SHARE INFORMATION WITH FULL RE WG</td>
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</table>
THE PURPOSE OF THE PERFORMANCE MONITORING & ACCOUNTABILITY WORKING GROUP (PMA WG) IS TO PROVIDE TECHNICAL ADVICE AND SUPPORT TO FP2020 FOR: A.) PROGRESS MONITORING AND EVALUATION FOR REACHING THE FP2020 GOAL AND ENSURING THAT GIRLS’ AND WOMEN’S RIGHTS TO VOLUNTARY CONTRACEPTION ARE RESPECTED AND PROMOTED; AND B.) STRENGTHENING ACCOUNTABILITY FOR IMPLEMENTING FINANCIAL, POLICY AND PROGRAMMING COMMITMENTS MADE BY COUNTRY GOVERNMENTS, DONORS, THE UN, CIVIL SOCIETY AND OTHERS.

OBJECTIVES

The specific objectives of the PMA WG are to:

- Advise and guide the process for establishing an annual progress assessment of MCPR growth rates and other key indicators with 2012 baseline
- Advise and guide on indicators for country and global use, including rights-based program monitoring with Rights & Empowerment WG (RE WG), and processes for data collection, reporting, and promoting use in the public domain
- Advise and guide on effective approaches for holding to account policy makers, officials, providers, and donors for progress against the goal, for rights-based programming and for commitments made
- Use the FP2020 partnership as a platform to promote a culture of data use within countries as well as international and regional initiatives
- Review, guide and approve the PMA WG annual and two-year work plan outputs and report progress against it to the Reference Group (RG)
- Develop and build consensus on the FP2020 measurement agenda
- Assess, review and provide feedback on PMA-related sections of the annual report provided by the Task Team and FP2020 contributions to the Every Woman Every Child (EWEC) accountability efforts including the Commission on Information & Accountability framework for global reporting, oversight and accountability on women's and children's health, Countdown to 2015 reports and the independent Expert Review Group (iERG)\(^1\)
- Building upon PMNCH and other tracking efforts of donor, government, civil society and others’ commitments to the Global Strategy, ensure that family planning commitments continue to be tracked and reported as agreed through FP2020 and EWEC processes, including financial resources at the country level
- Identify priorities for additional work and communications needs to the Task Team
- Provide feedback and advice on the scope and implementation of key PMA WG and related contracts and grants

\(^1\) The iERG was created to review progress of the UN Secretary General’s Global Strategy and implementation of the recommendations of the Commission of Information and Accountability (CoIA). It released its first report, *Every Woman Every Child: from Commitments to Action*, in September 2012, the first of four reviews up to and including the Millennium Development Goal target date of 2015.
## WORK STREAM 1 (WS1): STRENGTHENING ACCOUNTABILITY

<table>
<thead>
<tr>
<th>TASKS</th>
<th>ACTIVITIES</th>
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<th>TIMEFRAME</th>
<th>PERSONS RESPONSIBLE</th>
</tr>
</thead>
</table>
| **1.1** CONDUCT AN AUDIT OF THE GLOBAL FAMILY PLANNING ACCOUNTABILITY LANDSCAPE, INCLUDING TRACKING OF FP2020 FINANCIAL, POLICY AND SERVICE DELIVERY COMMITMENTS | Develop terms of reference for audit  
Carry out audit | Agreed terms of reference  
Report of findings from audit | End November 2013  
December 2013-end January 2014 | WS1 members  
PMA WG Co-leads  
PMA WG Manager |
| **1.2** IDENTIFY AND REPORT ON GAPS (IF APPLICABLE), AND RECOMMEND ACTIONS TO ALIGN WITH AND BUILD UPON THE EXISTING FAMILY PLANNING ACCOUNTABILITY AND REPORTING ARCHITECTURE | Gaps identified and agreed recommendations to FP2020  
Next steps (new or existing mechanisms scoped and described)  
Developing and implementing plan for agreed next steps | Agreed next steps for new or existing mechanisms with PMA WG Co-leads and FP2020 Director  
Budgeted plan for taking next steps forward  
Implementation and delivery from mid-2014 | Agreed process and next steps  
Begin Mid-December 2013  
Complete by March 1, 2014  
Budgeted plan  
Begin April 1, 2014,  
Complete by: June 1, 2014  
Implementation of plan including generation of data for 2014 FP2020 report  
Begin June 1, 2014, continue through end 2014 and beyond | WS1 members  
PMA WG Co-leads  
PMA WG Manager  
FP2020 Director |
| **1.3** IDENTIFY MECHANISMS FOR IDENTIFYING AND ADDRESSING VIOLATIONS OF HUMAN RIGHTS | Draft terms of reference for review paper  
Define scope and criteria for effectiveness (definition of what is included as good practice)  
Literature review, interviews as needed | Agreed terms of reference  
Draft and final review  
Menu of potential good practice models and approaches  
Promotion and dissemination through Global Strategy country work, DFID supported civil society accountability project, Hewlett funded activities, etc. | Q1 and Q2 2014  
Q2 2014 onwards | WS1 members  
PMA WG Co-leads  
PMA WG Manager  
In collaboration with RE WG Co-leads and RE WG WS1 |
### WORK STREAM 2 (WS2): INDICATORS AND DATA SOURCES

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<thead>
<tr>
<th>TASKS</th>
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<th>DELIVERABLES</th>
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</thead>
<tbody>
<tr>
<td>2.1</td>
<td>ADVISE AND GUIDE THE PROCESS FOR ESTABLISHING AN ANNUAL PROGRESS ASSESSMENT OF MCPR GROWTH AND OTHER KEY INDICATORS WITH 2012 BASELINE</td>
<td>Review content related to MCPR growth and other key indicators for FP2020 Progress Report</td>
<td>Methodology note on MCPR modeling approved by PMA WG</td>
<td>By March 2014</td>
</tr>
<tr>
<td>2.2</td>
<td>ADVISE ON DEVELOPMENT OF A NATIONAL FAMILY PLANNING COMPOSITE INDEX (NFPCI), TO BE ADDED TO CORE LIST OF FP2020 INDICATORS</td>
<td>Review options for calculating NFPCI</td>
<td>PMA WG recommended NFPCI indicator</td>
<td>Begin January 2014&lt;br&gt;Conclude March 2014</td>
</tr>
<tr>
<td>2.3</td>
<td>ADVISE ON THE DEVELOPMENT OF NEW INDICATORS TO BE INCLUDED ON THE CORE OR EXPANDED LIST OF FP2020 INDICATORS (INCLUDING STOCK-OUT INDICATOR)</td>
<td>Review options for new indicators</td>
<td>PMA WG recommended new indicators</td>
<td>Stock-out indicator to be presented at March 2014 PMA WG meeting&lt;br&gt;Additional indicators to be considered and presented on an ongoing basis</td>
</tr>
<tr>
<td>2.4</td>
<td>PREVIEW MONITORING AND ACCOUNTABILITY DATA AND TEXT FOR 2ND PROGRESS REPORT</td>
<td>Review draft versions of data and text</td>
<td>WS2 members to provide written comments on data and text</td>
<td>Complete by September 2014</td>
</tr>
<tr>
<td>2.5</td>
<td>ADVISE ON THE PRODUCTION OF A STANDARD INDICATOR MANUAL TO ACCOMPANY THE CORE LIST OF FP2020 INDICATORS</td>
<td>Sharing indicator definitions, where relevant</td>
<td>PMA WG recommended Indicator Manual</td>
<td>TBD</td>
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### WORK STREAM 3 (WS3): DATA UTILIZATION - PROMOTING A CULTURE OF DATA USE

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<tbody>
<tr>
<td><strong>3.1 REVIEW MONITORING AND ACCOUNTABILITY DATA FOR ANNUAL REPORT AND ANALYZE DATA TO HIGHLIGHT PROGRESS OR IDENTIFY CHANGES</strong></td>
<td>Revisit expanded list of indicators</td>
<td>Input into expanded list of indicators</td>
<td>March 2014 (for presentation at annual PMA WG meeting)</td>
<td>WS3 members coordinate with WS2 Data must be available by July</td>
</tr>
<tr>
<td></td>
<td>Review data for next report</td>
<td>Working Group recommendations on report</td>
<td></td>
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<tr>
<td><strong>3.2 CREATE NEW OR LEVERAGE EXISTING TOOLS (SUCH AS SCORECARDS) TO BE UTILIZED WITHIN COUNTRIES AS WELL AS IN INTERNATIONAL/REGIONAL INITIATIVES</strong></td>
<td>Review scorecards from other initiatives such as Countdown, Malaria, Education, Child survival in Ethiopia, IPPF, Ouagadougou</td>
<td>Recommendation for a dynamic scorecard that emphasizes both national and sub-national levels*</td>
<td>Share examples by January 15 2013</td>
<td>WS3 members Scott (Malaria, Ethiopia) Zeba (Education) Eliya(Countdown) Ian (IPPF) Cheikh (Ouagadougou) Connect with Track20</td>
</tr>
<tr>
<td></td>
<td>Identify opportunities for pre-testing scorecards</td>
<td>Initial set of best practices to inform formulation of capacity-building strategy</td>
<td>March 2014 (for presentation at annual PMA WG meeting)</td>
<td></td>
</tr>
<tr>
<td><strong>3.3 PROVIDE STRATEGIES TO STRENGTHEN CAPACITY FOR DATA UTILIZATION AT THREE LEVELS: POLICY AND ADVOCACY; RESOURCE; PROGRAM DESIGN AND IMPLEMENTATION</strong></td>
<td>Identify best practices and share with other countries (including through regional economic blocks), such as Ghana DHIMS, Ouagadougou for country ownership</td>
<td>Plan for disseminating best practices or linking through existing projects</td>
<td>Complete by March 2014 PMA WG meeting</td>
<td>Ian (DHIMS) Eliya (Measure Evaluation) Zeba (PNMCH)</td>
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<td></td>
<td>Invite PNMCH, DHS, Evidence, and Measure Evaluation to March 2014 PMA WG meeting to discuss their data utilization plans</td>
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</tr>
<tr>
<td><strong>3.4 ADVISE AND GUIDE THE PROCESSES FOR DATA COLLECTION, REPORTING, AND PROMOTING USE IN THE PUBLIC DOMAIN</strong></td>
<td>Consult implementers of Evidence, Measure Evaluation, DHS</td>
<td>Recommendation</td>
<td>March 2014</td>
<td>WS3 members</td>
</tr>
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</table>
## WORK STREAM 4 (WS4): DEVELOP A LEARNING AGENDA

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<tr>
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</table>
| 4.1   | **PROMOTE THE USE OF EXISTING BEST PRACTICES IN FAMILY PLANNING PROGRAMMING**  

Note:  
This is major focus of CE WG. The PMA WG learning agenda work stream will coordinate with CE WG (CE WG will take primary responsibility for this function). This process will also be coordinated in collaboration with the RE WG.  

|   | 4.1.1. In collaboration with CE WG and RE WG, assist in developing an inventory of databases, websites, and documented best practices in family planning generally, to be shared with members of all FP2020 working groups for their use in working with countries  
4.1.2. Share best practices specifically in performance monitoring and accountability, through documentation and dissemination of indicator development and data collection approaches and results | 4.1.1. Contribute to the collection and promotion of electronic resources related to best practices being prepared by the CEWG  
4.1.2. An annual brief on measurement approaches, challenges, and results | 4.1.1. Depending on CE WG work schedule, potentially early January 2014  
4.1.2. Annually | 1. WS4 members  
Support from PMA WG associate  
2. Collaboration with WS2 members  
Support from PMA WG associate |
| 4.2   | **ADVOCATE FOR ATTENTION AND RESOURCES TO ADDRESS PRIORITY ISSUES IDENTIFIED BY PMA WG, INCLUDING THE ROLE OF MEN AND UNMET NEED FOR FAMILY PLANNING, REASONS FOR NON-USE, DISCONTINUATION AND SWITCHING PROVIDER ATTITUDES AND BEHAVIOR, QUALITY AND ACCESS, AND CONTRACEPTIVE NEEDS OF YOUNG PEOPLE** | Clarify the specific research issues related to each of these issues, identify appropriate methodologies | Submit report to FP2020 Task Team | Complete by March 2014 | WS4 members  
Support from PMA WG associate |
| 4.3   | **ENHANCE COMMUNICATION AMONG RESEARCHERS (PROGRAM RESEARCHERS AND EVALUATORS) TO LEVERAGE POSSIBLE RESOURCES FOR NEW PROGRAM RESEARCH IN ORDER TO BETTER UNDERSTAND ISSUES LISTED ABOVE, AS WELL AS PROGRAMMATIC CHALLENGES HIGHLIGHTED IN MONITORING AND ACCOUNTABILITY DATA COLLECTION** | Develop an inventory of organizations currently working in family planning implementation science, and a mechanism for regular communication as new activities are developed | Regular communication, leveraging, and collaboration on issues identified above | Ongoing; initial listing of organizations and programs March 2014 | WS4 Co-leads  
To be confirmed: Collaboration with Evidence |
THE PURPOSE OF THE **FP2020 MARKET DYNAMICS WORKING GROUP (MD WG)** IS TO IMPROVE GLOBAL AND NATIONAL MARKETS TO SUSTAINABLY ENSURE CHOICE AND EQUITABLE ACCESS TO A BROAD RANGE OF HIGH QUALITY, AFFORDABLE CONTRACEPTIVE METHODS IN TARGET COUNTRIES. FUNDAMENTALLY, FP2020'S FOCUS ON MARKET DYNAMICS IS DRIVEN BY THE NEED TO ENSURE THAT FAMILY PLANNING (FP) COMMODITIES ARE AVAILABLE TO MEET THE GOAL OF 120 MILLION NEW USERS AND THAT THE MARKET IS HEALTHY ENOUGH TO SUSTAIN THIS DEMAND AFTER 2020. A WELL COORDINATED, EXPERT WORKING GROUP FOCUSED ON ADDRESSING TENSIONS AND INFORMATION GAPS IN THE MARKET CAN UNLOCK NEW AND IMPORTANT OPPORTUNITIES TO ENSURE THAT ACCESS TO CONTRACEPTIVE SUPPLIES AND SERVICES IS EXPANDED TO NEW PATIENTS. THAT IS THE AIM OF MARKET SHAPING, WHETHER IT IS ACHIEVED BY MAKING PRODUCTS MORE AFFORDABLE, ENSURING APPROPRIATE PRODUCT DESIGN, SECURING ADEQUATE AND SUSTAINED SUPPLIES, IMPROVING PRODUCT QUALITY; OR INCREASING PRODUCT AVAILABILITY TO END USERS. (MD WG TOR)

WORK STREAM 1 (WS1): KNOWLEDGE MANAGEMENT AND DATA TRANSPARENCY – ALAN, NORA AND JANET

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<tbody>
<tr>
<td>Task 1: Collect comprehensive market data for products and services; deploy data to support respective sector supply planning and long-term market visibility in the 28 FP2020 countries</td>
<td>Table of data sources, frequency of updates, gaps; high level recommendations</td>
<td>Start Date: Q4 2013 End Date: Q1 2014</td>
<td>Nora, Alan (with support from Hema), broader WG to be involved in data collection and follow-up</td>
</tr>
<tr>
<td>01 ASSESSMENT OF GAPS IN THE AVAILABILITY OF CONSUMPTION, ISSUES, AND STOCK LEVEL DATA</td>
<td>Data to be provided by UNFPA, USAID, MSI, PSI; coordinate with Coordinated Supply Planning Initiative via RHSC SSWG</td>
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<tr>
<td>02 CONSOLIDATION OF EXISTING EFFORTS TO MEASURE OUT OF POCKET AND INSURANCE FINANCING</td>
<td>Report of existing methods and recommendations on future estimates</td>
<td>Start Date: Q1 2014 End Date: Q1 2014</td>
<td>Janet</td>
</tr>
<tr>
<td>03 COLLECT SHIPMENT DATA FROM MANUFACTURERS AND PROCURERS BY PRODUCT CATEGORY AND COUNTRY</td>
<td>MoUs signed with at least three manufacturers</td>
<td>Start Date: Q4 2013 End Date: Q1 2014</td>
<td>Alan (with support from Hema) Tracey</td>
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</table>
## FP2020 MARKET DYNAMICS WORKING GROUP WORK PLAN | REVISED MARCH 4, 2014

### Task 1: Create market dynamics dashboard and new product landscape

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<tr>
<td>04</td>
<td>COLLECT DATA ON SERVICE DELIVERY CAPACITY FROM EXISTING SOURCES</td>
<td>Mapping of existing sources and their coverage</td>
<td>Start Date: Q1 2014 End Date: Q2 2014</td>
</tr>
<tr>
<td>05</td>
<td>WORK IN CONJUNCTION WITH WS2 SUBGROUP TO DISCUSS DASHBOARD COMPONENTS AND MODEL TO BE USED</td>
<td>Discussion/brainstorming session WS2 subgroup</td>
<td>Start Date: Ongoing End Date: Q4 2014</td>
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### Task 2: Monitor, analyze and disseminate policies on systems strengthening for provider-dependent methods at the national level (via CE WG)

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<tr>
<td>06</td>
<td>QUERY CONSULTATIVE NETWORK, CAPACITY PLUS PROJECT, ENGENDER HEALTH, AND MSI FOR INPUT (POSSIBLY PATHFINDER)</td>
<td>Table of 28 commitment countries/public and private providers</td>
<td>Start Date: Q4 2013 End Date: Q2 2014</td>
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### WORK STREAM 2 (WS2): DEVELOP A VISION OF A WELL FUNCTIONING MARKET

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| 07 | CONDUCT REVIEW OF HOW RELEVANT HEALTH INITIATIVES (HIV/AIDS, MALARIA, TB, FP, RH) HAVE DEFINED HEALTHY MARKETS | Literature review and white paper | Start Date: Q4 2013 End Date: Q1 2014 | James Droop to coordinate inputs from work stream members and beyond, including:  
  - Françoise Armand  
  - Krishna Jafa  
  - Fabio Castano  
  - Tom How |
<p>| 08 | DEFINE UNDERLINING PRINCIPLES OF A WELL FUNCTIONING MARKET AND KEY IMPEDIMENTS/BARRIERS | List of principles to inform framework | Start Date: Q1 2014 End Date: Q2 2014 |
| 09 | CREATE, VALIDATE AND DISSEMINATE FRAMEWORK FOR DIAGNOSIS AND DECISIONMAKING...THE PERFORMANCE OF RH MARKETS | Framework created, validated and disseminated | Start Date: Q1 2014 End Date: Q3 2014 |</p>
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</table>
| 10 IDENTIFY PARAMETERS, OBJECTIVES AND DESIRED UTILITY OF DASHBOARD | Scope of work for WS1 to create dashboard | Start Date: Q3 2014 End Date: Q4 2014 | Françoise Armand to coordinate inputs from WS members and beyond, including:  
  • Venkatesh Iyer  
  • Krishna Jafa  
  • Fabio Castano  
  • James Droop  
  • Tom How |
| 11 WORK WITH WS1, PROVIDING INPUT INTO CREATION OF DASHBOARD | Input given to WS1 | Start Date: Q2 2015 End Date: Q3 2015 |
| 12 REVIEW DASHBOARD OUTPUTS TO IDENTIFY GAPS, OPPORTUNITIES AND BOTTLENECKS | Review completed: analysis report with recommendations | Start Date: Q4 2015 End Date: Q4 2015 |
| 13 MAP AND IDENTIFY STAKEHOLDERS THAT CAN ADDRESS THE GAPS, OPPORTUNITIES AND BOTTLENECKS | | Start Date: Q4 2015 End Date: Q4 2015 |
## WORK STREAM 3 (WS3): PROCUREMENT AND REGULATORY IMPROVEMENTS

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<tbody>
<tr>
<td>Task 1 Alignment of procurement practices to achieve best value – Lead: Imanol Echevarria</td>
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| 14 | ASSESS CURRENT PRACTICES IN FAMILY PLANNING AND BEST PRACTICES FROM GLOBAL HEALTH | A. Collect and collate current RFP documents to understand current practices | A. Q2 2014  
B. Q3-Q4 2014 | A. Marcel Hendriks  
B. Task Team member |
| 15 | DEVELOP RECOMMENDATIONS FOR PROCUREMENT PRACTICES BASED ON CONJOINT ANALYSIS OF FAMILY PLANNING STAKEHOLDER PRIORITIES | A. Identify a representational sample of procurers, donors, procurement agencies (~15)  
B. Develop a survey/questionnaire that assess the value stakeholders ascribe to product/manufacturers offerings  
C. Conduct a conjoint analysis of questionnaire results | A. Q1-Q2 2014  
B. Q2 2014  
C. Q2-Q3 2014 | A. Wolfgang Becker-Jezuita and Task Team member  
B. Imanol Echevarria  
C. Task Team member |
| 16 | DEVELOP TOOLS AND STRATEGY TO ENSURE PRACTICE AND POLICY CHANGE AT BOTH THE GLOBAL AND COUNTRY LEVEL** | A. Translate results into white paper document to be shared with stakeholders and used to influence procurement practice change amongst global organizations  
B. Develop key talking points for the Champions group and parliamentarian groups to support advocacy for change within various government departments at the country level, prioritizing countries that have committed a significant budget line for commodity procurement | A. Q4  
B. Q1-Q4 2015 | A. Imanol Echevarria  
B. Mark Rilling  
C. Support from MD WG members |

** Area of linkage with Country Engagement Working Group (CE WG)
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<tr>
<td>17</td>
<td>ACCELERATE THE PACE OF REGISTRATION FOR FAMILY PLANNING PRODUCTS**</td>
<td></td>
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</tr>
<tr>
<td>A.</td>
<td>Task 2 Registration optimization – Lead: Mark Rilling</td>
<td>A.</td>
<td>Lester Chinery</td>
</tr>
<tr>
<td>A.</td>
<td>Concept Foundation registration database made available to stakeholders including working group</td>
<td>Q1 2014</td>
<td>B. Lester &amp; Lester</td>
</tr>
<tr>
<td>B.</td>
<td>Determine priority countries (~5) for fast-track registration intervention based on Concept Foundation’s data and ability to influence access to small volume, typically neglected countries to drive equity via the market place</td>
<td>Q1-Q2 2014</td>
<td>C. Mark Rilling with support from the WS3 team</td>
</tr>
<tr>
<td>C.</td>
<td>Leverage the political capital of FP2020 at the country level to elevate the importance of fast-tracking family planning</td>
<td>Q2-Q4 2014 (ongoing)</td>
<td>D. Task team member/ Lester Chinery</td>
</tr>
<tr>
<td>D.</td>
<td>Develop case study on successes in improving registration timelines</td>
<td>Q2 2014</td>
<td>E. Trisha Wood Santos</td>
</tr>
<tr>
<td>E.</td>
<td>Potentially expand CFs database to include additional manufacturers or products as necessary and feed into WS1 and 2 for inclusion in vision/data collection and dashboard analytics</td>
<td>Q1 2015</td>
<td>F. Mark Rilling with support from the WS 3 team</td>
</tr>
<tr>
<td>F.</td>
<td>Assess the need to create a ‘QuRHM’ style project to accelerate FP/RH registration to drive high impact over the next seven years. This is potentially an initiative to strengthen third party registration services</td>
<td>Q4 2014-Q1 2015</td>
<td></td>
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<tr>
<td>**Area of linkage with CE WG</td>
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<p>| 18         | EXPLORE THE OPPORTUNITIES REGARDING STANDARD PACKAGING AND PACK SIZES |            |                     |
| A.         | Define what a universal pack requirement is by product category | A.         | Task Team &amp; Mark Rilling with support from the WS3 team |
| B.         | Explore global bar code standards that would both allow for more efficient but equally effective packaging | A.         |                     |
|            |                                                                                   | B.         | Imanol             |</p>
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<tr>
<td>19 SUPPORT ON-GOING GLOBAL HARMONIZATION INITIATIVES</td>
<td>A. Get in touch with people working on the harmonization initiative and find out what FP/RH can do to lend some weight to this project or aspects of the project including encouraging countries to adopt the Common Technical Dossier already developed by the WHO sooner than later</td>
<td>A. Q1-Q3 2014</td>
<td>A. Trisha/Lester/Wolfgang/Tracey</td>
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| 20 ARTICULATE A NEW VISION FOR THE PROCUREMENT AND DISTRIBUTION OF COMMODITIES FROM MANUFACTURERS TO COUNTRIES | A. Develop a concept note for a vision that leverages economies of scale to bring new efficiencies to the market for family planning commodities  
B. Scope pilot projects or other interventions to test new theories/ways of working | A. Q2 2014-Q2 2015  
B. Q2 2015-Q4 2015 | A. Lester & Lester with support from WS3 team |
THE PURPOSE OF THE COUNTRY ENGAGEMENT WORKING GROUP (CE WG) IS TO WORK WITH EXISTING PARTNERS TO PROVIDE ADDITIONAL SUPPORT TO COUNTRIES AS THEY DEVELOP, IMPLEMENT AND MONITOR PROGRESS AGAINST THEIR TRANSFORMATIONAL FAMILY PLANNING (FP) PLANS, BUILDING ON EXISTING COUNTRY PLANS WHENEVER POSSIBLE, AND WITHIN THE CONTEXT OF COUNTRIES’ WIDER RMNCH AND HEALTH SECTOR PLANS (CE WG TOR).

WORK STREAM 1 (WS1): MAINTAINING ONGOING SURVEILLANCE ON COUNTRY PROGRESS ON FP

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| 01    | FAMILY PLANNING LANDSCAPE | Completed and updated landscape questionnaires (for countries who have made a commitment to FP2020) | A. Review landscaping questionnaire, make necessary amendments, and update landscape for all relevant countries  
B. Send landscaping questionnaire to new commitment countries via donor focal points | 1A. End of 2Q 2014  
1B. Ongoing | WS1 members and Task Team |
|       |              |               |           |                     |
|       | Areas of work with other working groups: CE will solicit input from other working groups on the landscape questions. | | | |
| 02    | MONITORING AND SURVEILLANCE | Work with focal points to track implementation  
Develop country snapshot for all countries with country plans, including country plan summary and indicators  
Develop “implementation reports” for countries without country plans | A. Identify donor focal points for all commitment countries  
B. Identify government focal points for all commitment countries  
C. Design template for country snapshots using information in country plan, landscape forms, and other sources. (Ensure this includes PMA core indicators). Populate as country plans are approved by governments.  
D. Design template for status reports  
E. Update snapshot and status report as information is provided | A. Ongoing  
B. Ongoing  
C. End 141Q  
D. End 141Q  
E. Ongoing | A. Co-leads  
B. Co-leads  
C. Task Team  
D. Task Team  
E. Task Team |
### WORK STREAM 2 (WS2): IDENTIFY EXISTING RESOURCES AVAILABLE AND PROACTIVELY MOBILIZE TECHNICAL ASSISTANCE AND FUNDING TO SUPPORT COUNTRY FP STRATEGIES

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<tbody>
<tr>
<td><strong>01</strong> IDENTIFY AND MAP EXISTING RESOURCES (COUNTRY, REGIONAL AND GLOBAL LEVEL)</td>
<td>A complete mapping of family planning funding available at country, regional and global level &lt;br&gt;Donor snapshot</td>
<td>A. Map where global funding is flowing from partners such as UNFPA, USAID, DFID and foundations by country when possible &lt;br&gt;B. Map regional funding streams &lt;br&gt;C. Obtain available data on country/national family planning budget to support the FP strategy &lt;br&gt;D. Create cheat sheets on the FP2020 donors (including USAID) to identify their priorities with respect to where their FP2020 pledge goes (technically, regionally, etc.) &lt;br&gt;E. Identify where donor commitments and country pledges are in-line in order to assist in matching country needs with available resources</td>
<td>A/B. April 30, 2014 &lt;br&gt;C. Ongoing &lt;br&gt;D. End 141Q &lt;br&gt;E. Ongoing</td>
<td>A/B. Task Team will request information from donors &lt;br&gt;C. Focal Points &lt;br&gt;D. Task Team &lt;br&gt;E. CE WG and Task Team</td>
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Areas of work with other working groups: CE will solicit input on donor snapshot from other WGs.

<p>| <strong>02</strong> REVIEW COUNTRY PLANS AGAINST BASELINE CRITERIA DEVELOPED IN WS 3 AND ANALYZE RESOURCE GAPS IDENTIFIED IN COUNTRY PLANS | Research different approaches to problem solving at global, regional and country level to support country needs? &lt;br&gt;Develop country snapshot for all countries with country plans, including gap analysis and financing needs | A. Analyze the country plans and identify gaps &lt;br&gt;B. Identify donor resources &lt;br&gt;C. If funding is needed, analyze financial data within the country plans and confirm the funding gap &lt;br&gt;D. Develop internal system for tracking incoming country plans | Ongoing | A. Focal points, WS1, Task Team &lt;br&gt;B/C. Focal points, WS1, Task Team &lt;br&gt;D. Task Team |</p>
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| 03    | FACILITATE ACCESS TO ASSISTANCE IN DEVELOPING, STRENGTHENING, REVIEWING, OR COSTING PLANS AS WELL AS ASSISTANCE IN IMPLEMENTING PLANS | List of technical experts, consultants and organizations that have track record developing costed country plans  
List of countries that have recently completed their costed plans with point person identified to share lessons learned with new countries (tracker)  
Document success stories where FP2020 was able to get additional resources to the country  
Utilizing the resource mapping in Task 1, identify if one of the country donors can fill the funding gap  
Develop process to broker funding and TA support to countries (algorithm)  
Develop a system to receive feedback from countries to improve the way we do business | A. Identify experts and consultants available to provide TA in developing FP strategies and costed plan with participation from current stakeholders  
B. Link countries in the beginning stage of plan development with key experts and countries that have gone through the process  
C. Develop plan tracker  
D. Work with organizations/consultants and focal points to support the development and launch country plans  
E. Process to proactively reach out to new countries with a welcome letter with information on FP2020 and next steps  
F. Develop a consensus-based resource package for focal points to assistant them | A. April 2014  
B. Ongoing  
C. January 2014  
D. Ongoing  
E. End 141Q  
F. Summer 2014 | A. Task Team  
B. Focal Points  
C. Task Team  
D. Focal Points and Task Team  
E. Task Team  
F. Task Team |
| 04    | DEVELOP A METHODOLOGY/PROTOCOL TO SUPPORT BROKERING ASSISTANCE | Using the list compiled in Task 1 and the recommendation by Task 3, link country in need with donor match or identified technical assistance partner  
If not able to fill a resource gap within six months, document the actions and bring the gap to the attention of the Task Team Director  
Survey designed to reach out to countries and find out if CE WG adding value and supporting the development and execution of their plans | A. End 1Q14  
B. Ongoing  
C. – | A. USAID  
B. Task Team  
C. – |
## WORK STREAM 3 (WS3): IDENTIFY, COLLATE AND DISSEMINATE SUCCESS STORIES, HIGH-IMPACT PRACTICES AND INNOVATIONS

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| **01** WHAT IS A FP2020 PLAN? DEVELOP DIAGNOSTIC TO DETERMINE IF COUNTRY PLANS MEET BASELINE | Diagnostic                                        | 1. Review approaches used to date in providing assistance to countries with plan development  
2. Work with technical experts to develop a diagnostic to use against reviewing country plans  
3. Share with countries and TA providers to use as a guide about globally accepted best practices | Summer 2014 | Task Team           |
| **02** IDENTIFY, COLLATE AND DISSEMINATE SUCCESS STORIES, BEST PRACTICES, AND INNOVATIONS (ENSURE LINKAGES WITH EXISTING PLATFORMS) | Best Practices Decision Tool                      | 4. Invite partners to avail listings, documentation and sources of best practices and success stories  
5. Develop a decision making tool to help countries decide which best practice to prioritize  
6. Prepare an inventory of existing best practices and success stories  
7. Coordinate with country programs to take advantage of national level and regional workshops and conferences to share and disseminate success stories and best practices  
8. Facilitate South to South learning through study tours to programs with success stories and innovations | TBD        | WS3 and Task Team   |
| **03** SUPPORT COUNTRIES TO ADAPT AND ADOPT SELECTED BEST PRACTICES   | List of countries that have recently adopted/adapted one/more best practices with point person identified to share lessons learned with new countries | Facilitate South to South learning between country programs.                  | Ongoing    | Focal Points        |

CE will solicit input from other working groups on all WS 3 activities through Task Team Knowledge Manager.
ANNEX 6
BROKERING RESOURCES: PROCESS ALGORITHM
Is funding/TA needed to implement the plan?

YES

NO

Is funding/TA needed to develop the plan?

YES

NO

Does costed plan exist?

YES

NO

Is funding/TA needed to develop the plan?

YES

NO

Regional Level

GLOBAL LEVEL

Can CE WG identify funding/TA among its membership?

YES

NO

Focal points assist government to consult with regional partnerships

Focal points assist government to make funding/TA request to FP2020 CE WG

Can partnerships meet funding/TA needs?

YES

NO

Regional partnerships

GLOBAL LEVEL

Can Task Team identify funding/TA?

YES

NO

Funding request is escalated to FP2020 Task Team

Can Task Team identify funding/TA?

YES

NO

Funding request is escalated to FP2020 donor group

Can donors provide funding?

YES

NO

Funding request is escalated to Reference Group

Can Reference Group identify funding resources?

YES

NO

What happens if no additional resources or only partial resources are identified?

Focal points assist government to consult with regional partnerships

Focal points assist government to make funding/TA request to FP2020 CE WG

Can CE WG identify funding/TA among its membership?

YES

NO

Focal points assist government to consult with regional partnerships

Focal points assist government to make funding/TA request to FP2020 CE WG

Can CE WG identify funding/TA among its membership?

YES

NO

Focal points assist government to consult with regional partnerships

Focal points assist government to make funding/TA request to FP2020 CE WG

Can CE WG identify funding/TA among its membership?

YES

NO

Funding/TA needs met

Pending question
ANNEX 7
KEY RESOURCES IN DEVELOPMENT BY THE FP2020 COUNTRY ENGAGEMENT WORKING GROUP
## Country Engagement Tools - Description

<table>
<thead>
<tr>
<th>Use</th>
<th>Purpose</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Welcome Letter</strong>&lt;br&gt;Donor focal point&lt;br&gt;Algorithm</td>
<td>Send to new commitment countries&lt;br&gt;Request government focal point and plan&lt;br&gt;Provide information on donor focal point&lt;br&gt;Describe how to request resources (algorithm)</td>
<td></td>
</tr>
<tr>
<td><strong>Resource Kit (In Development)</strong>&lt;br&gt;CIP elements&lt;br&gt;Implementation toolkit&lt;br&gt;Best practices&lt;br&gt;Diagnostic</td>
<td>Provide technical tools for countries, focal points and consultants to use to support countries&lt;br&gt;Vetted information on elements of a CIP, implementation toolkit, diagnostic, best practices and best practice decision tools</td>
<td>Developed through technical consultations</td>
</tr>
<tr>
<td><strong>Landscape Survey and Status Report</strong>&lt;br&gt;Request country information to inform CE about country status&lt;br&gt;Original done 2013; questions clarified and updated</td>
<td>Request country information to inform CE about country status&lt;br&gt;Information will be used to create Status Report&lt;br&gt;Status report information from landscape and donor annual reports</td>
<td>Governments vet information submitted in survey&lt;br&gt;Status report information from landscape and donor annual reports&lt;br&gt;Update to surveys requested annually (not new surveys)</td>
</tr>
<tr>
<td><strong>Country Snapshot</strong>&lt;br&gt;Summary to understand status of country plans&lt;br&gt;Includes gaps, plan summary and indicators&lt;br&gt;Post to website</td>
<td>Activity and financing gaps information will be used for matching to donor resources&lt;br&gt;Country plan summary and core indicator data will be used for monitoring</td>
<td>Country plans&lt;br&gt;FP2020 core indicator data</td>
</tr>
<tr>
<td><strong>Donor Snapshot</strong>&lt;br&gt;Internal document to understand donor priorities</td>
<td>For matching with country needs</td>
<td>Data supplied by donors&lt;br&gt;Open source information</td>
</tr>
</tbody>
</table>
ANNEX 8
REFERENCE GROUP AND WORKING GROUP MEMBERSHIP LISTS
The Reference Group’s purpose is to provide strategic direction and oversight of FP2020.

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

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

**DR. FLAVIA BUSTREO**  
World Health Organization

**KATHY CALVIN**  
United Nations Foundation

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

**NICK DYER**  
UK Department for International Development

**DR. TEWODROS BEKELE**  
Director General, Health Promotion and Disease Prevention DG at the Ministry of Health-Ethiopia.

**DR. TORE GODAL**  
Ministry of Foreign Affairs, Norway

**ANURADHA GUPTA**  
Ministry of Health and Family Welfare, India

**DR. KELLY HENNING**  
Bloomberg Philanthropies

**JANE WAMBUI KIRAGU**  
Satima Consultants, Ltd., Kenya

**TEWODROS MELESSE**  
International Planned Parenthood Federation

**POONAM MUTTREJA**  
Population Foundation of India

**TBC, NIGERIA**

**DR. ARIEL PABLOS-MENDEZ**  
USAID

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

**JOHN SKIBIAC**  
Reproductive Health Supplies Coalition

**DR. JULIANTO WITJAKSONO**  
National Population Family Planning Agency, Indonesia

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

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

**CO-LEAD -**
**ELLEN STARBIRD**  
USAID

**DR. ABOSEDE ADENIRAN**  
Federal Health Ministry, Nigeria

**DR. MUHAMMED ASLAM**  
Bayer

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

**DR. RITA COLUMBIA**  
United Nations Population Fund

**DR. BOCAR DAFF**  
Ministry of Health, Senegal

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

**DR. ABU JAMIL FAISEL**  
EngenderHealth

**MONICA KERRIGAN**  
Bill & Melinda Gates Foundation

**DR. ABDISSA KURKIE**  
Ministry of Health, Ethiopia

**DR. JEAN-PIERRE MANSHANDE**  
MSD/Merck

**DR. JOTHAM MUSINGUZI**  
Partners in Population and Development

**GRETHE PETERSEN**  
Marie Stopes International

**SARA RUSLING**  
UK Department for International Development

**HALIMA SHARIFF**  
Johns Hopkins University Center for Communications Programs

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

**VINCENT SNIJDERS**  
Government of the Netherlands

**FATIMATA SY**  
IntraHealth International
The Market Dynamics Working Group will improve the availability, affordability and variety of quality family planning methods.

**CO-LEAD -**

**JOHN SKIBIACK**
Reproductive Health Supplies Coalition

**CO-LEAD -**

**ALAN STAPLE**
Clinton Health Access Initiative

**MS. FRANÇOISE ARMAND**
Abt Associates, United States

**DR. M. AYYAPPAN**
HLL Lifecare Limited, India

**MR. WOLFGANG BECKER-JEZUITA**
Bayer Pharma AG, Germany

**MS. TRACEY BRETT**
Marie Stopes International, South Africa

**DR. FABIO CASTANO**
Management Sciences for Health, United States

**MR. LESTER CHINERY**
Concept Foundation, United Kingdom

**MR. LESTER Coutinho**
The David & Lucile Packard Foundation, United States

**MR. JAMES DROOP**
UK Department for International Development, United Kingdom

**MR. IMANOL ECHEVARRIA**
Pfizer, United Kingdom

**MR. THOMAS HOW**
International Planned Parenthood Federation, United Kingdom

**MR. VENKATESWARAN IYER**
Famy Care Limited, India

**DR. KRISHNA JAAFA**
Population Services International, United States

**MR. KOEN C. KRYUTFBOSCH**
Merck/MSD, Switzerland

**MR. YONG LI**
Zizhu Pharmaceuticals, China

**MRS. NORA QUESADA**
John Snow, Inc., Colombia

**MS. SANGEETA RAJA**
The World Bank, United States

**MR. MARK RILLING**
United States Agency for International Development, United States

**MR. FRANK ROIJMANS**
I+ Solutions, Netherlands

**DR. JOE THOMAS**
Partners in Population and Development, Bangladesh

**MS. JANET VAIL**
PATH, United States

**MS. RENEE VAN DE WEERDT**
United Nations Population Fund, United States

**MS. TRISHA WOOD SANTOS**
Bill & Melinda Gates Foundation, United States

**NB: a representative from the African Union is yet to be confirmed**

**PERFORMANCE MONITORING & ACCOUNTABILITY WORKING GROUP (PMA WG)**

The Performance Monitoring & Accountability Working Group will enable the data collection and analysis necessary to bolster accountability for implementing financial, policy, and programming commitments.

**CO-LEAD -**

**DR. ZEBA SATHAR**
Population Council, Pakistan

**CO-LEAD -**

**DR. MARLEEN TEMMERMAN**
World Health Organization

**DR. IAN ASKEW**
Population Council

**ANN BIDDLECOM**
United Nations Population Division

**DR. WIN BROWN**
Bill & Melinda Gates Foundation

**JULIA BUNTING**
International Planned Parenthood Federation

**ABHIJIT DAS**
Centre for Health and Social Justice

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

**NEL DRUCE**
UK Department for International Development

**DESMOND KOROMA**
United Nations Population Fund

**DR. CHEIKH MBACKE**
Independent Consultant, Hewlett Foundation
The Rights & Empowerment Working Group will provide guidance and support to all FP2020 Working Groups on rights-based approaches to family planning.