Developing the “120 by 20” Goal for the Global FP2020 Initiative

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This report describes the purpose for developing a quantitative goal for the London Summit on Family Planning held in July 2012, the methodology behind its formulation, and the lessons learned in the process. The London Summit has evolved into the global initiative known as FP2020, and the goal has become “120 by 20,” or reaching 120 million additional users of modern contraceptive methods by 2020 in the world’s poorest countries. The success of FP2020 will first be evaluated on the basis of quantitative verification to determine that the “120 by 20” goal was reached. More important, however, is the extent to which the goal today serves as a global rallying cry to mobilize resources and leadership around current family planning programs, with a focus on voluntary family planning and quality of care, and with an emphasis on meeting girls’ and women’s unmet needs and their right to practice contraception. We hope this article provides greater transparency and understanding of the FP2020 goal, and that the global goal spurs annual monitoring of progress toward national goals in the world’s poorest countries. (STUDIES IN FAMILY PLANNING 2014; 45[1]: 73–84)

As a global health initiative, the London Summit on Family Planning of July 2012 succeeded in reinvigorating commitments to family planning that support the rights of women and girls to decide freely and for themselves whether, when, and how many children to have. One year later, the term “120 by 20” is frequently heard in the field, a shorthand expression for the London Summit’s goal of having an additional 120 million women and adolescent girls become users of modern contraceptives by the year 2020. In this article, the ten members of the London Summit on Family Planning Metrics Group explain why the London Summit organizers decided to establish a quantitative goal, how the goal was calculated, and what the field can gain from the lessons learned in this process.

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THE NEED FOR A FAMILY PLANNING GOAL

By early 2012, principals from the UK Department for International Development (DFID) and the Bill & Melinda Gates Foundation (BMGF) had decided to jointly convene the London Summit on Family Planning. Working closely with leadership from the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID), the group—referred to here as the London Summit organizers—also agreed on the importance of establishing an overall goal for the field.

The London Summit organizers wanted to set a single, overarching goal that would allow the Summit to stand out amid the 100-plus global health partnerships, initiatives, and campaigns that have been created since 2000 (WHO 2009). More specifically, despite landmark events such as the 1994 International Conference on Population and Development (ICPD) in Cairo, and the prominence of the Millennium Development Goals (MDGs), progress in family planning has been mixed at best. In the majority of the world’s poorest countries, contraceptive prevalence is low and unmet need for family planning is high (Cleland et al. 2006; Bhutta et al. 2010; Singh and Darroch 2012; United Nations 2013). Building on and contributing to the momentum created by the Reproductive Health Supplies Coalition and the UN Secretary General’s Global Strategy for Women and Children’s Health in 2010, the London Summit partners recognized the unsatisfactory state of progress in women’s and couples’ reproductive health in regard to family planning, and worked with other donors, organizations, and countries to revitalize commitment to meeting these needs.

The current significance of global goal-setting in international public health arguably dates to the work of James Grant, who led the United Nations Children’s Fund (UNICEF) from 1980 to 1995. Under Grant’s leadership, UNICEF spearheaded what would later become known as the “child survival revolution”: a blend of goal setting, campaigning, and global summitry that was successful in driving rapid global diffusion of child health interventions. Considered by many at the time to be foolishly unrealistic, the achievements were extraordinary; the efforts were credited with saving millions of children’s lives. Grant’s work paved the way for a more recent example of the power of goal-setting: the World Health Organization’s (WHO’s) “3 by 5” initiative. Kim and Ammann (2004) noted that all the great public projects of the modern period “began with the establishment of a ringing collective priority,” and this was their inspiration for the 3 by 5 initiative. They argued that having a clear, operationally defined, consensus goal signaled the importance to the world of what success looks like, and rallied different stakeholders around clarity of purpose.

Neither the ICPD in Cairo nor the MDGs had family planning goals that captured global attention the way the child survival revolution and the 3 by 5 initiative did. The ICPD was associated more with a political agenda than with a quantifiable goal around which the field rallied to move forward with a cohesive plan. The MDGs were intrinsically measurable and designed for the purpose of global monitoring, but not for family planning, which was deemed so politically risky that the original MDG formulation contained nothing regarding family planning. This omission has been viewed as a major constraint to the political commitment needed to achieve success (Campbell, Merrick, and Yazbeck 2006).

In 2007, Target 5b was added to the MDGs: “Achieve, by 2015, universal access to reproductive health,” and two of its four indicators are contraceptive prevalence and unmet need.
for family planning. These indicators, however, are not associated with quantitative goals, the measurement of which can help mobilize and guide development efforts by emphasizing outcomes and providing benchmarks for program advocacy. Although the impact of MDG activities on trends in development has been questioned (Friedman 2013), McArthur (2013) argues that explicit goals can be a focal point for coalescing political support for action, and that the MDGs “have shown how much can be achieved when ambitious and specific targets are matched with rigorous thinking, serious resources, and a collaborative global spirit” (p. 162). Recognizing the role that quantifiable goals and monitoring have had in other areas (and the lag in substantively integrating family planning into the MDGs), the London Summit organizers decided that the time was right to provide world leaders with a clear, measurable goal as a rallying point for collective action on the part of governments, donors, and implementing organizations.

**DEVELOPMENT OF THE “120 BY 20” GOAL**

In January 2012, the London Summit organizers established a working group to develop this goal. Co-chaired by Win Brown and Nel Druce, the “London Summit on Family Planning Metrics Group” consisted of the ten authors of this article, with substantial technical input from Jacqui Darroch and Susheela Singh of the Guttmacher Institute and John Stover of the Futures Institute. The Metrics Group was tasked with formulating an appropriate goal for the London Summit that was applicable to the world’s 69 poorest countries, defined as the Summit’s effective catchment population.

We launched the working group with sensitivity to the prospect of in-country interpretation of the quantitative goals as mandated targets, which in our field raises the specter of population control policies and coercive family planning practice. It was therefore critical to formulate the overall goal in a way that would not be construed as a series of country-specific targets, but rather could be viewed as a global rallying cry. In conjunction with national plans, the goal would be framed as a means of mobilizing country programs to accelerate access to modern contraceptive services, information, and supplies in the context of voluntary family planning and quality of care, and the need for integrated, comprehensive sexual and reproductive health services.

**Choice of Metric**

Developing an overall quantitative goal for the London Summit presented more challenges than anyone had imagined. The first challenge involved the choice of metric. Our criteria for the Summit’s overall goal were that it be measurable, be measurable in all 69 countries on an annual basis, and provide a clear perspective on whether family planning programs are progressing to scale.

We had initially assumed that because unmet need for family planning was at the center of most discussions about the London Summit, the metric would be used as the Summit’s

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1 The 69 countries had a gross national income per capita of $2,500 or less as of 2010. [http://data.worldbank.org/indicator/NY.GNP.PCAP.CD](http://data.worldbank.org/indicator/NY.GNP.PCAP.CD)
goal. Because unmet need reflects both the respondent’s fertility intentions and her current practice of contraception, however, the metric could be problematic for tracking progress. This is because family planning programs’ successful stimulation of demand to space or limit births can sometimes lead to short-term increases in the proportion having an unmet need for contraception. This phenomenon occurs primarily in countries having low contraceptive prevalence, many of which are included among the 69 countries. Therefore, unmet need is not necessarily a unidirectional indicator of success. Measurement of unmet need also requires that a lengthy set of survey items be administered to ensure accuracy. Finally, the relationship between unmet need and actual demand for family planning, as measured by available surveys, is not always straightforward (Westoff 2006 and 2012; Darroch, Sedge, and Ball 2011).

Toward the end of our deliberations on unmet need for family planning, a Demographic and Health Survey (DHS) report discussing the definition of unmet need was published. The report confirmed what we were beginning to conclude as a group—namely, that despite the inclusion of unmet need as an MDG indicator (and the importance of monitoring unmet need that this inclusion implied), the problems stated above rendered the reduction of unmet need relatively unsuitable as an overall goal for tracking the progress of family planning programs. The authors of the DHS report confirm as much: “This research demonstrates that unmet need is an extremely complex indicator that is difficult to fully understand” (Bradley et al. 2012: 59).

Deciding against unmet need resulted in our selection of current use of modern contraceptive methods—specifically, the modern contraceptive prevalence rate (MCPR)—as the most reasonable choice to satisfy our criteria. Although the MCPR is ubiquitous as a family planning metric, its selection did not necessarily make the work of the Metrics Group any easier. The fundamental concern, again, was that an overemphasis on reaching an absolute number of new users could lead to the abuse of girls’ and women’s reproductive rights. Thus, it was imperative that reports on progress in MCPR be supported by companion indicators of voluntary family planning and quality of care at the country level. Toward that end, the Metrics Group focused during the second quarter of 2012 on expanding its membership to include a range of experts in human rights and family planning, and on developing a set of core indicators for the London Summit that were reflective of these dimensions. Today, two of the four FP2020 Working Groups—Performance Monitoring & Accountability and Rights & Empowerment—are collaborating closely on these indicators and striving to ensure their systematic measurement in the field.

Establishing a Baseline for 2012

The major analytic challenge regarding MCPR was determining how much gain in contraceptive prevalence could realistically occur between 2012 and 2020. A precedent was set by the Hand-to-Hand Campaign organized by the Reproductive Health Supplies Coalition, which set out to increase between 2008 and 2015 by 100 million the number of women practicing modern contraception. This served as a useful point of departure for examining the feasibility and parameters of a global goal built around the practice of modern contraception.

The first question to be answered was, “How are we doing in regard to reaching that goal?” The answer was that we were not doing very well. We found that in the developing world as a
whole, the rate of increase in MCPR from 2008 to 2012 was about half the rate of increase that had occurred during the previous five-year period (Singh and Darroch 2012; Darroch and Singh 2013). The average annual increase in number of modern method users between 2008 and 2012 was approximately 10 million. By comparison, the average annual increase between 2003 and 2008 was 20 million. What stood out for us was the surprisingly small growth in contraceptive prevalence during the more recent period. MCPR was essentially the same in 2008 as it was in 2012 (56 percent and 57 percent, respectively). Whereas the averages across such large aggregations mask important progress that occurred in countries such as Ethiopia, Malawi, and Rwanda, overall these findings tempered our assumptions of how much the MCPR could increase between 2012 and 2020 and contributed to our sense of urgency for developing the goal as a global family planning rallying point.

The task for the Metrics Group was to update and refine this picture by establishing baseline 2012 estimates of MCPR for all 69 countries. Here we relied heavily on the contributions from the Futures Institute and the Guttmacher Institute, because establishing the 2012 baselines with associated numbers of modern contraceptive users proved technically challenging. National estimates of modern contraceptive use were available for the majority of the 69 countries through national surveys, including the Demographic and Health Surveys, Reproductive Health Surveys (RHS) conducted by the US Centers for Disease Control and Prevention, Multiple Indicator Cluster Surveys (MICS) conducted by UNICEF, and others. These surveys form a common database for the global family planning community and, together with demographic projections from the United Nations Population Division (UNPD), comprised the major evidence base for our work.

Despite this wealth of data, the resulting picture of contraceptive prevalence across the 69 countries was neither uniform nor complete. Because surveys are conducted on an infrequent basis and are often released a year or more after data collection, the survey estimation points we had for many countries were relatively out of date. For example, we had DHS data for 48 of the 69 countries, but for 23 of these 48 countries the available data were from 2003 or earlier, for 21 countries the data were from 2004 to 2008, and only for the remaining 4 countries did we have data from 2009 or later. Overall, we had DHS or MICS data for 64 of the 69 countries. Of the remaining 5 countries, we were able to refer to available national surveys for 4 of them (Afghanistan, Democratic People’s Republic of Korea, Papua New Guinea, and the Solomon Islands). For Western Sahara, no adequate data were available; thus, all of the survey items for Western Sahara had to be imputed, as did one or two items of missing data from each of 26 other countries. These missing values, which were needed to project trends in modern contraceptive use for currently married and/or unmarried women, were imputed by the Guttmacher Institute. The values were imputed by employing the following techniques: using regional averages, matching countries according to equivalent demographic and family planning profiles, taking estimates from countries that were contiguous, drawing upon earlier survey data containing the missing items, or drawing from published reports of subnational surveys from countries having little or no national survey information regarding a particular item. The details regarding the methods of filling in missing data are contained in the “FP2020 Technical Note” of the London Summit on Family Planning Metrics Group, which can be accessed on the FP2020 website (http://www.familyplanning2020.org/resources/meeting-documents).
All of the available surveys contained MCPR, expressed as the proportion of currently married/in union women of reproductive age—usually but not always 15–49 years old—reported as practicing modern contraception at the time of the survey. Modern contraceptives were defined as all hormonal methods (pills, injectables, implants), intrauterine devices, male and female sterilization, condoms, modern vaginal methods (e.g., spermicides), and the Standard Days Method. Women using traditional methods were included in the definition of having unmet need for modern contraception.

We constructed a dataset consisting of multiple cross-sectional national surveys for all of the 69 countries. Not all of the MCPR estimates were in a form that allowed international comparison, however, and most of the estimates were several years old. Therefore, the Futures Institute used linear projection from the last two available survey results (including those that were imputed) to estimate 2012 MCPR among currently married women for each country. At the same time, the Guttmacher Institute projected the number of unmarried women aged 15–49 years who were practicing modern contraception in 2012. They did this by drawing upon UNPD data to construct estimates of country-specific populations of women aged 15–49 by marital status, and then calculating generalized ratios of modern contraceptive use between married and unmarried women. The estimates from the Futures Group and the Guttmacher Institute were combined to form the 2012 MCPR baseline, including numbers of users for all women—married and unmarried—for each of the 69 countries. Women not using modern methods were distributed into categories of those not in need or those having unmet need for modern contraception based on country-level estimates for 2012 from the Guttmacher Institute.

The results of this work indicated that the unweighted average annual percentage point increase in MCPR for the world’s poorest countries has been less than one percentage point for the last several rounds of cross-sectional surveys; about 0.7 percent per year overall. We projected a 2012 baseline of 258 million women currently practicing modern contraception (the rounded figure of 260 million is used in other texts for communication purposes). Finally, we estimated that 160 million women in the 69 lowest-income countries indicated a desire to delay or limit births but were not reporting current use of a modern contraceptive method and thus had unmet need for contraception. These projections of numbers of modern method users in 2012 and numbers having unmet need closely matched the annual estimates and projections published by UNPD several months later (Alkema et al. 2013).

Projecting Progress Forward to 2020

Having established the recent pattern of modern contraceptive use across all 69 countries and the estimated 2012 baselines, our next step was to use all of this information to inform MCPR projections from 2012 to 2020. We based the projections on the proportion of the population practicing modern contraception as derived from the recent country-specific patterns of MCPR. In this sense, we built the overall FP2020 goal from the country estimates up to the global level, not the other way around. Because of the time pressure to provide the organizers of the London Summit with a goal, and commitments to achieve that goal in less than six months, we could not systematically use the disparate but rich sources of country-specific data to refine our projections of MCPR and unmet need. Time permitting, use of additional
national surveys, together with service statistics, could have sharpened the estimates and provided an effective vehicle for country participation in the goal-setting process.2

The question became, “What levels of modern contraceptive use could be achieved given more focus, investment, and global attention to family planning?” Stated differently, the question for the Metrics Group was how to estimate both what would be an achievable rate of growth in MCPR and the amount of funds that would be needed to realize that pace of growth. To answer the first part, we used our dataset to conduct in-depth analyses of recent MCPR dynamics (e.g., method mix, unmet need, user characteristics) and family planning policies and programs at the country level. We factored in the available country-specific strategic plans for family planning among the 69 countries. The country plans helped form the upper boundaries of this part of the goal-setting exercise. Many national plans showed MCPR goals that were more ambitious than anything considered by the Metrics Group, although collectively they were less ambitious than progress projected previously for the Hand-to-Hand campaign (see Figure 1, high-aspiration line).

We had found that 0.7 percent per year was the overall MCPR annual growth rate across all 69 countries before 2012, but significant variation in the trends existed. For example, Ethiopia, Rwanda, and Uganda experienced rapid MCPR growth during the past decade, demonstrating the potential for other countries to make similar gains, and providing insight into an upper limit of what might be possible to achieve. On the other hand, data from India suggested a recent stall

FIGURE 1 Global goal-setting scenarios for London Summit on Family Planning projecting number of additional users of modern contraceptives by 2015 and 2020 across 69 countries having GNI per capita of less than US$2,500

![Figure 1](https://example.com/figure1.png)

NOTES: We estimated that about 15 percent (18 million) of these net additional users are derived from projecting the numbers of women at 2012 out to 2020, holding the estimated 2012 MCPR growth rate constant. Another 25 percent of users (30 million) are added to account for the expected population growth among women of reproductive age from 2012 to 2020. Finally, 60 percent (72 million) of the additional users represent the predicted FP2020 effect: the accelerated MCPR growth expected to result from implementation of the commitments made at the London Summit.


2 Baseline and growth estimates for individual countries were not published because they are based on modeled and often non-current data. The aggregate estimate builds up from country estimates, but countries will need to lead in establishing consensus regarding baselines and national goals.
in MCPR growth. We categorized countries into three levels of MCPR growth based on the distribution of recent trends. Table 1 shows how this categorization formed the starting point for country-specific projections of MCPR growth during two periods: 2012–2015 and 2016–2020.

Specifically, for each country a schedule of MCPR acceleration was set according to a ramp-up period of growth from 2012 to 2015, and a sustained faster-growth period from 2016 through the end of 2020. For example, if a country was classified into the low-growth category, depending on where exactly its estimated 2012 MCPR growth rate fell within the range of 0–0.5 percent per year, the MCPR acceleration rates were applied stepwise to achieve an average growth rate of 1.3 percent per year by 2015, and then to increase to an average rate of 1.8 percent by 2020. Thus, the Metrics Group attempted to avoid making MCPR projections according to simple monotonic linear increases. The projected MCPR percentage point increases scheduled for the eight-year period for a country classified as low-growth are as follows:

1. 2012–13: 0.7
2. 2013–14: 1.0
3. 2014–15: 1.4
4. 2015–16: 1.6
5. 2016–17: 1.8
6. 2017–18: 1.8
7. 2018–19: 1.9
8. 2019–20: 1.8

If this projection schedule was applied to a country having an estimated 2012 MCPR of 30 percent, then the MCPR acceleration rates shown above would result in an MCPR of 30.7 percent in 2013, 31.7 percent in 2014, 33.1 percent in 2015, and so on all the way to 2020, when the projected MCPR would have increased to 42 percent. As noted, the 2012 MCPR estimates were adjusted on a per country basis to more closely represent all women—married and unmarried—not just those currently married. This adjustment is necessary because MCPR is typically derived from currently married women, among whom contraceptive use in the aggregate tends to be higher compared with unmarried women.

For each of the eight years of projection between 2012 and 2020, the MCPR rate is multiplied by the projected total number of all women aged 15 to 49 years (married and unmar-

### Table 1: Historical and projected rates (percentages) of annual MCPR growth under FP2020

<table>
<thead>
<tr>
<th>Level of MCPR growth</th>
<th>Historical</th>
<th>2012–15</th>
<th>2016–20</th>
<th>Index case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (n = 37 countries)</td>
<td>0–0.5</td>
<td>1.3</td>
<td>1.8</td>
<td>Uganda 0% from 2000–06</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.6% from 2006–11</td>
</tr>
<tr>
<td>Medium (n = 12 countries)</td>
<td>0.5–1.0</td>
<td>1.8</td>
<td>2.3</td>
<td>Ethiopia 1.4% from 2000–05</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.3% from 2005–11</td>
</tr>
<tr>
<td>High (n = 20 countries)</td>
<td>1.1–3.0</td>
<td>2.3</td>
<td>2.8</td>
<td>Rwanda 0.9% from 2000–05</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>7.0% from 2005–08</td>
</tr>
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MCPR = Modern contraceptive prevalence rate.

*Historical MCPR annual growth rates were calculated through 2012 from 48 out of the 69 FP2020 priority countries where DHS results were available.*

*Index case of rapid annual MCPR growth per category.*

**NOTES:** These MCPR acceleration categories were applied to the 22 countries that made a pledge at the London Summit and met the GNI per capita criterion. Annual MCPR acceleration in the remaining 47 of 69 countries was projected to increase only slightly, to reflect a potential diffusion or halo effect of FP2020 attention and activities in the pledging countries.
ried) to determine the estimated number of users of modern methods. Population estimates are obtained from UNPD. The annual number of additional women practicing modern contraception is calculated by taking the difference between the baseline (2012) number of users and the projected number of users for the year in question. The total number of additional women practicing modern contraception during the entire FP2020 period is the difference between the projected number at 2020 and the baseline number at 2012.

Taken as a whole, the evidence suggested that if a large-scale initiative succeeded in generating momentum to expand and improve services, an aspirational yet achievable goal would be to realize an approximate doubling of the average annual MCPR growth from 0.7 to 1.4 percentage points by 2020 across all 69 countries. Projecting MCPR out to the year 2020 based on the growth categories shown in Table 1 results in adding 120 million net additional/new users in the 69 poorest countries: from 258 million in 2012 to 378 million in 2020 (see Figure 1). This 120 million new users projected by the year 2020 is the basis for the expression “120 by 20.”

We recognize the conundrum that population growth presents in setting an empirical goal: country and global monitoring systems must be able to detect the effects of population growth alone on number of additional users (and the programmatic efforts required just to keep pace with population growth) from the additional users that are generated through new actions that would not have occurred without extra efforts to accelerate progress. This is one reason why the work of country-level statistical offices and demographers to continue refining estimates of country-level population dynamics is so important, especially as it contributes to the annual estimates produced by UNPD.

**Estimating the Benefits and Costs of Achieving the Goal**

The focus and funding needed to achieve the “120 by 20” goal is in addition to the resources currently being used to maintain service provision to the 258 million current users in the 69 countries. Although estimates are based on country-level data and growth expectations, the goal of the London Summit is expressed as an aggregate for all 69 countries, recognizing that each country will progress at a different rate and according to the provisions of its national plan.

The estimated impact of achieving the “120 by 20” goal was calculated using the methodology created by the Guttmacher Institute in its “Adding It Up” series. The Metrics Group projected that reaching 120 million additional users of modern contraceptives would help avert an estimated 116 million unintended pregnancies, 52 million abortions, 212,000 maternal deaths, and 2.8 million infant deaths during the next eight years (2013–20, inclusive) (Singh and Darroch 2012). Achieving this goal would satisfy approximately 75 percent of the unmet need that existed in 2012 in the world’s 69 poorest countries.

The Metrics Group also worked on estimating the costs for reaching the “120 by 20” goal. We calculated these in four separate categories (commodity, supply, labor, and systems and program costs) at the country level using unit costs and then aggregated to the global level. Based on the number of women anticipated to be added each year and individual countries’ specific method mix, cumulative costs to reach 120 million additional users by 2020 are estimated to be approximately US$4.3 billion. This amount is in addition to the approximate US$10 billion required to maintain services for the existing 258 million contraceptive users in the 69 low-income countries through 2020. These estimates will inevitably fluctuate; we have
already seen a 50 percent price reduction in implants—a cost saving that can be reinvested in quality programming (Bayer HealthCare 2012; MSD 2013). Overall, these estimates should help set guideposts to link goal achievement and costs to ensure efficient spending.

WHAT DID WE LEARN?

What can the field gain in terms of lessons learned from this process? The main lesson is that the FP2020 goal is more than a quantitative measure. The goal was conceived by the London Summit organizers and constructed by the Metrics Group as a tool for galvanizing commitments across multiple actors and for monitoring achievements. We hope that the “real” goal is going to be realized through increased actions toward improving and accelerating voluntary family planning services in the poorest countries among all who need and want it. As action is taken at the country level, we hope that the quantitative focus is on using the goal and other metrics to monitor progress of programs against national plans.

The main challenge that the Metrics Group faced was the lack of up-to-date comparable national estimates. For a data-driven field that has such a rich history of survey development and methodological advancements, we were surprised at how difficult it was to construct the 2012 baseline for numbers of users of modern contraceptives. We needed more, and more frequent, internationally comparable survey estimates. Given that the measurement agenda for FP2020 calls for annual progress updates toward reaching the “120 by 20” goal, where will the data to inform these updates be drawn from? Countries would benefit from having annual DHS-like data available for the purpose of monitoring progress against their national plans. Such annual, rapid surveys could include samples of facilities, allowing for better opportunities to link service statistics and survey estimates, thereby increasing the usefulness of service statistics as valid sources for monitoring of national family planning goals.

The Metrics Group constructed the FP2020 goal in early 2012 with little external input, driven by the pressure to formulate a goal in time for the July 2012 London Summit. More country involvement in the formulation of the global goal would have been preferred (although it might not have resulted in substantially different numbers) to make the goal more immediately relevant and meaningful to stakeholders at the country level. To have crafted the goal on the basis of full participation from all 69 countries, however, would have involved a much longer process than time allowed. At issue for our field is how to achieve consensus on such goals, especially in a short time period. Conference calls among large numbers of participants across multiple time zones do not easily lead to clear consensus, nor do email conversations containing crowded “To” and “cc” lists, because participation and substantive input is so variable. Face-to-face gatherings tend to be expensive and logistically challenging when participants are many and are distributed around the world. We need to explore more innovative methods of using the Internet and other virtual platforms to generate global consensus processes.

Moving forward, the translation of the FP2020 global goal into country action plans is critical to success. Despite the relative lack of country engagement in the goal’s initial formulation, the “120 by 20” designation is on its way toward achieving the broad rallying cry that it was designed to produce, effectively paving the way for its traction at the country level. This is important, because at the global level we have learned that such a goal can be construed as
assigning priority to those countries having the most “numbers” toward achieving “120 by 20.” For FP2020, contraceptive use and unmet need in the smallest of the 69 countries is just as valuable as contraceptive use and unmet need in the largest. We learned that communication regarding the goal must include clear statements of equity—that family planning activities under FP2020 are not to be biased toward the demographic weight of the largest countries or subpopulations within countries—and should articulate strategies for reaching the most vulnerable populations, including adolescent girls and the poorest women.

Critically, the Metrics Group always intended for the quantitative MCPR goal to be qualified by measures of respect for rights and voluntary family planning and service quality, and by better understanding and addressing the many dimensions of unmet need, informed by girls’ and women’s perspectives. This is an unfinished agenda. Although we have written here about the limitations to the availability of data concerning contraceptive use, generating annual estimates on quality and voluntary family planning that are representative at the country level will not be any easier. Our field has a long and rich history of methodological work on quality and related aspects of informed consent. Building on this history to make these measures more prominent in the way we monitor and evaluate family planning progress is a core component of the FP2020 measurement agenda and an exciting challenge ahead.

In November 2013, the FP2020’s first annual report was released during the International Conference on Family Planning at Addis Ababa, Ethiopia (http://www.familyplanning2020.org/images/content/documents/FP2020_Partnership_in_Action_2012-2013.pdf). That report—the “FP 2020 Partnership in Action 2012–2013”—outlined the parameters of the global initiative and the measurement plan designed to monitor progress toward the “120 by 20” goal. Ultimately, how will success be judged? The answer is not solely on the basis of numeric counts—of surpassing the “120 by 20” mark—but rather by the measures indicating that increased contraceptive use is grounded in the right of women and girls across the world’s poorest countries to decide freely and for themselves whether, when, and how many children to have.

The hope is that in developing the FP2020 goal, the global family planning field can be mobilized around a measurable, operationally defined vision for success, and place higher priority on the kinds of indicators and data systems that are needed to monitor progress toward 2020 that balance quantitative scale-up with quality and informed consent. Equally, FP2020 is committed to working to improve the use of data for local, national, and global accountability purposes, to align with and contribute to the work of the Commission on Information and Accountability (CoIA) and the independent Expert Review Group (iERG) for the UN Secretary General’s Global Strategy, and above all, to ensure that FP2020’s ultimate accountability is to the girls and women who are at the heart of the FP2020 movement.

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