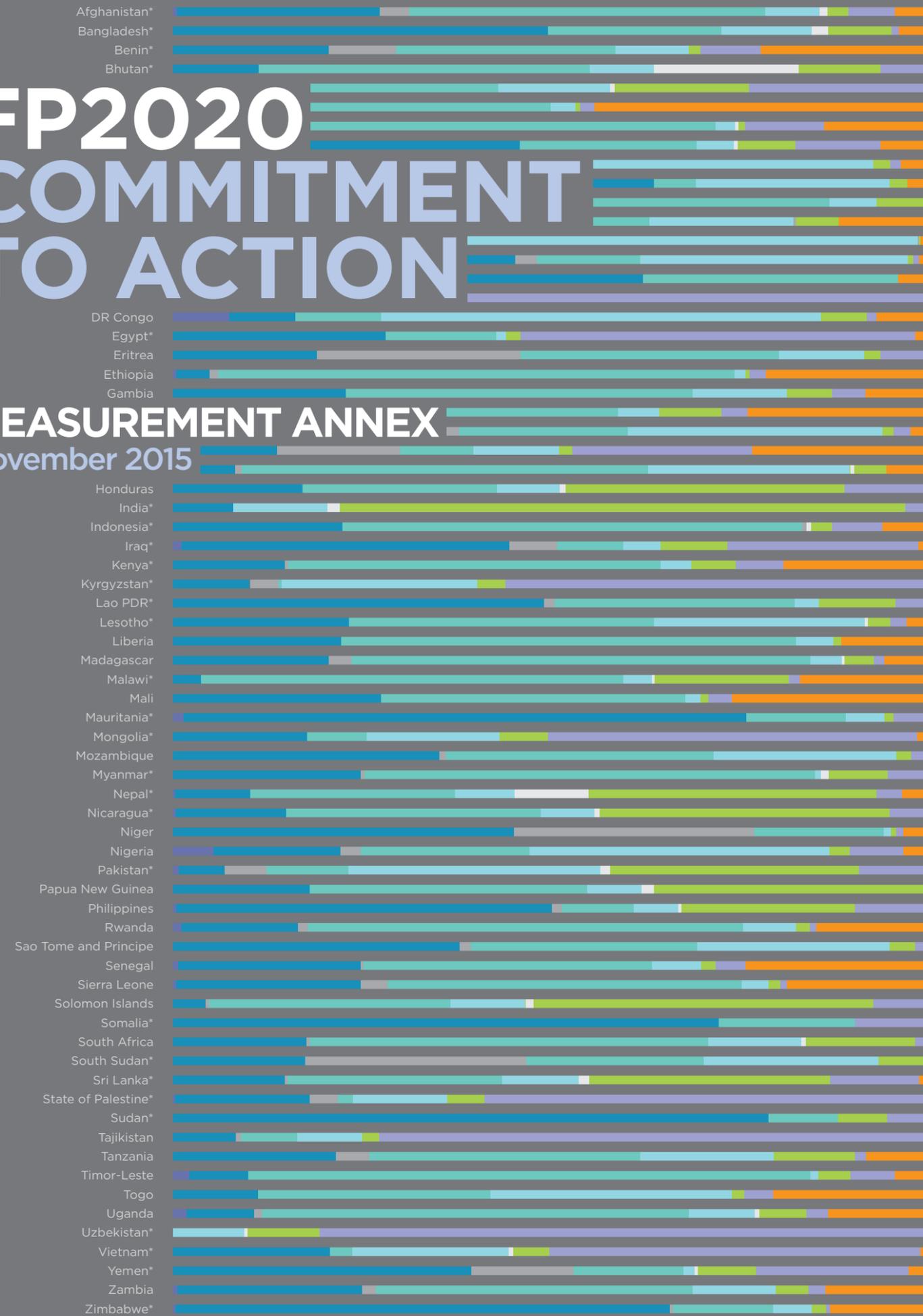


FP2020 COMMITMENT TO ACTION

MEASUREMENT ANNEX November 2015



Cover:
Core Indicator 9: Modern
contraceptive method mix,
69 FP2020 focus countries,
and South Africa

Cover: Core Indicator 9: Modern contraceptive method mix, 69 FP2020 focus countries, and South Africa

* Method mix data based on contraceptive use of married women. All other estimates are for all women use.

-  Implant
-  IUD
-  Sterilization (female)
-  Sterilization (male)
-  Condom (male)
-  Injection
-  LAM
-  Pill
-  Other modern methods

FP2020 COMMITMENT TO ACTION

MEASUREMENT ANNEX

November 2015



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[#fp2020progress](https://twitter.com/fp2020progress)

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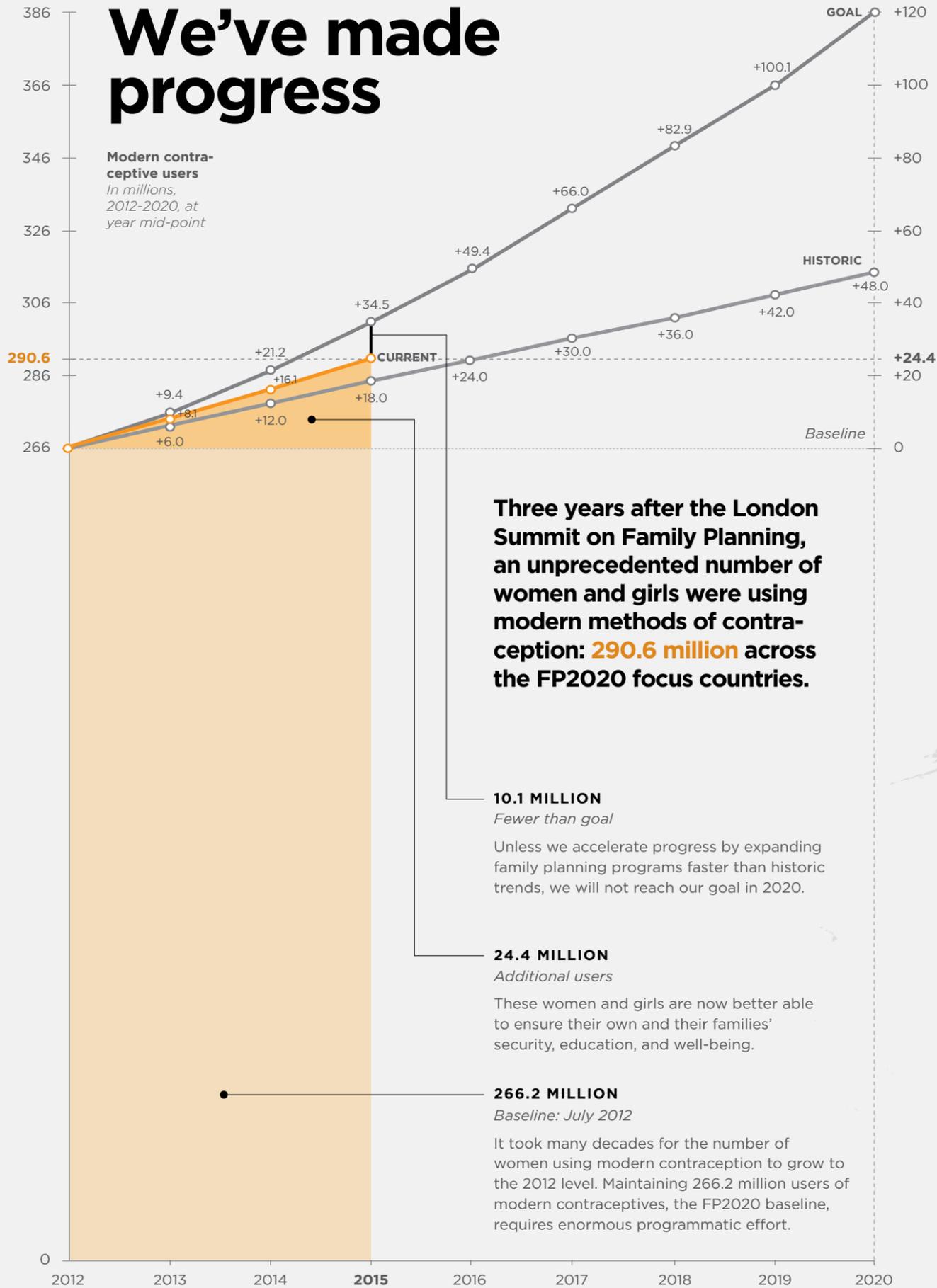
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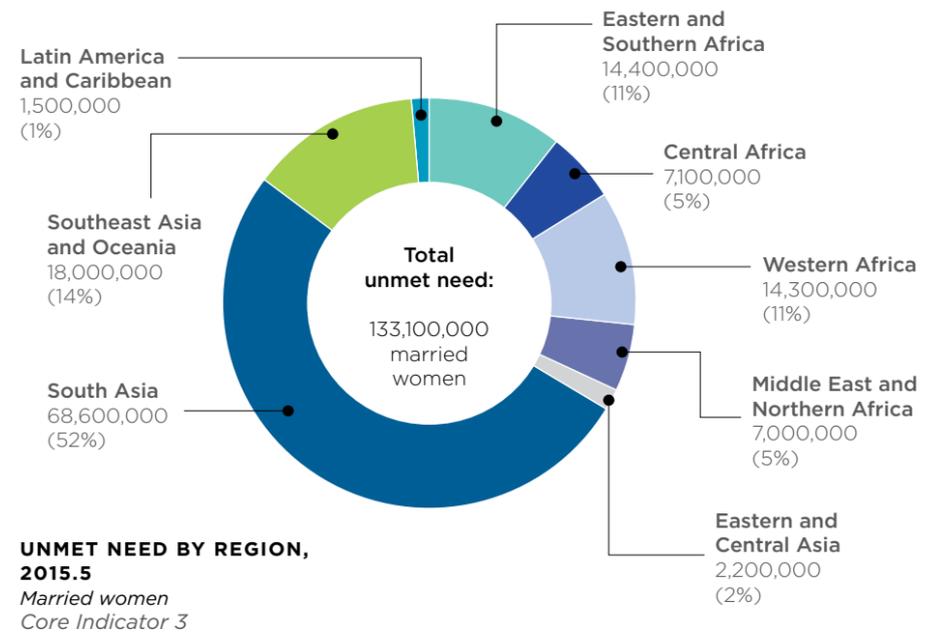
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**Appendix
FP2020 Focus
Countries, Acronyms,
and Acknowledgements**

We've made progress



We must do more to meet unmet need



24.4 million additional users of modern contraception is 10.1 million fewer than the benchmark for 2015 that we announced at the London Summit.

These are 10.1 million women and girls whom FP2020, collectively, committed to reach — but did not.

It is to these women and girls, and the millions more with an unmet need for family planning, that we are ultimately accountable.

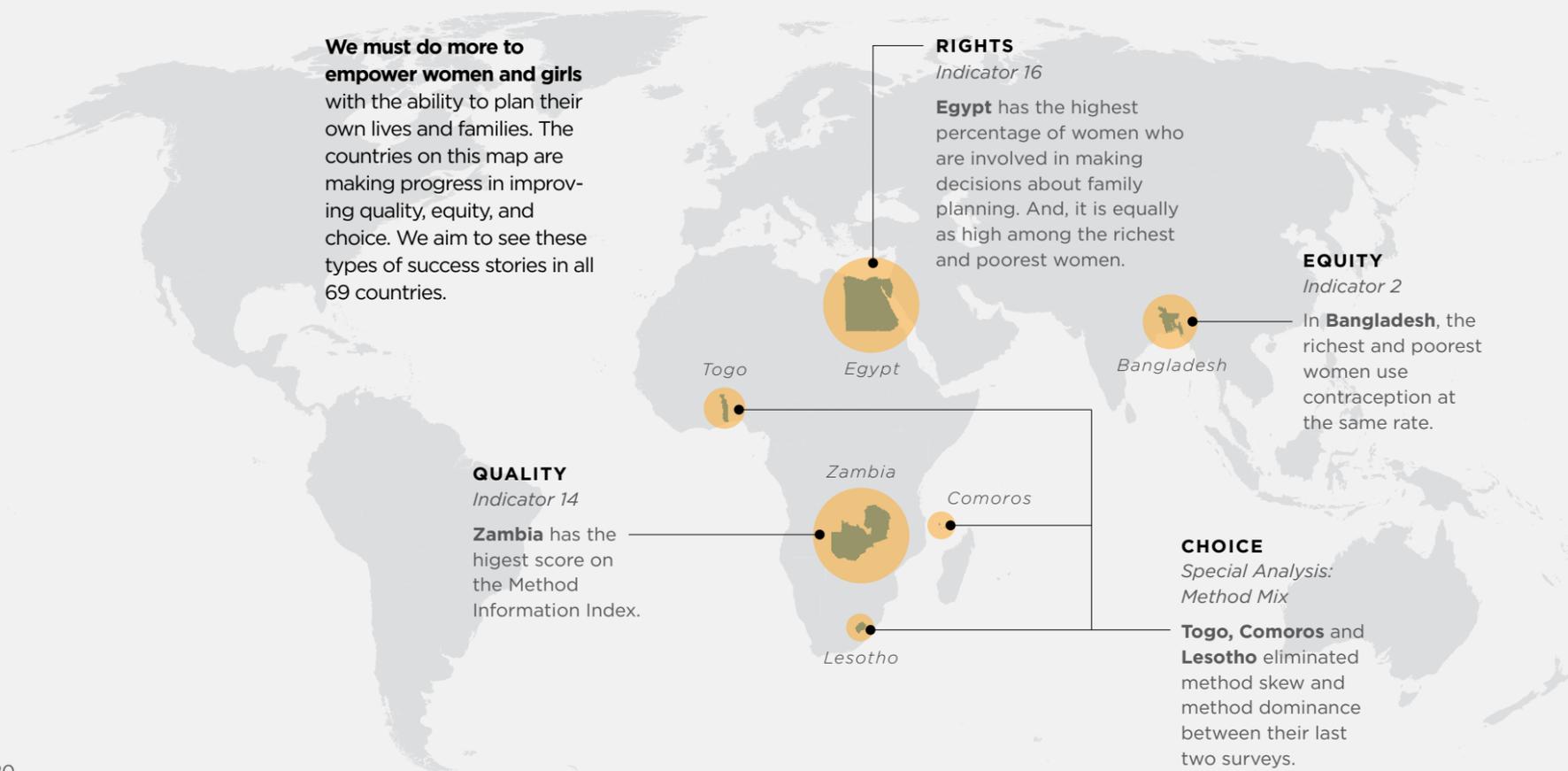
We must do more to empower women and girls with the ability to plan their own lives and families. The countries on this map are making progress in improving quality, equity, and choice. We aim to see these types of success stories in all 69 countries.

RIGHTS
Indicator 16
Egypt has the highest percentage of women who are involved in making decisions about family planning. And, it is equally as high among the richest and poorest women.

EQUITY
Indicator 2
In **Bangladesh**, the richest and poorest women use contraception at the same rate.

QUALITY
Indicator 14
Zambia has the highest score on the Method Information Index.

CHOICE
Special Analysis: Method Mix
Togo, Comoros and Lesotho eliminated method skew and method dominance between their last two surveys.



Executive Summary

By the third anniversary of the July 2012 London Summit on Family Planning, an unprecedented number of women and girls were using modern methods of contraception: **290.6 million** across the 69 FP2020 focus countries.

This means there were **24.4 million** more women and girls using modern methods of contraception by July 2015, the end of the FP2020's third year, than there were in July 2012.

Core Indicator 1, the number of additional women of reproductive age using modern contraception compared to 2012, is our most direct measure of progress toward achieving the goal of adding 120 million contraceptive users by the year 2020.

But FP2020 is about much more than numbers. The 24.4 million additional women and girls who, by July 2015, were using modern methods of contraception are now better able to ensure their families' security, education, and well-being. The enormous health and economic benefits of family planning extend beyond individuals to communities and countries, and are essential to sustainable development.

However, 24.4 million is **10.1 million** less than the benchmark for 2015 that we projected at the time of the London Summit. Again, 10.1 million represents far more than a numerical gap: these are 10.1 million women and girls whom FP2020, collectively, committed to reach – but has not. It is to these women and girls, and the millions more with an unmet need for family planning, that we are ultimately accountable.

To achieve the FP2020 goal, countries must increase the number of users of modern methods of contraception so that a greater proportion of all women and girls of reproductive age are served. Further, this percentage – the modern contraceptive prevalence rate (mCPR) – must grow at a pace that exceeds the historic trajectory.

Core Indicator 2, mCPR for all women of reproductive age, averaged 33.2% in 2015, compared to 32% in 2012 across the 69 FP2020 focus countries. From July 2012 to July 2015, the average increase in mCPR was two times greater among the

34¹ commitment-making countries (1.2% points) than it was among non-commitment-making countries (0.5% points). The countries where mCPR grew most quickly are **Burundi, Kenya, Lesotho, Malawi, and Senegal**.

Core Indicator 3 is unmet need for modern methods of contraception. Across the 69 FP2020 focus countries, we estimate that **133 million** married or in-union women had an unmet need for modern methods of contraception as of July 2015.²

On average, approximately one out of five married or in-union women and girls do not want to get pregnant but are not using a modern method of contraception. We can reasonably assume that the true level of unmet need, which would include women and girls who are not currently married or in-union, is much greater.

Core Indicator 4, the percentage of total demand for family planning satisfied by a modern method of contraception, reflects FP2020's fundamental rights and empowerment principles. UNFPA, USAID, and other FP2020 partners have recommended this indicator³ as a metric for the Sustainable Development Goals because it “reflects the aim of family planning – to support the rights of individuals and couples to choose whether and when to have a child by providing them the means to implement their decision – and promotes voluntarism, informed choice, rights, and equity.”⁴

Core Indicator 5, the total number of unintended pregnancies, is important because of its impact on both maternal and newborn health outcomes. In 2015, an estimated **48.8 million** unintended pregnancies occurred across the 69 FP2020 countries: approximately two out of every five pregnancies were unintended. Unintended pregnancies happen both as a result of method failure and of women not using contraception. While we are making progress, this large number tells us there is much more work to be done.

Core Indicators 6, 7, and 8 show the positive impact of women using modern methods of contraception; that is, unintended pregnancies, unsafe abortions and maternal deaths that are prevented because women are using modern contraception. In 2015, the use of modern methods of contraception by 290.6 million women across the 69 FP2020 countries averted **80 million** unintended pregnancies, **26.8 million** unsafe abortions, and **111,000** maternal deaths.

Compared to the time of the London Summit, increases in contraceptive use and changes in method mix (as women switched to more effective methods) resulted in averting **6.6 million** more unintended pregnancies in 2015 compared to 2012; averting **2.1 million** more unsafe abortions in 2015 compared to 2012; and averting **13,000**⁵ more maternal deaths in 2015 compared to 2012.

Core Indicator 9, modern contraceptive method mix, shows the percentage distribution of contraceptive users by type of method used. Method mix varies greatly across countries, reflecting the different contexts in which women live. A more diverse method mix helps meet the varied family planning needs of women, girls, and couples.

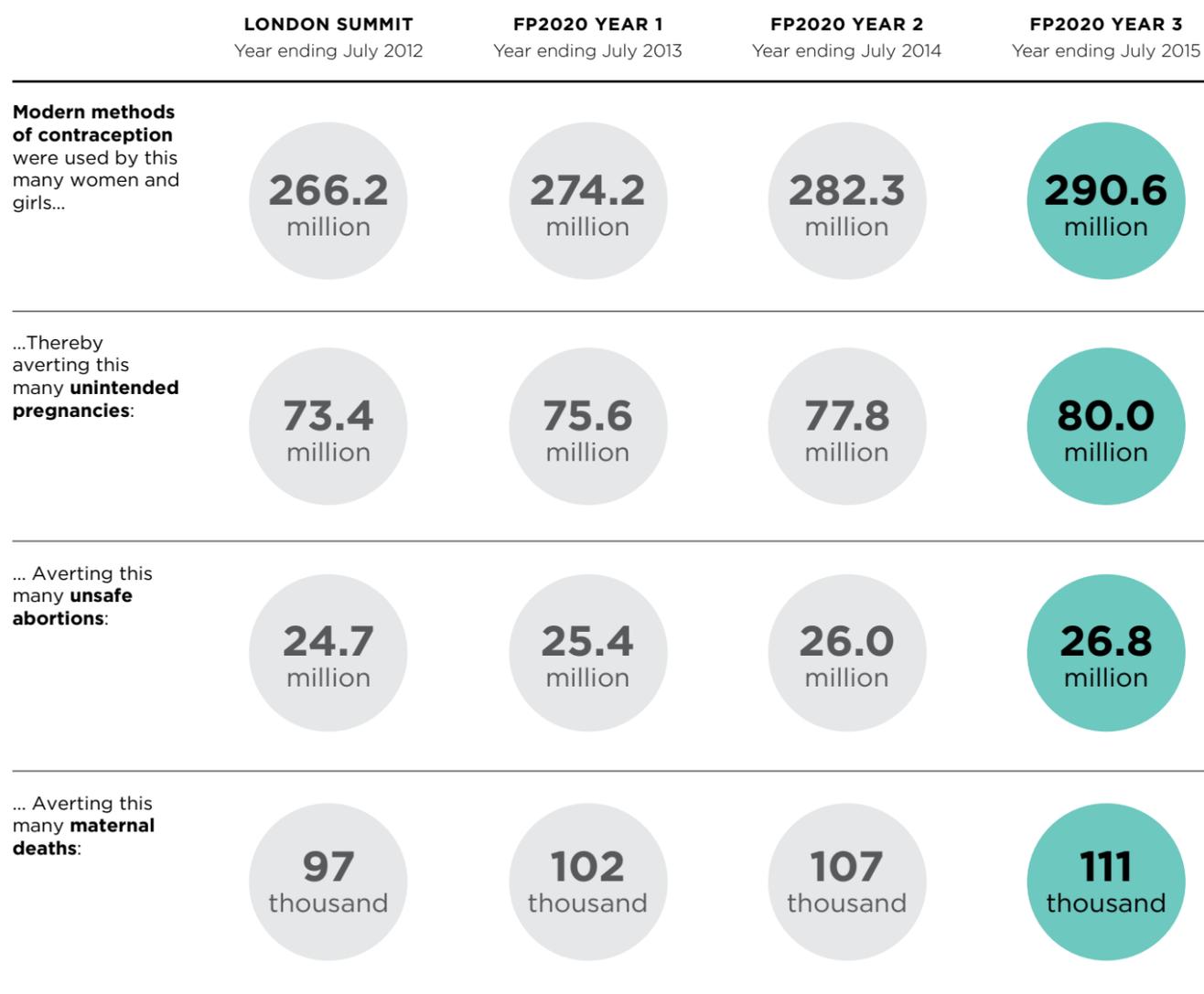
Countries offering more types of modern contraceptive methods in their programs also have higher percentages of contraceptive use (mCPR).⁶ Of the FP2020 focus countries, 88% have six or more types of modern contraceptive methods in use by women of reproductive age in the country.

In February 2015, the FP2020 Reference Group formally adopted two new indicators that will help gauge whether investments in family planning are translating into increased commodity availability and choice of methods at the facility level. **Core Indicator 10** measures stock-outs of contraceptive supplies, and **Core Indicator 11** measures the number of modern methods available by type of facility.

The most useful way to understand contraceptive stock availability is by method. For 2014, these data

1. At the time this analysis was conducted, Madagascar had not yet made a formal commitment to FP2020. This analysis excludes South Africa, which is not one of the 69 FP2020 focus countries.
2. This indicator is currently reported for married / in-union women. FP2020 intends to report this indicator for all women and girls of reproductive age starting in 2016.
3. The indicator recommended by USAID, UNFPA, et al., is demand for family planning met with modern contraceptive methods among all sexually active women of reproductive age who want to delay or limit childbearing.
4. Fabric M, Choi Y, Bongaarts J, Darroch J, Ross J, Stover J, Tsui A, Upadhyay J, Starbird E. Meeting demand for family planning within a generation: the post-2015 agenda. *Lancet*. Published online July 1, 2014.
5. Rounded total.
6. Ross J, Stover J. Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009. *Glob Health Sci Pract*. 2013;1(2):203-212. <http://dx.doi.org/10.9745/GHSP-D-13-00010>.

Impacts of contraceptive use in the 69 FP2020 focus countries



were available for 14 of the 29 FP2020 focus countries where surveys were conducted on contraceptive security.⁷ Overall, for the 14 countries, stock-outs of female condoms and emergency contraception were most common. On average, 40% of facilities in the 14 countries were stocked-out of female condoms and 31% of facilities were stocked-out of emergency pills. For male condoms, pills, and injections, stock-outs

were lower on average, with 10 of the 14 countries reporting less than 20% of facilities stocked out.

When using the more restrictive definition of being stocked-out of any modern contraceptive method, stock-outs appear to be pervasive across the 28 surveyed countries. On average, over 60% of facilities were stocked-out of at least one modern method on the day of survey in the 28 countries where these data were available.

Core Indicator 12 is government domestic expenditures on family planning. Over the past three years, the global community has laid the foundation for producing estimates in the future. However, at the current time, very limited data are available for public reporting. Estimates for 2013 were available for just three countries: **Burkina Faso, Democratic Republic of the Congo, and India.**

Core Indicator 13, couple-years of protection (CYPs), is the estimated number of years of protection provided by family planning services during a one-year period. It is our only Core Indicator to come directly from routine data systems. Since countries need to have robust data systems in order to report on this indicator, it can also serve as a proxy for the importance of investing in data systems and using routine data in countries. In the previous FP2020 Progress Report, we presented CYP estimates for the five countries that provided us with estimates; this year, the total increased to 14 countries.

Core Indicator 14, the Method Information Index, speaks directly to key dimensions of rights and empowerment: informed consent, method choice, and the quality of consultation offered by family planning providers. This year, we report Method Information Index estimates for the 24 FP2020 focus countries with sufficient data collected at or since the time of the London Summit.

Core Indicator 15 shows what proportion of women received family planning information in the last year, either during a visit with a community health worker or at a health facility. This question is asked of all women of reproductive age, regardless of whether they are currently users of contraception. Of the 23 countries with sufficient data for this analysis, on average, around one-quarter of women reported receiving family planning information during the last year. The values range from 6.6% in **Guinea** to 52.4% in **Pakistan.**

Core Indicator 16 shows the percentage of women who make family planning decisions alone or jointly with their husband or partner. Across the 25 countries with data available since the London Summit, the average value of this indicator is fairly high at 87.7%, ranging from 71% in **Comoros** to 98% in **Egypt.** Despite the high scores, in 14 of the 25 countries, more than 10% of women using contraception report that they were not involved in making these decisions.

Core Indicator 17, the adolescent birth rate, is expressed as the number of births to adolescent girls (aged 15 to 19) per 1,000 adolescent girls. Among the 25 countries with sufficient recent data to produce estimates, the adolescent birth rate ranged from 44 per 1,000 in **Pakistan** and **Kyrgyzstan**, to 206 per 1,000 in **Niger.** In general, the highest rates are seen in francophone Africa, a reflection of the proliferation of child marriage and low levels of contraceptive use among all women in that region. High adolescent birth rates may also be attributed to policies that limit young people's access to contraceptives as well as social stigma and provider bias.

The National Composite Index on Family Planning (NCIFP) is a new tool developed to support FP2020's efforts to improve the enabling environment for family planning. It measures the existence of policies and guidelines, as well as the extent to which family planning program implementation includes measurable dimensions of quality service provision. The NCIFP builds on the long-standing National Family Planning Effort Index (FPE), and, in 2014-2015, the two questionnaires were fielded jointly in 90 countries.⁸

FP2020's Core Indicator estimates are produced by Track20, a project of Avenir Health, in collaboration with a network of country family planning M&E officers. **Track20** trains country M&E officers to use the FP2020 Core Indicators in alignment with country family planning strategies, and supports annual data consensus workshops where government Ministries of Health and diverse stakeholders conduct reviews of family planning data and assess progress on national family planning strategies. As of October 2015, there were 22 Track20-trained and supported M&E officers working at the country level, and data consensus workshops had been held in 19 commitment-making countries.

7. PMA2020 R1 surveys were used for Ethiopia (since the UNFPA survey measured only combined method availability) and Malawi (since the Service Provision Assessment Survey was based on the data consensus workshop). Four countries had no UNFPA surveys, and for these countries alternative sources were used: PMA2020 survey data were used for Ghana, Kenya, and Burkina Faso, and logistics report data were used for Côte d'Ivoire.

8. Data collection for both the FPE and NCIFP was jointly funded by Bill and Melinda Gates Foundation, through Avenir Health, and USAID, through Health Policy Project, implemented by Palladium. The analysis of the NCIFP was conducted by Track20/Avenir Health with funding from the Bill and Melinda Gates Foundation.

Notes on Data Sources and Methodologies

TIME PERIODS COVERED IN THIS REPORT

For this report, we measure annual increments from mid-year point to mid-year point. This allows us to present estimates that are dated one year, two years, and three years after the July 2012 London Summit on Family Planning. For example, our “2015” estimate of the number of unintended pregnancies covers 12 months ending July 2015; our baseline year of “2012” refers to the 12 months ending July 2012.

DATA RECENCY

Due to variations in data sources, the strength and “recency” (how old the data are) of the estimates differ from indicator to indicator and country to country. To provide transparency on the recency of various estimates, some of the tables in this report show one of three symbols next to country names.

These symbols, shown below, indicate how recent the last available data is, whether used to produce a modeled estimate or a “stand alone” survey-based estimate. Note that because different indicators may require different data sources for the same country, the recency of sources within a country may vary.

Special analyses and further disaggregation of indicators are restricted to countries that have sufficient “recent” data: we define “recent” as surveys conducted in 2012 or later. Depending on the indicator, there are approximately 20 to 35 countries with sufficient recent data to allow disaggregated and special analyses. For the remaining countries, no

 7 or more years old	 4 to 6 years old	 0 to 3 years old <i>(collected 2012 or later)</i>
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recent data source exists from which to provide estimates. The one exception is Core Indicator 9, modern contraceptive method mix, which is reported from the most recent survey for all countries, regardless of recency. The survey used to produce the estimate for each country is noted in the Core Indicator 9 table.

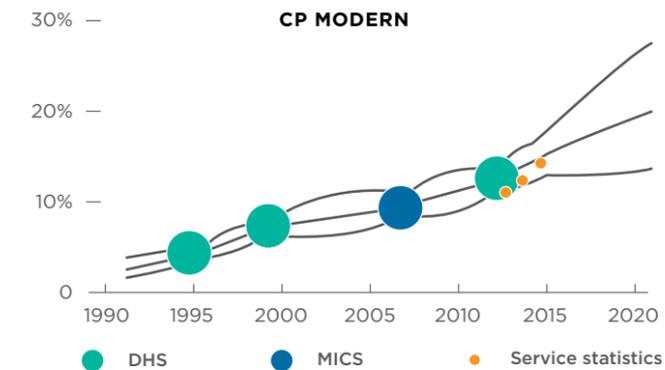
THE ROLLING BASELINE AND RE-ESTIMATING THE ENTIRE TREND

The methodology we use to estimate the number of additional users of modern methods of contraception has two important components, both of which confer advantages related to data quality and accuracy. The first is the designation of 2012 as the baseline year or starting point for our calculation—the point at which we appropriately set the number of additional users at zero. For each reporting period, we will compare the total number of users in the current year to the total number of users in the baseline year (2012). The difference between the two totals is the number of additional users.

The second component is the use of a “rolling” baseline, by which we mean we will recalculate our annual estimates (starting with 2012) on an ongoing basis as new data become available. Continuously incorporating new data improves our ability to monitor progress, so that by 2020 our estimates for all years (2012-2020) will represent the most comprehensive and accurate data available. Calculations of the number of additional users depend on mCPR and the population of women of reproductive age (WRA). There is often a lag time of a year, and sometimes longer, before the surveys used to calculate mCPR are released. In addition, updated population estimates (including WRA) often include retrospective modifications of past estimates based on newly released census data and other sources.

Consequently, as new data become available, they affect not only current year estimates but those calculated in pre-

FPET output for Côte d'Ivoire



vious years as well. The advantage of using rolling estimates is seen by comparing the estimate of the number of users of modern contraception that was calculated for the London Summit on Family Planning in 2012 (258 million) to the updated estimate for 2012 that we use now (266.2 million).

Our calculation incorporates new population-based surveys and updated population estimates for 2012 that were not available two years ago, and as a result, we now consider the total number of users in 2012 to be 8.2 million greater than we previously thought. Were we to use the old estimate for 2012, this discrepancy could be misconstrued as an increase of 8.2 million additional users since 2012.

Not only is our 2012 estimate updated, but so is our 2013 estimate. This means that the number of additional users that we previously estimated in our last report (8.4 million additional users in 2013) has also been re-estimated. Based on the new data added, our new estimate for 2013 additional users is slightly lower: 8.1 million. Because of these changes, it is important not to compare estimates in this report to estimates in the last Progress Report. Instead, this report publishes the entire 2012 to 2015 trend based on the most recent data for comparison of changes over time.

9. Alkema L, Kantorova V, Menozzi C, Biddlecom A. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *Lancet*. 2013; 381(9878): 1642-52. doi: 10.1016/S0140-9736(12)62204-1.

10. At the time this analysis was conducted, Madagascar had not yet made a formal commitment to FP2020. Western Sahara has been excluded from all analyses and data tables due to lack of data.

USING SERVICE STATISTICS TO IMPROVE ESTIMATES

In selected countries, Track20 analyzed service statistics to determine if they were usable to inform mCPR trends. This validation included checking for:

- Consistent levels of reporting over time (so changes in volume of service statistics do not represent more facilities reporting, rather than an increase in service delivered);
- At least three years of consistent data, with at least one year overlapping with a survey, so that the model can calibrate the two trends; and
- At least one year of service statistics reported after the most recent survey: if a survey is the most recent data point, the survey will be used to inform the mCPR trend.

In 2015, four countries were able to use service statistics to inform their mCPR estimates: Burundi, Côte d'Ivoire, Mozambique, and Nigeria. An example from Côte d'Ivoire is shown; three years of service statistics have been included, informing the growth since their 2011-2012 DHS. While in Côte d'Ivoire both the shape and level of service statistics match to the mCPR, in some countries, the service statistics trend might sit below or above the mCPR trend. It is the shape of the curve rather than the level that is used in the Family Planning Estimation Tool (the statistical modeling tool used to produce FP2020's mCPR estimates⁹). More countries are expected to use service statistics to inform the next round of estimates.

FP2020 COMMITMENT-MAKING COUNTRIES

This report focuses on the 69 FP2020 focus countries, and in particular on the subset of commitment-making countries. As of July 2015, there were 35¹⁰ FP2020 commitment-making countries. One of these 35 countries – South Africa – is not one of the 69 focus countries. Data for South Africa are included in our tables listing individual countries in the interest of sharing as much information as we have, though totals, averages, and other estimates of the set of 69 countries do not include data from South Africa.

Part 01

FP2020's Measurement Agenda

Advancing the Measurement Agenda

From its inception, FP2020 has been committed to leading a transformation in the global monitoring and evaluation of family planning.

Our success is dependent on a broad range of partners at the national and global levels working in concert to achieve an ambitious goal within a few short years.

This requires aggressive measurement of country-level progress so that decision makers can make needed program adjustments, donors can wisely target their investments, and all stakeholders can determine whether progress is being made equitably and in accordance with fundamental principles of rights and empowerment.

FP2020's rigorous, robust measurement agenda promotes **harmonization and alignment** of indicators and methodologies among partners, platforms, and frameworks. This allows us to produce internationally comparable estimates on an annual basis across the 69 FP2020 focus countries, using indicators that reflect the increasing focus on rights-based programming.

FP2020 is **improving the infrastructure** and **building the capacity** required to support the frequency and quality of data needed to monitor progress and inform decision making. And we are using better measures of the enabling environment for family planning, contraceptive commodity security, family planning expenditures, and dimensions of rights and empowerment including quality, equity, and choice.

The FP2020 **Performance Monitoring & Evidence Working Group** (PME WG) was convened with the mandate to provide technical guidance, contribute analytic depth, and exercise intellectual stewardship and quality control over the measurement agenda, including the annual assessment of the FP2020 Core Indicators. The Core Indicators are the suite of quantitative metrics we use to monitor progress annually across the 69 FP2020 focus countries.

The FP2020 Core Indicator estimates are produced by **Track20**, a project of Avenir Health, in collaboration with a network of country family planning M&E officers. Track20 trains country M&E officers to use the FP2020 Core Indicators in alignment with country family planning strategies, and supports annual data consensus workshops where government Ministries of Health and diverse stakeholders conduct reviews of family planning data and assess progress on national family planning strategies. As of October 2015, there were 22 Track20-trained and supported M&E officers working at the country level, and data consensus workshops had been held in 19 commitment-making countries in 2015.

FP2020 CORE INDICATORS

Core Indicator No. 1

Number of additional users of modern methods of contraception

Core Indicator No. 2

Contraceptive prevalence rate, modern methods (mCPR)

Core Indicator No. 3

Percentage of women with an unmet need for modern methods of contraception

Core Indicator No. 4

Percentage of women with demand satisfied for a modern method of contraception

Core Indicator No. 5

Number of unintended pregnancies

Core Indicator No. 6

Number of unintended pregnancies averted due to use of modern methods of contraception

Core Indicator No. 7

Number of unsafe abortions averted due to use of modern methods of contraception

Core Indicator No. 8

Number of maternal deaths averted due to use of modern methods of contraception

Core Indicator No. 9

Percentage of women using each modern method of contraception

Core Indicator No. 10

Percentage of facilities stocked-out of contraceptives, by method offered, on the day of assessment

Core Indicator No. 11

Percentage of service delivery points with at least three modern methods of contraception at the primary level / five modern methods of contraception at the secondary-tertiary levels (reported separately), on the day of assessment

Core Indicator No. 12

Annual expenditure on family planning from government's domestic budget

Core Indicator No. 13

Couple-years of protection (CYPs)

Core Indicator No. 14

Method Information Index

Core Indicator No. 15

Percentage of women who were provided with information on family planning during their last visit with a health service provider

Core Indicator No. 16

Percentage of women who make family planning decisions alone or jointly with their husbands or partners

Core Indicator No. 17

Adolescent birth rate

Revisions to the Core Indicator suite approved by the FP2020 Reference Group April 2015

ALIGNMENT AND HARMONIZATION

The FP2020 Core Indicator suite was envisioned as a tool to help improve and harmonize the measurements and methodologies used by partners at the country and global levels for monitoring and evaluating family planning. The Core Indicators were selected with country M&E and data systems in mind to avoid creating parallel measurement systems. The list was kept short to allow FP2020 to focus on indicators with global relevance and comparability across the 69 FP2020 focus countries, while leaving space for countries to identify indicators that are aligned with their own family planning strategies and priorities.

Attention was paid to link indicators with important global platforms in order to foster collaboration and avoid duplication of efforts. These include, but are not limited to, *Every Woman Every Child*, the *International Conference on Population and Development's Programme of Action*, and the *Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights*.

Changes in the international family planning field, led by FP2020, have refocused the most commonly used measure – contraceptive prevalence (CPR) for married or in-union women of reproductive age – to one that looks at modern contraceptive prevalence for all women of reproductive age (mCPR, **Core Indicator 2**). This shift underscores the importance of access to safe and effective family planning for all women and girls, without barriers, regardless of marital status.

The enormous health and economic benefits of family planning extend beyond individuals to communities and countries, and are essential to sustainable development. **Core Indicator 4**, the percentage of women with demand satisfied for a modern method of contraception, aligns with the indicator¹¹ recommended by UNFPA, USAID, and other FP2020 partners as a metric for the Sustainable Development Goals.

Demand satisfied “reflects the aim of family planning – to support the rights of individuals and couples to choose whether and when to have a child by providing them the means to implement their decision – and promotes voluntarism, informed choice, rights, and equity.”¹²

Core Indicators 6, 7, and 8 quantify the impact of contraceptive use on women's health, information that is

critically important to both program planning and advocacy. There are several models and approaches to calculate these impacts, serving different needs in the sector; they include *Adding It Up* (Guttmacher Institute), *Impact 2* (Marie Stopes International), *ImpactNow* (Health Policy Project), *RealityCheck* (EngenderHealth), and FamPlan/LiST (Avenir Health and the Health Policy Project).

The FP2020 impact indicators are calculated using the methodologies and assumptions agreed upon by the STEP-UP consortium, in alignment with the harmonization of measurement in this area. The **STEP-UP** consortium, led by the Population Council and funded by DFID, was convened to address the concern that differences among estimated impacts could create confusion in the family planning community. Over the course of two years, the STEP-UP consortium brought together technical experts to review the models, identify the reasons for discrepant results, and ultimately agree on areas that could be harmonized across the different models.¹³

In February 2015, the FP2020 Reference Group formally adopted two new indicators that will help gauge whether investments in family planning are translating into increased commodity availability and choice of methods at the facility level. **Core Indicator 10** measures stock-outs of contraceptive supplies; **Core Indicator 11** measures the number of modern contraceptive methods available by type of facility. Both are important metrics for monitoring whether women have access to the full range of contraceptive choices, which is a critical dimension of FP2020's rights and empowerment principles for family planning.

Core Indicators 10 and 11 were derived from a harmonized suite of contraceptive commodity indicators developed by the **Reproductive Health Supplies Coalition** (RHSC). The harmonized suite is the culmination of a more than two-year effort by RHSC's System Strengthening Working Group to develop tools that will allow the global community to “speak the same language” about stock-outs.

RHSC's harmonized suite is made up of 12 indicators in four categories: methods offered, range of methods avail-

11. The indicator recommended by USAID, UNFPA et al is demand for family planning met with modern contraceptive methods among all sexually active women of reproductive age who want to delay or limit childbearing.

12. Fabric M, Choi Y, Bongaarts J, Darroch J, Ross J, Stover J, Tsui A, Upadhyay J, Starbird E. Meeting demand for family planning within a generation: the post-2015 agenda. *Lancet* Published online July 1 2014.

13. http://www.popcouncil.org/uploads/pdfs/2014STEPUP_MeasuringImpact.pdf

able, point-in-time stock-outs, and frequency and duration of stock-outs over time. With the leadership of John Snow, Inc., UNFPA, and Management Sciences for Health, the harmonized suite was field tested in Bangladesh and Zambia for feasibility before final guidance was drafted.

The estimates we present for Core Indicators 10 and 11 were calculated using data provided by two sources: **UNFPA Supplies** (formerly the Global Programme to Enhance Reproductive Health Commodity Security) and **Performance Monitoring and Accountability 2020** (PMA2020).

UNFPA Supplies is a thematic fund that supports countries' efforts to build stronger health systems and ensure access to a reliable supply of contraceptives and condoms for family planning and HIV/STI prevention, and life-saving medicines for maternal health. From 2013 to 2020, UNFPA Supplies is providing priority support to 46 countries grappling with high maternal death rates, low rates of contraceptive use, and a growing unmet need for family planning. UNFPA Supplies surveys provide data on both public and private facilities and report on primary, secondary, and tertiary facilities that are authorized to provide the particular methods.

PMA2020 collects data on stock-outs in both private and public facilities. In 2014 data from PMA2020 and UNFPA Supplies were available for both private and public facilities in 29 FP2020 focus countries where surveys were conducted.

IMPROVING INDICATORS AND METHODOLOGIES

In order to produce mCPR estimates for all women of reproductive age on an annual basis across 69 countries, Track20 had to address two persistent challenges. First, some country surveys collect this data only for married or in-union women; where data are collected for all women, often they are not analyzed and presented in actionable ways. Second, the major sources of data for mCPR are large-scale population-based surveys that aren't conducted on an annual basis in most countries.

To produce reliable annual estimates despite gaps in data sources, Track20 uses the **Family Planning Estimation Tool** (FPET), which uses statistical modeling that originated with the United Nations Population Division.¹⁴ FPET uses an adapted model

that incorporates family planning service statistics¹⁵ – routinely collected family planning data such as information about the number of commodities distributed to clients, or the number of client visits – to help inform the trajectory of a country's mCPR growth. This improves the accuracy of annual estimates produced in years without a major population-based survey (see infographic on following page for details).

FP2020 continues to explore ways to measure dimensions of rights and empowerment in family planning programs. In 2015, a landscaping survey was commissioned to evaluate current and soon-to-be-launched initiatives looking at similar areas with regard to rights. Upon completion, FP2020 will launch an effort to develop and test new indicators, working closely with partners in the family planning and measurement spheres to avoid duplication and harmonize with ongoing efforts.

The **National Composite Index on Family Planning** (NCIFP) is a new tool developed to support FP2020 efforts to improve the enabling environment for family planning. It measures the existence of policies and guidelines, as well as the extent to which family planning program implementation includes measurable dimensions of quality service provision.

The FP2020 PME Working Group and Rights & Empowerment Working Group provided oversight and technical guidance for the development of the NCIFP. Track20 led the development process and analysis of the results. The NCIFP builds on the long-standing National Family Planning Effort Index (FPE), and, in 2014-2015, the two questionnaires were fielded jointly in 90 countries.¹⁶ For further analysis, see Part Three of this report and visit www.familyplanning2020.org/measurement-hub.

14. Alkema L, Kantorova V, Menozzi C, Biddlecom A. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *Lancet*. 2013; 381(9878): 1642-52 doi: 10.1016/S0140-9736(12)62204-1.

15. The version of FPET used by Track20 was developed by Jin Rou New and Leontine Alkema of the National University of Singapore.

16. Data collection for both the FPE and NCIFP was jointly funded by Bill and Melinda Gates Foundation, through Avenir Health, and USAID, through Health Policy Project, implemented by Palladium. The analysis of the NCIFP was conducted by Track20 /Avenir Health with funding from the Bill and Melinda Gates Foundation.

FP2020 uses multiple data sources

Data limitations present a significant challenge to tracking key indicators on an annual basis. To produce reliable annual estimates despite gaps in data sources, FP2020 uses the Family Planning Estimation Tool (FPET). FPET projects estimates for mCPR, unmet need, and demand satisfied based on historic survey data from multiple sources. Below are the main data sources and number of surveys used to calculate the estimates in this report.

DHS

198 surveys

The Demographic Health Surveys (DHS) program, supported by USAID, began in 1984. It has provided technical assistance to 90 countries on more than 300 surveys.

NATIONAL & OTHER

188 surveys

This group includes national surveys as well as smaller-scale international surveys, such as socio-economic or fertility surveys, and national health surveys.

MICS

78 surveys

The Multiple Indicator Cluster Survey (MICS), supported by UNICEF, began in 1995 and has carried out close to 300 surveys in more than 100 countries.

PMA2020

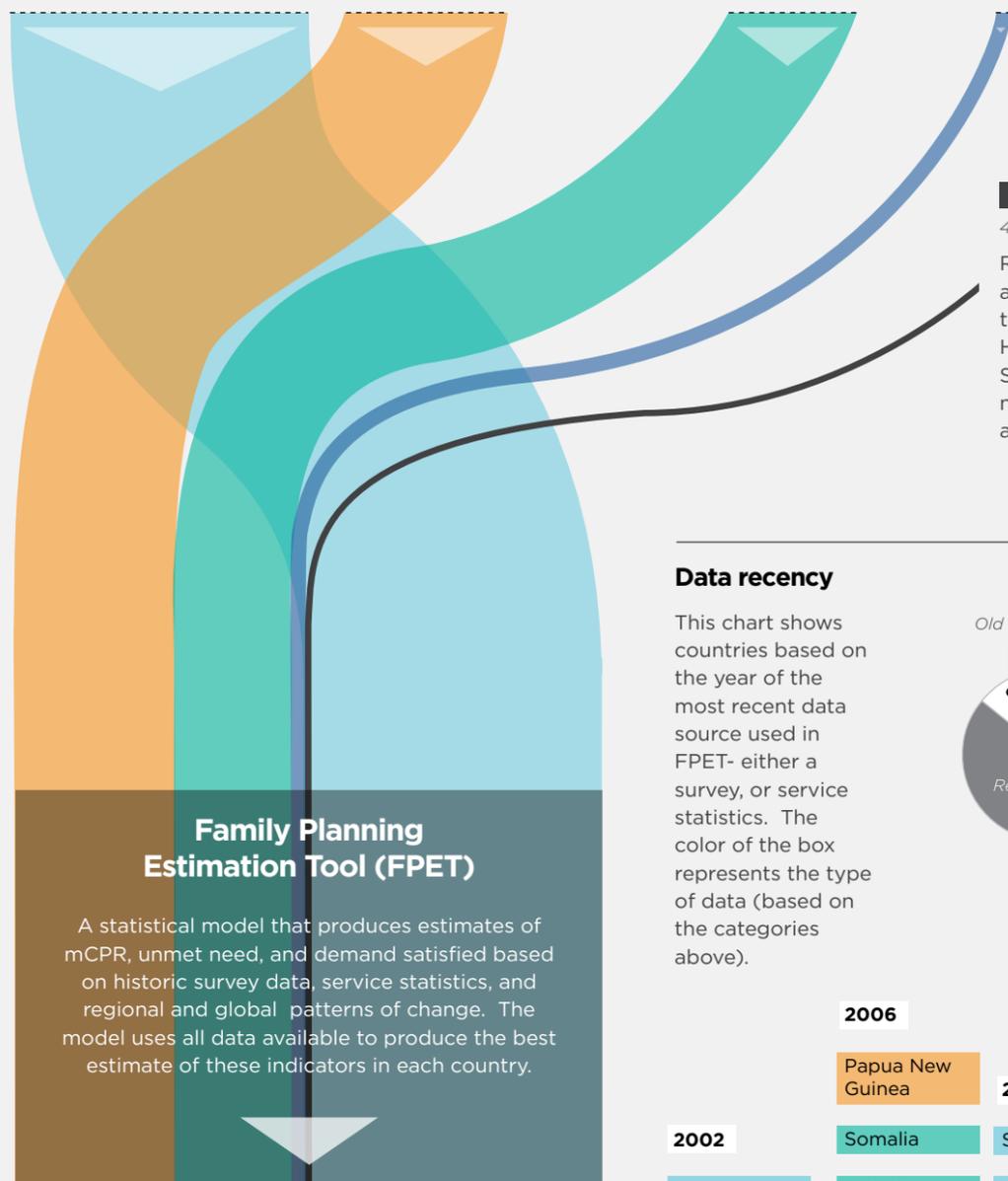
10 surveys

Performance Monitoring and Accountability 2020 (PMA2020), supported by the Bill and Melinda Gates Foundation, began in 2013 and carries out mobile-based household and facility surveys in 8 countries.

SERVICE STATISTICS

4 countries

Routine data on FP client visits and/or commodities distributed to clients are collected through Health Management Information Systems. Where good quality, nationally representative data is available, it can be used in FPET.



Behind the numbers

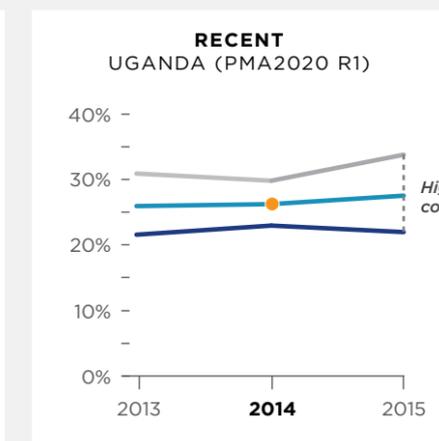
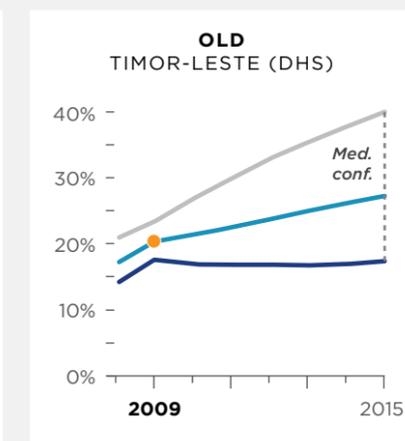
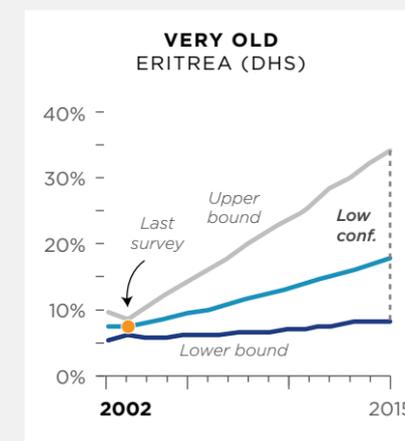
As our data and methodology improve, estimates are more accurate

Confidence and data recency

Variation in the recency of data means that the confidence in our estimates differ from country to country. In countries without recent data, the width

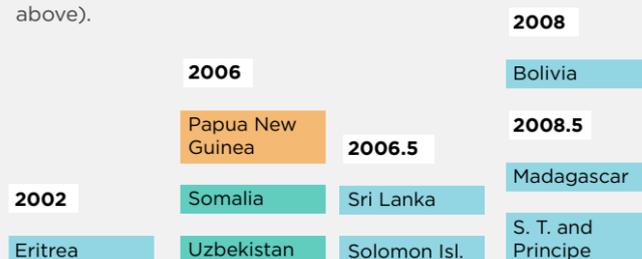
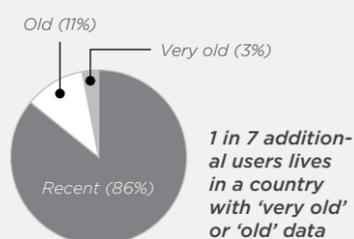
of the confidence intervals, which show the range within which we are 95% confident the true value lies, are generally larger than in countries with

recent data. Therefore, in countries without recent data, estimates may be less reliable and should be taken with some caution.



Data recency

This chart shows countries based on the year of the most recent data source used in FPET- either a survey, or service statistics. The color of the box represents the type of data (based on the categories above).



VERY OLD

OLD

RECENT

A statistical model that produces estimates of mCPR, unmet need, and demand satisfied based on historic survey data, service statistics, and regional and global patterns of change. The model uses all data available to produce the best estimate of these indicators in each country.

**FP2020 Estimates
Core Indicators 2, 3 and 4**

A new way to estimate the **total expenditure on family planning** from all sources (public, private, and out-of-pocket) across the 69 FP2020 focus countries has been developed by Track20 with the help of a group of experts convened as the International Family Planning Expenditure Tracking Advisory Group. Despite the importance of monitoring expenditure levels, data are difficult to obtain and the validation process is challenging. Track20's new methodology draws from ongoing work by numerous partners to improve the collection and understanding of data on family planning expenditures including donor contributions, spending by NGOs and corporations, and out-of-pocket expenditures.

Track20 estimates that in 2013, a total of **US\$3.1 billion** was spent on family planning across the 69 FP2020 focus countries. This estimate brings together expenditure data from the Kaiser Family Foundation (KFF), UNFPA/ Netherlands Interdisciplinary Demographics Institute Resource Flows Project, World Health Organization System of Health Accounts, Countdown 2015 Europe, USAID/Deliver Project, PMA2020, and Track20. For more information, visit www.familyplanning2020.org/measurement-hub.

TRACK20: DATA FOR DECISION MAKERS

Track20 works with FP2020 commitment-making countries to identify, train, and support dedicated family planning M&E officers. Officers are placed in the country Ministry of Health, Office of Population, or other relevant office, to act as the point person for family planning data from both the public and private sectors.

In April 2015, Track20 organized its second annual training for M&E officers and partners, with participants from 22 FP2020 commitment-making countries: Bangladesh, Benin, Burkina Faso, Burundi, DR Congo, Ethiopia, India, Indonesia, Kenya, Malawi, Myanmar, Nepal, Niger, Nigeria, Pakistan, Senegal, South Africa, Tanzania, Togo, Uganda, Zambia, and Zimbabwe.

There are M&E officers trained and supported by Track20 working in 17 FP2020 commitment-making countries: Benin, Burkina Faso, Côte d'Ivoire, DR Congo, Ethiopia, India, Indonesia, Kenya, Malawi, Niger, Nigeria, Pakistan, Philippines, Senegal, South Africa, Togo, and Uganda. Some countries (India, Indonesia, and Nigeria) have more than one M&E officer in place; others are in the process of bringing M&E officers on board (Mozambique, Rwanda, Tanzania, Zambia, and Zimbabwe).

The M&E officer's activities vary according to a country's needs - in one country, he or she may focus on producing sub-national estimates of key family planning indicators,

while in another he or she may provide data and M&E support for the national family planning strategy or Costed Implementation Plan (CIP) - but in all countries, the M&E officer serves as a key liaison among country partners dedicated to encouraging the use of quality data in family planning programming and policy decision making.

All Track20 M&E officers are engaged in producing data for and organizing annual data consensus workshops led by the Ministry of Health. In 2015, data consensus workshops were held in 19 FP2020 commitment-making countries: Benin, Burundi, Côte d'Ivoire, DR Congo, Ethiopia, India, Indonesia, Kenya, Malawi, Mozambique, Myanmar, Nigeria, Pakistan, Senegal, South Africa, Tanzania, Togo, Uganda, and Zambia.¹⁷

Data consensus workshops serve as a platform where the government and partners come together to support the use of data in country-level decision making to improve program implementation and quality of services. The agenda typically includes the review of available data; discussions on the quality of that data; utilization of statistical models and other methodologies to produce annual estimates of the FP2020 Core Indicators; and assessment of progress toward a country's national family planning strategy. The Track20 M&E officer plays a key role in the data consensus workshop by supporting the use of new methodologies and tools and providing detailed information about the available data.

Data consensus workshops are of paramount importance in ensuring that annual monitoring is a country-driven process. They also provide an important opportunity for transparency about data and methodologies used in-country and internationally, with a focus on synergizing estimates that are used by all partners. Participation in the data consensus workshop varies from country to country, but generally includes public and private sector technical experts from other relevant government ministries, UN agencies, donors, NGOs, and implementing partners.

TOOLS FOR DATA USE

User-friendly tools to support family planning M&E efforts are available on the Track20 website.¹⁷ For example, Track20's Rapid Assessment Tool was designed to help countries assess their capacity for recording, reporting, and analyzing family planning data. The tool helps users evaluate existing data sources such as service statistics, government surveys (i.e., labor force or socioeconomic surveys), private sector omnibus surveys, and any other relevant data. Findings from the assessment are used to guide country M&E activities.

17. <http://track20.org/pages/resources/>

In 2015, Track20 data consensus workshops were held in 20 FP2020 commitment-making countries	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	
<p>All Track20 M&E officers are engaged in organizing annual data consensus workshops, which are usually led by the Ministry of Health. Participation in the data consensus workshop varies from country to country, but generally includes public and private sector technical experts from other relevant government ministries, UN agencies, donors, NGOs, and implementing partners.</p>	Senegal		Annual Track20 M&E officer training	Benin Indonesia Kenya Malawi Mozambique Myanmar Tanzania Zambia	Burundi Ethiopia Togo	Côte d'Ivoire India South Africa	Pakistan	Nigeria	DR Congo Uganda	<p>SPOTLIGHT: KENYA</p> <p>In May, the Track20 Kenya team organized its national data consensus workshop. It was chaired by Dr. Josephine Kibaru-Mbae, Director General at the National Council for Population and Development. Alongside the Ministry of Health, participants in the workshop included representatives of DFID, FHI360, Bill and Melinda Gates Foundation, International Center for Reproductive Health at the University of Nairobi, Marie Stopes, Pathfinder International, Population Services Kenya, UNFPA, USAID, and the World Bank.</p>

PMA2020: INNOVATION AND EXPANSION

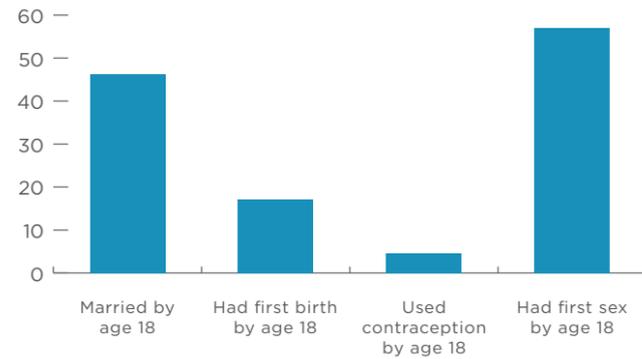
Performance Monitoring and Accountability 2020

(PMA2020) is active in nine FP2020 commitment-making countries, where the project is using innovative mobile technology to collect routine, low-cost, and rapid-turnaround survey data that provide annual updates to key family planning indicators at the individual, household, and facility level.

The project has collected nationally representative data in Burkina Faso, Ethiopia, Ghana, Kenya, Indonesia, and Uganda, and sub-national data for the Democratic Republic of the Congo (Kinshasa), Niger (Niamey), and Nigeria (Lagos and Kaduna). Within the next year, the project will launch in two states in India (Rajasthan and Tamil Nadu) and two provinces in Pakistan (Sindh and Punjab provinces.) They will expand to national samples in Nigeria and Niger, and add Bas Congo to the DRC survey.

Partnering with local universities and research organizations, the project builds local capacity to train and deploy a cadre of female resident enumerators who conduct the survey using smartphones. In the

**PMA2020/Burkina Faso
Percentage among all women aged 18-24**



first two project years, PMA2020 has already equipped over 1,200 women with the skills and supplies needed to conduct interviews and record data using a customized version of the mobile software package, Open Data Kit (ODK).

After 20 rounds of data collection in nine countries, the female resident enumerators have interviewed more than 70,000 women and collected over 150,000 survey forms providing critical data for family planning decision makers.

With survey rounds every six months for the first two years in each country and annually thereafter, the project is providing unprecedented frequency of data, showing changing trends over time and facilitating data-driven decision making from program planners and policy makers in project countries.

Local stakeholders are already using the data to inform family planning strategies, track national family planning progress, and inform budget allocations for family planning resources at both the national and sub-national levels.

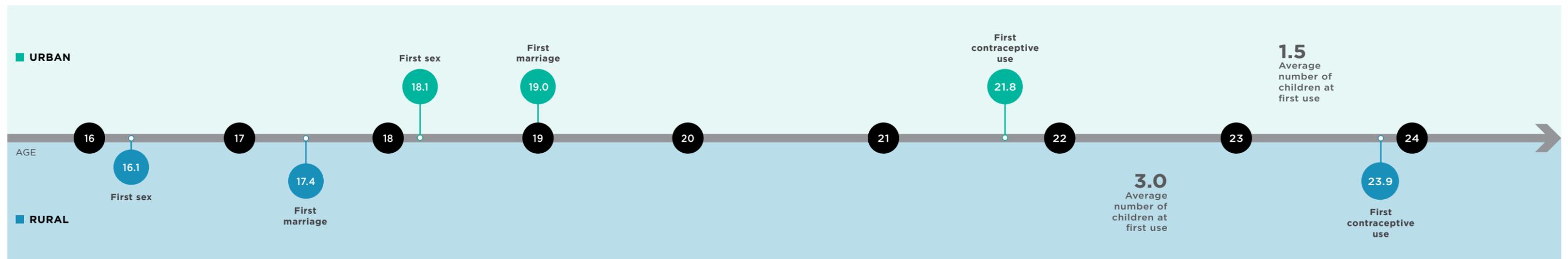
In Uganda, PMA2020 data have been used by the Federal Ministry of Health to develop key family planning policy and program goals in their CIP for the 2015-2020 period. PMA2020 has also been used as a key data source in the annual “performance management plan” (PMP) meetings for tracking targets and goals of the CIP and the overall family planning policy agenda, thereby contributing to

policy formulation at the Uganda Ministry of Health.

In Ghana, the family health division of the Ghana Health Service (GHS), a branch of the Ghanaian Ministry of Health that is responsible for implementation of national policies, has revised key family planning health targets based on PMA2020 Ghana data. Specifically, GHS has used PMA2020 estimates for contraceptive prevalence rate (CPR) and the total fertility rate (TFR) to set policy and program goals in their targeted five-year plan. Moreover, the Ministry of Local Government and Rural Development is planning to use the water, sanitation, and hygiene (WASH) data to inform decisions related to environmental health and sanitation at the national level.

In DR Congo, the first three rounds of data collection have focused exclusively on Kinshasa. However, as family planning programs and activities expand outside of Kinshasa to the province of Bas Congo (previously Kongo Central) in fall 2015, the PMA2020 project will also extend its coverage there, providing baseline data on contraceptive supply and demand just months before the start of new programmatic initiatives in this province.

**Average age at reproductive events:
PMA2015/Ethiopia R3**



Part 2

Core Indicators

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No. 01

Additional Users of Modern Contraception

By the third anniversary of the July 2012 London Summit on Family Planning, an unprecedented number of women and girls were using modern methods of contraception: 290.6 million across the 69 FP2020 focus countries.

This means there were 24.4 million more women and girls using modern methods of contraception by July 2015, the end of the FP2020's third year, than there were in July 2012.

Core Indicator 1 is our most direct measure of progress toward achieving the goal of adding 120 million contraceptive users by the year 2020. But FP2020 is about much more than numbers, and so is Core Indicator 1.

The 24.4 million additional women and girls who, by July 2015, were using modern methods of contraception are now better able to ensure their families' security, education, and well-being. The enormous health and economic benefits of family planning extend beyond

individuals to communities and countries, and are essential to sustainable development.

However, 24.4 million is 10.1 million less than the benchmark for 2015 that we had projected at the time of the London Summit. Again, 10 million represents far more than a numerical gap: these are 10.1 million women and girls whom FP2020, collectively, committed to reach – but did not. It is to these women and girls, and the millions more with an unmet need for

DEFINITION

Number of additional users of modern methods of contraception:

The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method, compared to the number in 2012

SCOPE

Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE

UN Population Division (for number of women of reproductive age); Family Planning Estimation Tool (FPET) for mCPR, using all available household surveys such as Demographic and Health Surveys (DHS), PMA2020, MICS, RHS, and comparable national sources, including service statistics where possible

family planning, that we are ultimately accountable.

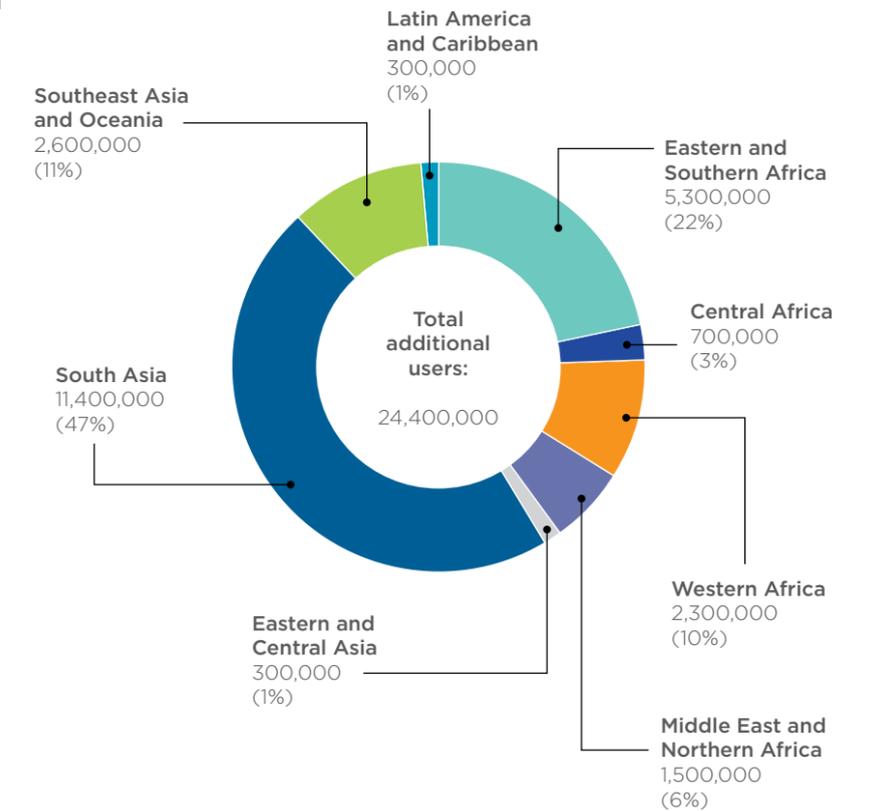
The largest youth cohort that the world has ever seen is entering its reproductive years. Across the 69 FP2020 focus countries, there were 45.4 million more women of reproductive age in 2015 than there were in 2012. Closer examination of Core Indicator 1 shows that nearly half of the 24.4 million additional users of contraception are in South Asia (47%), which is not surprising, since the most populous of the FP2020 69 focus countries are in that region. Nearly one-quarter of additional users live in Eastern and Southern Africa (22%).

To keep pace with population growth, family planning programs must serve greater numbers of clients. Just keeping the proportion of users – the country's mCPR – constant in the context of a growing population translates to more contraceptive users in absolute numbers. In 2015, just over half of the additional users reached were the result of keeping pace with population growth, while the remaining half were from increases in mCPR.

There are large regional variations in this pattern. Across Sub-Saharan Africa, 63% of additional users were from growth in mCPR, as compared to South Asia, where only 41% of additional users were from mCPR growth. This pattern is partially driven by the fact that modern contraceptive use is generally lower in Sub-Saharan Africa, meaning there is more “room” for these countries to increase mCPR.

To achieve the FP2020 goal, countries must not only increase their mCPR, but must do so at a rate faster than their historic growth trajectory. We examine acceleration of mCPR growth in our analysis of Core Indicator 2.

Additional users by region, 2015.5



KEY

Region
Number of additional users
(% of total additional users)

SPOTLIGHT

Re-estimating Additional Users

We use a “rolling baseline” to estimate the number of additional users: we recalculate the baseline estimate, and every subsequent estimate, of additional users on an annual basis as more data is released to the public. This means that the number of additional users we presented in the previous FP2020 Progress Report (8.4 million additional users in 2013) has been re-estimated.

Our new estimate – 8.1 million additional users in 2013 – reflects data that were not yet available at the time of the last report. It is important to not compare estimates in this report to those in the last report, since they reflect different data sets. Instead, this report presents our new estimate of the total number of modern contraceptive users in 2012 – our new baseline estimate – and new estimates of the number of additional users for the years 2013, 2014, and 2015.

No. 02

Modern Contraceptive Prevalence Rate (mCPR)

To achieve the FP2020 goal, countries must increase the number of users of modern methods of contraception so that a greater proportion of all women and girls of reproductive age are served. Further, this percentage – or mCPR – must grow at a rate that exceeds the historic trajectory.

Across the 69 FP2020 focus countries, mCPR averaged 33.2% in 2015, compared to 32% in 2012.

Over the three years since the London Summit, the countries where mCPR grew most quickly are Burundi, Kenya, Lesotho, Malawi, and Senegal.

For the 12 month period ending mid-year 2015, in 13 of the 69 FP2020 focus countries, mCPR was greater than 40%. In 27 countries, mCPR ranged from 40% to 20%, and in 28 countries, mCPR was less than 20%.

From 2012 to 2015, the average increase in mCPR was two times greater among 34¹⁸ commitment-making countries (1.2% points) than it was among non-commitment-making countries (0.5% points).

To examine whether a country had accelerated its growth in mCPR, we looked at the 41 FP2020 focus countries with data collected since the time of

DEFINITION

Contraceptive prevalence rate, modern methods (mCPR):

The percentage of all women of reproductive age who are using (or whose partner is using) a modern method of contraception at a particular point in time

SCOPE

Reported annually, for all 69 FP2020 focus countries (except Western Sahara).

SOURCE

Family Planning Estimation Tool (FPET), using all available household surveys such as Demographic and Health Surveys (DHS), PMA2020, MICS, RHS, and comparable national sources including service statistics where possible

the London Summit.¹⁹ We found that in 14 of the 41 countries the new data show an acceleration of mCPR growth that is higher than previously estimated, with the most rapid acceleration seen in Burundi, Kenya, Lesotho, Malawi, and Senegal. This group also includes some of the most populous FP2020 countries: Bangladesh, Ethiopia, and Indonesia.

Ten of the 41 countries are continuing along their same trajectory, showing that the new data are in line with the previous trend. These 10 countries are home to 50% of the women of reproductive age across the 69 FP2020 focus countries, meaning this lack of acceleration has a large impact on achieving FP2020's goal. This group of 10 countries includes some of the most populous, such as India, Pakistan, and the Philippines.

In very large countries, increasing mCPR is very difficult. For example, in India, each additional one percentage point increase in mCPR translates to 3.3 million women.

Another consideration is the programmatic effort required to ensure that women can continue using modern contraceptives each year, especially in countries where the method mix is

18. This analysis was conducted before Madagascar made its FP2020 commitment, in addition, it excludes South Africa which is not one of the FP2020 focus countries.

19. To determine an acceleration in growth, FPET was re-run for the 41 countries with recent survey data (2012-2014) removed to see their projected trend to 2015 without the new data point. This allows us to see if with the new survey, the mCPR growth curve to 2015 has shifted up, stayed the same, or shifted down. Simply comparing changes in mCPR growth rates between surveys does not provide a good picture of acceleration due to factors including large differences in inter-survey periods making it difficult to compare growth rates, and expected increases or decreases in mCPR growth rates (since it follows an S-curve and not a line).

20. In some cases, a decline was seen between different types of surveys (e.g., DHS, MICS, or national survey), so some discrepancies in mCPR may be due to survey design and sampling implementation.

SPOTLIGHT

The Shift to "All Women" Estimates of MCPR

FP2020 monitors modern contraceptive use among all women, rather than only married or in-union women. FP2020's use of this methodology represents our fundamental belief that all women, regardless of marital status, should have access to the high-quality family planning services of their choosing.

This is a global shift in how contraceptive prevalence is normally reported at both the international and national

levels. When considering estimates of mCPR, it is important to note which population is being measured because in most countries, mCPR for married or in-union women will be higher than mCPR for all women.

In this report, "all women" estimates are presented whenever possible. However, in some cases, data were available only for married or in-union women. To mark this distinction, you will see "AW" (all women) or "MW" (married or in-union women) next to the estimates to indicate which population was surveyed.

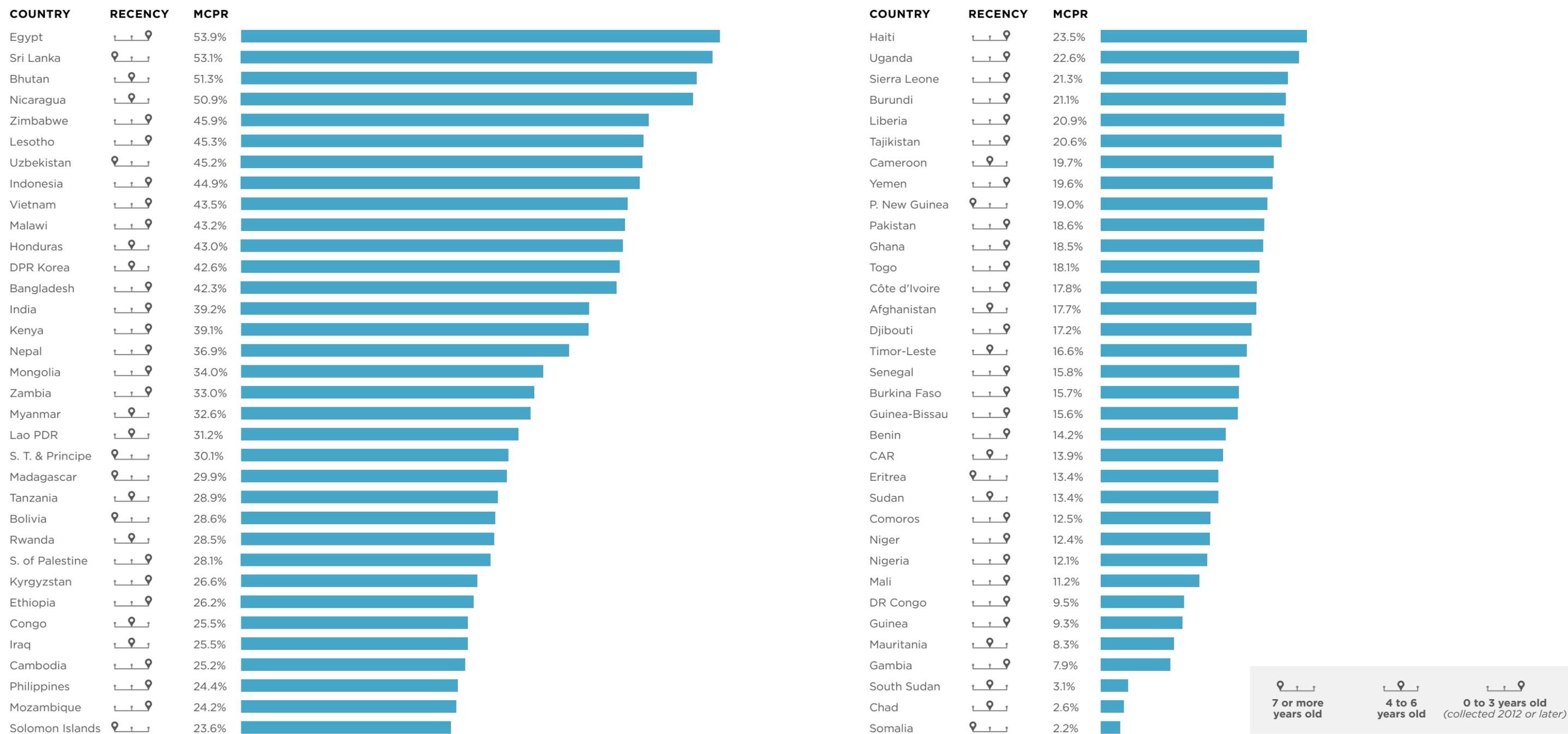
dominated by short-term methods, which means that women need continual access to services and products in order to be protected. In Nigeria, just maintaining mCPR at the 2012 level in 2015 would translate to 3.8 million injections given, 9.4 million pill cycles distributed, 120 thousand long-acting and permanent method (LAPM) services delivered, and condoms provided to nearly 2 million women.

Of the remaining 17 of the 41 countries, all but one (Vietnam) showed some degree of growth from 2012 to 2015; however, these countries' latest surveys show them reaching a lower mCPR in 2015 than their previous projected trajectory, which means that progress has slowed. In 11 of these 17 countries, an actual decline in mCPR was seen between two recent surveys,²⁰ indicating a pressing need for action.

For the 28 countries with no new data since the London Summit to inform our mCPR estimates, we cannot say if progress is accelerating or not. For now, we can only assume that these countries are continuing along their projected paths.

FP2020 focus countries: mCPR

July 2015, listed in descending order



No. 03

Unmet Need for Modern Contraception

The international community has agreed that reproductive rights include the right to determine, freely and responsibly, the number and spacing of one's children.

Core Indicator 3, unmet need for modern methods of contraception, is one measure of women's ability to exercise this right. As such, it is not only an important criterion for assessing the performance of national family planning programs; it is also a critical indicator of women's empowerment, as well as the degree to which governments and the global community - including FP2020 - are meeting our commitment to make family planning services available to all who want them.

Across the 69 FP2020 focus countries, we estimate that, in July 2015, 133 million married or in-union women of reproductive age have an unmet need for modern methods of contraception.

On average, approximately one out of five married or in-union women do not want to get pregnant but are not using a modern method of contraception. We can reasonably assume that the true level of unmet need, which would include women who are not currently married or in-union, is much greater.

Core Indicator 3, unmet need for modern methods of contraception, quantifies the number of fecund women who want to delay pregnancy or have no more children but who are not using a modern contraceptive method. The estimates presented here represent unmet need among married or in-union women only; in 2016, we hope to begin

DEFINITION

Percentage of women with an unmet need for modern methods of contraception:

The percentage of fecund women of reproductive age who want no more children or want to postpone having a child, but are not using a modern contraceptive method, plus women who are currently using a traditional method of family planning. Women using a traditional method are assumed to have an unmet need for modern contraception. This indicator is currently reported for married and in-union women. FP2020 intends to report this indicator for all women of reproductive age starting in 2016.

SCOPE

Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE

FPET, using all available household surveys such as DHS, PMA2020, MICS, and RHS

publishing estimates of unmet need for all women of reproductive age.

On average, the percentage of married or in-union women of reproductive age with an unmet need for modern methods of contraception was 22.5% across the 69 FP2020 focus countries. There are large variations among the countries, ranging from the low of 10.9%, in Nicaragua, to a high of 41.8% in the Congo (Brazzaville).

In 23 of the 69 countries, more than 3 out of every 10 married or in-union women have an unmet need for modern contraception.

To identify changes in the level of unmet need over time, we examined the 38 FP2020 focus countries with sufficient data collected since the time of London Summit.

Twenty-six of the 38 countries experienced a decline in their level of unmet need between 2012 and 2015; the average drop over the three-year period is 1.5%. The greatest declines in unmet need were in Kenya, Malawi, and Zambia, which saw unmet need decrease by more than three percentage points since the London Summit.

Unmet need is a complex measure that is best understood in concert with other Core Indicators, such as mCPR. For example, one cannot assume, based only on an estimate that shows no decline in unmet need, that progress is not being made. It is possible for mCPR and unmet need to grow at the same time.

For example, in a country where mCPR has been very low but is beginning to increase, more women may begin expressing a desire to control their fertility, and this increase in demand could outpace a country's ability to provide family planning services. This is the case in Niger, where both mCPR and unmet need among married and in-union women have increased in recent years.

Unmet need by region, 2015.5

Percentage of married women



SPOTLIGHT

Modern vs. Traditional Methods

FP2020 monitors the unmet need for a modern method of contraception. We consider women using a traditional method of contraception along with those using no method of contraception as having unmet need.

This recognizes that women using traditional methods are at higher risk

of unintended pregnancy due to the low effectiveness of these methods, and would therefore benefit from using more effective modern methods.

The FP2020 methodology differs from the approach of calculating unmet need by counting only those women who use no method of contraception - regardless of the method's effectiveness.

No. 04

Demand Satisfied for Modern Contraception

Core Indicator 4, the percentage of total demand for family planning satisfied by a modern method of contraception, reflects the fundamental rights and empowerment principles of FP2020.

UNFPA, USAID, and other FP2020 partners have recommended this indicator²¹ as a metric for the Sustainable Development Goals because it “reflects the aim of family planning – to support the rights of individuals and couples to choose whether and when to have a child by providing them the means to implement their decision – and promotes voluntarism, informed choice, rights, and equity.”²²

Because Core Indicator 4 measures the percentage of total demand (all fecund married or in-union women who want to control their fertility) currently covered by services, this indicator provides a more specific measure of family planning program success than Indicator 3, unmet need for modern contraception, which

measures a negative – those who are not covered by services.

Levels of demand satisfied vary greatly across the 69 countries, from a low of 8.9% among married or in-union women in Somalia, to a high of 87.4% among married or in-union women in Nicaragua. Among the 69 FP2020 focus countries, demand satisfied was less than 30% in 10 countries. In 35 countries, demand satisfied was between 30% and 60%, and in 23 countries, demand satisfied was greater than 60%.

However, demand satisfied must be interpreted within the context of total demand in a country—meaning both unmet need and use of modern contraception (mCPR). Where total demand is low, it is relatively easier to satisfy than in a country where total demand is high.

For example, in Niger (see figure below) demand satisfied is relatively high (41.6%). However, due to low levels of both mCPR and unmet need, only 33% of

DEFINITION

Percentage of women with demand satisfied for a modern method of contraception:

The percentage of fecund women of reproductive age who want no more children or want to postpone having a child, and who are currently using a modern method of contraception. Women using a traditional method of family planning are assumed to have an unmet need for modern contraception. This indicator is currently reported for married / in-union women. FP2020 intends to report this indicator for all women of reproductive age starting in 2016.

SCOPE

Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE

FPET, using all available household surveys such as DHS, PMA2020, MICS, and RHS

Demand satisfied by country, 2015.5

COUNTRY	REC.	MCPR	COUNTRY	REC.	MCPR	COUNTRY	REC.	MCPR
Nicaragua	📍	87.4%	Madagascar	📍	58.9%	Burkina Faso	📍	39.4%
Bhutan	📍	84.9%	Ethiopia	📍	58.7%	Ghana	📍	38.8%
Zimbabwe	📍	83.2%	Iraq	📍	58.5%	Liberia	📍	37.7%
Indonesia	📍	82.5%	Cambodia	📍	57.5%	Eritrea	📍	37.4%
Uzbekistan	📍	82.3%	Tajikistan	📍	55.1%	Sierra Leone	📍	37.1%
Egypt	📍	81.5%	Philippines	📍	53.9%	Côte d'Ivoire	📍	35.6%
Vietnam	📍	78.7%	Burundi	📍	53.6%	Congo	📍	35.4%
DPR Korea	📍	78.5%	Tanzania	📍	52.8%	Cameroon	📍	34.4%
Honduras	📍	76.7%	Solomon Islands	📍	52.5%	Togo	📍	34.2%
Lesotho	📍	75.7%	Bolivia	📍	51.6%	Comoros	📍	32.9%
Bangladesh	📍	73.4%	S. T. & Principe	📍	50.5%	Sudan	📍	32.2%
Kenya	📍	73.3%	Yemen	📍	49.8%	Nigeria	📍	31.4%
Malawi	📍	72.8%	Pakistan	📍	49.5%	Mali	📍	29.6%
India	📍	72.0%	Haiti	📍	48.4%	CAR	📍	28.5%
Myanmar	📍	71.5%	Timor-Leste	📍	48.4%	Mauritania	📍	28.0%
Sri Lanka	📍	71.0%	P. New Guinea	📍	46.4%	Gambia	📍	27.1%
Mongolia	📍	70.2%	Afghanistan	📍	45.5%	Benin	📍	27.0%
Rwanda	📍	67.0%	Mozambique	📍	44.2%	Guinea	📍	19.3%
Kyrgyzstan	📍	66.4%	Uganda	📍	43.5%	DR Congo	📍	18.2%
Lao PDR	📍	65.5%	Djibouti	📍	43.4%	South Sudan	📍	11.0%
Zambia	📍	64.2%	Senegal	📍	42.9%	Chad	📍	10.0%
S. of Palestine	📍	63.4%	Niger	📍	41.6%	Somalia	📍	8.9%
Nepal	📍	63.0%	Guinea-Bissau	📍	39.7%			

married women in Niger are considered to have a demand for modern contraception. The 14% mCPR for married women represents 41.6% of this total demand.

This compares to a country like Senegal (data not shown) where just over half of married women have a demand for family planning – so achieving a similar level of demand satisfied in this country (42.9%) requires a much higher mCPR among married women (22%).

Among the 38 FP2020 focus countries with sufficient data to support this analysis, we identified 35 countries where the percentage of demand

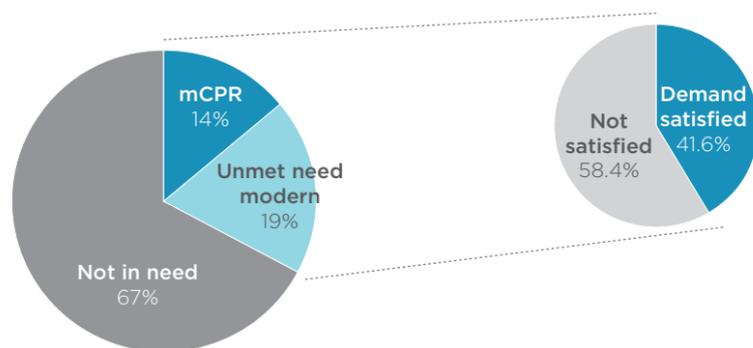
satisfied increased over the three years since the London Summit. This increase averaged 3.2% points over the three year period. The largest increases in percentage of demand satisfied were in Djibouti, Ethiopia, Kenya, Malawi, Sierra Leone, and Zambia. All 6 countries had increases of greater than 5% points between 2012 and 2015.

21. The indicator recommended by USAID, UNFPA et al is demand for family planning met with modern contraceptive methods among all sexually active women of reproductive age who want to delay or limit childbearing.

22. Fabic M, Choi Y, Bongaarts J, Darroch J, Ross J, Stover J, Tsui A, Upadhyay J, Starbird E. Meeting demand for family planning within a generation: the post-2015 agenda. Lancet. Published online July 1, 2014.

Demand satisfied as a percentage of total demand: Niger

Percentage of married women



No. 05

Number of Unintended Pregnancies

Over 12 months ending mid-year 2015, an estimated 48.8 million unintended pregnancies occurred across the 69 FP2020 countries. This was an estimated 1.2 million more unintended pregnancies than were experienced in the year ending mid-2012.

Across the 69 FP2020 countries, roughly two out of every five pregnancies are unintended.

Unintended pregnancies happen both as a result of method failure and of women not using contraception.

The information that we have about pregnancy intention comes from surveys, such as DHS or PMA2020, and regional estimates of abortion incidence - an area in which we have many data limitations.

In countries without recent surveys, or without robust abortion incidence estimates, the proportion of pregnancies that are unintended may be lower today than at the time of the last survey due to increases in modern contraceptive use and other changes. Therefore, as we get more and newer data, we would expect to see this proportion decline.

While some progress is being made to reduce the number of unintended pregnancies, we know that there are still millions of women with an unmet need for modern contraception across the 69 countries- women who remain at risk of experiencing an unintended pregnancy.

The number of unintended pregnancies is an important indicator because of its impact on maternal and newborn health outcomes (for example, women who experience an unintended pregnancy are more likely to experience an unsafe abortion) and because of its impact on the lives and families of women and girls (for example, if a girl or woman becomes pregnant, she may drop out of school or lose her job).

While progress is being made, the large number of unintended pregnancies tells us there is much more work to be done.

DEFINITION

Number of unintended pregnancies:

The number of pregnancies that occurred at a time when women (and their partners) either did not want additional children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies, including current pregnancies

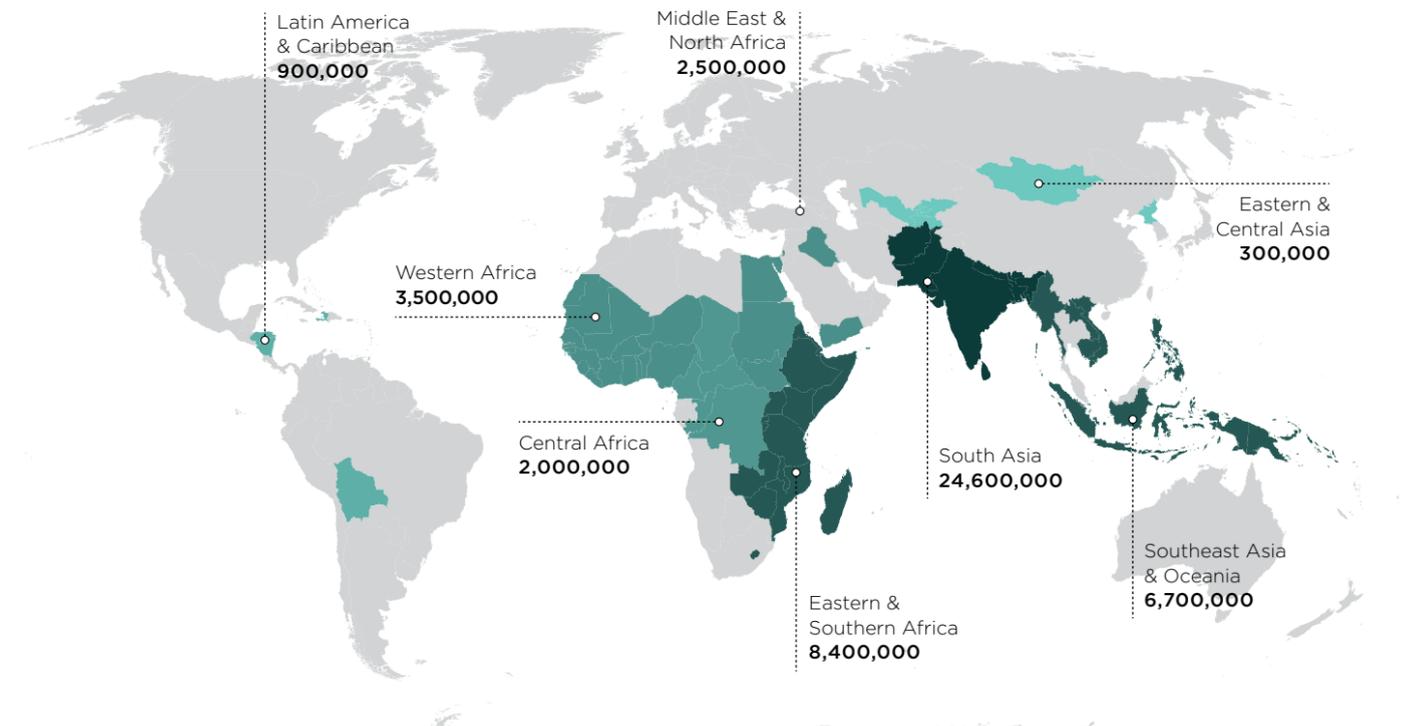
SCOPE

Reported annually, for all 69 FP2020 focus countries

SOURCE

FPET in combination with regional and global parameters established through modeling including country, regional and global parameters

Unintended pregnancies by region, 2015.5



LEGEND

Number of unintended pregnancies, in thousands

- 0 - 490
- 500 - 999
- 1,000 - 2,499
- 2,500 - 4,999
- 5,000 - 9,999
- 10,000 - 25,000

REGION

UNINTENDED PREGNANCIES

Eastern and Central Asia	300,000
Latin America and Caribbean	900,000
Central Africa	2,000,000
Middle East and North Africa	2,500,000
Western Africa	3,500,000
Southeast Asia and Oceania	6,700,000
Eastern and Southern Africa	8,400,000
South Asia	24,600,000

No. 06

Unintended Pregnancies Averted

Core Indicators 6, 7, and 8 show the positive impact of women using modern methods of contraception; that is, the unintended pregnancies, unsafe abortions, and maternal deaths that do not occur because women are using modern contraception.

Over 12 months ending mid-year 2015, the use of modern methods of contraception by 290.6 million women across the 69 FP2020 countries averted 80 million unintended pregnancies.

Compared to the time of the London Summit, increases in contraceptive use and changes in method mix resulted in 6.6 million more unintended pregnancies averted in the 12 months ending July 2015 compared to the 12 months ending July 2012.

Over the 12 months ending in July 2012, there were 266.2 million women already using modern methods of contraception across the 69 countries, meaning that these women were already being protected from experiencing unintended pregnancies, unsafe abortions, and maternal deaths.

Modern contraceptive use was already playing an important role in improving the health of women: if no women had been using contraception in 2012, there

would have been more than 73 million additional unintended pregnancies across the 69 FP2020 focus countries. The efforts of FP2020 have helped to sustain this impact, and to increase it.

The number of pregnancies averted will vary in each country based on the number of women using modern contraceptives, as well as the mix of methods being used. In countries where more women rely on less-effective methods, such as those that are user-dependent, more modern contraceptive users will experience method failures.

In 2015 there were large regional variations in method failure; from 3 out of every 100 modern contraceptive users experiencing a pregnancy from method failure in Eastern and Central Asia, to 8 out of every 100 modern contraceptive users experiencing a pregnancy from method failure in Central Africa.

Improving the quality of counseling is an important aspect of addressing method failure - ensuring that women are using the method that is most appropriate for their needs, that they understand the side effects, and that they are able to use the method correctly and consistently to improve its efficacy.

DEFINITION

Number of unintended pregnancies averted due to use of modern methods of contraception:

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

SCOPE

Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE

FPET in combination with country, regional and global parameters established through modeling

No. 07

Unsafe Abortions Averted

Levels of unsafe abortion vary greatly across the 69 FP2020 focus countries depending on the legal context, the availability of safe abortion services, and the levels of unintended pregnancy experienced.²³

In the 12 months ending mid-2015, the use of modern methods of contraception by 290.6 million women across the 69 FP2020 countries averted 26.8 million unsafe abortions.

Compared to the time of the London Summit, increases in contraceptive use and changes in contraceptive method mix have resulted in averting 2.1 million more unsafe abortions in the 12 months ending July 2015 than in the 12 months ending July 2012.

In 2015, the World Health Organization released its guidelines Health worker roles in providing safe-abortion care and post-abortion contraception. The guidelines state that globally, nearly 22 million unsafe abortions take place each year, contributing significantly to maternal mortality and morbidity. Furthermore, "policy and regulatory barriers, stigma or the unwillingness of some health care providers to provide care may further limit the availability of safe abortion and post-abortion care

DEFINITION

Number of unsafe abortions averted due to use of modern methods of contraception:

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

SCOPE

Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

SOURCE

FPET in combination with regional and global parameters established through modeling

providers in many contexts. This leaves particular subpopulations of women - for example, rural, less educated, poor, adolescent or unmarried women - at risk of unsafe abortion."²⁴

By comparing Core Indicators 6 and 7, we can estimate the proportion of unintended pregnancies that will end in an unsafe abortion for the FP2020 focus countries in each region. The range is very large, from 18% in Eastern and Central Asia to 40% in the Middle East and North Africa.

A rights-based approach to family planning that ensures women have access to contraceptives no matter where they live is of paramount importance in reducing the rate of unsafe abortion. However, it is important to note that the consequences faced by a woman if she experiences an unintended pregnancy are not the same across the world, or even within a country or community.

23. Data on unsafe abortions are very limited. In most cases we relied on regional estimates, rather than country-specific estimates.

24. WHO. Health worker roles in providing safe abortion care and post-abortion contraception. World Health Organization, Geneva; 2015. http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/.

No. 08

Maternal Deaths Averted

Access to family planning is essential to saving the lives of women and girls. In the 12 months ending July 2015, the use of modern methods of contraception by 290.6 million women across the 69 FP2020 countries averted 111,000 maternal deaths.

Compared to the time of the London Summit, increases in contraceptive use, and changes in contraceptive method mix have resulted in 13,000 more maternal deaths averted in the 12 months ending July 2015 than in the 12 months ending July 2012.

Levels of maternal mortality vary greatly across the 69 countries. By comparing Core Indicators 6 and 8, we are able to estimate the risk a women faces of dying from an unintended pregnancy. This risk varies depending on the risk of dying during childbirth, the

level of unsafe abortion, and the level of mortality associated with having an unsafe abortion.

Among the 69 FP2020 focus countries, the lowest risk is in Eastern and Central Asia, where 1 in 3,835 women with an unintended pregnancy will die from pregnancy-related causes. The highest risk is in Central Africa, where an astonishing 1 in 190 women with an unintended pregnancy will die from pregnancy-related causes.

Reducing the number of unintended pregnancies will play a substantial role in preventing some of these maternal deaths. However, we must improve the wider health care systems to ensure that no pregnant woman, regardless of whether the pregnancy is planned or unintended, faces such high risk of dying.

DEFINITION

Number of maternal deaths averted due to use of modern methods of contraception:

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

SCOPE

Reported annually, for all 69 FP2020 focus countries (except Western Sahara)

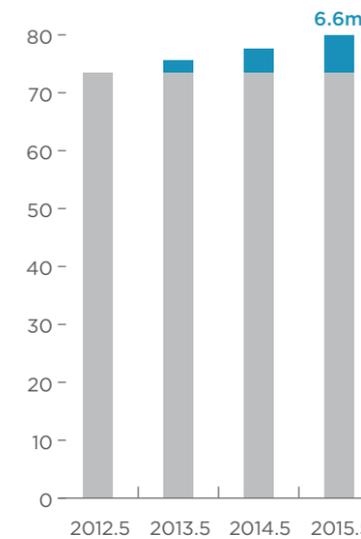
SOURCE

FPET in combination with country, regional, and global parameters established through modeling

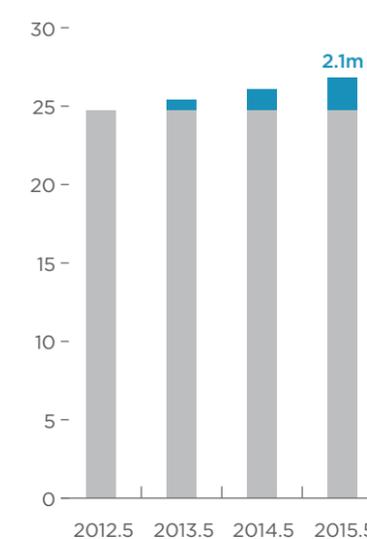
Impact over time, 2012.5-2015.5

■ Sustain 2012 impact
■ Additional impact

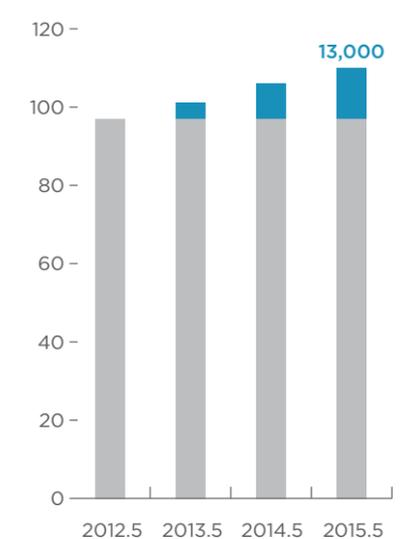
Unintended pregnancies averted
In millions



Unsafe abortions averted
In millions



Maternal deaths averted
In thousands



Impact by region, 2015.5

Region	X in 100 women will experience an unintended pregnancy due to method failure	Percent of unintended pregnancies ending in unsafe abortion	One in X women with an unintended pregnancy will die from pregnancy related causes
Eastern and Central Asia	3 in 100	18%	1 in 3,835
South Asia	3 in 100	34%	1 in 1,066
Latin America and Caribbean	4 in 100	35%	1 in 963
Southeast Asia and Oceania	4 in 100	35%	1 in 767
Eastern and Southern Africa	4 in 100	29%	1 in 287
Middle East and North Africa	4 in 100	40%	1 in 967
Western Africa	7 in 100	32%	1 in 219
Central Africa	8 in 100	23%	1 in 190

No. 09

Modern Contraceptive Method Mix

Core Indicator 9, modern contraceptive method mix, shows the percentage distribution of contraceptive users by type of modern method used.

Method mix varies greatly across the 69 FP2020 countries, reflecting the different contexts in which women live. A more diverse contraceptive method mix helps meet the varied family planning needs of women, girls, and couples. Analyses have shown that countries offering more types of modern contraceptive method in their programs also have higher percentages of contraceptive use (mCPR).²⁵

Of the FP2020 focus countries, 88% have six or more types of modern method as part of their contraceptive method mix. Aside from India, the remaining countries (those with five or fewer method types used) all have mCPRs that are lower than 20%, with generally high levels of reliance on short-term methods. In India, more than 75% of married contraceptive users have undergone female sterilization; and only four other methods contribute to their method mix (condoms: 12.6%; pills; 8.2%; IUD: 2.5%; and male sterilization: 1.5%).

Core Indicator 9 looks at modern methods of contraception, using a country's most recent national survey. For countries with recent surveys, the method mix estimates we present reflect the current situation. For countries where the most recent survey is out-of-date,

the method mix may be different today than it was when data were last collected. Not only does the number of methods used vary, the contribution that each method type makes to the method mix also varies greatly across countries.

In 30 of the 69 countries, injections make up the largest share of the method mix, ranging from 29% of the method mix in Benin (2014, MW) to 75% of the method mix in Timor-Leste (2010, AW).

This is followed by pills, in 15 countries, ranging from 38% of the method mix in Sao Tome and Principe (2008-2009, AW) to 79.5% of the method mix in Sudan (2006, MW).

Next is IUDs, in nine countries, ranging from 24% of the method mix in Guinea-Bissau (2014, MW) to 94% of the method mix in DPR Korea (2010, MW).

Contraceptive preferences vary according to a person's stage in the reproductive cycle and the intention to delay, space, or limit births. Contraceptive preferences also reflect differing needs based on age, levels of exposure to risk of pregnancy, parity, economic activity, and socio-

25. Ross J, Stover J. Use of modern contraception increases when more methods become available: analysis of evidence from 1982-2009. *Glob Health Sci Pract.* 2013;1(2):203-212. <http://dx.doi.org/10.9745/GHSP-D-13-00010>.

26. Ross J, Keesbury J, Hardee K. Trends in contraceptive method mix in low- and middle-income countries: analysis using a new "average deviation" measure. *Glob Health Sci Pract.* 2015;3(1):34-55. <http://dx.doi.org/10.9745/GHSP-D-14-00199>

DEFINITION

Percentage of women using each modern method of contraception:

The percentage of total family planning users using each modern method of contraception, reported for each method, as follows:

- **Long-acting and permanent methods:** implant; IUD (intrauterine device); sterilization (male); sterilization (female)

- **Short-term methods:** condom (male); injection; LAM (Lactational Amenorrhea Method); pill

- **Other short-term methods (methods with prevalence of 3% or less):** condom (female); diaphragm; emergency contraception; foam/jelly; SDM (Standard Days Method)

Where available, this indicator is reported as the method mix among all women (AW) using modern contraceptives. However, in some countries, the method mix reported is among married women (MW). Some differences in these two method mixes are expected given differences in needs and preferences.

SCOPE

Reported annually, for all 69 FP2020 focus countries. Survey years vary from 2002 to 2014.

SOURCE

Most recent survey, which may be: DHS, MICS, PMA2020, other national surveys.

Countries by number of modern methods used

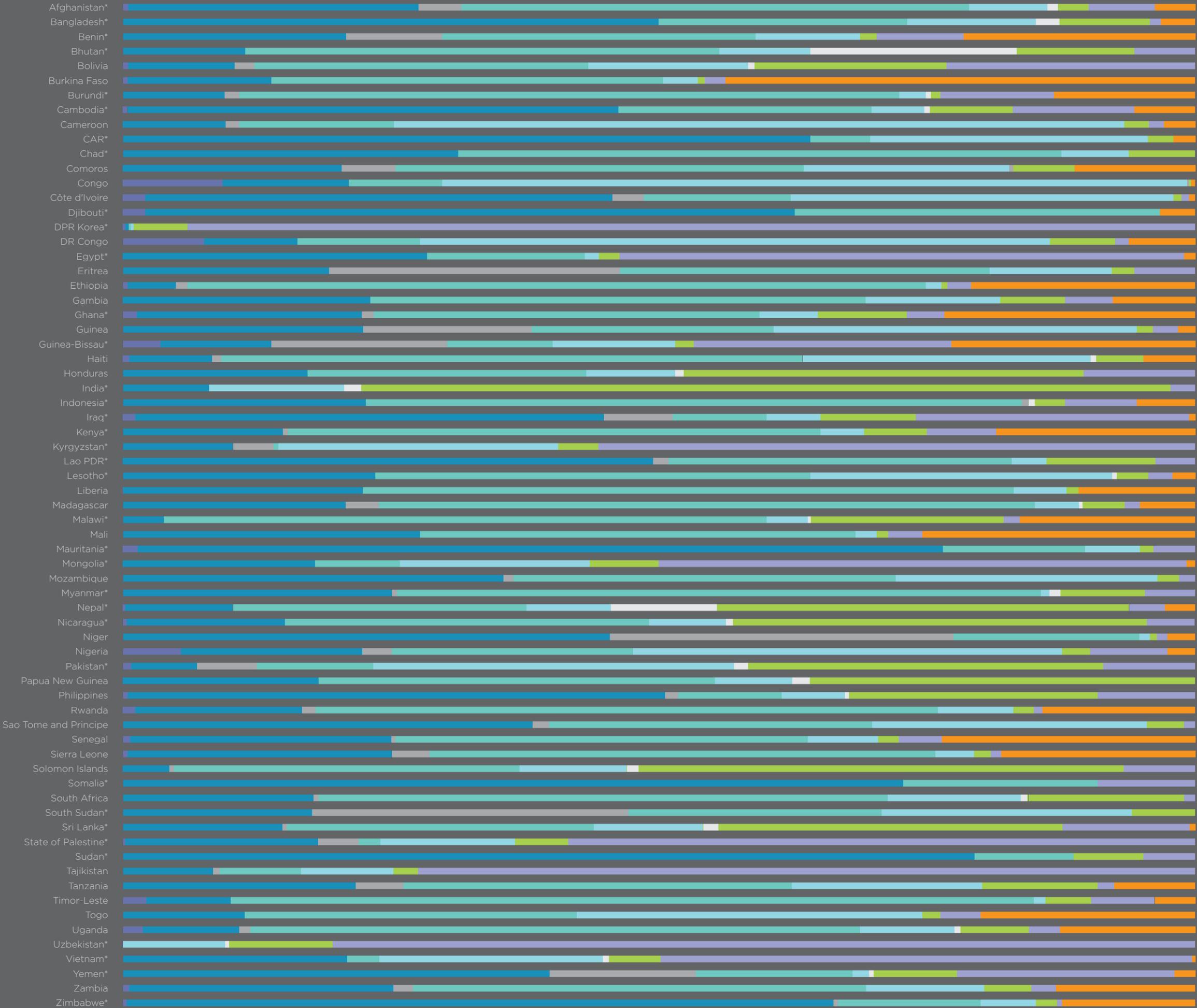
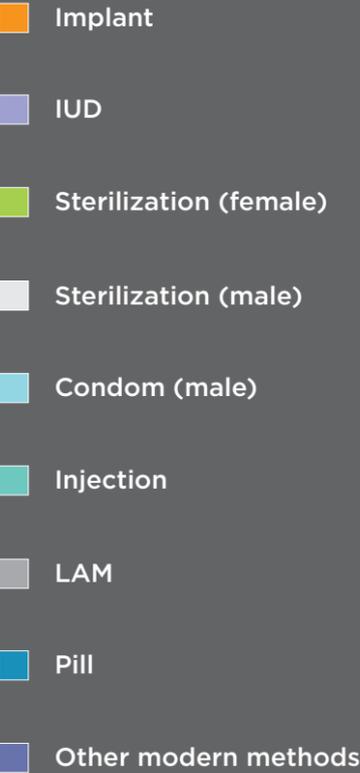
9 methods	8 methods	7 methods	6 methods	5 methods	< 5 methods
Afghanistan*	Bolivia	Bangladesh*	Comoros	CAR*	Chad*
Uganda	Burundi*	Benin*	Congo	India*	Djibouti*
Uzbekistan*	Cambodia*	Bhutan*	DPR Korea	P. N. Guinea	Somalia*
	Côte d'Ivoire	Burkina Faso	Eritrea	South Sudan*	Sudan*
	Ethiopia	Cameroon	Gambia		
	Ghana*	DR Congo	Honduras		
	Guinea-Biss.*	Egypt*	Kyrgyzstan*		
	Haiti	Guinea	Liberia		
	Iraq*	Indonesia*	Mali		
	Madagascar	Kenya*	Mauritania		
	Myanmar*	Lao PDR*	Mongolia*		
	Nepal*	Lesotho*	Mozambique		
	Nigeria	Malawi*	S.T. & Principe		
	Pakistan*	Nicaragua*	Tajikistan		
	Philippines	Niger	Togo		
	Rwanda	Sol. Islands			
	Senegal	S. of Palestine*			
	Sierra Leone	Tanzania			
	Sri Lanka*	Timor-Leste			
	Yemen*	Vietnam*			
	Zambia				
	Zimbabwe*				

cultural norms. The availability of contraceptive commodities and trained health personnel to provide contraceptives also plays an important role. Having a variety

of options makes it more likely the user will select a method that meets her specific needs and preferences, and thus increases contraceptive use.²⁶

See **Part 3** of this report for more information about how method mix has changed over time.

Method mix by country



* Method mix data based on contraceptive use for married women. All other estimates are for all women use.

See Data Tables for source information, including data recency.

No. 10

Contraceptive Supply Stock-Outs

Reducing contraceptive supply stock-outs is a critical measure of FP2020’s success. We cannot address unmet need without ensuring that family planning providers are consistently offering a wide range of contraceptive methods to women and couples. Capturing stock-out data by method will help guide policy decisions to improve access to contraception as well as improve stock management.

This is the first year that FP2020 is reporting estimates on contraceptive stock-outs at the facility level. Most of the 69 FP2020 focus countries do not routinely collect and share reliable information at the facility level; instead, they more regularly monitor stock status at central distribution points. We plan to publish more comprehensive estimates next year; starting in 2016, all UNFPA surveys will measure stock-outs by method, while all PMA2020 surveys currently do.

The most useful way to understand contraceptive stock availability is by method. For 2014, these data were available for 14 of the 29 FP2020 focus countries where surveys were conducted on contraceptive security.²⁷ All stock-outs figures use the UNFPA Supplies survey definition of stock-outs on day of survey, meaning that there is

not a single unit of that method available on the survey day.

Among countries with data on stock-outs by method type, Burkina Faso reports the lowest levels of stock-outs: there were zero stock-outs at facilities for four of the seven methods reported. The highest stocks-out in the country were for female condoms, but only 2.6% of facilities were stocked-out of this method.

Overall, for the 14 countries with sufficient data, we find that stock-outs of female condoms and emergency contraception dominate. On average, 40% of facilities in the 14 countries were

27. PMA2020 R1 survey used for Ethiopia, since UNFPA survey in Ethiopia only measured combined method availability (stock out of any method). The Service Provision Assessment Survey was used for Malawi based on the consensus meeting recommendation. Four countries had no UNFPA surveys and for these countries alternative sources were used: PMA2020 survey data was used for Ghana, Kenya and Burkina Faso and the annual logistics report in Cote d'Ivoire.

DEFINITION

Percentage of facilities stocked-out of contraceptives, by method offered, on the day of assessment:

Percentage of facilities stocked-out of each type of contraceptive offered, on the day of assessment (date of last logistics report or day of visit).

Note: Where data from reporting day or day of visit are unavailable, logistics reports may be substituted. Estimates derived from data on reporting day or day of visit and those derived from logistics reports will be presented in separate columns.

SCOPE

2014; 14 countries (those with sufficient data)

SOURCE

UNFPA facility surveys; PMA2020 facility surveys

stocked-out of female condoms and 31% of facilities were stocked-out of emergency pills. For male condoms, pills, and injections, stock-outs were on average lower, with 10 of the 14 countries reporting fewer than 20% of facilities as stocked-out.

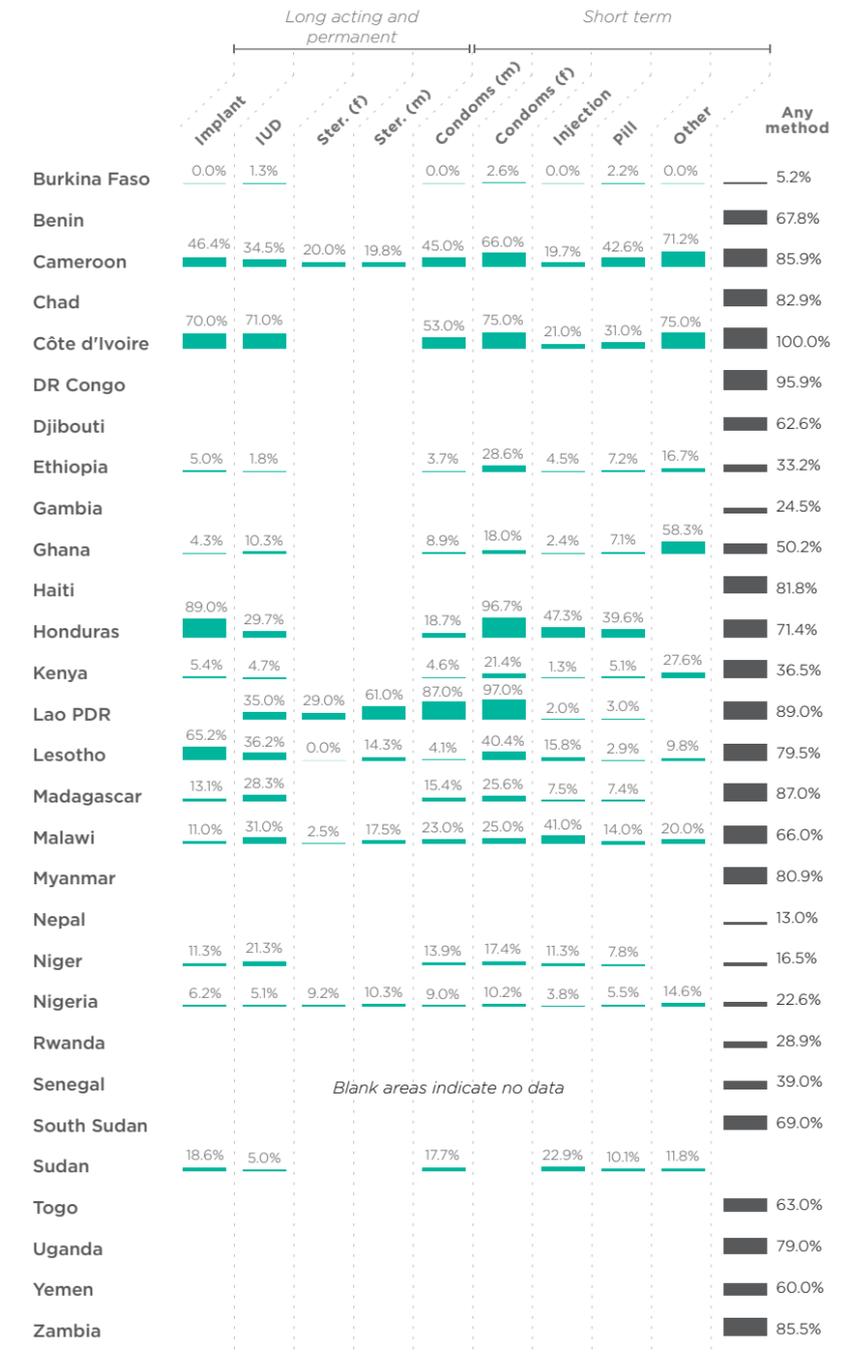
Average stock-outs for implants was 27%, and for IUDs, 23%, but these numbers are driven by high stock-outs in a few countries. Côte d'Ivoire reported the highest level of stock-outs for implants and IUDs while three countries – Burkina Faso, Ethiopia, and Kenya – report very low stock-outs for these two methods.

Surveys also measured stock-outs of “any modern method.” Of the 29 countries with data, 28 countries had information on this metric. Facilities were considered “stocked-out” if any modern method was out of stock at the time of the survey. This is a stricter measure of stock-outs since by this standard, facilities that fail to keep a low-demand method (such as female condoms) in stock but have all other methods will be counted as being stocked-out.

When using the more restrictive definition of being stocked-out of any modern method, stock-outs appear to be pervasive across the 28 surveyed countries. On average, more than 60% of facilities were stocked-out of at least one modern method on the day of survey in the 28 countries where this data was available.

Ten countries – Cameroon, Chad, Côte d'Ivoire, DR Congo, Haiti, Laos, Lesotho, Madagascar, Myanmar, and Zambia – reported 80% or more of facilities with stock-outs of at least one modern method. In the five countries that performed best overall, fewer than 25% of the facilities were stocked-out of any modern method: Burkina Faso, Gambia, Nepal, Niger, and Nigeria (table, right).

Percentage of facilities stocked out, by method offered, on the day of assessment



No. 11

Contraceptive Supply Availability

In 2014, of the 29²⁸ countries with sufficient data on method availability, only four countries had usable data to assess availability of at least three and five modern methods on the day of survey. Beginning in 2016, we expect more countries to report on these indicators. Information for the four countries was obtained from PMA2020 national-level survey data and include Burkina Faso, Ethiopia, Ghana, and Kenya.

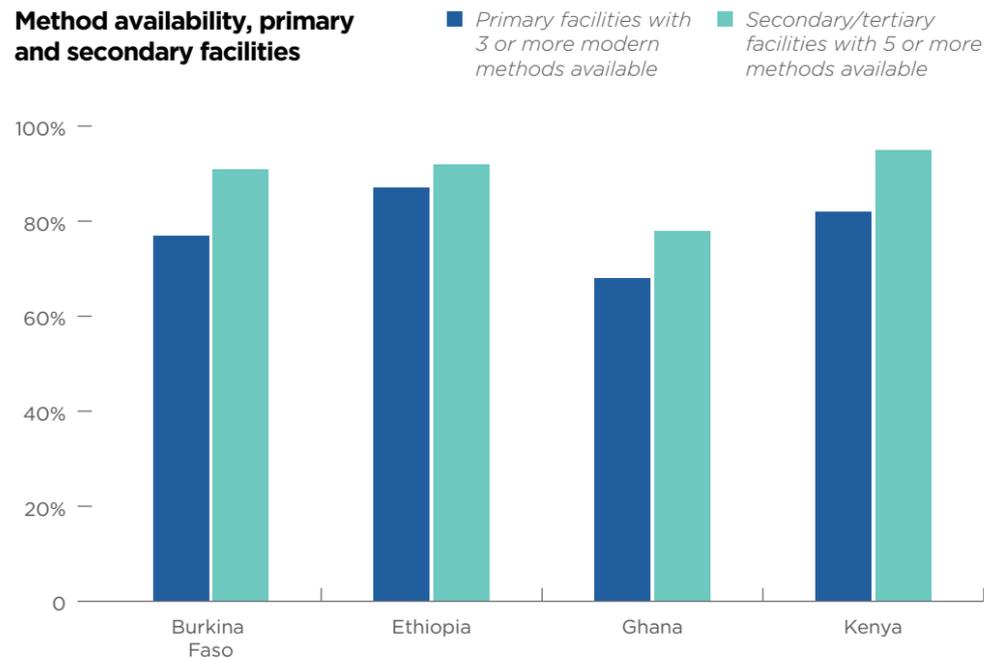
The data on availability show that on average, for the four countries in question, 79% of primary facilities and 89%

of secondary facilities had three and five methods available on day of survey, respectively.

Ethiopia had the highest proportion of primary facilities where three methods were available to the client on the day of survey. A very high proportion of secondary facilities had five or more methods available (over 90%), with the exception of Ghana where 78% of such facilities had five methods available on day of survey.

Most countries currently measure availability in terms of regular offer as opposed to physical availability on the

Method availability, primary and secondary facilities



DEFINITION

11a: Percentage of primary level service delivery points (SDPs) with at least three modern methods of contraception available on day of assessment (date of last logistics report or day of visit)

11b: Percentage of secondary / tertiary level SDPs with at least five modern methods of contraception available on day of assessment (reporting day or day of visit)

Note: Where data from reporting day or day of visit are unavailable, logistics reports may be substituted. Estimates derived from data on reporting day or day of visit and those derived from logistics reports will be presented in separate columns.

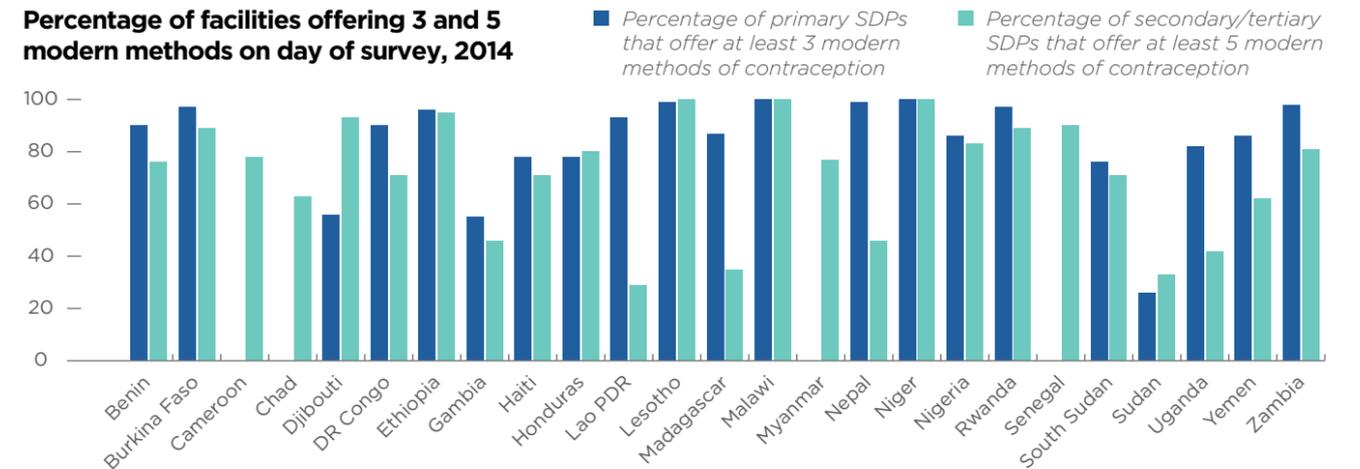
SCOPE

2014; four countries (those with sufficient data)

SOURCE

PMA2020 facility surveys

Percentage of facilities offering 3 and 5 modern methods on day of survey, 2014



day of the assessment. While offer is a commonly used measure, it is different from the definition that FP2020 adopted for Core Indicator 11.

Data on whether five methods are regularly offered are available for 28 countries, and for 24 countries for three methods offered, primarily through UNFPA Supplies surveys. Facilities that are aware that they are expected to provide a range of methods are asked if they regularly provide these methods. Reasons for unavailability range from delay in resupply, to lack of trained personnel at the time of survey, to lack of demand.

The data on offer show that on average, among primary facilities required to provide the methods, 84.1% offer three or more modern methods of contraception, and among secondary and higher facilities required to provide methods, only 71.9% regularly offer five or more modern methods.

Comparing method availability to offer, we find that in all four countries for which we have data, fewer primary facilities had the method available in stock,²⁹ compared to what they regularly offer³⁰ on the day of survey.

Hence, it is likely that when countries

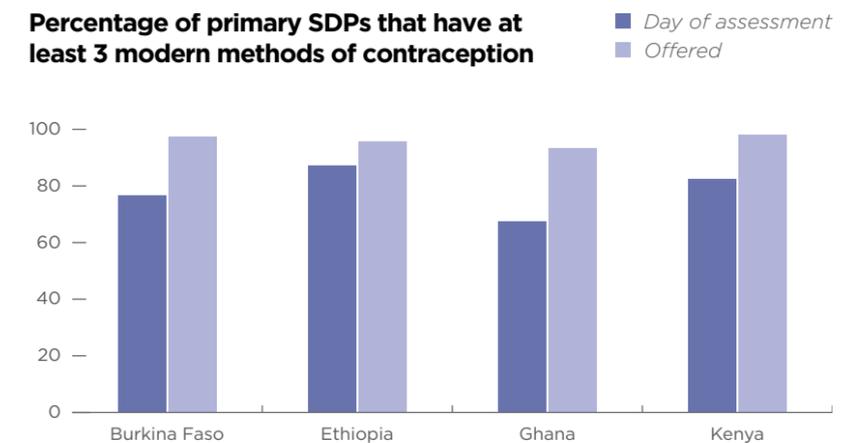
measure choice in methods offered, they may be overestimating what is actually available in stock for the client on a given day.

28. Note: Côte d'Ivoire data is from a logistics report, not a survey, and is not included in totals for Core Indicators 11 a and b.

29. Data on method "availability" come from PMA2020 surveys for the four countries.

30. Data on methods "offered" come from PMA2020 surveys for Kenya and Ghana, and from UNFPA Supplies surveys for Burkina Faso and Ethiopia.

Percentage of primary SDPs that have at least 3 modern methods of contraception



No. 12

Government Expenditure for Family Planning

There are two main sources for expenditure data. Both have broadly captured expenditure data on reproductive health, but not on family planning in particular. Over the past few years, there have been ongoing efforts to improve visibility of government spending on family planning:

- UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI) have tracked expenditures through the Resource Flows project based on country self-reporting. In 2014, they collected information on family planning specifically. These data are not yet in the public domain.
- The WHO System Health Accounts (SHA) has added a family planning expenditure module to its collection of national health expenditures, which has now been included in 15 low-income countries.

These efforts have laid the foundation for producing robust country government expenditure estimates in the future. However, at the current time, very limited data are available for public reporting. A reconciliation process is needed for the different sources with expenditure data for the same country. This process was started in 2015 and will be further developed in 2016.

Of the countries with WHO/SHA accounts, public reports for 2013 expenditures are available only in two countries (Burkina Faso and DR Congo). In addition, India was able to develop a country expenditure estimate through the work of their Track20 M&E officer and FP2020 Focal Points. This estimate was vetted during their data consensus workshop in July 2015.

Annual expenditure on family planning

COUNTRY	2013	2014	SOURCE
India	\$USD 142.6 million	\$USD 219.3 million	Consensus workshops
Burkina Faso	\$USD 1 million	n/a	WHO/SHA
DR Congo	\$USD 3 million	n/a	WHO/SHA

DEFINITION

Annual expenditure on family planning from government's domestic budget:

Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.

SCOPE

Three countries with available data

SOURCE

WHO/System of Health Accounts (SHA), and country expenditure estimates reviewed at data consensus workshops

No. 13

Couple-Years of Protection CYPs

Couple-years of protection is the only Core Indicator to come directly from routine data systems. Countries collect information about the number of services and products provided to clients because this information is vital for monitoring performance, forecasting stocks to ensure adequate supplies are available, and tracking progress over time.

Since countries need to have robust data systems to report on CYPs, it can also serve as a proxy for the importance of investing in data systems and using routine data in countries.

Routine information collected by countries, such as the number of services and products provided to clients, are converted into couple-years of protection (CYPs) to allow for easy comparison. This is needed because providing one IUD and one condom generate very different levels of protection for the clients who receive them. The CYP evens out this discrepancy, showing the total years of protection that will result from the services provided or products distributed/sold in a given year.

The CYP estimates we present here

were reviewed by countries at their annual data consensus workshops using 2014 data, and are based on data from the countries routine information systems. These data are converted into CYPs to allow for easy comparison.

In the previous FP2020 Progress Report, we presented CYP estimates for the five countries that provided us with estimates; this year, the total increased to 14 countries.

While there are limitations to what a CYP estimate can tell us, including this indicator signals the importance of improving routine data systems. FP2020 uses these data to inform estimates for Core Indicator 2 (mCPR) and, in-country, the data are used for performance management of family planning programs.

DEFINITION

Couple-years of protection (CYPs):

The estimated number of years of 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

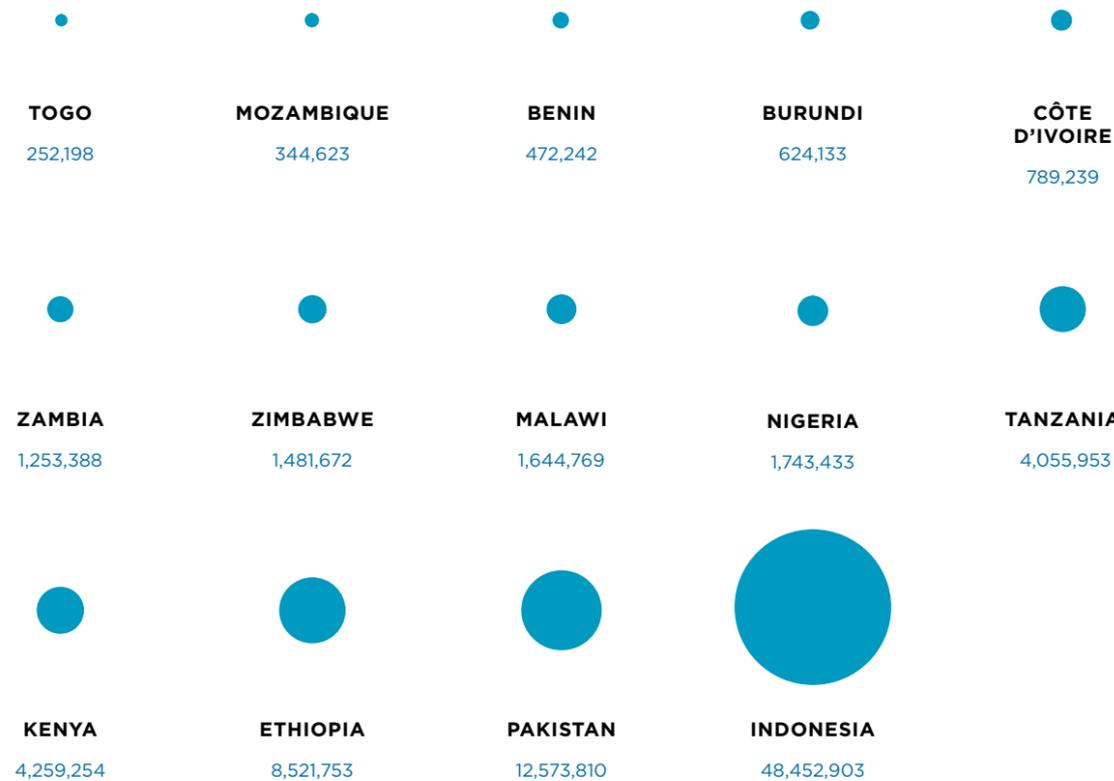
SCOPE

14 countries with sufficient available data, reported for 2014

SOURCE

Calculated from Logistics Management Information Systems (LMIS) or other service statistic sources

Couple-years of protection by country, 2014



SPOTLIGHT: Indonesia

Decentralization and the Need for Routinely Collected and Reported Data

Indonesia began decentralization of its health care system in the early 2000s. Legislative and policy actions since then have shifted increasing responsibility for the provision of health and social services to provincial and district governments.

Although Indonesia is a country rich in survey data, the available survey data provide very limited statistically reliable,

district-level information for use by local health, family planning, and government officials in program planning and monitoring. Accordingly, Indonesia has embarked on several actions to improve the availability of data at the district level.

First, a collaborative effort of the Ministry of Health, the National Population and Family Planning Board (BKKBN), and DHS2 will result in the production of national, provincial, and district level dashboards that are integrated across

public health programs and that include up-to-date service statistics as well as the most recent survey data available. Second, the heightened attention to routine program data has prompted the BKKBN to undertake a data quality assessment of their routine recording and reporting system. A pilot test of revised recording and reporting protocols is currently under development.

No. 14

Method Information Index

The Method Information Index (MII) speaks directly to key dimensions of rights and empowerment: informed consent, method choice, and the quality of consultation offered by family planning providers.

It uses existing survey questions to construct a proxy estimate that measures what type of information is being made available when women obtain a method of contraception. A low score may indicate a lack of provision of basic information on a routine basis, and argues for the need for further investigation into the quality of services and choice of methods offered.

The MII is a summary measure of the adequacy of information provided to women by family planning service providers. The MII is constructed from three questions asked of current contraceptive users with regard to the occasion when they obtained the

method they are currently using. The MII value is the percentage of respondents answering “yes” to all three questions:

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

This year, we report MII estimates for the 24 FP2020 focus countries with sufficient data collected at or since the time of the London Summit. Depending on the country, the respondents may be all women (AW) of reproductive age currently using contraception, or only married or in-union women (MW) using contraception.

We present the estimates in several ways. As we have in previous years, we

DEFINITION

Method Information Index:

An index measuring the extent to which women were made aware of alternative methods of contraception and were provided adequate information about them. The index score is equal to the number of women who respond “yes” to the following 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?*

Estimates disaggregated by method of modern contraception:

- **Long-acting and permanent methods:** implant; IUD (intrauterine device); sterilization (male); sterilization (female)
- **Short-term methods:** condom (male); injection; LAM (Lactational Amenorrhea Method); pill
- **Other short-term (methods with prevalence of 3% or less):** condom (female); diaphragm; emergency contraception; foam/jelly; SDM (Standard Days Method)

SCOPE

24 countries; reported for the year with the most recent national survey data, from 2012 to 2015

SOURCE

For each country, the most recent national survey (DHS, PMA2020). Data may reflect all women (AW) or married or in-union women (MW) use.

Method Information Index disaggregated by method

	Total	Implant	IUD	Female sterilization	Injection	Pill
Pakistan	13.5%		20.6%	7.6%	18.3%	11.2%
Indonesia	20.8%	21.2%	36.6%	19.5%	21.0%	16.9%
DR Congo	28.4%	50.4%		6.4%	35.6%	12.0%
Niger	28.4%	39.8%*	0.0%		34.4%	25.5%
Egypt	28.8%	27.3%	30.4%	25.4%	30.0%	25.5%
Ethiopia	30.5%	43.0%			27.2%	32.9%
Gambia	31.0%		29.9%*		33.5%	26.5%
Guinea	31.3%	0.0%			29.1%	28.6%
Mali	33.3%	41.8%	50.1%*		31.2%	25.4%
Comoros	36.2%	51.4%			30.0%	40.1%
Burkina Faso	36.7%	38.7%			34.4%	47.3%*
Ghana	40.1%	58.6%			58.0%	19.5%
Uganda	41.0%	71.6%	39.3%*		36.0%	37.4%
Nigeria	47.1%	73.3%	64.4%	23.8%*	52.5%	30.9%
Kenya	50.0%	58.1%	71.0%	39.8%	51.8%	47.7%
Haiti	51.7%	62.1%		30.0%	54.3%	38.7%
Philippines	52.1%		69.5%	45.9%	58.5%	50.5%
Kyrgyzstan	56.2%	0.0%	59.5%	26.9%*	0.0%	46.5%
Tajikistan	59.4%	0.0%	59.1%		65.4%	60.7%
Liberia	61.4%	75.6%			62.3%	51.9%
Senegal	64.8%	54.4%	72.4%*		74.2%	63.3%
Togo	67.5%	79.8%	72.0%		68.8%	44.4%
Sierra Leone	69.8%	78.0%	76.7%	54.0%*	72.1%	59.7%
Zambia	71.8%	83.8%	82.3%	49.9%	73.8%	62.4%

No country had a large enough sample size to analyze male sterilization.

* Low sample size (between 25-50)

Method Information Index disaggregated by question

	Told of other methods	Told of side effects	Told what to do about side effects***
Burkina Faso	71.8%	46.6%	42.3%
Comoros	62.2%	54.5%	45.7%
DR Congo	50.8%	57.2%	47.5%
Egypt **	56.0%	45.0%	34.5%
Ethiopia	60.8%	46.1%	34.7%
Gambia	57.5%	47.2%	41.8%
Ghana	70.1%	53.6%	42.7%
Guinea	48.6%	48.6%	43.1%
Haiti	64.6%	70.2%	63.7%
Indonesia	51.1%	36.4%	29.4%
Kenya	72.7%	61.5%	55.8%
Kyrgyzstan	64.6%	70.5%	67.1%
Liberia	72.0%	75.0%	72.9%
Mali	56.8%	53.1%	46.3%
Niger	55.9%	39.6%	35.4%
Nigeria	64.8%	60.3%	54.8%
Pakistan**	28.2%	34.0%	28.1%
Philippines	71.4%	67.8%	67.9%
Senegal	84.5%	72.7%	76.8%
Sierra Leone	82.7%	75.7%	74.9%
Tajikistan	68.1%	77.0%	71.8%
Togo	82.7%	78.1%	74.6%
Uganda	63.1%	54.7%	47.2%
Zambia	83.3%	79.7%	78.1%

** Egypt & Pakistan surveys represent married women; all other estimates represent all women.

*** This is among all women who responded to this set of questions, not those who were told about side effects.

show an aggregated score that groups all three questions together. We also show the values for each question constituting the MII.

Finally, we show the MII value disaggregated by five types of contraceptive method used by respondents. Unfortunately, we had sufficiently large sample sizes in only 11 countries to show values by method.

On average, users of implants and IUDs have the highest MII values, while female sterilization scores the lowest. Female sterilization scored lower than average in all countries and had the lowest score of any method in 10 of the 11 countries with sufficient data (Indonesia being the only exception).

However, a further investigation of these results is warranted. For example, the type of provider and facility offering different methods may have an impact on the results: women can obtain injections or pills from a wider range of facilities and providers, compared to the more select group that offers long-acting and permanent methods.

The MII estimate for female sterilization can be complicated by the fact that women who underwent female sterilization may have had the procedure many years prior to the survey and thus do not recall the details of the services received; also, service quality and method choice may have changed since the time of their procedure.

Further analysis was conducted to see if the MII values for sterilization varied based on the number of years since the respondent underwent the procedure, but the results were inclusive due to small sample sizes. The higher MII values for implants, a relatively new method in many countries, may suggest that updated training has resulted in recent improvements in counseling.

No. 15

Family Planning Counseling

This indicator shows what proportion of women received family planning information in the last year, either during a visit with a community health worker or at a health facility. This question is asked of all women of reproductive age, regardless of whether they were currently users of contraception.

On average, around one-quarter of women reported receiving family planning information during the last year. The values range from 6.6% in Guinea, to 52.4% in Pakistan.

It is important for these results to be viewed in context, as not all women want or need family planning information. For example, a woman who is already using a contraceptive method that is suited to her needs may not want to receive further information.

Different patterns can be observed when the results for this indicator are disaggregated by wealth. In some places,

such as DR Congo and Niger, the proportion of the poorest women who reported receiving family planning information in the past year was much smaller than the richest (indicated by a ratio less than 1). In other countries, like the Philippines and Kyrgyzstan, the opposite is true: the proportion of the poorest women who received family planning information was greater than the wealthiest (indicated by a ratio greater than 1).

In this analysis, the 'wealthiest' means women in the top wealth quintile; and the 'poorest' means women in the bottom wealth quintile.

DEFINITION

Percentage of women who were provided with information on family planning during their last visit with a health service provider:

The percentage of women who were provided information on family planning 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, information, education and communication materials or talks/conversations about family planning.

SCOPE

23 countries; Reported for year with most recent national survey data, from 2012 to present

SOURCE

For each country, the most recent national survey (DHS, PMA2020)

Percentage of women who were given information on family planning

Wealth comparison

COUNTRY	POPULATION	TOTAL	RATIO*
Guinea	All	6.6%	0.41
Gambia	All	9.7%	1.18
DR Congo	All	11.0%	0.39
Nigeria	All	12.5%	0.09
Indonesia	All	13.8%	0.79
Comoros	All	16.2%	1.01
Mali	All	16.4%	0.63
Niger	All	16.9%	0.45
Haiti	All	20.2%	1.01
Togo	All	21.1%	1.26
Senegal	All	22.2%	0.61
Kyrgyzstan	All	23.6%	1.67
Ghana	All	24.2%	1.92
Tajikistan	All	27.8%	0.82
Ethiopia	All	28.3%	1.03
Philippines	All	28.8%	1.94
Zambia	All	30.2%	1.08
Kenya	All	34.2%	1.27
Burkina Faso	All	36.5%	0.93
Uganda	All	38.3%	1.22
Sierra Leone	All	42.3%	1.08
Liberia	All	52.4%	0.70
Pakistan	Married	52.6%	1.08

* Ratio of poorest to richest

Ratio < 1: poorest women given less information than wealthiest.

Ratio > 1: poorest women given more information than wealthiest.

No. 16

Family Planning Decision Making

This indicator shows the percentage of women who make family planning decisions alone or jointly with their husband or partner. Across the 25 countries with sufficient data available since the London Summit, the average value of this indicator is fairly high at 87.7%, ranging from 71% in Comoros to 98% in Egypt.

Despite the high scores, in more than half of these countries (14 of 25), more than 10% of women using contraception report that they were not involved in making these decisions, a sign that further investigation is needed.

When disaggregating these estimates by wealth quintile, similar results can be seen among the poorest and the richest women in most countries (as seen by ratios near to 1).

Niger had the largest discrepancy between rich and poor in decision making, with only 53% of the poorest women reporting that they make decisions alone or jointly, compared to 81% in the richest quintile.

Percentage of women who make family planning decisions alone or jointly

COUNTRY	POPULATION	TOTAL	RATIO*
Comoros	Married	71.0%	1.04
Niger	Married	77.0%	0.65
Mali	Married	81.0%	1.08
Sierra Leone	Married	82.0%	1.01
Zambia	Married	83.0%	0.97
Gambia	Married	84.0%	0.97
Togo	Married	84.0%	1.01
DR Congo	Married	85.0%	0.97
Nigeria	Married	85.0%	0.93
Tajikistan	Married	86.0%	0.94
Burkina Faso	All	86.1%	0.95
Ethiopia	Married	88.2%	1.10
Uganda	All	88.6%	0.92
Liberia	Married	89.0%	0.90
Haiti	Married	91.4%	1.00
Indonesia	Married	91.5%	0.98
Ghana	All	91.8%	1.05
Guinea	Married	92.0%	0.92
Pakistan	Married	92.0%	1.00
Philippines	Married	92.0%	0.97
Senegal	Married	93.0%	0.88
Kyrgyzstan	Married	95.0%	0.97
Kenya	All	97.5%	1.00
Egypt	Married	98.0%	0.98

* Ratio of poorest to richest

DEFINITION

Percentage of women who make family planning decisions alone or jointly with their husbands or partners:

The percentage 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 or partner

SCOPE

24 countries; Reported for year with most recent national survey data, from 2012 to present

SOURCE

For each country, the most recent national survey (DHS, PMA2020)

No. 17

Adolescent Birth Rate

According to the WHO, despite declines in adolescent childbearing, more than 11% of births worldwide are to 15- to 19-year-old girls.³¹

Each day, 20,000 girls under the age of 18 give birth in developing countries.³² Among this group, complications from pregnancy and childbirth are the second leading cause of death globally, killing 70,000 adolescents annually.³³

Ensuring that girls and adolescents have the means to avoid unintended pregnancies is critical to their health and their futures.

Core Indicator 17, the adolescent birth rate, provides a measure of the rate at which adolescent females are bearing children and is expressed as the number of births per 1,000 girls aged 15 to 19 years.

Note that calculations of this indicator do not include births that occur to girls aged 10 to 14 years, despite the United Nations definition of “adolescents” as all young people aged 10 to 19 years. DHS, the primary data source for this indicator, asks sexual and reproductive health questions only of adolescents aged 15 and older. The dearth of data on the youngest

adolescents can result in the underestimation of the sexual and reproductive health needs of this vulnerable population.

Among the 25 countries with sufficient recent data to produce estimates, the adolescent birth rate ranged from 44 per 1,000 in Pakistan and Kyrgyzstan, to 206 per 1,000 in Niger.

In general, the highest rates are seen in francophone Africa, a reflection of the proliferation of child marriage and low levels of contraceptive use among all women in that region. High adolescent birth rates may also be attributed to policies that limit young people’s access to contraceptives, as well as to social stigma and provider bias. Because of the small samples in these surveys of young women giving birth, further disaggregation of this indicator was not possible.

31. State of the World Population 2013. <http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013.pdf>

32. State of the World Population 2013. <http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013.pdf>

33. State of the World Population 2013. <http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013.pdf>

Adolescent birth rate

COUNTRY	ABR*	COUNTRY	ABR	COUNTRY	ABR	COUNTRY	ABR
Pakistan	44	Ethiopia	63	Kenya	96	Guinea	146
Kyrgyzstan	44	Haiti	66	Comoros	101	Liberia	149
Indonesia	48	Ghana	76	Bangladesh	113	Mali	172
Tajikistan	54	Togo	84	Nigeria	122	Niger	206
Egypt	56	Gambia	88	Sierra Leone	125		
Cambodia	57	Senegal	90	DR Congo	138		
Philippines	57	Lesotho	94	Zambia	141		

* Per 1,000 girls aged 15 to 19 years old

DEFINITION

Adolescent birth rate:

The number of births to adolescent females, aged 15 to 19 occurring during a given reference period per 1,000 adolescent females. When possible, report estimates disaggregated by wealth quintile; however, sample size limitations make this unlikely.

SCOPE

25 countries; reported for year with most recent national survey data, from 2012 to present

SOURCE

For each country, the most recent national survey (DHS, PMA2020)

Part 03

Special Analyses

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Contraceptive Method Mix

In this section we present three analyses of contraceptive method mix.³⁴

First, we analyze contraceptive prevalence for evidence of method skew, based on the latest available survey from each of the 69 FP2020 countries.

Next, for a subset of countries with sufficient data collected since 2012, we examine how method skew has changed over time.

Last, for the same subset of countries, we examine the most pronounced changes in the prevalence of specific types of contraceptive method.

The analyses presented here demonstrate that patterns of method mix are complex, and must be examined in the context of multiple factors. Examining method skew alone does not present a complete picture; but looking at it together with method diversity, traditional method use, and overall contraceptive prevalence can give us a better understanding of how “balanced” a country’s method mix actually is, and what implications this might have for women’s choice.

SECTION 1

Method Skew in the 69 FP2020 Focus Countries

In this section we examine the prevalence of 10 types of contraceptive methods in a country’s overall method mix. Method prevalence is the proportion or “share” of use held by each contraceptive method type, with the sum of all types equaling 100%.

The method mix examined here is composed of 10 types: four long-acting and permanent methods (LAPMs), five short-term methods (STMs), and all traditional methods grouped together.

When the prevalence of a single method is 40% or greater, we refer to method skew. The range of 40% to 60% is considered a moderate level of method skew; 60% or greater is a high level of skew. The degree to which a method is disproportionately prevalent is referred to as **method dominance**.

Using each country’s most recent national survey,³⁵ we analyzed the prevalence of 10 types of contraceptive methods and found method skew to exist in 40 out of the 69 FP2020 countries. Notably, of these 40 countries, “traditional” was the dominant method type in only four. LAPMs were the dominant method type in nine countries, while STMs were dominant in 27.

The presence of an unbalanced method mix or moderate level of skew is not necessarily negative. Method skew could be the result of user preference, or of the successful introduction of a new method. When method skew occurs hand-in-hand with increases in overall use, method skew might be indicative of a positive development: increased method

34. The estimates in this section differ from those we present for Core Indicator 9, modern contraceptive method mix, because these analyses include traditional methods as a method type.

35. Note that only 38 of the 69 FP2020 focus countries had adequate national survey data from 2012 or later to support these analyses. Where all women surveys were unavailable, married/in-union women surveys were used.

Contraceptive method types

LONG-ACTING AND PERMANENT METHODS (LAPM)

Implant

IUD

Sterilization (female)

Sterilization (male)

SHORT TERM METHODS (STM)

Condom (male and female)

Injection

LAM (Lactational Amenorrhea Method)

Pill

Other (methods with 3% or less prevalence):

Diaphragm

Emergency contraception

Foam/jelly

SDM (Standard Days Method)

TRADITIONAL

Traditional methods are grouped together as one type of method. Traditional methods are included here only for the purposes of these analyses; FP2020 Core Indicator 9 (method mix) excludes traditional methods.

availability and choice, and increased contraceptive prevalence.³⁶ Examples are presented in the next section.

Further, “A totally balanced mix, with even shares for all methods, is never a program objective since it would mean, for example, that condom use would equal that of the implant and IUD use would equal that of male sterilization. Instead, the objective is to generally move away from an obviously distorted mix, without specifying precisely how fully balanced the mix should be, while enlarging access to a wider variety of method choices.”³⁷

Figure 3.1.1 presents the countries where one method dominates the method mix, grouped by moderate or high skew, and showing the dominant method. Countries are sub-grouped by their CPR: low (0%-15%), moderate (15%-45%), and high (45% and greater), derived from the survey used to report method skew.

As shown in Figure 3.1.1, both moderate and high levels of method skew exist at all levels of CPR.

Method skew should be interpreted within the context of the country’s CPR; in a very low CPR country, the dominance of a particular method may be the result of early adopters of contraception sharing similar preferences, or the uptake of one method spurring growth in CPR. Method dominance in a high-CPR country may reflect women’s preferences, or, may be a reflection of the infrastructure for family planning service delivery in the county.

36. Ross J, Stover J. Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009. *Glob Health Sci Pract.* 2013;1(2):203–212. <http://dx.doi.org/10.9745/GHSP-D-13-00010>.

37. Ross J, Keesbury J, Hardee K. Trends in contraceptive method mix in low- and middle-income countries: analysis using a new “average deviation” measure. *Glob Health Sci Pract.* 2015;3(1):34–55. <http://dx.doi.org/10.9745/GHSP-D-14-00199>

Method dominance

Method	Number of countries	Country
LONG-ACTING AND PERMANENT METHODS (LAPM)		
Implant	1	Burkina Faso
IUD	7	DPR Korea Egypt Kyrgyzstan Mongolia State of Palestine Tajikistan Uzbekistan
Sterilization (f.)	1	India
SHORT TERM METHODS (STM)		
Condom (m.)	1	Cameroon
Injection	17	Afghanistan Bhutan Burundi Chad Ethiopia Gambia Haiti Indonesia Kenya Liberia Madagascar Malawi Myanmar Rwanda Sierra Leone Timor-Leste Uganda
Pill	9	Bangladesh CAR Djibouti Lao PDR Mauritania Niger Somalia Sudan Zimbabwe
TRADITIONAL		
Traditional	4	Bolivia Congo DR Congo South Sudan

SECTION 2

Changes in Method Skew Over Time

How has method skew changed over time in the FP2020 focus countries? To answer this question, we limited our analysis to the 38 countries with sufficient survey data from 2012 or later, which allows us to see how things have changed since the time of the London Summit.

Method skew was identified in 23 of the 38 countries, either in their most recent survey, in the survey it was compared to previously, or in both.³⁸ We then categorized the countries as having moved into, or out of, either moderate skew (a single method is 40%-60% of prevalence) or high skew (a single method is ≥60% of prevalence).

We identified shifts (either into or out of skew, and between moderate and high levels of skew) in 13 countries, as shown on pages 66-67.

- Four countries decreased from high to moderate skew (Djibouti, DR Congo, Egypt, and Kyrgyzstan)
- Three countries shifted away from having method skew altogether; in two of these countries, the shift was away from the dominance of traditional methods (Comoros, Togo); in the other country, injection became non-dominant. (Lesotho).
- Six countries who shifted from no skew to having moderate method skew; in all six, the newly dominant method was modern (injection: Gambia, Haiti, Liberia, Sierra Leone; pill: Niger; implant: Burkina Faso). All six countries have low CPR,³⁹ ranging from 7.1% (Gambia, married or in-union women) to 23.6% (Haiti, all women).
- 10 countries had no change in their method skew; all continued to have either moderate or high level of skew, with dominance by a modern method.

See infographic on pages 66-67 for more detail.

Notably, in countries with low CPR, the increased use of a modern method, while moving the country into method skew, may actually be contributing to an overall increase in CPR as a result of users choosing a method that had not previously been available.⁴⁰

A case in point is Liberia, where injections have come to dominate the method mix in their 2013 DHS survey, and where the CPR (for all women) in the same year is 21.7%, as compared to a CPR of 13.3% in their 2007 DHS survey.

This example, combined with the finding that all five countries whose method mix profiles have demonstrated shifts into method skew are countries with lower CPRs (below 25%), points to the importance of examining method mix in the context of overall contraceptive prevalence.

38. The previous survey was chosen based on whether it had method mix data for the same population (all women or married or in-union women) as the newer survey. In two countries (Gambia and Tajikistan), the new survey data for all women could not be used in the analysis, as these countries have no previous surveys with all women data; thus we cannot do a comparison. Therefore, values for married women from the most recent survey were used in the comparative analysis.

39. CPR is shown from the newest survey, to match the method mix values shown.

40. Ross J, Keesbury J, Hardee K. Trends in the contraceptive method mix in low- and middle-income countries: analysis using a new “average deviation” measure. *Glob Health Sci Pract.* 2015;3(1):34–55. <http://dx.doi.org/10.9745/GHSP-D-14-00199>

FIGURE 3.1.1

Moderate method skew

Single method comprises 40% - 60% of method mix

High method skew

Single method comprises 60% or more of method mix

REGENCY	COUNTRY	DOMINANT METHOD	REC.	COUNTRY	DOM. METH.	REC.	COUNTRY	DOMINANT METHOD
Low CPR (0% - 15%)						Low CPR (0% - 15%)		
📉	Burundi	Injections				📉	Mauritania	Pill
📉	CAR	Pill				📉	Sudan	Pill
📉	Chad	Injections				📉	Timor-Leste	Injections
📉	Gambia	Injections						
📉	Niger	Pill						
📉	Somalia	Pill						
📉	South Sudan	Traditional						
Moderate CPR (15% - 45%)						Moderate CPR (15% - 45%)		
📉	Afghanistan	Injections	📉	Haiti	Injections	📉	Ethiopia	Injections
📉	Bolivia	Traditional	📉	Kyrgyzstan	IUD	📉	Tajikistan	IUD
📉	Burkina Faso	Implants	📉	Liberia	Injections			
📉	Cameroon	Condoms	📉	Madagascar	Injections			
📉	Congo	Traditional	📉	Rwanda	Injections			
📉	DR Congo	Traditional	📉	Sierra Leone	Injections			
📉	Djibouti	Pill	📉	Uganda	Injections			
High CPR (> 45%)						High CPR (> 45%)		
📉	Bangladesh	Pill	📉	Malawi	Injections	📉	DPR Korea	IUD
📉	Bhutan	Injections	📉	Mongolia	IUD	📉	India	Steril. (f.)
📉	Egypt	IUD	📉	Myanmar	Injections	📉	Indonesia	Injections
📉	Kenya	Injections	📉	S. of Palestine	IUD	📉	Uzbekistan	IUD
📉	Lao PDR	Pill	📉			📉	Zimbabwe	Pill

SECTION 3

Shifts in Use of Method Types

Which methods have increased the most in use? Of the 69 FP2020 focus countries, 29 have sufficient data collected since the time of the London Summit to support this analysis. We compared these countries' most recent surveys with data from their previous survey of the same type (that is, we compared a country's most recent DHS survey to its previous DHS survey; or its most recent PMA2020 survey to its previous PMA2020 survey, and so on).⁴¹

The average duration between surveys was six years, ranging from

(LAM), and Zimbabwe (pill). In the remaining countries, all methods experienced growth in use.

The growth in the prevalence of injections is consistent with the findings of our analysis of method skew. The increased prevalence of implants, however, has not translated to changes in method skew, since in many countries baseline levels of implant use were very low. However, implants were shown to increase the diversity of modern methods in the method mix.

“It has long been recognized that the availability of only 1 or 2 contraceptive methods in a country constrains total contraceptive use and limits the options that women and couples have to manage their pregnancies. Conversely, adding methods expands choice for women and men and increases contraceptive use.”

- ROSS ET AL 2015

one to 16 years apart. For each method, the average annual change in method prevalence (e.g., percentage of women using the method) was considered.

Overall, two methods stood out as experiencing the most frequent, and largest increases: injections and implants. The graphs below show, for each method, the five countries with the largest average annual increase between their two surveys.⁴²

In three countries, increases in these methods were coupled with declines in use of other methods. The countries are Ethiopia (injections), Zambia

See infographic on pages 66-67 for more detail.

41. Because of differences in methodology between DHS, MICS, PMA2020, and other surveys it is best to compare changes in specific methods prevalence from two data points that come from the same type of survey. Therefore, in some cases an older survey was used for comparison if the previous survey was of a different type. This also meant excluding countries with recent surveys that did not have a previous survey of the same type. The following countries were excluded from this analysis: Benin, Burkina Faso, Burundi, Djibouti, Gambia, India, Mongolia, Nepal, Tajikistan, Uganda, and Vietnam.

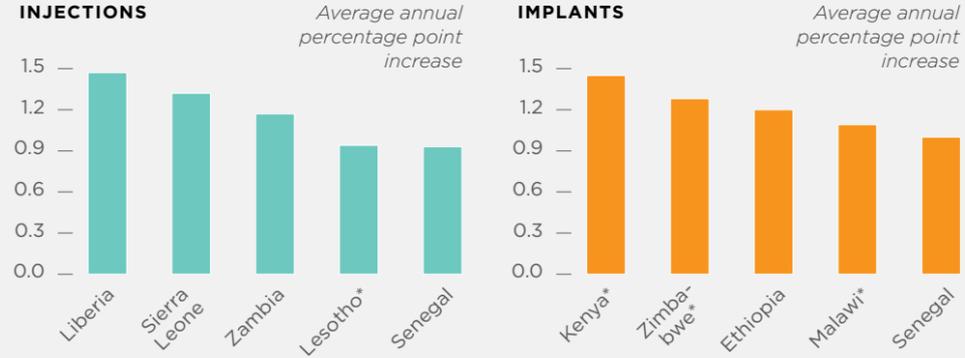
42. Sources: Ethiopia (AW): PMA2020 2014 R2 and PMA2020 2014 R1; Kenya (MW): pDHS 2014 and DHS 2008-9; Lesotho (MW): pDHS 2014 and DHS 2009; Liberia (AW): DHS 2013 and DHS 2007; Malawi (MW): MICS 2014 and MICS 2006; Senegal (AW): DHS 2014 and DHS 2012-2013; Sierra Leone (AW): DHS 2013 and DHS 2008; Zambia (AW): DHS 2013-2014 and DHS 2007; Zimbabwe (MW): MICS 2014 & MIMS (MICS) 2009

Which contraceptive methods are women using?

Patterns, changes and implications

Change in method prevalence

Prevalence of implants and injectables is growing faster than other methods in recent years. The five countries with the largest percentage point increases are shown here for each method.



* Married women only

Change in skew

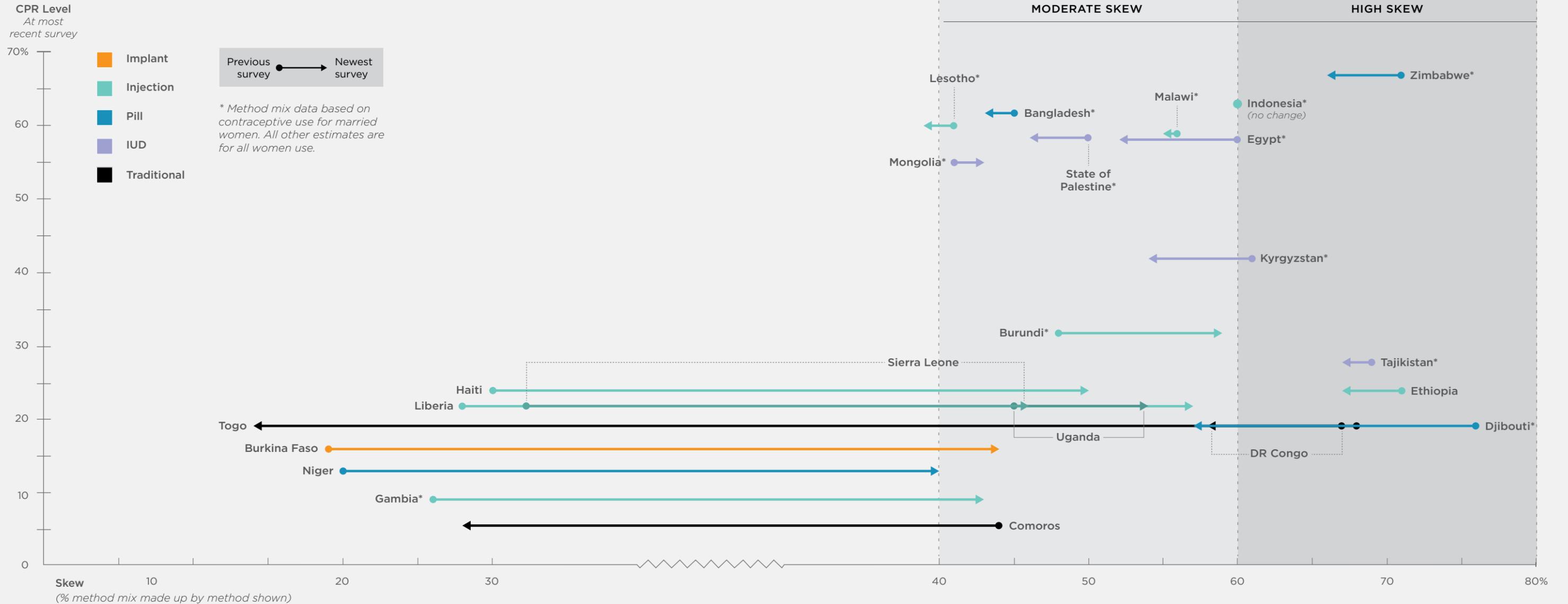
The change analysis below focuses on a subset of 23 countries based on data availability. These 23 countries showed skew in the most recent survey, previous survey or both. The arrows denote how skew changed in these countries between the last two surveys. Four

countries saw a reduction in dominance (from high to moderate); three countries shifted out of dominance, six low to moderate CPR countries shifted into dominance, and ten countries did not show a change in their level of dominance.

Skew by CPR level

Skew is present at all levels of CPR, although it may be driven by different factors, such as a woman's method preference, provider training and the availability of methods. A country's skew should be interpreted by its level of CPR and the pace of CPR growth. For example, in

Liberia, injections have come to dominate the method mix, but this happened in the context of fairly large CPR growth. The presence of skew, although not necessarily problematic, provides governments with the opportunity to further investigate drivers of skew.



Youth and Contraceptive Use

FP2020's goal of empowering 120 million additional women and girls to use modern contraception must be attained in a way that is inclusive of all women, including young people.

The analyses presented in this section give a snapshot of contraceptive use and non-use among married and unmarried sexually active young women. It is clear that patterns of use among young women vary greatly by country; some countries seem to have much more equitable use and knowledge of family planning by both married and unmarried young women, whereas in other countries, large discrepancies exist.

FP2020 is often asked what percentage of additional users of family planning since the London Summit can be attributed to youth. Unfortunately, given data limitations and the methodology used to estimate additional users, it is not possible to disaggregate this global number by age. However, where recent survey data are available, we can look at contraceptive use and non-use among youth aged 15 to 24 in specific countries.

While we don't have a reliable estimate of unmet need among all youth (married and unmarried), it is clear that the need for contraception is pervasive. Comprehensive sexuality education can ensure that young people have the knowledge and tools to

make informed decisions about using contraception, preventing unwanted pregnancies, and protecting themselves from sexually transmitted infections, including HIV. In some countries, policies restrict young people's fundamental right to sexual and reproductive health information, services, and supplies. Even when policy barriers have been removed, stigma and provider bias often prevent young people from seeking or receiving information and services.

The following analysis will look at the available evidence regarding contraceptive use, knowledge, and attitudes among both unmarried and married young women aged 15 to 24.

SECTION 1

Unmarried Youth

Are unmarried youth using modern methods of contraception? Modern contraceptive prevalence among unmarried women is measured among those who are sexually active (defined as women who reported having had sex in the four weeks prior to the survey). The following analysis looks exclusively at sexually active unmarried young women aged 15 to 24.

Of the 41 countries with data collected since the time of the London Summit on Family Planning, 13 countries have usable data on sexually active unmarried youth.⁴³ The graph below shows that in these 13 countries, levels of contraceptive use among this group vary widely, from just under 20% in Indonesia, to nearly 60% in Sierra Leone and Nigeria.

Current levels of use are important, but it is also useful to see how contraceptive use among this group is changing over time. In the chart on page 70, countries have been categorized based on changes between the last two surveys in mCPR for sexually active unmarried young women, and how these changes compare to changes in mCPR among married young women.⁴⁴

Countries fell into one of four groups: mCPR increase in both married and unmarried sexually active youth; mCPR decrease in both populations; and the opposites of both groups.

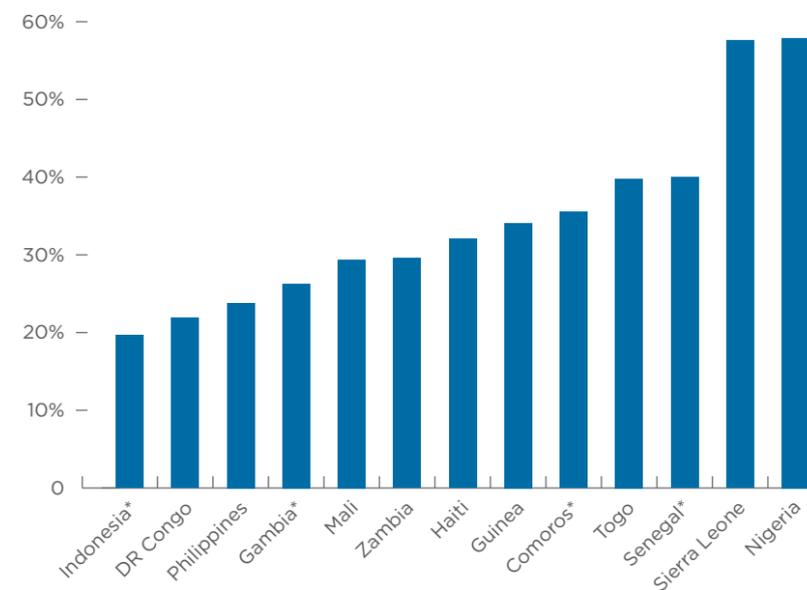
In the majority of countries, increases in mCPR among both unmarried and married young women were observed. Of these countries, Sierra Leone is notable because mCPR for unmarried young women grew nearly four times faster than mCPR among married young women.

Four countries experienced declines in mCPR among unmarried young women, and in most of these countries this decline happened despite increases in mCPR among married young women.

Nigeria also stands out in this analysis: while there was no increase in mCPR for married young women, a very large increase among unmarried young women was seen.

mCPR among sexually active youth (15 – 24) from last survey

Unmarried youth



* Low sample size (between 25-50)

43. The following countries collected data on unmarried youth, but had to be excluded from the analysis for the reasons noted: DHS surveys in Cambodia, Niger and Tajikistan were excluded from the analysis due to too-few sexually active unmarried women in the sample. DHS surveys in Ghana, Kenya and Lesotho were excluded because at the time of writing, only the Key Indicator Reports were available for these countries, which do not provide data on unmarried sexually active contraceptive users by age. PMA2020 surveys were excluded due to an inconsistency in the calculation of recent sexual activity. This inconsistency has been corrected, and PMA2020 data will be included in the next youth analysis, where sample sizes permit.

44. Note: Gambia and Indonesia were excluded from this analysis because no prior estimate of sexually active unmarried mCPR was available for comparison.

SECTION 2

Married Youth

Does marriage lead to improved access to contraception for young women? It is sometimes assumed that once women are married, barriers to contraception will be removed. However, in some places, young married women still face barriers to contraceptive use.

One way to look at this is by examining the ratio of unmet need for contraception among young married women age 15-19 compared to all married women of reproductive age. A ratio of 1 would mean that their levels of unmet need are identical. Anything less than 1 indicates young married women have lower unmet need, and anything greater than 1 indicates young married women have higher unmet need.

As can be seen in the graph to the right, in more than half of the 30 countries with sufficient recent data, unmet need is higher among young married women.

In Nepal, the unmet need among married 15- to 19-year-old women is nearly twice that of the total unmet need for all married women of reproductive age.

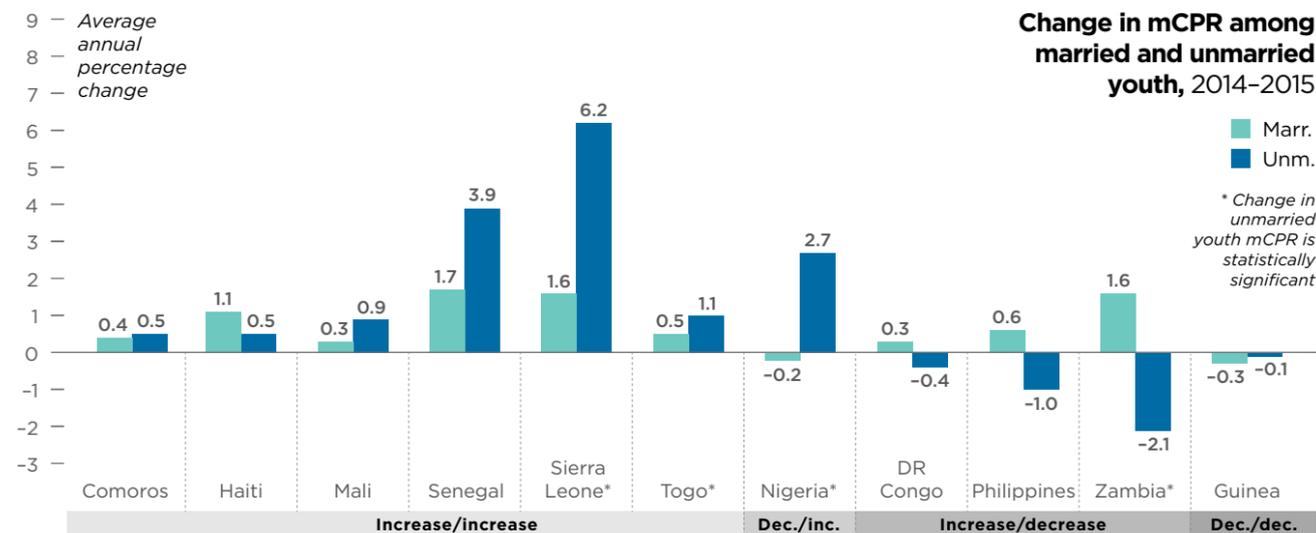
There are many complex factors that drive these different patterns in unmet need among young unmarried women. To fully understand why countries have a low or high ratio of unmet need among young

married women compared to all married women of reproductive age would require further study at the country level regarding the cultural context and other drivers of these issues. However, we can begin to analyze some of the underlying dynamics.

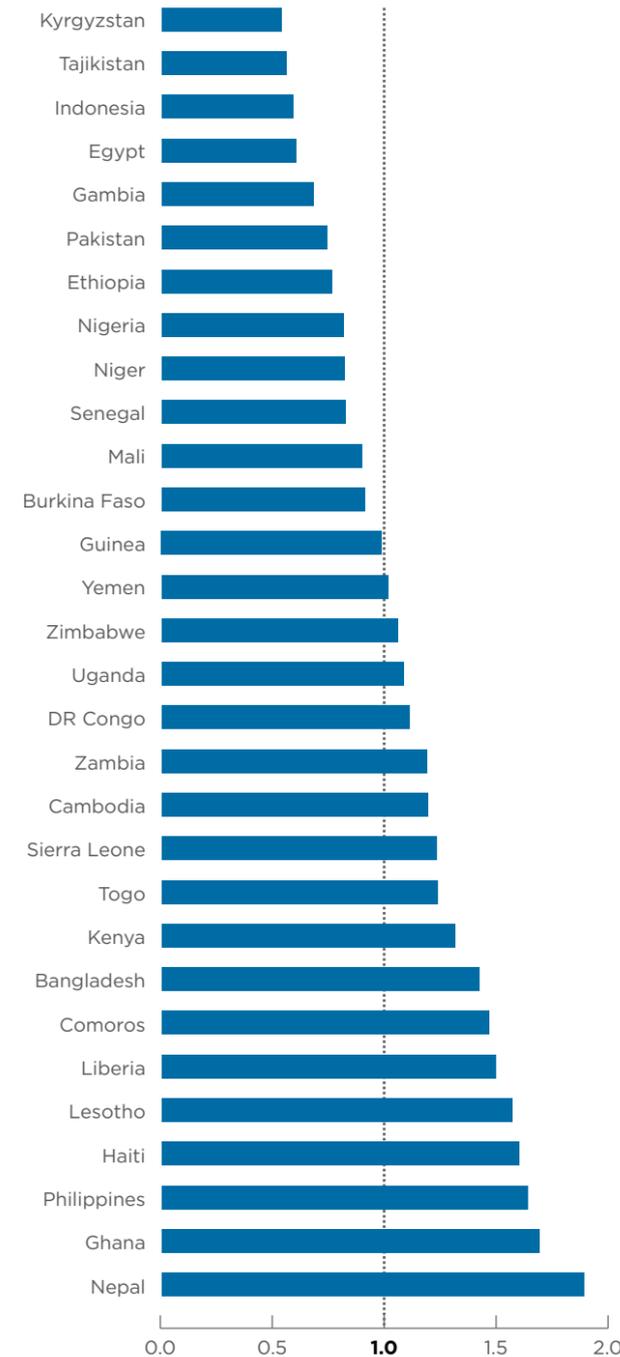
One potential driver of this pattern could be discrepancies in knowledge of modern contraception. Overall, the knowledge level of modern methods is fairly similar across all age groups. However, when looking at knowledge of at least one long-acting contraceptive method (IUD or implant), large discrepancies can be seen.⁴⁵ In fact, in all countries included in this analysis, a lower proportion of non-users age 15 to 19 could name at least one long-acting method, compared to all married women of reproductive age (graph on far right).

This pattern does not match to the ratios of unmet need, meaning it cannot explain all of the difference in unmet need between young married women and all married women of reproductive age. However, it suggests that in some countries, more work is needed to ensure that all married women have the same access to information about contraceptives.

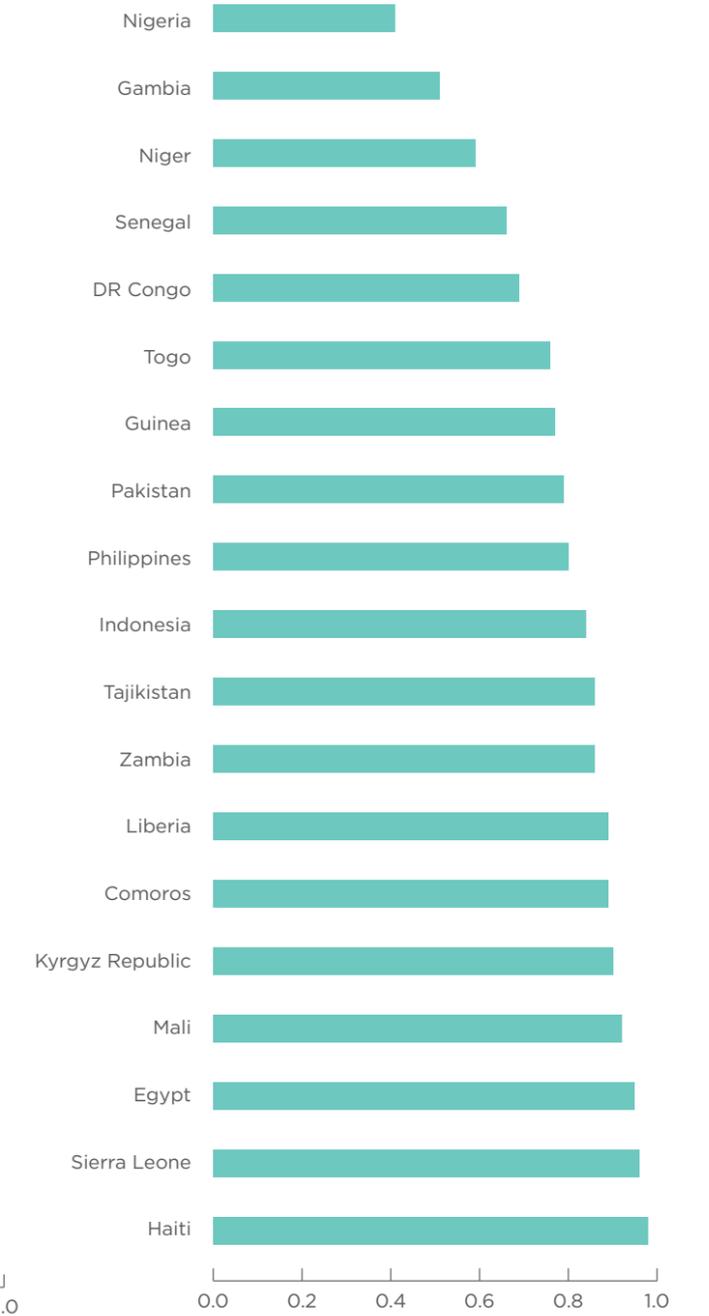
45. Note: some countries are excluded from this analysis because their full data sets were not available.



Ratio of unmet need: young married women (15 - 19) to all married women



Ratio of % non-users who can name at least one long-acting method: young married women (15 - 19) to all married women



SECTION 3

Comparing Married and Unmarried Youth

What similarities and differences are there between married and unmarried sexually active youth? Understanding differences in the reasons for not using contraception and exposure to family planning health care providers may help to explain some of the differences in levels of use between these two groups. This analysis includes six countries that have had a recent DHS survey with a sufficient number of unmarried sexually active women to allow for further analysis.

Do the reasons for non-use of contraception vary for married and unmarried sexually active youth? To answer this, responses to four selected questions about reasons for non-use are shown. Young women were able to respond “yes” to more than one reason, meaning that the same women may be counted under different reasons.

As might be expected, we see that infrequent sex is more commonly cited as a reason for non-use among unmarried sexually active young women than among married young women (28.2% vs. 8.9%, on average). And similarly, we see that many more married young women cited breastfeeding as a reason for non-use (40.1% vs. 3.1%, on average).

For some reasons for non-use, we see less distinction between responses from married and unmarried young women. Non-use due to fear of side effects varies largely across countries, and between married and unmarried young women.

Non-use due to lack of access or services too far is generally low, but, some differences between married and unmarried women can be seen. This is especially true in Sierra Leone, where four times the percentage of unmarried young women cited this as

a reason for non-use than did married young women.

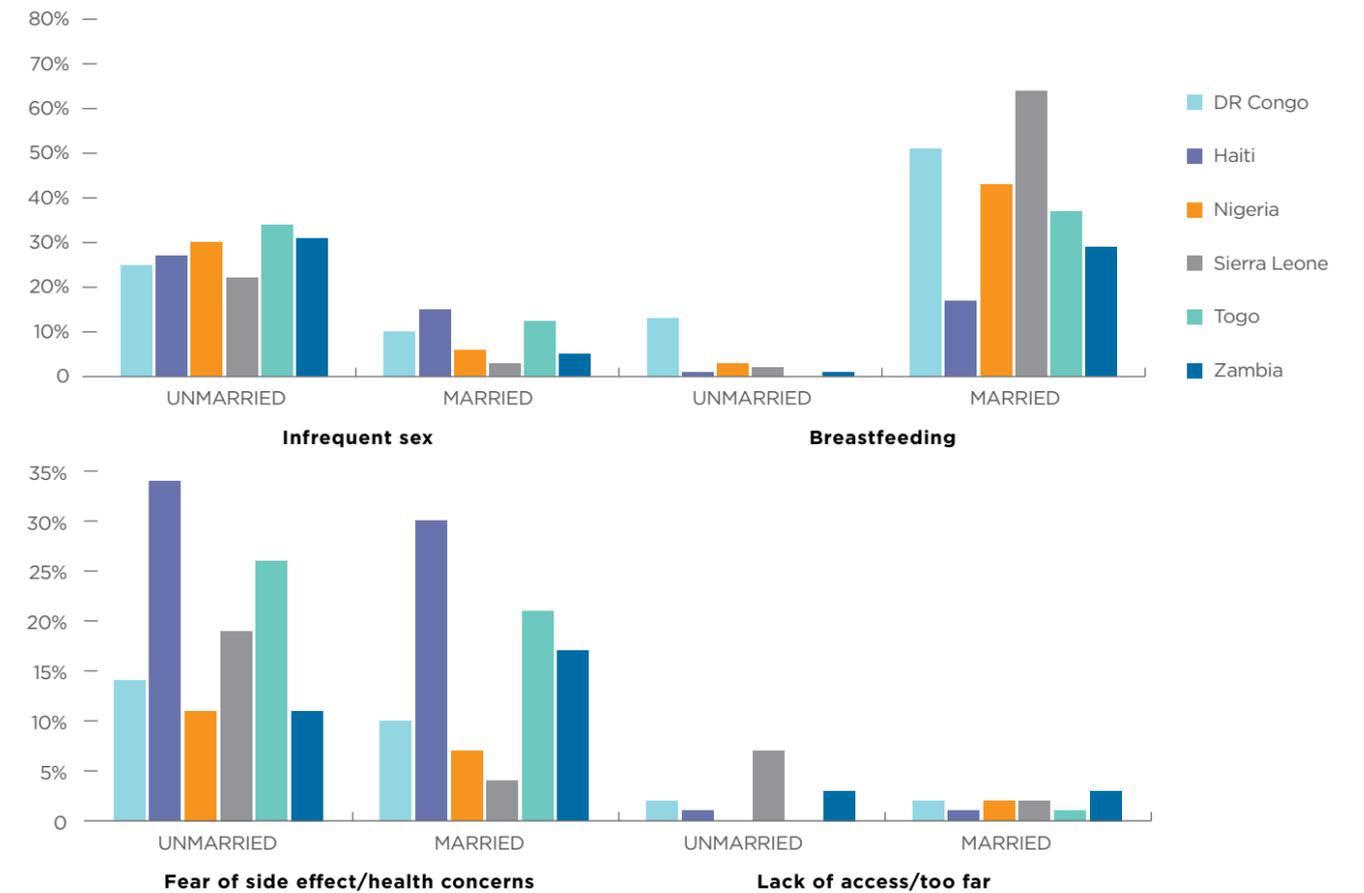
Do married and unmarried sexually active young women have the same access to family planning service providers? To answer this, three questions related to interactions with service providers were examined. For both unmarried sexually active and married young women, visits by family planning health workers are fairly low (10.3% and 11.8%, on average).

More variation is seen in terms of visiting health facilities (31.3% and 53.1%, on average), and for those visiting facilities being told about family planning (31.6% and 44.8%, on average). Comparing the ratio between married and sexually active unmarried young women highlights gaps in exposure to family planning services. Aside from Sierra Leone, in all five of the other countries, exposure to family planning information and services is considerably lower for unmarried sexually active young women than married young women, regardless of the venue in which this exposure happens (visit with family planning worker or at a facility).

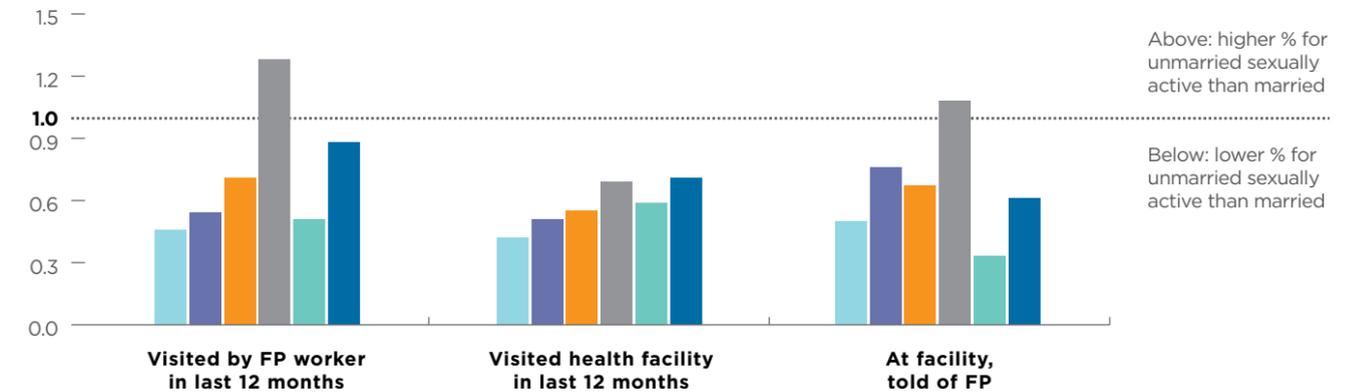
An Unfinished Agenda

To better understand what is driving these trends, the country context and more country-specific knowledge is needed. For example, what can be learned from countries such as Nigeria and Sierra Leone, which have seen large increases in modern contraceptive use by unmarried sexually active young women? And, what can be learned from countries such as Haiti and Egypt, which have been able to ensure that young married women have the same levels of contraceptive knowledge as do their older married counterparts?

Selected reasons for non-use: comparing married and unmarried sexually active youth (15-24)



Ratio of unmarried sexually active to married youth on exposure to FP workers



National Composite Index on Family Planning (NCIFP)

The NCIFP is a new tool developed to support FP2020's efforts to improve the enabling environment for family planning. It measures the existence of policies and guidelines, as well as the extent to which family planning program implementation includes measurable dimensions of quality service provision.

The FP2020 Performance Monitoring & Evidence (PME) and Rights & Empowerment (RE) Working Groups provided oversight and technical guidance for the development of the NCIFP. Avenir Health's Track20 Project led the development process and analysis of the results.

The NCIFP builds on the long-standing National Family Planning Effort Index (FPE), and, in 2014-2015, the two questionnaires were fielded jointly in 90 countries by Avenir Health and Palladium Group.⁴⁶

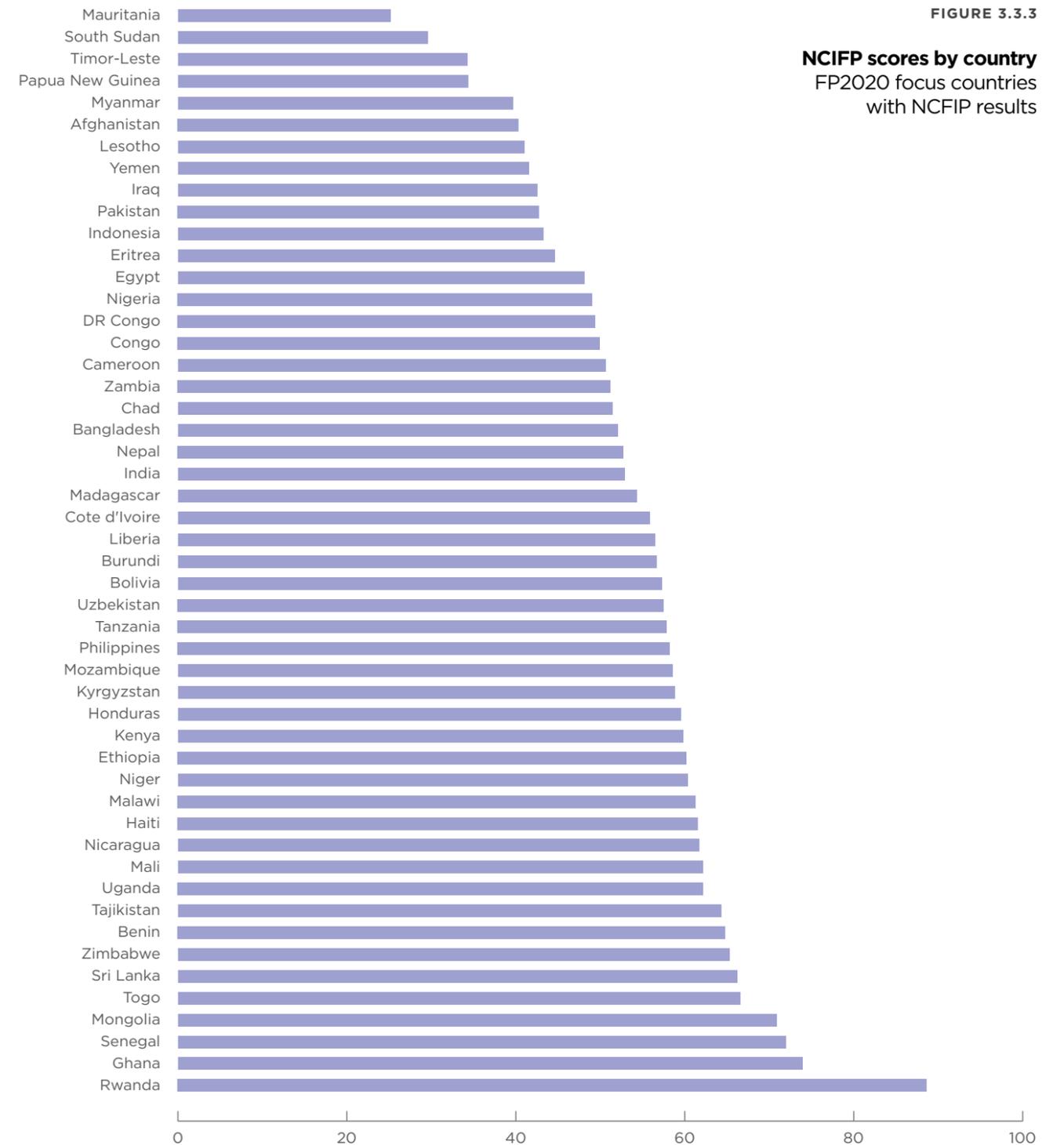
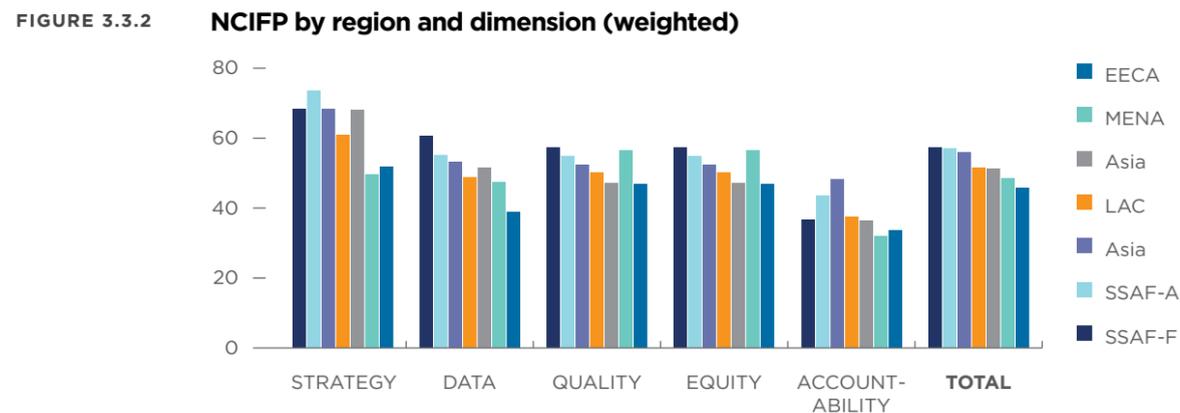
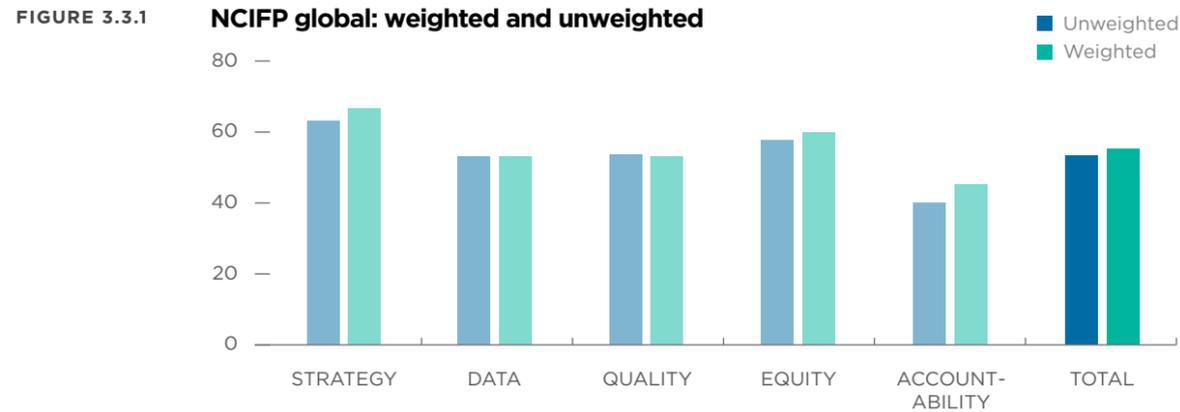
For each country, between 10 and 15 highly informed respondents were selected to answer the two questionnaires. To obtain a variety of perspectives, respondents were drawn from the

staff of government family planning programs, local NGOs, local academic or research institutions, and international agencies working locally. Scores for each country reflect the average of the responses across the respondents. The NCIFP consists of 35 items organized under five dimensions: strategy, data, quality, equity, and accountability. 18 items require yes or no answers, 12 use a scale of 1 to 10, and the remaining 5 are composite scores based on averages from a battery of individual questions.

46. Data collection for both the FPE and NCIFP was jointly funded by Bill and Melinda Gates Foundation, through Avenir Health, and USAID, through Health Policy Project, implemented by Palladium. The analysis of the NCIFP was conducted by Avenir Health with funding from the Bill and Melinda Gates Foundation.

Asia	Latin America & Caribbean	Middle East & North Africa	Sub-Saharan Africa, Anglophone	Sub-Saharan Africa, Francophone	Eastern Europe & Central Asia
17 countries	15	12	19	15	11
Afghanistan	Bolivia	Algeria	Cameroon	Benin	Armenia
Bangladesh	Costa Rica	Egypt	Eritrea	Burundi	Azerbaijan
Cambodia	Dom Rep.	Iran	Ethiopia	Chad	Georgia
China	Ecuador	Iraq	Ghana	Congo	Kazakhstan
India	El Salvador	Jordan	Kenya	Côte d'Ivoire	Kyrgyzstan
Indonesia	Guatemala	Lebanon	Lesotho	DR Congo	Moldova
Malaysia	Haiti	Libya	Liberia	Guinea Bissau	Romania
Mongolia	Honduras	Morocco	Malawi	Madagascar	Tajikistan
Myanmar	Jamaica	Oman	Mauritius	Mali	Turkmenistan
Nepal	Mexico	Tunisia	Namibia	Mauritania	Ukraine
Pakistan	Nicaragua	Turkey	Nigeria	Mozambique	Uzbekistan
Papua NG	Panama	Yemen	South Africa	Niger	
Philippines	Paraguay		South Sudan	Rwanda	
Sri Lanka	Peru		Swaziland	Senegal	
Thailand	Trinidad & Tobago		Tanzania	Togo	
Timor-Leste			Gambia		
Vietnam			Uganda		
			Zambia		
			Zimbabwe		

NCIFP: Number of questions by type and dimension	Item type	Strategy	Data	Quality	Equity	Accountability
	Yes/no	4	3	6	0	5
	Scale 1 - 10	2	3	6	1	0
	Composite	0	1	0	4	0



SECTION 1

Results

Across the 86 countries for which data was available at the time of this analysis,⁴⁷ the total unweighted score on the NCIFP was 53.7. Weighting based on the number of women of reproductive age (WRA) living in each country makes some slight difference to the total scores (see Figure 3.3.1). Overall, the “strategy” dimension scored the highest, and, “accountability” scored the lowest. Regional differences, by dimension, are shown in Figure 3.3.2. To clarify regional patterns we show Asia first as a whole, and again without India and China. Sub-Saharan Africa is divided by Anglophone and Francophone (SSAF-A and SSAF-F). Eastern European and Central Asian (EECA) countries are kept separate.

A surprise was that the Sub-Saharan

African countries scored the highest overall, and in several dimensions, as shown in the two rightmost “Total” bars. This pattern is most pronounced in the data and quality dimensions when considering weighted results. Further analysis of regional patterns can be found in the full NCIFP report.⁴⁸ Looking to the 50 FP2020 focus countries included in the NCIFP analysis, considerable variations on country scores can be seen (Figure 3.3.3), ranging from Rwanda (88.6) to Mauritania (25.1). Although not presented here, further analysis by dimension and individual score can help explain what is driving these different scores.

47. Countries for which data was not yet available: Cambodia, Dominican Republic, Lebanon, and Russia

48. www.familyplanning2020.org/measurement-hub

SECTION 2

A Closer Look at Equity

The equity dimension of the NCIFP is of particular interest because it is a domain that existing measures do not adequately address. While the NCIFP is not the full answer to the challenge of measuring equity, it provides a new tool for understanding the perception of equity in countries.

In order to understand what the equity dimension may signify, a comparison has been made to another measure of equity in relation to family planning: the ratio of modern contraceptive use (mCPR) among the poorest and richest women in a country. A ratio of 1 means use is the same; a ratio less than 1 means the mCPR among the poorest is lower than among the richest; and, a ratio greater than 1 means mCPR among the poorest is greater than among the richest.⁴⁹

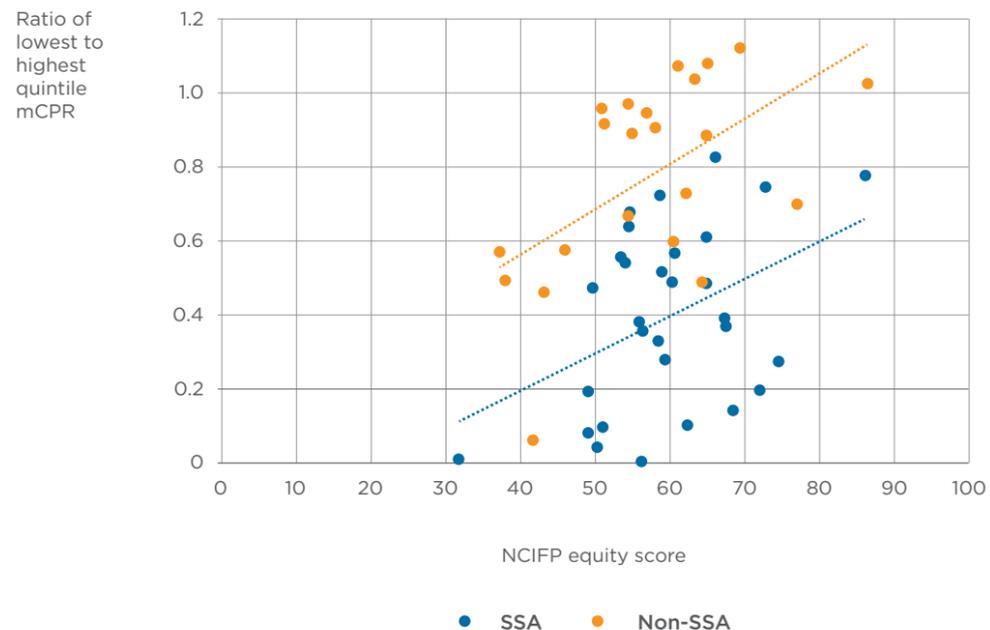
The figure below shows a positive relationship between the two equity measures, shown separately for the two

regional groups. The line for the SSA countries falls below that for the non-SSA countries because the use ratios are generally lower there.

There is substantial variation within both regions, and some SSA countries do better on the ratio of use than some Non-SSA countries. But the pattern is clear, that in general a higher score on the equity dimension is accompanied by a smaller gap between the poorest and richest wealth quintile in contraceptive use. That is true for both the SSA countries and the non-SSA countries. Where the NCIFP equity score is high, the mCPR ratio between the poorest and wealthiest quintiles is also more equitable.

49. Data were taken from the most recent DHS survey in each country. A total of 52 countries with available mCPR rates (married women) by quintile were included in this analysis, based on data ranging from 1996 to 2014.

Equity Score (NCIFP) versus ratio of mCPR in lowest and highest quintiles



Conclusion

The NCIFP represents a new and innovative measurement tool for examining the enabling environment in which family planning programs are implemented. It is the first comprehensive measurement tool addressing the important topics of equity and accountability. While there is room for further improvement and refinement of the NCIFP, these initial results give us important insights. Like the FPE, the NCIFP is a valuable source of information for the global family planning community, and it should help to inform qualitative assessments of family planning programs. It can also be a useful tool for stimulating and facilitating stakeholder discussions about the factors that contribute to a strong family planning program, as well as perceptions of quality and equity.

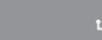
Part 04

Estimate Tables

DATA RECENCY


7 or more
years old


4 to 6
years old


0 to 3 years old
(collected 2012 or later)

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Country information

INDICATOR NO. 1

Additional users of modern contraception

Since the London Summit on Family Planning

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	0	96,000	192,000	302,000
📍	Bangladesh	0	304,000	573,000	981,000
📍	Benin	0	36,000	77,000	105,000
📍	Bhutan	0	3,000	6,000	10,000
📍	Bolivia	0	29,000	61,000	90,000
📍	Burkina Faso	0	34,000	70,000	110,000
📍	Burundi	0	65,000	62,000	91,000
📍	Cambodia	0	39,000	74,000	119,000
📍	Cameroon	0	67,000	143,000	215,000
📍	CAR	0	12,000	22,000	36,000
📍	Chad	0	7,000	15,000	23,000
📍	Comoros	0	2,000	3,000	5,000
📍	Congo	0	14,000	29,000	45,000
📍	Côte d'Ivoire	0	76,000	177,000	255,000
📍	Djibouti	0	3,000	5,000	8,000
📍	DPR Korea	0	14,000	24,000	33,000
📍	DR Congo	0	64,000	230,000	406,000
📍	Egypt	0	151,000	321,000	571,000
📍	Eritrea	0	16,000	33,000	51,000
📍	Ethiopia	0	595,000	1,221,000	1,499,000
📍	Gambia	0	0	1,000	4,000
📍	Ghana	0	0	85,000	147,000
📍	Guinea	0	23,000	46,000	71,000
📍	Guinea-Bissau	0	4,000	9,000	13,000
📍	Haiti	0	29,000	55,000	83,000
📍	Honduras	0	23,000	48,000	72,000
📍	India	0	2,604,000	5,233,000	8,137,000
📍	Indonesia	0	623,000	797,000	1,226,000
📍	Iraq	0	97,000	197,000	309,000
📍	Kenya	0	290,000	574,000	746,000
📍	Kyrgyzstan	0	17,000	34,000	42,000
📍	Lao PDR	0	24,000	50,000	74,000
📍	Lesotho	0	14,000	28,000	36,000
📍	Liberia	0	21,000	35,000	46,000
📍	Madagascar	0	104,000	217,000	324,000
📍	Malawi	0	149,000	227,000	311,000

INDICATOR NO. 1

Additional users of modern contraception

Since the London Summit on Family Planning

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Mali	0	25,000	51,000	82,000
📍	Mauritania	0	5,000	11,000	17,000
📍	Mongolia	0	0	3,000	7,000
📍	Mozambique	0	205,000	442,000	570,000
📍	Myanmar	0	146,000	283,000	421,000
📍	Nepal	0	129,000	255,000	385,000
📍	Nicaragua	0	15,000	28,000	43,000
📍	Niger	0	35,000	71,000	106,000
📍	Nigeria	0	194,000	667,000	1,064,000
📍	Pakistan	0	470,000	984,000	1,512,000
📍	Papua New Guinea	0	14,000	28,000	42,000
📍	Philippines	0	254,000	449,000	679,000
📍	Rwanda	0	48,000	96,000	147,000
📍	Sao Tome and Principe	0	1,000	1,000	2,000
📍	Senegal	0	50,000	102,000	159,000
📍	Sierra Leone	0	42,000	61,000	81,000
📍	Solomon Islands	0	1,000	2,000	3,000
📍	Somalia	0	6,000	13,000	22,000
📍	South Africa†	0	57,000	113,000	170,000
📍	South Sudan	0	9,000	21,000	34,000
📍	Sri Lanka	0	9,000	18,000	27,000
📍	State of Palestine	0	12,000	25,000	37,000
📍	Sudan	0	94,000	182,000	291,000
📍	Tajikistan	0	22,000	43,000	67,000
📍	Tanzania	0	204,000	426,000	644,000
📍	Timor-Leste	0	3,000	5,000	8,000
📍	Togo	0	21,000	42,000	61,000
📍	Uganda	0	85,000	172,000	334,000
📍	Uzbekistan	0	46,000	98,000	145,000
📍	Vietnam	0	0	0	0
📍	Yemen	0	63,000	148,000	235,000
📍	Zambia	0	90,000	185,000	249,000
📍	Zimbabwe	0	105,000	209,000	279,000
	Total	0	8,100,000	16,100,000	24,400,000
	Commitment making total	0	7,100,000	14,100,000	21,200,000

INDICATOR NO. 2

Modern contraceptive prevalence rate (mCPR)

All women

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	15.2%	16.0%	16.8%	17.7%
📍	Bangladesh	42.2%	42.2%	42.1%	42.3%
📍	Benin	11.2%	12.3%	13.6%	14.2%
📍	Bhutan	49.6%	50.1%	50.6%	51.3%
📍	Bolivia	27.0%	27.5%	28.2%	28.6%
📍	Burkina Faso	14.3%	14.7%	15.2%	15.7%
📍	Burundi	18.3%	20.9%	20.3%	21.1%
📍	Cambodia	23.1%	23.8%	24.4%	25.2%
📍	Cameroon	17.2%	18.0%	18.9%	19.7%
📍	CAR	11.8%	12.6%	13.1%	13.9%
📍	Chad	2.1%	2.3%	2.4%	2.6%
📍	Comoros	10.4%	11.1%	11.8%	12.5%
📍	Congo	23.0%	23.7%	24.6%	25.5%
📍	Côte d'Ivoire	14.8%	15.8%	17.0%	17.8%
📍	Djibouti	14.3%	15.3%	16.2%	17.2%
📍	DPR Korea	42.5%	42.6%	42.6%	42.6%
📍	DR Congo	8.1%	8.2%	8.8%	9.5%
📍	Egypt	53.6%	53.5%	53.5%	53.9%
📍	Eritrea	11.3%	11.9%	12.7%	13.4%
📍	Ethiopia	22.2%	24.0%	25.9%	26.2%
📍	Gambia	7.6%	7.1%	7.5%	7.9%
📍	Ghana	17.5%	16.7%	18.0%	18.5%
📍	Guinea	7.5%	8.1%	8.7%	9.3%
📍	Guinea-Bissau	13.7%	14.3%	15.0%	15.6%
📍	Haiti	21.7%	22.4%	22.9%	23.5%
📍	Honduras	42.7%	42.8%	42.9%	43.0%
📍	India	38.2%	38.5%	38.8%	39.2%
📍	Indonesia	44.3%	44.8%	44.7%	44.9%
📍	Iraq	24.4%	24.7%	25.0%	25.5%
📍	Kenya	35.4%	37.1%	38.6%	39.1%
📍	Kyrgyzstan	24.0%	25.1%	26.1%	26.6%
📍	Lao PDR	29.2%	29.9%	30.6%	31.2%
📍	Lesotho	41.1%	42.9%	44.7%	45.3%
📍	Liberia	18.0%	19.6%	20.4%	20.9%
📍	Madagascar	26.9%	27.9%	29.0%	29.9%

INDICATOR NO. 2

Modern contraceptive prevalence rate (mCPR)

All women

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Malawi	38.8%	41.6%	42.3%	43.2%
📍	Mali	9.6%	10.1%	10.6%	11.2%
📍	Mauritania	7.1%	7.4%	7.8%	8.3%
📍	Mongolia	33.5%	33.4%	33.7%	34.0%
📍	Mozambique	16.5%	19.5%	22.8%	24.2%
📍	Myanmar	30.5%	31.3%	31.9%	32.6%
📍	Nepal	34.5%	35.4%	36.1%	36.9%
📍	Nicaragua	51.0%	51.0%	50.9%	50.9%
📍	Niger	10.8%	11.4%	11.9%	12.4%
📍	Nigeria	10.3%	10.5%	11.4%	12.1%
📍	Pakistan	16.6%	17.2%	17.9%	18.6%
📍	Papua New Guinea	18.2%	18.5%	18.8%	19.0%
📍	Philippines	23.1%	23.7%	24.0%	24.4%
📍	Rwanda	26.5%	27.2%	27.8%	28.5%
📍	Sao Tome and Principe	28.7%	29.2%	29.6%	30.1%
📍	Senegal	12.5%	13.6%	14.7%	15.8%
📍	Sierra Leone	17.3%	19.7%	20.5%	21.3%
📍	Solomon Islands	22.6%	22.9%	23.2%	23.6%
📍	Somalia	1.5%	1.7%	1.9%	2.2%
📍	South Africa†	55.0%	55.2%	55.4%	55.5%
📍	South Sudan	2.2%	2.4%	2.8%	3.1%
📍	Sri Lanka	52.6%	52.8%	52.9%	53.1%
📍	State of Palestine	27.4%	27.7%	27.9%	28.1%
📍	Sudan	11.1%	11.9%	12.5%	13.4%
📍	Tajikistan	18.5%	19.2%	19.8%	20.6%
📍	Tanzania	25.7%	26.7%	27.8%	28.9%
📍	Timor-Leste	14.6%	15.2%	16.0%	16.6%
📍	Togo	15.7%	16.6%	17.4%	18.1%
📍	Uganda	21.0%	21.2%	21.5%	22.6%
📍	Uzbekistan	44.9%	45.0%	45.2%	45.2%
📍	Vietnam	43.9%	43.5%	43.4%	43.5%
📍	Yemen	17.6%	18.1%	18.8%	19.6%
📍	Zambia	28.9%	30.6%	32.3%	33.0%
📍	Zimbabwe	43.5%	44.7%	45.8%	45.9%

INDICATOR NO. 3

Unmet need

Married women

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	31.3%	31.1%	30.9%	30.6%
📍	Bangladesh	20.1%	20.1%	20.1%	20.0%
📍	Benin	33.6%	33.8%	34.0%	33.8%
📍	Bhutan	12.9%	12.5%	12.2%	11.9%
📍	Bolivia	41.3%	40.6%	39.7%	38.8%
📍	Burkina Faso	27.0%	27.3%	27.5%	27.4%
📍	Burundi	31.5%	29.9%	30.0%	29.4%
📍	Cambodia	31.3%	30.8%	30.2%	29.9%
📍	Cameroon	33.3%	33.5%	33.5%	33.6%
📍	CAR	31.3%	31.5%	31.6%	31.8%
📍	Chad	24.4%	24.7%	25.0%	25.2%
📍	Comoros	37.0%	36.9%	36.7%	36.5%
📍	Congo	43.2%	42.7%	42.3%	41.8%
📍	Côte d'Ivoire	28.6%	28.8%	28.9%	29.0%
📍	Djibouti	31.2%	30.9%	30.8%	30.4%
📍	DPR Korea	17.4%	17.3%	17.3%	17.3%
📍	DR Congo	40.7%	40.7%	40.7%	40.8%
📍	Egypt	12.9%	13.1%	13.2%	13.1%
📍	Eritrea	30.3%	30.3%	30.2%	30.1%
📍	Ethiopia	27.5%	26.7%	25.9%	25.8%
📍	Gambia	26.2%	25.9%	26.1%	26.3%
📍	Ghana	36.3%	35.3%	34.7%	34.5%
📍	Guinea	24.7%	25.1%	25.3%	25.5%
📍	Guinea-Bissau	22.9%	23.1%	23.3%	23.5%
📍	Haiti	38.5%	37.8%	37.1%	36.4%
📍	Honduras	20.0%	19.8%	19.6%	19.4%
📍	India	21.0%	20.8%	20.6%	20.4%
📍	Indonesia	13.2%	12.9%	12.9%	12.9%
📍	Iraq	29.2%	29.1%	28.9%	28.7%
📍	Kenya	23.7%	22.1%	20.5%	20.1%
📍	Kyrgyzstan	20.5%	20.3%	20.0%	20.0%
📍	Lao PDR	26.2%	25.7%	25.2%	24.7%
📍	Lesotho	21.8%	20.7%	19.6%	19.0%
📍	Liberia	33.1%	32.5%	32.3%	32.2%
📍	Madagascar	27.9%	27.5%	27.0%	26.5%

INDICATOR NO. 3

Unmet need

Married women

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Malawi	24.7%	22.4%	21.7%	20.9%
📍	Mali	27.0%	27.1%	27.2%	27.3%
📍	Mauritania	32.6%	32.5%	32.4%	32.4%
📍	Mongolia	21.6%	21.8%	21.6%	21.4%
📍	Mozambique	28.7%	28.8%	28.7%	28.5%
📍	Myanmar	20.6%	20.3%	19.9%	19.5%
📍	Nepal	31.1%	30.1%	29.1%	28.2%
📍	Nicaragua	10.9%	10.9%	11.0%	10.9%
📍	Niger	18.0%	18.4%	18.8%	19.2%
📍	Nigeria	23.3%	22.6%	23.1%	23.4%
📍	Pakistan	30.1%	30.1%	30.0%	29.8%
📍	Papua New Guinea	33.8%	33.5%	33.3%	33.1%
📍	Philippines	34.8%	34.3%	33.9%	33.4%
📍	Rwanda	27.4%	26.6%	25.8%	25.1%
📍	Sao Tome and Principe	38.4%	37.7%	37.0%	36.3%
📍	Senegal	30.5%	29.7%	28.9%	29.0%
📍	Sierra Leone	27.3%	26.7%	26.9%	26.9%
📍	Solomon Islands	28.7%	28.6%	28.5%	28.4%
📍	Somalia	30.3%	30.5%	30.6%	30.8%
📍	South Africa†	12.2%	12.1%	12.0%	11.9%
📍	South Sudan	30.3%	30.5%	30.7%	30.8%
📍	Sri Lanka	23.2%	23.1%	22.8%	22.7%
📍	State of Palestine	26.6%	26.4%	26.3%	26.2%
📍	Sudan	30.2%	30.3%	30.3%	30.3%
📍	Tajikistan	25.1%	25.0%	24.9%	24.7%
📍	Tanzania	31.4%	30.9%	30.4%	30.0%
📍	Timor-Leste	30.4%	29.9%	29.5%	29.1%
📍	Togo	36.9%	36.5%	36.2%	35.9%
📍	Uganda	37.6%	37.0%	36.5%	35.7%
📍	Uzbekistan	13.8%	13.7%	13.7%	13.6%
📍	Vietnam	17.3%	17.9%	17.8%	17.7%
📍	Yemen	33.6%	33.2%	32.8%	32.4%
📍	Zambia	29.2%	27.6%	26.0%	25.4%
📍	Zimbabwe	15.0%	14.1%	13.3%	13.1%

INDICATOR NO. 4

Demand satisfied

Married women

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	41.2%	42.6%	43.9%	45.5%
📍	Bangladesh	73.2%	73.2%	73.2%	73.4%
📍	Benin	22.6%	24.2%	25.9%	27.0%
📍	Bhutan	83.3%	83.9%	84.4%	84.9%
📍	Bolivia	48.5%	49.4%	50.6%	51.6%
📍	Burkina Faso	37.5%	38.0%	38.5%	39.4%
📍	Burundi	48.3%	52.9%	52.1%	53.6%
📍	Cambodia	54.3%	55.4%	56.5%	57.5%
📍	Cameroon	31.6%	32.5%	33.5%	34.4%
📍	CAR	25.7%	26.7%	27.5%	28.5%
📍	Chad	8.3%	8.9%	9.4%	10.0%
📍	Comoros	28.7%	30.1%	31.5%	32.9%
📍	Congo	32.3%	33.3%	34.3%	35.4%
📍	Côte d'Ivoire	31.0%	32.0%	34.6%	35.6%
📍	Djibouti	38.3%	40.1%	41.7%	43.4%
📍	DPR Korea	78.3%	78.5%	78.5%	78.5%
📍	DR Congo	16.1%	16.3%	17.3%	18.2%
📍	Egypt	81.7%	81.4%	81.3%	81.5%
📍	Eritrea	33.3%	34.6%	36.0%	37.4%
📍	Ethiopia	53.0%	55.7%	58.3%	58.7%
📍	Gambia	26.6%	25.4%	26.3%	27.1%
📍	Ghana	36.3%	35.8%	38.0%	38.8%
📍	Guinea	16.6%	17.4%	18.4%	19.3%
📍	Guinea-Bissau	37.3%	38.1%	39.0%	39.7%
📍	Haiti	44.9%	46.2%	47.2%	48.4%
📍	Honduras	76.0%	76.3%	76.5%	76.7%
📍	India	70.9%	71.2%	71.6%	72.0%
📍	Indonesia	82.0%	82.5%	82.4%	82.5%
📍	Iraq	57.0%	57.4%	57.9%	58.5%
📍	Kenya	67.8%	70.3%	72.6%	73.3%
📍	Kyrgyzstan	63.5%	64.8%	66.0%	66.4%
📍	Lao PDR	62.6%	63.6%	64.6%	65.5%
📍	Lesotho	71.1%	73.0%	74.9%	75.7%
📍	Liberia	33.7%	36.0%	37.0%	37.7%
📍	Madagascar	55.0%	56.3%	57.7%	58.9%

INDICATOR NO. 4

Demand satisfied

Married women

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Malawi	67.0%	70.6%	71.6%	72.8%
📍	Mali	26.8%	27.7%	28.6%	29.6%
📍	Mauritania	24.7%	25.8%	26.9%	28.0%
📍	Mongolia	69.7%	69.4%	69.7%	70.2%
📍	Mozambique	34.9%	38.7%	42.6%	44.2%
📍	Myanmar	69.0%	69.8%	70.7%	71.5%
📍	Nepal	59.1%	60.4%	61.8%	63.0%
📍	Nicaragua	87.4%	87.4%	87.3%	87.4%
📍	Niger	40.0%	40.6%	41.3%	41.6%
📍	Nigeria	28.1%	29.2%	30.4%	31.4%
📍	Pakistan	46.4%	47.6%	48.4%	49.5%
📍	Papua New Guinea	44.7%	45.4%	45.9%	46.4%
📍	Philippines	51.5%	52.5%	53.1%	53.9%
📍	Rwanda	63.4%	64.7%	65.9%	67.0%
📍	Sao Tome and Principe	47.9%	48.8%	49.6%	50.5%
📍	Senegal	36.1%	38.6%	41.1%	42.9%
📍	Sierra Leone	32.1%	35.5%	36.3%	37.1%
📍	Solomon Islands	51.2%	51.6%	52.0%	52.5%
📍	Somalia	6.2%	7.0%	7.8%	8.9%
📍	South Africa†	84.3%	84.5%	84.6%	84.8%
📍	South Sudan	8.2%	9.0%	10.0%	11.0%
📍	Sri Lanka	70.3%	70.5%	70.8%	71.0%
📍	State of Palestine	62.4%	62.8%	63.1%	63.4%
📍	Sudan	28.4%	29.7%	30.8%	32.2%
📍	Tajikistan	52.1%	53.1%	54.0%	55.1%
📍	Tanzania	48.7%	50.1%	51.5%	52.8%
📍	Timor-Leste	44.1%	45.6%	47.1%	48.4%
📍	Togo	30.6%	32.0%	33.2%	34.2%
📍	Uganda	40.5%	41.2%	41.8%	43.5%
📍	Uzbekistan	82.0%	82.2%	82.2%	82.3%
📍	Vietnam	79.2%	78.5%	78.6%	78.7%
📍	Yemen	46.2%	47.1%	48.5%	49.8%
📍	Zambia	57.7%	60.5%	63.1%	64.2%
📍	Zimbabwe	80.4%	81.8%	83.0%	83.2%

INDICATOR NO. 5

Unintended pregnancies

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	618,000	616,000	614,000	612,000
📍	Bangladesh	2,184,000	2,169,000	2,153,000	2,138,000
📍	Benin	130,000	132,000	134,000	136,000
📍	Bhutan	9,000	9,000	9,000	9,000
📍	Bolivia	342,000	344,000	346,000	348,000
📍	Burkina Faso	102,000	104,000	106,000	107,000
📍	Burundi	246,000	250,000	255,000	260,000
📍	Cambodia	199,000	199,000	198,000	198,000
📍	Cameroon	305,000	309,000	313,000	317,000
📍	CAR	57,000	57,000	57,000	58,000
📍	Chad	153,000	156,000	159,000	162,000
📍	Comoros	14,000	14,000	14,000	14,000
📍	Congo	73,000	74,000	75,000	75,000
📍	Côte d'Ivoire	345,000	351,000	355,000	361,000
📍	Djibouti	24,000	24,000	24,000	24,000
📍	DPR Korea	179,000	180,000	180,000	181,000
📍	DR Congo	1,288,000	1,310,000	1,333,000	1,355,000
📍	Egypt	655,000	654,000	653,000	651,000
📍	Eritrea	105,000	106,000	107,000	108,000
📍	Ethiopia	2,282,000	2,301,000	2,320,000	2,340,000
📍	Gambia	35,000	36,000	37,000	38,000
📍	Ghana	541,000	543,000	545,000	547,000
📍	Guinea	124,000	125,000	127,000	129,000
📍	Guinea-Bissau	27,000	28,000	28,000	28,000
📍	Haiti	250,000	249,000	249,000	248,000
📍	Honduras	188,000	188,000	189,000	190,000
📍	India	18,274,000	18,843,000	18,917,000	18,875,000
📍	Indonesia	2,161,000	2,190,000	2,223,000	2,214,000
📍	Iraq	364,000	370,000	375,000	381,000
📍	Kenya	1,109,000	1,120,000	1,131,000	1,142,000
📍	Kyrgyzstan	14,000	14,000	14,000	14,000
📍	Lao PDR	142,000	142,000	142,000	143,000
📍	Lesotho	55,000	55,000	55,000	55,000
📍	Liberia	84,000	85,000	86,000	87,000
📍	Madagascar	173,000	177,000	181,000	184,000
📍	Malawi	510,000	521,000	531,000	542,000
📍	Mali	174,000	179,000	183,000	187,000

INDICATOR NO. 5

Unintended pregnancies

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Mauritania	68,000	69,000	70,000	70,000
📍	Mongolia	32,000	32,000	32,000	31,000
📍	Mozambique	274,000	278,000	281,000	285,000
📍	Myanmar	727,000	721,000	715,000	710,000
📍	Nepal	375,000	374,000	373,000	372,000
📍	Nicaragua	105,000	105,000	104,000	104,000
📍	Niger	131,000	135,000	140,000	145,000
📍	Nigeria	1,074,000	1,093,000	1,112,000	1,131,000
📍	Pakistan	2,383,000	2,386,000	2,388,000	2,390,000
📍	Papua New Guinea	77,000	78,000	79,000	79,000
📍	Philippines	2,222,000	2,239,000	2,256,000	2,273,000
📍	Rwanda	277,000	279,000	282,000	284,000
📍	Sao Tome and Principe	5,000	5,000	5,000	5,000
📍	Senegal	237,000	240,000	243,000	246,000
📍	Sierra Leone	55,000	55,000	55,000	55,000
📍	Solomon Islands	6,000	6,000	6,000	6,000
📍	Somalia	156,000	160,000	163,000	166,000
📍	South Africa†	1,078,000	1,070,000	1,063,000	1,055,000
📍	South Sudan	138,000	141,000	144,000	147,000
📍	Sri Lanka	227,000	224,000	220,000	217,000
📍	State of Palestine	46,000	46,000	47,000	48,000
📍	Sudan	609,000	616,000	622,000	628,000
📍	Tajikistan	36,000	36,000	36,000	36,000
📍	Tanzania	881,000	897,000	914,000	930,000
📍	Timor-Leste	19,000	19,000	19,000	20,000
📍	Togo	126,000	127,000	128,000	129,000
📍	Uganda	1,255,000	1,282,000	1,310,000	1,337,000
📍	Uzbekistan	67,000	66,000	66,000	66,000
📍	Vietnam	1,090,000	1,076,000	1,062,000	1,048,000
📍	Western Sahara	7,000	7,000	7,000	7,000
📍	Yemen	617,000	621,000	626,000	630,000
📍	Zambia	426,000	437,000	448,000	459,000
📍	Zimbabwe	252,000	256,000	260,000	264,000
Total		47,600,000	48,400,000	48,700,000	48,800,000
Commitment making total		40,800,000	41,600,000	41,900,000	42,100,000

INDICATOR NO. 6

Unintended pregnancies averted

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	258,000	283,000	308,000	337,000
📍	Bangladesh	4,662,000	4,740,000	4,806,000	4,907,000
📍	Benin	59,000	67,000	76,000	82,000
📍	Bhutan	27,000	28,000	29,000	30,000
📍	Bolivia	193,000	200,000	210,000	217,000
📍	Burkina Faso	156,000	165,000	176,000	187,000
📍	Burundi	106,000	123,000	123,000	131,000
📍	Cambodia	243,000	253,000	263,000	275,000
📍	Cameroon	203,000	219,000	236,000	253,000
📍	CAR	31,000	35,000	37,000	40,000
📍	Chad	15,000	17,000	19,000	21,000
📍	Comoros	4,000	5,000	5,000	6,000
📍	Congo	49,000	52,000	55,000	59,000
📍	Côte d'Ivoire	197,000	215,000	238,000	256,000
📍	Djibouti	8,000	9,000	10,000	10,000
📍	DPR Korea	827,000	832,000	835,000	838,000
📍	DR Congo	331,000	346,000	382,000	425,000
📍	Egypt	3,068,000	3,109,000	3,156,000	3,227,000
📍	Eritrea	36,000	39,000	43,000	46,000
📍	Ethiopia	1,346,000	1,514,000	1,691,000	1,769,000
📍	Gambia	9,000	8,000	9,000	10,000
📍	Ghana	275,000	268,000	295,000	310,000
📍	Guinea	43,000	48,000	53,000	59,000
📍	Guinea-Bissau	13,000	14,000	15,000	16,000
📍	Haiti	150,000	158,000	164,000	171,000
📍	Honduras	247,000	253,000	260,000	267,000
📍	India	35,103,000	35,853,000	36,610,000	37,445,000
📍	Indonesia	8,192,000	8,360,000	8,417,000	8,531,000
📍	Iraq	491,000	515,000	539,000	569,000
📍	Kenya	1,039,000	1,120,000	1,197,000	1,246,000
📍	Kyrgyzstan	94,000	99,000	103,000	105,000
📍	Lao PDR	133,000	140,000	146,000	153,000
📍	Lesotho	55,000	58,000	62,000	64,000
📍	Liberia	47,000	53,000	57,000	60,000
📍	Madagascar	380,000	408,000	437,000	465,000
📍	Malawi	389,000	431,000	453,000	477,000
📍	Mali	87,000	94,000	101,000	110,000

INDICATOR NO. 6

Unintended pregnancies averted

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Mauritania	16,000	17,000	19,000	20,000
📍	Mongolia	74,000	74,000	75,000	76,000
📍	Mozambique	235,000	286,000	345,000	377,000
📍	Myanmar	1,285,000	1,327,000	1,362,000	1,401,000
📍	Nepal	724,000	762,000	796,000	834,000
📍	Nicaragua	232,000	236,000	240,000	244,000
📍	Niger	76,000	83,000	90,000	97,000
📍	Nigeria	916,000	961,000	1,070,000	1,162,000
📍	Pakistan	1,922,000	2,040,000	2,169,000	2,301,000
📍	Papua New Guinea	90,000	94,000	98,000	101,000
📍	Philippines	1,495,000	1,563,000	1,613,000	1,670,000
📍	Rwanda	203,000	216,000	229,000	243,000
📍	Sao Tome and Principe	3,000	3,000	4,000	4,000
📍	Senegal	114,000	128,000	142,000	157,000
📍	Sierra Leone	68,000	79,000	84,000	89,000
📍	Solomon Islands	9,000	9,000	9,000	10,000
📍	Somalia	9,000	10,000	12,000	14,000
📍	South Africa†	2,081,000	2,097,000	2,114,000	2,126,000
📍	South Sudan	11,000	13,000	15,000	18,000
📍	Sri Lanka	800,000	802,000	803,000	806,000
📍	State of Palestine	76,000	79,000	82,000	85,000
📍	Sudan	251,000	275,000	297,000	326,000
📍	Tajikistan	109,000	116,000	121,000	129,000
📍	Tanzania	716,000	768,000	825,000	881,000
📍	Timor-Leste	9,000	10,000	11,000	12,000
📍	Togo	67,000	73,000	78,000	84,000
📍	Uganda	455,000	478,000	502,000	547,000
📍	Uzbekistan	1,005,000	1,018,000	1,034,000	1,046,000
📍	Vietnam	3,021,000	3,000,000	3,001,000	3,015,000
📍	Yemen	249,000	264,000	283,000	304,000
📍	Zambia	247,000	271,000	295,000	312,000
📍	Zimbabwe	385,000	412,000	439,000	456,000
Total		73,400,000	75,600,000	77,800,000	80,000,000
	<i>Additional from 2012 levels</i>		<i>2,200,000</i>	<i>4,300,000</i>	<i>6,600,000</i>
	Commitment making total	61,200,000	63,100,000	65,000,000	66,900,000

INDICATOR NO. 7

Unsafe abortions averted

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	79,000	86,000	94,000	103,000
📍	Bangladesh	1,424,000	1,448,000	1,468,000	1,499,000
📍	Benin	19,000	21,000	24,000	26,000
📍	Bhutan	8,000	8,000	9,000	9,000
📍	Bolivia	73,000	76,000	80,000	82,000
📍	Burkina Faso	50,000	53,000	56,000	60,000
📍	Burundi	31,000	37,000	37,000	39,000
📍	Cambodia	85,000	88,000	91,000	95,000
📍	Cameroon	47,000	50,000	54,000	58,000
📍	CAR	7,000	8,000	8,000	9,000
📍	Chad	3,000	4,000	4,000	5,000
📍	Comoros	1,000	1,000	2,000	2,000
📍	Congo	11,000	12,000	13,000	13,000
📍	Côte d'Ivoire	63,000	69,000	76,000	82,000
📍	Djibouti	2,000	3,000	3,000	3,000
📍	DPR Korea	3,000	3,000	3,000	3,000
📍	DR Congo	76,000	79,000	88,000	98,000
📍	Egypt	1,413,000	1,432,000	1,454,000	1,486,000
📍	Eritrea	11,000	12,000	13,000	14,000
📍	Ethiopia	401,000	451,000	503,000	526,000
📍	Gambia	3,000	3,000	3,000	3,000
📍	Ghana	88,000	86,000	95,000	99,000
📍	Guinea	14,000	15,000	17,000	19,000
📍	Guinea-Bissau	4,000	4,000	5,000	5,000
📍	Haiti	25,000	26,000	27,000	28,000
📍	Honduras	99,000	101,000	104,000	107,000
📍	India	12,205,000	12,466,000	12,729,000	13,020,000
📍	Indonesia	2,848,000	2,907,000	2,927,000	2,966,000
📍	Iraq	94,000	99,000	104,000	109,000
📍	Kenya	309,000	333,000	356,000	371,000
📍	Kyrgyzstan	29,000	30,000	31,000	32,000
📍	Lao PDR	46,000	49,000	51,000	53,000
📍	Lesotho	10,000	11,000	12,000	12,000
📍	Liberia	15,000	17,000	18,000	19,000
📍	Madagascar	113,000	121,000	130,000	138,000
📍	Malawi	121,000	134,000	140,000	148,000
📍	Mali	28,000	30,000	32,000	35,000

INDICATOR NO. 7

Unsafe abortions averted

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Mauritania	5,000	5,000	6,000	6,000
📍	Mongolia	300	300	300	300
📍	Mozambique	45,000	55,000	66,000	72,000
📍	Myanmar	447,000	462,000	474,000	487,000
📍	Nepal	221,000	233,000	243,000	255,000
📍	Nicaragua	93,000	94,000	96,000	98,000
📍	Niger	24,000	27,000	29,000	31,000
📍	Nigeria	293,000	307,000	342,000	372,000
📍	Pakistan	668,000	709,000	754,000	800,000
📍	Papua New Guinea	4,000	5,000	5,000	5,000
📍	Philippines	520,000	543,000	561,000	581,000
📍	Rwanda	60,000	64,000	68,000	72,000
📍	Sao Tome and Principe	800	800	800	900
📍	Senegal	36,000	41,000	45,000	50,000
📍	Sierra Leone	22,000	25,000	27,000	29,000
📍	Solomon Islands	400	400	500	500
📍	Somalia	3,000	3,000	3,000	4,000
📍	South Africa†	398,000	401,000	405,000	407,000
📍	South Sudan	3,000	4,000	5,000	5,000
📍	Sri Lanka	244,000	245,000	245,000	246,000
📍	State of Palestine	15,000	15,000	16,000	16,000
📍	Sudan	115,000	127,000	137,000	150,000
📍	Tajikistan	33,000	35,000	37,000	39,000
📍	Tanzania	213,000	229,000	246,000	262,000
📍	Timor-Leste	3,000	4,000	4,000	4,000
📍	Togo	22,000	23,000	25,000	27,000
📍	Uganda	136,000	142,000	149,000	163,000
📍	Uzbekistan	307,000	311,000	316,000	319,000
📍	Vietnam	1,050,000	1,043,000	1,043,000	1,048,000
📍	Yemen	48,000	51,000	54,000	58,000
📍	Zambia	47,000	52,000	57,000	60,000
📍	Zimbabwe	115,000	123,000	131,000	136,000
Total		24,700,000	25,400,000	26,000,000	26,800,000
	<i>Additional from 2012 levels</i>		<i>700,000</i>	<i>1,400,000</i>	<i>2,100,000</i>
	Commitment making total	20,600,000	21,200,000	21,800,000	22,500,000

INDICATOR NO. 8

Maternal deaths averted

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Afghanistan	700	800	900	900
📍	Bangladesh	5,000	6,000	6,000	6,000
📍	Benin	200	200	200	200
📍	Bhutan	20	20	20	30
📍	Bolivia	200	200	200	200
📍	Burkina Faso	600	600	600	700
📍	Burundi	400	500	500	500
📍	Cambodia	200	200	200	200
📍	Cameroon	900	1,000	1,000	1,000
📍	CAR	200	200	300	300
📍	Chad	100	100	200	200
📍	Comoros	10	10	20	20
📍	Congo	200	200	200	200
📍	Côte d'Ivoire	1,000	1,000	1,000	1,000
📍	Djibouti	10	20	20	20
📍	DPR Korea	200	200	200	200
📍	DR Congo	2,000	2,000	2,000	2,000
📍	Egypt	2,000	2,000	2,000	2,000
📍	Eritrea	100	100	100	200
📍	Ethiopia	4,000	5,000	6,000	6,000
📍	Gambia	30	30	30	40
📍	Ghana	800	800	900	900
📍	Guinea	200	300	300	300
📍	Guinea-Bissau	60	60	70	70
📍	Haiti	300	300	400	400
📍	Honduras	200	200	200	200
📍	India	32,000	32,000	33,000	34,000
📍	Indonesia	15,000	16,000	16,000	16,000
📍	Iraq	200	300	300	300
📍	Kenya	3,000	4,000	4,000	4,000
📍	Kyrgyzstan	60	60	60	60
📍	Lao PDR	100	200	200	200
📍	Lesotho	200	200	200	200
📍	Liberia	200	300	300	300
📍	Madagascar	2,000	2,000	2,000	2,000
📍	Malawi	2,000	2,000	2,000	2,000
📍	Mali	400	400	500	500

INDICATOR NO. 8

Maternal deaths averted

Recency	Country	2012.5	2013.5	2014.5	2015.5
📍	Mauritania	40	50	50	50
📍	Mongolia	10	10	10	10
📍	Mozambique	1,000	1,000	2,000	2,000
📍	Myanmar	1,000	1,000	1,000	1,000
📍	Nepal	1,000	1,000	1,000	1,000
📍	Nicaragua	100	100	100	100
📍	Niger	400	500	500	500
📍	Nigeria	5,000	5,000	5,000	6,000
📍	Pakistan	2,000	2,000	2,000	2,000
📍	Papua New Guinea	100	100	100	200
📍	Philippines	900	900	900	1,000
📍	Rwanda	500	600	600	600
📍	Sao Tome and Principe	5	5	5	5
📍	Senegal	300	300	400	400
📍	Sierra Leone	600	800	800	900
📍	Solomon Islands	10	10	10	10
📍	Somalia	60	80	90	100
📍	South Africa†	2,000	2,000	2,000	2,000
📍	South Sudan	70	80	100	100
📍	Sri Lanka	200	200	200	200
📍	State of Palestine	30	30	30	30
📍	Sudan	1,000	1,000	1,000	2,000
📍	Tajikistan	40	40	40	40
📍	Tanzania	3,000	3,000	3,000	3,000
📍	Timor-Leste	10	10	20	20
📍	Togo	200	200	300	300
📍	Uganda	1,000	1,000	1,000	2,000
📍	Uzbekistan	300	300	300	300
📍	Vietnam	800	700	700	700
📍	Yemen	500	500	500	600
📍	Zambia	800	900	1,000	1,000
📍	Zimbabwe	2,000	2,000	2,000	2,000
	Total	97,000	102,000	107,000	111,000
	<i>Additional from 2012 levels</i>		<i>4,000</i>	<i>9,000</i>	<i>13,000</i>
	Commitment making total	87,000	91,000	95,000	99,000

INDICATOR NO. 9
Percentage of women using each modern method

		Long acting and permanent methods			
		Implant	IUD	Sterilization (female)	Sterilization (male)
🇦🇫	Afghanistan	3.9%	5.9%	3.0%	1.0%
🇧🇩	Bangladesh	3.2%	1.1%	8.5%	2.2%
🇧🇯	Benin	21.8%	8.1%	1.6%	0.0%
🇧🇹	Bhutan	0.2%	5.7%	10.9%	19.3%
🇧🇴	Bolivia	0.0%	23.3%	17.9%	0.4%
🇧🇫	Burkina Faso	43.9%	1.9%	0.6%	0.0%
🇧🇷	Burundi	13.2%	10.6%	1.0%	0.3%
🇰🇲	Cambodia	5.7%	11.3%	7.7%	0.3%
🇨🇲	Cameroon	3.1%	1.2%	2.5%	0.0%
🇨🇩	CAR	2.2%	0.0%	2.2%	0.0%
🇨🇩	Chad	0.0%	0.0%	6.3%	0.0%
🇨🇴	Comoros	11.2%	0.0%	6.1%	0.0%
🇨🇩	Congo	0.4%	0.0%	0.4%	0.0%
🇨🇮	Côte d'Ivoire	0.7%	0.7%	0.7%	0.0%
🇩🇯	Djibouti	3.3%	0.0%	0.0%	0.0%
🇰🇵	DPR Korea	0.0%	94.0%	4.9%	0.0%
🇨🇩	DR Congo	6.3%	1.3%	6.3%	0.0%
🇪🇬	Egypt	0.9%	52.9%	2.1%	0.0%
🇪🇷	Eritrea	0.0%	5.8%	1.9%	0.0%
🇪🇹	Ethiopia	21.0%	2.1%	0.8%	0.0%
🇬🇲	Gambia	7.7%	4.6%	6.2%	0.0%
🇬🇦	Ghana	23.3%	3.6%	8.5%	0.0%
🇬🇳	Guinea	1.4%	2.8%	1.4%	0.0%
🇬🇼	Guinea-Bissau	22.8%	24.1%	1.4%	0.0%
🇮🇪	Haiti	5.1%	0.0%	4.2%	0.5%
🇭🇿	Honduras	0.0%	10.7%	37.1%	0.5%
🇮🇳	India	0.0%	2.5%	75.2%	1.5%
🇮🇩	Indonesia	5.5%	6.7%	2.8%	0.5%
🇮🇶	Iraq	0.3%	26.0%	8.6%	0.0%
🇰🇪	Kenya	18.6%	6.4%	6.0%	0.0%
🇰🇾	Kyrgyzstan	0.0%	56.1%	3.3%	0.0%
🇱🇦	Lao PDR	0.2%	3.7%	10.7%	0.0%
🇱🇸	Lesotho	2.3%	2.2%	2.8%	0.2%
🇱🇮	Liberia	11.2%	0.0%	1.0%	0.0%
🇲🇩	Madagascar	5.2%	1.3%	3.9%	0.4%

		Short term methods					Source	Population
		Condoms (male)	Injection	LAM*	Pill	Other modern methods		
🇦🇫	Afghanistan	7.4%	47.3%	3.9%	27.1%	0.5%	MICS 2010-11	Married
🇧🇩	Bangladesh	11.9%	23.0%	0.0%	50.1%	0.0%	pDHS 2014	Married
🇧🇯	Benin	9.7%	29.0%	8.9%	21.0%	0.0%	MICS 2014	Married
🇧🇹	Bhutan	8.4%	44.2%	0.0%	11.5%	0.0%	MICS 2010	Married
🇧🇴	Bolivia	15.0%	30.8%	2.1%	10.0%	0.4%	DHS 2008	All
🇧🇫	Burkina Faso	3.2%	36.3%	0.0%	13.4%	0.6%	PMA2020 2014 R1	All
🇧🇷	Burundi	2.6%	61.7%	1.0%	9.6%	0.0%	PMS 2012	Married
🇰🇲	Cambodia	5.4%	23.5%	0.0%	45.9%	0.3%	pDHS 2014	Married
🇨🇲	Cameroon	67.7%	14.3%	1.2%	9.9%	0.0%	DHS 2011	All
🇨🇩	CAR	26.1%	5.4%	0.0%	64.1%	0.0%	MICS 2010	Married
🇨🇩	Chad	6.3%	56.3%	0.0%	31.3%	0.0%	MICS 2010	Married
🇨🇴	Comoros	19.4%	37.8%	5.1%	20.4%	0.0%	DHS 2012	All
🇨🇩	Congo	69.5%	8.5%	0.0%	11.7%	9.4%	DHS 2011-12	All
🇨🇮	Côte d'Ivoire	35.7%	13.6%	2.9%	43.6%	2.1%	DHS 2011-12	All
🇩🇯	Djibouti	0.0%	33.9%	0.0%	60.6%	2.2%	PAPFAM 2012	Married
🇰🇵	DPR Korea	0.3%	0.3%	0.0%	0.3%	0.2%	RHS 2010	Married
🇨🇩	DR Congo	58.8%	11.3%	0.0%	8.8%	7.5%	DHS 2013-14	All
🇪🇬	Egypt	0.9%	14.9%	0.0%	28.1%	0.2%	DHS 2014	Married
🇪🇷	Eritrea	11.5%	34.6%	26.9%	19.2%	0.0%	DHS 2002	All
🇪🇹	Ethiopia	1.3%	68.9%	0.8%	4.6%	0.4%	PMA2020 2014 R2	All
🇬🇲	Gambia	12.3%	46.2%	0.0%	23.1%	0.0%	DHS 2013	All
🇬🇦	Ghana	5.4%	35.9%	0.9%	21.1%	1.3%	pDHS 2014	Married
🇬🇳	Guinea	33.8%	22.5%	15.5%	22.5%	0.0%	DHS 2012	All
🇬🇼	Guinea-Bissau	11.7%	9.7%	16.6%	10.3%	3.4%	MICS 2014	Married
🇮🇪	Haiti	26.9%	54.2%	0.9%	7.9%	0.5%	DHS 2012	All
🇭🇿	Honduras	8.4%	26.1%	0.0%	17.2%	0.0%	DHS 2011-12	All
🇮🇳	India	12.6%	0.0%	0.0%	8.2%	0.0%	AHS&DLHS 2012-13	Married
🇮🇩	Indonesia	0.8%	61.1%	0.0%	22.6%	0.0%	Susenas 2013	Married
🇮🇶	Iraq	5.3%	8.6%	6.4%	43.8%	1.1%	MICS 2011	Married
🇰🇪	Kenya	4.1%	49.6%	0.2%	15.0%	0.0%	pDHS 2014	Married
🇰🇾	Kyrgyzstan	26.1%	0.5%	3.8%	10.3%	0.0%	MICS 2014	Married
🇱🇦	Lao PDR	2.6%	31.8%	1.4%	49.5%	0.0%	MICS/DHS 2011-12	Married
🇱🇸	Lesotho	28.6%	40.1%	0.0%	23.7%	0.0%	pDHS 2014	Married
🇱🇮	Liberia	4.9%	60.7%	0.0%	21.4%	1.0%	DHS 2013	All
🇲🇩	Madagascar	4.3%	60.8%	3.4%	20.7%	0.0%	DHS 2008-9	All

INDICATOR NO. 9
Percentage of women using each modern method

		Long acting and permanent methods			
		Implant	IUD	Sterilization (female)	Sterilization (male)
🇸🇩	Malawi	16.4%	1.7%	17.8%	0.2%
🇲🇱	Mali	25.5%	3.2%	1.1%	0.0%
🇲🇷	Mauritania	0.0%	3.9%	1.3%	0.0%
🇲🇳	Mongolia	1.0%	48.9%	6.7%	0.0%
🇲🇿	Mozambique	0.0%	1.7%	1.7%	0.0%
🇲🇲	Myanmar	0.2%	4.6%	7.9%	0.9%
🇳🇵	Nepal	2.8%	3.6%	38.1%	10.0%
🇳🇮	Nicaragua	0.0%	4.6%	38.9%	0.5%
🇳🇪	Niger	2.7%	0.9%	0.9%	0.0%
🇳🇮	Nigeria	2.7%	7.1%	2.7%	0.0%
🇵🇰	Pakistan	0.0%	8.8%	33.2%	1.1%
🇵🇬	Papua New Guinea	0.0%	0.0%	35.8%	1.7%
🇵🇭	Philippines	0.0%	9.3%	22.9%	0.4%
🇷🇼	Rwanda	14.3%	0.8%	2.0%	0.0%
🇸🇹	Sao Tome and Principe	0.0%	1.1%	3.3%	0.0%
🇸🇳	Senegal	23.7%	4.1%	2.0%	0.0%
🇸🇱	Sierra Leone	18.4%	1.0%	1.4%	0.0%
🇸🇮	Solomon Islands	0.0%	6.8%	45.4%	1.0%
🇸🇴	Somalia	0.0%	9.1%	0.0%	0.0%
🇸🇦	South Africa†	0.0%	1.2%	14.5%	0.6%
🇸🇩	South Sudan	0.0%	0.0%	5.9%	0.0%
🇸🇷	Sri Lanka	0.6%	12.0%	32.1%	1.3%
🇵🇸	State of Palestine	0.0%	59.3%	4.1%	0.0%
🇸🇩	Sudan	0.0%	5.1%	6.4%	0.0%
🇹🇯	Tajikistan	0.0%	72.4%	2.3%	0.0%
🇹🇼	Tanzania	7.7%	1.7%	10.6%	0.0%
🇹🇲	Timor-Leste	3.9%	6.3%	3.9%	0.0%
🇹🇬	Togo	20.5%	3.6%	1.2%	0.0%
🇺🇬	Uganda	12.8%	2.8%	6.2%	0.5%
🇺🇿	Uzbekistan	0.2%	80.3%	3.4%	0.2%
🇻🇳	Vietnam	0.4%	49.6%	4.9%	0.2%
🇾🇪	Yemen	2.1%	20.2%	7.9%	0.3%
🇿🇲	Zambia	12.9%	2.8%	4.0%	0.0%
🇿🇼	Zimbabwe	12.7%	0.6%	1.4%	0.0%

		Short term methods						
		Condoms (male)	Injection	LAM*	Pill	Other modern methods	Source	Population
🇸🇩	Malawi	3.8%	56.2%	0.0%	3.8%	0.0%	MICS 2014	Married
🇲🇱	Mali	2.1%	40.4%	0.0%	27.7%	0.0%	DHS 2012-13	All
🇲🇷	Mauritania	5.3%	13.2%	0.0%	75.0%	1.3%	MICS 2007	Married
🇲🇳	Mongolia	17.7%	7.7%	0.0%	18.1%	0.0%	SISS 2013	Married
🇲🇿	Mozambique	24.8%	35.5%	0.8%	35.5%	0.0%	DHS 2011	All
🇲🇲	Myanmar	0.9%	60.2%	0.2%	25.2%	0.0%	MICS 2010	Married
🇳🇵	Nepal	7.8%	27.5%	0.0%	10.0%	0.2%	MICS 2014	Married
🇳🇮	Nicaragua	7.0%	33.9%	0.0%	14.8%	0.3%	National 2011-12	Married
🇳🇪	Niger	0.9%	17.3%	31.8%	45.5%	0.0%	DHS 2012	All
🇳🇮	Nigeria	40.2%	22.3%	2.7%	17.0%	5.4%	DHS 2013	All
🇵🇰	Pakistan	33.6%	10.7%	5.7%	6.1%	0.8%	DHS 2012-13	Married
🇵🇬	P. New Guinea	7.3%	36.9%	0.0%	18.4%	0.0%	Nat'l Survey 2006	All
🇵🇭	Philippines	5.9%	9.7%	1.3%	50.0%	0.4%	DHS 2013	All
🇷🇼	Rwanda	7.1%	57.9%	1.2%	15.5%	1.2%	DHS 2010	All
🇸🇹	S. T. and Principe	25.9%	29.9%	1.5%	38.3%	0.0%	DHS 2008-9	All
🇸🇳	Senegal	6.3%	38.5%	0.5%	24.3%	0.7%	DHS 2014	All
🇸🇱	Sierra Leone	3.4%	47.3%	3.4%	24.6%	0.5%	DHS 2013	All
🇸🇮	Solomon Islands	9.8%	32.2%	0.5%	4.4%	0.0%	DHS 2006-2007	All
🇸🇴	Somalia	0.0%	18.2%	0.0%	72.7%	0.0%	MICS 2006	Married
🇸🇦	South Africa†	12.4%	53.2%	0.2%	17.9%	0.0%	DHS 2003	All
🇸🇩	South Sudan	23.5%	23.5%	29.4%	17.6%	0.0%	SHHS2 2010	Married
🇸🇷	Sri Lanka	10.4%	28.5%	0.2%	15.0%	0.0%	DHS 2006-7	Married
🇵🇸	State of Palestine	12.7%	2.0%	3.6%	18.1%	0.2%	MICS 2014	Married
🇸🇩	Sudan	0.0%	9.0%	0.0%	79.5%	0.0%	MICS 2006	Married
🇹🇯	Tajikistan	8.6%	7.5%	0.6%	8.6%	0.0%	DHS 2012	All
🇹🇼	Tanzania	17.9%	36.2%	4.3%	21.7%	0.0%	DHS 2010	All
🇹🇲	Timor-Leste	0.8%	75.0%	0.0%	7.8%	2.3%	DHS 2010	All
🇹🇬	Togo	32.5%	30.7%	0.0%	11.4%	0.0%	DHS 2013-14	All
🇺🇬	Uganda	9.0%	56.9%	0.9%	9.0%	1.9%	PMA2020 2014 R1	All
🇺🇿	Uzbekistan	3.6%	4.4%	4.2%	3.7%	0.2%	MICS 2006	Married
🇻🇳	Vietnam	21.1%	3.0%	0.0%	20.9%	0.0%	MICS 2013-14	Married
🇾🇪	Yemen	1.7%	14.4%	13.7%	39.7%	0.0%	pDHS 2013	Married
🇿🇲	Zambia	11.1%	42.5%	1.5%	24.6%	0.6%	DHS 2013-14	All
🇿🇼	Zimbabwe	5.3%	13.6%	0.2%	66.1%	0.3%	MICS 2014	Married

INDICATOR NO. 10

Percentage of facilities stocked out, by method offered, on the day of assessment

	Long acting and permanent methods				Short term methods	
	Implant	IUD	Sterilization (female)	Sterilization (male)	Condoms (male)	Condoms (female)
Burkina Faso	0.0%	1.3%	no data	no data	0.0%	2.6%
Benin						
Cameroon	46.4%	34.5%	20.0%	19.8%	45.5%	66.0%
Chad						
Côte d'Ivoire	70.0%	71.0%	no data	no data	53.0%	75.0%
DR Congo						
Djibouti						
Ethiopia	5.0%	1.8%	no data	no data	3.7%	28.6%
Gambia						
Ghana	4.3%	10.3%	no data	no data	8.9%	18.0%
Haiti						
Honduras	89.0%	29.7%	no data	no data	18.7%	96.7%
Kenya	5.4%	4.7%	no data	no data	4.6%	21.4%
Lao PDR		35.0%	29.0%	61.0%	87.0%	97.0%
Lesotho	65.2%	36.2%	0.0%	14.3%	4.1%	40.4%
Madagascar	13.1%	28.3%	no data	no data	15.4%	25.6%
Malawi	11.0%	31.0%	2.5%	17.5%	23.0%	25.0%
Myanmar						
Nepal						
Niger	11.3%	21.3%	no data	no data	13.9%	17.4%
Nigeria	6.2%	5.1%	9.2%	10.3%	9.0%	10.2%
Rwanda						
Senegal						
South Sudan						
Sudan	18.6%	5.0%	no data	no data	17.7%	no data
Togo						
Uganda						
Yemen						
Zambia						

	Short term methods (continued)				Source
	Injection	Pill	Other modern methods (EC)	Any modern method*	
Burkina Faso	0.0%	2.2%	0.0%	5.2%**	PMA2020 R1 2014
Benin				67.8%	UNFPA 2014
Cameroon	19.7%	42.6%	71.2%	85.9%	UNFPA 2014
Chad				82.9%	UNFPA 2014
Côte d'Ivoire	21.0%	31.0%	75.0%	100.0%	PNSR/PF/ENSEA 2014
DR Congo				95.9%	UNFPA 2014
Djibouti				62.6%	UNFPA 2014
Ethiopia	4.5%	7.2%	16.7%	33.2%**	PMA2020 R2 2014
Gambia				24.5%	UNFPA 2014
Ghana	2.4%	7.1%	58.3%	50.2%	PMA2020 R3 2014
Haiti				81.8%	UNFPA 2014
Honduras	47.3%	39.6%	no data	71.4%	UNFPA 2014
Kenya	1.3%	5.1%	27.6%	36.5%	PMA2020/R2 2014
Laos	2.0%	3.0%		89.0%	UNFPA 2014
Lesotho	15.8%	2.9%	9.8%	79.5%	UNFPA 2014
Madagascar	7.5%	7.4%	no data	87.0%	UNFPA 2014
Malawi	41.0%	14.0%	20.0%	66.0%	UNFPA/DHS SPA 2013/2014
Myanmar				80.9%	UNFPA 2014
Nepal				13.0%	UNFPA 2014
Niger	11.3%	7.8%	no data	16.5%	UNFPA 2014
Nigeria	3.8%	5.5%	14.6%	22.6%	UNFPA 2014
Rwanda				28.9%	UNFPA 2014
Senegal				39.0%	UNFPA 2014
South Sudan				69.0%	UNFPA 2014
Sudan	22.9%	10.1%	11.8%	no data	UNFPA 2014
Togo				63.0%	UNFPA 2014
Uganda				79.0%	UNFPA 2014
Yemen				60.0%	UNFPA 2014
Zambia				85.5%	UNFPA 2014

INDICATOR NO. 11

Percentage of SDPs based on number of modern methods of contraception available on day of assessment

	Percentage of primary SDPs that have at least 3 modern methods of contraception available on day of assessment	Percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment	Source	Year
Burkina Faso	76.6%	90.7%	PMA2020 R1	2014
Ethiopia	87.3%	92.1%	PMA2020 R2	2014
Ghana	67.5%	78.2%	PMA2020 R3	2014
Kenya	82.4%	94.9%	PMA2020 R2	2014

INDICATOR NO. 12

Government expenditure on family planning

	2013	2014	Source
India	\$USD 142.6 million	\$USD 219.3 million	Consensus workshops
Burkina Faso	\$USD 1 million	n/a	WHO/SHA
DR Congo	\$USD 3 million	n/a	WHO/SHA

INDICATOR NO. 13

Couple-Years of Protection (CYPs)

	2012	2013	2014	Source
Benin	180,574	401,468	472,242	Consensus workshop
Burundi	613,716	740,136	624,133	Système d'information sanitaire de routine (statistiques de services)
Côte d'Ivoire	639,428	733,399	789,239	Consensus workshop
Ethiopia			8,521,753	Consensus workshop
India	95,169,398			Consensus workshop
Indonesia	57,876,292	56,212,255	48,452,903	BKKBN service statistics
Kenya			4,259,254	Consensus workshop
Malawi			1,644,769	Logistics Management Information System/JSI-Deliver
Mozambique	234,846	285,914	344,623	MOH (MISAU)
Nigeria		839,558	1,743,433	MOH
Pakistan	8,848,371	10,174,766	12,573,810	BOS and LMIS
Tanzania			4,055,953	DHIS2
Togo	183,905	180,174	252,198	Consensus workshop
Zambia			1,253,388	DHIS2
Zimbabwe	731,989	1,159,723	1,481,672	HMIS

INDICATOR NO. 14

	Method Information Index	LAPM			STM	
	Total	Implant	IUD	FS	Injection	Pill
Burkina Faso	36.7%	38.7%			34.4%	47.3%*
Comoros	36.2%	51.4%			30.0%	40.1%
DR Congo	28.4%	50.4%		6.4%	35.6%	12.0%
Egypt†	28.8%	27.3%	30.4%	25.4%	30.0%	25.5%
Ethiopia	30.5%	43.0%			27.2%	32.9%
Gambia	31.0%		29.9%*		33.5%	26.5%
Ghana	40.1%	58.6%			58.0%	19.5%
Guinea	31.3%	0.0%			29.1%	28.6%
Haiti	51.7%	62.1%		30.0%	54.3%	38.7%
Indonesia	20.8%	21.2%	36.6%	19.5%	21.0%	16.9%
Kenya	50.0%	58.1%	71.0%	39.8%	51.8%	47.7%
Kyrgyzstan	56.2%	0.0%	59.5%	26.9%*	0.0%	46.5%
Liberia	61.4%	75.6%			62.3%	51.9%
Mali	33.3%	41.8%	50.1%*		31.2%	25.4%
Niger	28.4%	39.8%*	0.0%		34.4%	25.5%
Nigeria	47.1%	73.3%	64.4%	23.8%*	52.5%	30.9%
Pakistan†	13.5%		20.6%	7.6%	18.3%	11.2%
Philippines	52.1%		69.5%	45.9%	58.5%	50.5%
Senegal	64.8%	54.4%	72.4%*		74.2%	63.3%
Sierra Leone	69.8%	78.0%	76.7%	54.0%*	72.1%	59.7%
Tajikistan	59.4%	0.0%	59.1%		65.4%	60.7%
Togo	67.5%	79.8%	72.0%		68.8%	44.4%
Uganda	41.0%	71.6%	39.3%*		36.0%	37.4%
Zambia	71.8%	83.8%	82.3%	49.9%	73.8%	62.4%

Method Information Index

	Told of other methods - all users modern method	Told about side effects - all users modern method	Told what to do about side effects - all users modern method **	Source
Burkina Faso	71.8%	46.6%	42.3%	2014 PMA2020 R1
Comoros	62.2%	54.5%	45.7%	2012 DHS
DR Congo	50.8%	57.2%	47.5%	2013/14 DHS
Egypt	56.0%	45.0%	34.5%	2014 DHS
Ethiopia	60.8%	46.1%	34.7%	2014 PMA2020 R2
Gambia	57.5%	47.2%	41.8%	2013 DHS
Ghana	70.1%	53.6%	42.7%	2014 PMA2020 R3
Guinea	48.6%	48.6%	43.1%	2012 DHS
Haiti	64.6%	70.2%	63.7%	2012 DHS
Indonesia	51.1%	36.4%	29.4%	2012 DHS
Kenya	72.7%	61.5%	55.8%	2014 PMA2020 R2
Kyrgyzstan	64.6%	70.5%	67.1%	2012 DHS
Liberia	72.0%	75.0%	72.9%	2013 DHS
Mali	56.8%	53.1%	46.3%	2012.5 DHS
Niger	55.9%	39.6%	35.4%	2012 DHS
Nigeria	64.8%	60.3%	54.8%	2013 DHS
Pakistan	28.2%	34.0%	28.1%	2012.5 DHS
Philippines	71.4%	67.8%	67.9%	2013 DHS
Senegal	84.5%	72.7%	76.8%	2014 DHS
Sierra Leone	82.7%	75.7%	74.9%	2013 DHS
Tajikistan	68.1%	77.0%	71.8%	2012 DHS
Togo	82.7%	78.1%	74.6%	2013/14 DHS
Uganda	63.1%	54.7%	47.2%	2014 PMA2020 R1
Zambia	83.3%	79.7%	78.1%	2013/14 DHS

INDICATOR NO. 15

Family planning counseling

	Indicator 15: Percentage of women who were provided with information on family planning during their last visit with a health service provider**	Indicator 15 by wealth quintile:					Ratio of poorest to richest	Source
		Poorest	Poorer	Middle	Richer	Richest		
Burkina Faso	36.5%	28.1%	40.4%	42.4%	43.3%	30.1%	0.9	2014 PMA2020 R1
Comoros	16.2%	20.1%	22.1%	20.0%	18.1%	19.8%	1.0	2012 DHS
DR Congo	11.0%	12.1%	16.6%	15.7%	24.4%	31.2%	0.4	2013/14 DHS
Ethiopia	28.3%	29.9%	28.3%	26.2%	28.4%	28.9%	1.0	2014 PMA2020 R2
Gambia	9.7%	21.7%	22.6%	20.0%	17.4%	18.3%	1.2	2013 DHS
Ghana	24.2%	33.8%	26.7%	21.5%	21.8%	17.6%	1.9	2014 PMA2020 R3
Guinea	6.6%	15.0%	13.5%	17.4%	17.4%	36.7%	0.4	2012 DHS
Haiti	20.2%	18.7%	17.8%	24.3%	20.6%	18.6%	1.0	2012 DHS
Indonesia	13.8%	16.8%	18.7%	21.3%	22.0%	21.3%	0.8	2012 DHS
Kenya	34.2%	37.8%	39.1%	33.0%	31.7%	29.8%	1.3	2014 PMA2020 R2
Kyrgyzstan	23.6%	25.1%	21.5%	18.8%	19.6%	15.0%	1.7	2012 DHS
Liberia	52.4%	15.3%	17.7%	21.4%	23.6%	22.0%	0.7	2013 DHS
Mali	16.4%	17.0%	15.6%	17.1%	23.6%	26.8%	0.6	2012.5 DHS
Niger	16.9%	12.1%	18.4%	22.8%	20.0%	26.8%	0.5	2012 DHS
Nigeria	12.5%	3.5%	9.3%	18.1%	29.3%	39.8%	0.1	2013 DHS
Pakistan†	52.6%	17.7%	20.9%	23.1%	21.9%	16.3%	1.1	2012.5 DHS
Philippines	28.8%	25.4%	23.6%	21.0%	16.9%	13.1%	1.9	2013 DHS
Senegal	22.2%	15.0%	16.7%	20.1%	23.5%	24.7%	0.6	2014 DHS
Sierra Leone	42.3%	18.1%	20.0%	21.3%	23.9%	16.8%	1.1	2013 DHS
Tajikistan	27.8%	17.7%	17.6%	20.2%	23.0%	21.6%	0.8	2012 DHS
Togo	21.1%	23.6%	19.7%	20.2%	17.8%	18.7%	1.3	2013/14 DHS
Uganda	38.3%	42.8%	42.6%	37.6%	35.2%	35.0%	1.2	2014 PMA2020 R1
Zambia	30.2%	19.7%	21.7%	20.7%	19.7%	18.3%	1.1	2013/14 DHS

† Values based on married women, other data reported for all women

** Received FP information from provider in last 12 months

Note: Egypt is excluded from this indicator because the question was not asked.

INDICATOR NO. 16

Decision-making

	Indicator 16: Percentage of women who make family planning decisions alone or jointly with their husbands or partners	Indicator 16 by wealth quintile:					Ratio of poorest to richest	Source
		Poorest	Poorer	Middle	Richer	Richest		
Burkina Faso	86.1%	90.8%	83.3%	79.5%	78.3%	95.4%	1.0	2014 PMA2020 R1
Comoros†	71.0%	72.0%	73.0%	71.0%	72.0%	69.0%	1.0	2012 DHS
DR Congo†	85.0%	86.0%	85.0%	80.0%	81.0%	89.0%	1.0	2013/14 DHS
Egypt†	98.0%	97.0%	97.0%	97.0%	97.0%	99.0%	1.0	2014 DHS
Ethiopia	88.2%	92.6%	84.1%	90.1%	91.0%	84.4%	1.1	PMA2020 R2
Gambia†	84.0%	84.0%	77.0%	89.0%	81.0%	87.0%	1.0	2013 DHS
Ghana	91.8%	92.6%	94.5%	94.5%	89.4%	88.6%	1.0	2014 PMA2020 R3
Guinea†	92.0%	80.0%	97.0%	98.0%	95.0%	87.0%	0.9	2012 DHS
Haiti†	91.4%	91.0%	92.0%	92.0%	91.0%	91.0%	1.0	2012 DHS
Indonesia†	91.5%	90.0%	91.0%	92.0%	92.0%	92.0%	1.0	2012 DHS
Kenya	97.5%	97.3%	97.7%	97.5%	97.3%	97.6%	1.0	2014 PMA2020 R2
Kyrgyzstan†	95.0%	94.0%	95.0%	96.0%	93.0%	97.0%	1.0	2012 DHS
Liberia†	89.0%	84.0%	86.0%	87.0%	92.0%	93.0%	0.9	2013 DHS
Mali†	81.0%	85.0%	86.0%	79.0%	82.0%	79.0%	1.1	2012.5 DHS
Niger†	77.0%	53.0%	75.0%	82.0%	81.0%	81.0%	0.7	2012 DHS
Nigeria†	85.0%	80.0%	83.0%	82.0%	84.0%	86.0%	0.9	2013 DHS
Pakistan†	92.0%	93.0%	94.0%	91.0%	92.0%	93.0%	1.0	2012.5 DHS
Philippines†	92.0%	91.0%	93.0%	92.0%	93.0%	94.0%	1.0	2013 DHS
Senegal†	93.0%	84.0%	86.0%	94.0%	95.0%	96.0%	0.9	2014 DHS
Sierra Leone†	82.0%	84.0%	78.0%	83.0%	82.0%	83.0%	1.0	2013 DHS
Tajikistan†	86.0%	86.0%	80.0%	89.0%	82.0%	92.0%	0.9	2012 DHS
Togo†	84.0%	82.0%	90.0%	87.0%	82.0%	81.0%	1.0	2013/14 DHS
Uganda	88.6%	82.4%	88.5%	88.5%	90.0%	89.7%	0.9	2014 PMA2020 R1
Zambia†	83.0%	82.0%	82.0%	83.0%	83.0%	85.0%	1.0	2013/14 DHS

* Low sample size (between 25-50)

No countries had a big enough sample size to analyze male sterilization

** Received FP information from provider in last 12 months

	ABR*	Source
Bangladesh	113	pDHS 2014
Cambodia	57	pDHS 2014
Comoros	101	DHS 2012
DR Congo	138	DHS 2013
Egypt	56	DHS 2014
Ethiopia	63	PMA2020 2014 R1/R2
Gambia	88	DHS 2013
Ghana	76	pDHS 2014
Guinea	146	DHS 2012
Haiti	66	DHS 2012
Indonesia	48	DHS 2012
Kenya	96	pDHS 2014
Kyrgyzstan	44	DHS 2012
Lesotho	94	pDHS 2014
Liberia	149	DHS 2013
Mali	172	DHS 2012/13
Niger	206	DHS 2012
Nigeria	122	DHS 2013
Pakistan	44	DHS 2012/13
Philippines	57	DHS 2013
Senegal	90	DHS 2014
Sierra Leone	125	DHS 2013
Tajikistan	54	DHS 2012
Togo	84	DHS 2013/14
Zambia	141	DHS 2013/14

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Disaggregated Estimates

MCPR, MARRIED OR IN-UNION WOMEN

DISAGGREGATED FROM RECENT SURVEY

Country	Total	Age in 5 year categories						
		15-19	20-24	25-29	30-34	35-39	40-44	45-49
Bangladesh	54.1%	46.7%	54.5%	62.7%	64.7%	60.6%	45.2%	25.0%
Burkina Faso	18.1%	10.6%	17.0%	20.7%	23.7%	17.6%	19.2%	10.2%
Cambodia	38.8%	20.2%	34.4%	43.8%	47.5%	47.4%	38.4%	18.6%
Comoros	14.2%	13.5%	14.3%	14.9%	14.5%	16.8%	14.4%	5.3%
DR Congo	7.8%	5.4%	8.2%	6.9%	10.3%	8.3%	7.8%	5.1%
Egypt	56.9%	18.9%	4.0%	53.5%	62.8%	71.0%	69.9%	52.3%
Ethiopia	34.2%	36.7%	38.7%	38.4%	33.5%	26.8%	12.9%	
Gambia	8.1%	2.2%	5.7%	8.0%	10.2%	11.5%	9.6%	6.6%
Ghana	22.2%	16.7%	24.8%	27.5%	23.0%	21.0%	19.4%	15.7%
Guinea	4.6%	2.6%	3.9%	5.7%	6.2%	5.4%	4.3%	2.4%
Haiti	31.3%	24.0%	34.1%	37.2%	35.9%	31.3%	26.6%	16.9%
Indonesia	57.9%	47.6%	59.3%	60.4%	61.8%	62.7%	59.5%	41.6%
Kenya	53.2%	36.8%	49.8%	57.3%	59.1%	57.7%	51.1%	37.2%
Kyrgyzstan	33.7%	5.2%	19.5%	29.6%	46.9%	42.2%	42.8%	28.5%
Lesotho	59.8%	35.3%	57.4%	65.3%	66.8%	70.1%	59.3%	39.4%
Liberia	19.1%	13.2%	22.5%	22.9%	22.5%	20.3%	14.7%	6.2%
Mali	9.9%	6.5%	10.0%	9.5%	11.8%	11.9%	10.5%	5.5%
Nepal	47.1%	16.6%	27.5%	40.9%	53.8%	62.2%	62.1%	51.9%
Niger	12.2%	5.9%	12.6%	16.0%	14.3%	15.0%	8.8%	3.2%
Nigeria	9.8%	1.2%	6.2%	8.8%	12.6%	13.6%	14.4%	8.3%
Pakistan	26.1%	6.9%	14.9%	21.0%	31.4%	36.6%	33.3%	26.8%
Philippines	37.6%	20.6%	34.3%	42.2%	44.9%	42.4%	38.6%	23.5%
Senegal	20.3%	12.3%	12.2%	24.5%	22.8%	27.9%	18.9%	15.6%
Sierra Leone	15.6%	7.8%	13.6%	15.2%	20.1%	18.2%	16.5%	10.5%
Tajikistan	25.8%	1.8%	9.5%	24.8%	37.4%	43.9%	34.6%	17.0%
Togo	17.3%	7.6%	15.3%	19.3%	19.3%	18.4%	18.5%	11.8%
Uganda	25.7%	11.5%	25.0%	29.6%	25.1%	30.5%	29.3%	18.3%
Yemen	29.2%	12.1%	23.0%	32.8%	35.6%	34.5%	30.6%	22.9%
Zambia	44.8%	35.8%	44.1%	48.6%	48.7%	47.1%	44.2%	27.5%
Zimbabwe	66.5%	48.4%	64.7%	71.9%	71.9%	71.5%	65.2%	47.4%

Country	Residence		Wealth				
	Urban	Rural	Lowest	Second	Middle	Fourth	Highest
Bangladesh	56.2%	53.2%	55.1%	54.9%	55.8%	51.9%	53.2%
Burkina Faso	27.9%	16.2%	13.9%	14.2%	16.6%	20.7%	28.3%
Cambodia	32.8%	39.9%	39.6%	42.4%	38.3%	39.2%	34.6%
Comoros	20.6%	11.0%	10.9%	13.2%	14.1%	17.8%	14.2%
DR Congo	14.6%	4.6%	3.3%	4.7%	4.5%	11.0%	17.2%
Egypt	59.5%	55.5%	54.2%	54.3%	58.0%	58.1%	59.3%
Ethiopia	47.2%	31.5%	26.1%	25.8%	33.4%	39.1%	47.9%
Gambia	11.8%	4.4%	4.2%	4.8%	5.5%	10.8%	15.1%
Ghana	20.3%	24.2%	21.4%	24.8%	23.6%	22.1%	19.8%
Guinea	7.4%	3.5%	2.3%	3.9%	4.0%	5.0%	8.8%
Haiti	31.3%	31.2%	29.7%	29.8%	34.8%	34.3%	27.5%
Indonesia	57.0%	58.7%	53.0%	61.4%	60.2%	58.7%	55.4%
Kenya	56.9%	50.9%	29.2%	54.1%	59.5%	60.9%	57.7%
Kyrgyzstan	34.2%	33.4%	36.4%	35.2%	32.6%	30.5%	34.0%
Lesotho	65.2%	57.3%	49.9%	56.3%	62.3%	60.8%	65.9%
Liberia	21.6%	16.3%	13.2%	16.5%	21.1%	24.5%	20.7%
Mali	21.8%	6.8%	3.3%	5.0%	5.6%	12.8%	23.3%
Nepal	47.5%	47.1%	44.1%	46.8%	50.1%	48.9%	45.4%
Niger	27.0%	9.7%	8.7%	7.7%	8.3%	12.8%	23.7%
Nigeria	16.9%	5.7%	0.9%	3.7%	9.1%	14.4%	23.4%
Pakistan	32.0%	23.1%	18.1%	22.9%	26.9%	30.3%	31.6%
Philippines	37.8%	37.4%	32.9%	40.3%	41.4%	39.1%	33.9%
Senegal	28.8%	13.0%	10.4%	12.6%	17.2%	29.4%	29.0%
Sierra Leone	24.7%	12.3%	11.5%	11.5%	12.1%	19.2%	26.3%
Tajikistan	29.0%	24.8%	23.3%	22.7%	23.7%	25.8%	33.3%
Togo	18.8%	16.3%	15.5%	16.7%	16.7%	16.4%	20.8%
Uganda	31.2%	24.5%	15.5%	21.2%	26.7%	29.7%	34.9%
Yemen	40.2%	24.0%	n/a	n/a	n/a	n/a	n/a
Zambia	53.4%	39.0%	31.3%	39.3%	44.8%	49.5%	58.3%
Zimbabwe	69.5%	65.1%	62.1%	63.5%	65.6%	69.4%	70.2%

MCPR, MARRIED OR IN-UNION WOMEN (CONTINUED)

DISAGGREGATED FROM RECENT SURVEY

Country	Education					
	No education	Primary	Primary incomplete	Primary complete	Secondary or Middle/JSS	Secondary incomplete
Bangladesh	50.5%		55.7%	54.3%		56.0%
Burkina Faso	15.4%	24.7%			33.5%	
Cambodia	39.9%	39.8%				
Comoros	10.7%	15.3%				
DR Congo	4.0%	4.9%				
Egypt	57.9%	57.7%				
Ethiopia	29.7%	37.5%			49.5%	
Gambia	5.5%	6.4%				
Ghana	17.4%	26.8%			22.8%	
Guinea	3.9%	6.1%				
Haiti	27.8%	31.7%				
Indonesia	41.8%	59.6%				
Kenya	15.3%		51.1%	59.6%		
Kyrgyzstan					33.9%	
Lesotho	38.1%		52.3%	58.0%	63.3%	
Liberia	14.7%	18.1%				
Mali	7.8%	12.9%				
Nepal	54.4%	48.5%			39.6%	
Niger	10.4%	18.4%				
Nigeria	1.7%	13.6%				
Pakistan	23.4%	28.8%				
Philippines	16.1%	36.1%				
Senegal	14.3%	29.6%				
Sierra Leone	13.2%	18.9%				
Tajikistan	22.6%	18.7%				
Togo	13.0%	19.5%				
Uganda	12.9%	24.9%			35.9%	
Yemen	24.8%	32.5%			37.4%	
Zambia	32.6%	41.8%				
Zimbabwe	45.6%	62.1%			68.3%	

Country	Education (continued)			Marital status			Source
	Sec. complete or higher	Higher	Sec. or higher	Unmarried sexually active	All	Currently married	
Bangladesh	53.2%					0.5	2014 pDHS
Burkina Faso		49.7%		0.3	0.2	0.2	2014 PMA2020 R1
Cambodia			58.4%			0.4	2014 pDHS
Comoros			17.4%	0.3	0.1	0.1	2012 DHS
DR Congo			12.9%	0.2	0.1	0.1	2013-14 DHS
Egypt			56.4%			0.6	2014 DHS
Ethiopia		29.9%		0.4	0.2	0.3	2014 PMA2020 R2
Gambia			15.0%	0.4	0.1	0.1	2013 DHS
Ghana			23.7%	0.3		0.2	2014 pDHS
Guinea			8.8%	0.4	0.1	0.0	2012 DHS
Haiti			32.8%	0.3	0.2	0.3	2012 DHS
Indonesia			57.7%	0.2	0.4	0.6	2012 DHS
Kenya			59.0%	0.6		0.5	2014 pDHS
Kyrgyzstan		33.8%		0.4	0.2	0.3	2012 DHS
Lesotho		66.8%		0.7		0.6	2014 pDHS
Liberia			27.1%	0.3	0.2	0.2	2013 DHS
Mali			26.5%	0.3	0.1	0.1	2012-13 DHS
Nepal		35.6%				0.5	MICS 2014
Niger			30.0%	0.4	0.1	0.1	2012 DHS
Nigeria			19.5%	0.5	0.1	0.1	2013 DHS
Pakistan			30.1%			0.3	2012-13 DHS
Philippines			38.4%	0.3	0.2	0.4	2013 DHS
Senegal			33.4%			0.2	2014 DHS
Sierra Leone			24.6%	0.6	0.2	0.2	2013 DHS
Tajikistan			26.2%	0.4	0.2	0.3	2012 DHS
Togo			20.8%			0.2	2013 DHS
Uganda		40.3%		0.3	0.2	0.3	PMA2020 2014 R1
Yemen		40.8%					2013 pDHS
Zambia			52.8%	0.4	0.3	0.4	2014 DHS
Zimbabwe		74.9%				0.7	MICS 2014

UNMET NEED FOR A MODERN METHOD MARRIED OR IN-UNION WOMEN

DISAGGREGATED FROM RECENT SURVEY

Country	Total	Age in 5 year categories						
		15-19	20-24	25-29	30-34	35-39	40-44	45-49
Bangladesh	12.0%	17.1%	14.7%	12.2%	11.2%	10.2%	8.4%	7.0%
Burkina Faso	38.1%	34.7%	44.8%	45.4%	40.5%	34.4%	28.6%	19.2%
Cambodia	12.5%	14.9%	13.6%	11.4%	9.7%	12.9%	13.9%	14.5%
Comoros	32.3%	47.4%	42.9%	30.7%	34.6%	31.8%	20.0%	16.4%
DR Congo	27.7%	30.8%	29.2%	30.4%	29.1%	27.8%	25.0%	12.4%
Egypt	11.6%	7.0%	9.2%	10.8%	11.4%	11.9%	14.0%	14.8%
Ethiopia	24.1%	18.4%	23.1%	22.3%	24.8%	28.8%	29.8%	19.5%
Gambia	24.9%	16.9%	23.5%	28.2%	25.6%	26.4%	27.8%	18.9%
Ghana	29.9%	50.7%	34.0%	30.8%	29.5%	35.3%	28.5%	14.2%
Guinea	23.7%	23.4%	26.8%	21.9%	26.6%	23.6%	28.1%	12.4%
Haiti	35.3%	56.6%	41.1%	34.9%	32.1%	35.8%	34.7%	23.8%
Indonesia	11.4%	6.7%	8.3%	8.9%	9.7%	11.2%	14.9%	16.2%
Kenya	17.5%	23.0%	18.9%	14.9%	15.9%	18.5%	21.9%	16.8%
Kyrgyzstan	18.0%	9.7%	22.9%	20.2%	18.6%	18.4%	16.5%	11.0%
Lesotho	18.4%	28.9%	21.5%	17.4%	16.3%	15.1%	19.8%	14.1%
Liberia	31.1%	46.6%	38.6%	33.5%	30.2%	31.4%	27.2%	11.4%
Mali	26.0%	23.3%	24.5%	26.0%	30.5%	27.7%	27.2%	16.8%
Nepal	25.2%	47.7%	39.0%	31.4%	21.8%	17.8%	14.2%	10.5%
Niger	16.0%	13.1%	18.4%	16.4%	16.2%	13.6%	18.9%	14.1%
Nigeria	16.1%	13.1%	16.6%	16.8%	17.1%	17.6%	16.8%	11.5%
Pakistan	20.1%	14.9%	20.6%	22.1%	21.4%	21.2%	19.7%	14.3%
Philippines	17.5%	28.7%	22.2%	18.2%	14.7%	16.1%	16.8%	16.6%
Senegal	25.1%	20.7%	25.9%	24.0%	27.9%	22.8%	29.3%	21.9%
Sierra Leone	25.0%	30.8%	25.9%	25.3%	23.3%	28.4%	24.1%	17.3%
Tajikistan	22.9%	12.8%	28.2%	28.3%	26.0%	20.1%	18.1%	12.3%
Togo	33.6%	41.6%	39.5%	35.3%	35.1%	35.7%	28.3%	18.7%
Uganda	34.7%	37.7%	32.8%	33.9%	37.5%	39.0%	31.1%	28.8%
Yemen	28.7%	29.2%	29.2%	29.9%	28.6%	31.6%	25.8%	22.4%
Zambia	21.1%	25.1%	22.0%	18.9%	20.8%	23.2%	23.0%	16.2%
Zimbabwe	10.4%	11.0%	9.5%	8.4%	9.0%	10.4%	14.0%	16.9%

Country	Residence		Household wealth index				
	Urban	Rural	Lowest	Second	Middle	Fourth	Highest
Bangladesh	9.6%	12.9%	13.2%	10.8%	11.4%	13.2%	11.3%
Burkina Faso	30.7%	39.4%	41.0%	43.2%	40.5%	31.3%	31.9%
Cambodia	10.8%	12.8%	17.0%	11.2%	13.5%	10.8%	10.1%
Comoros	24.3%	36.2%	42.1%	34.1%	33.6%	28.6%	25.0%
DR Congo	28.4%	27.3%	28.4%	26.8%	28.3%	28.7%	26.1%
Egypt	9.5%	13.1%	15.3%	12.7%	11.7%	10.6%	8.2%
Ethiopia	15.5%	25.9%	27.0%	26.8%	27.6%	23.8%	14.2%
Gambia	24.4%	25.4%	24.3%	26.7%	25.2%	24.8%	23.5%
Ghana	28.5%	31.4%	31.2%	32.1%	32.6%	30.1%	24.8%
Guinea	25.7%	22.9%	21.6%	21.3%	21.9%	27.1%	27.4%
Haiti	34.1%	36.3%	35.8%	40.5%	34.9%	35.6%	31.0%
Indonesia	11.8%	10.9%	13.5%	10.2%	10.3%	10.9%	12.3%
Kenya	13.4%	20.2%	28.7%	23.2%	17.1%	12.0%	11.0%
Kyrgyzstan	16.3%	18.8%	15.7%	17.8%	19.8%	21.8%	14.5%
Lesotho	13.7%	20.7%	24.5%	23.1%	17.3%	17.0%	13.5%
Liberia	29.5%	33.0%	35.1%	32.1%	31.9%	29.2%	26.6%
Mali	23.9%	26.5%	25.1%	25.5%	28.3%	27.6%	23.4%
Nepal	22.9%	25.7%	27.2%	25.1%	24.9%	24.9%	24.3%
Niger	17.3%	15.8%	17.7%	15.4%	15.2%	16.0%	15.9%
Nigeria	14.9%	16.8%	14.3%	15.4%	20.0%	18.7%	13.0%
Pakistan	17.1%	21.6%	24.5%	23.2%	19.0%	18.8%	15.3%
Philippines	16.7%	18.2%	21.3%	16.7%	15.5%	16.1%	17.9%
Senegal	22.1%	27.7%	28.9%	27.9%	23.3%	23.0%	23.4%
Sierra Leone	26.1%	24.6%	23.8%	26.2%	25.3%	24.7%	25.0%
Tajikistan	21.0%	23.4%	26.8%	21.7%	22.4%	24.2%	19.5%
Togo	33.0%	34.0%	34.8%	34.0%	33.5%	35.8%	30.1%
Uganda	32.8%	35.2%	42.5%	39.0%	31.1%	34.0%	27.5%
Yemen	20.3%	32.7%	n/a	n/a	n/a	n/a	n/a
Zambia	16.7%	24.1%	25.2%	25.7%	23.3%	19.1%	12.6%
Zimbabwe	9.5%	10.8%	13.9%	11.5%	9.2%	8.8%	9.2%

UNMET NEED FOR A MODERN METHOD MARRIED OR IN-UNION WOMEN (CONTINUED)

DISAGGREGATED FROM RECENT SURVEY

Country	Highest educational level				
	No education	Primary	Primary incomplete	Primary complete	Secondary or Middle/JSS
Bangladesh	10.3%		11.4%	11.5%	
Burkina Faso	39.4%	33.5%			33.8%
Cambodia	13.7%	13.1%			10.9%
Comoros	34.7%	33.3%			
DR Congo	26.9%	28.9%			
Egypt	14.2%	13.7%			
Ethiopia	26.9%	21.6%			17.8%
Gambia	24.7%	27.5%			
Ghana	17.4%	26.8%			22.8%
Guinea	22.5%	28.5%			
Haiti	34.5%	38.6%			
Indonesia	13.4%	12.3%			
Kenya	27.9%		23.4%	15.3%	
Kyrgyzstan					18.3%
Lesotho	31.8%		20.0%	23.5%	15.7%
Liberia	28.7%	34.5%			
Mali	26.3%	26.5%			
Nepal	19.0%	27.8%			31.1%
Niger	15.9%	17.5%			
Nigeria	14.9%	19.3%			
Pakistan	21.9%	19.1%			
Philippines	23.5%	17.9%			
Senegal	27.7%	21.7%			
Sierra Leone	24.5%	25.4%			
Tajikistan	29.9%	26.5%			
Togo	34.7%	33.7%			
Uganda	43.7%	36.2%			25.3%
Yemen	33.0%	25.4%			21.8%
Zambia	23.9%	23.0%			
Zimbabwe	21.4%	12.5%			9.4%

Country	Highest educational level (continued)				Survey
	Secondary incomplete	Secondary complete or higher	Higher	Secondary or higher	
Bangladesh	13.7%	11.9%			pDHS 2014
Burkina Faso			20.8%		PMA2020 2014 R1
Cambodia					2014 pDHS
Comoros				29.0%	2012 DHS
DR Congo				26.8%	2013-14 DHS
Egypt				9.8%	2014 DHS
Ethiopia			9.2%		2014 PMA2020 R2
Gambia					2013 DHS
Ghana				23.7%	2014 pDHS
Guinea				27.3%	2012 DHS
Haiti				32.6%	2012 DHS
Indonesia				10.6%	2012 DHS
Kenya				12.4%	2014 pDHS
Kyrgyzstan			15.4%		2012 DHS
Lesotho			12.5%		2014 pDHS
Liberia				31.6%	2013 DHS
Mali				22.5%	2012-13 DHS
Nepal			32.4%		MICS 2014
Niger				15.7%	2012 DHS
Nigeria				16.0%	2013 DHS
Pakistan				16.9%	2012-13 DHS
Philippines				17.3%	2013 DHS
Senegal				21.9%	2014 DHS
Sierra Leone				27.2%	2013 DHS
Tajikistan				22.6%	2012 DHS
Togo				31.7%	2013 DHS
Uganda			23.0%		PMA2020 2014 R1
Yemen			15.3%		pDHS 2013
Zambia				17.1%	2014 DHS
Zimbabwe			6.5%		MICS 2014

DEMAND SATISFIED FOR A MODERN METHOD, MARRIED OR IN-UNION WOMEN

DISAGGREGATED FROM RECENT SURVEY

Country	Total	Age in 5 year categories						
		15-19	20-24	25-29	30-34	35-39	40-44	45-49
Bangladesh	83.9%	74.9%	80.1%	84.7%	86.8%	87.7%	87.9%	84.4%
Burkina Faso	32.0%	23.3%	27.5%	31.3%	36.9%	33.6%	40.1%	34.6%
Cambodia	81.9%	66.0%	77.8%	84.4%	87.5%	83.9%	81.1%	68.3%
Comoros	37.4%	29.3%	30.8%	41.0%	36.8%	39.3%	50.1%	33.9%
DR Congo	42.5%	28.9%	39.9%	38.5%	46.3%	46.1%	47.2%	53.1%
Egypt	82.3%	69.4%	79.4%	82.3%	82.8%	85.2%	85.0%	77.2%
Ethiopia	59.2%	62.7%	62.2%	63.8%	61.2%	54.3%	48.7%	42.0%
Gambia	26.5%	16.4%	21.3%	23.0%	31.1%	31.3%	28.6%	29.0%
Ghana	47.2%	26.8%	46.5%	50.4%	48.3%	42.6%	47.0%	56.4%
Guinea	19.1%	10.6%	15.6%	24.2%	21.1%	21.9%	15.8%	19.0%
Haiti	49.4%	31.2%	46.7%	53.1%	55.0%	49.7%	48.6%	45.6%
Indonesia	84.5%	87.8%	88.0%	87.7%	87.1%	85.9%	81.4%	73.8%
Kenya	76.8%	62.5%	73.8%	80.3%	80.0%	77.3%	73.0%	72.6%
Kyrgyzstan	66.8%	34.8%	48.7%	60.5%	72.7%	71.9%	73.8%	73.4%
Lesotho	76.5%	55.0%	72.9%	79.0%	80.4%	82.5%	75.0%	73.9%
Liberia	39.4%	22.1%	37.4%	42.6%	43.0%	40.2%	38.1%	40.2%
Mali	28.5%	22.4%	29.6%	27.7%	28.6%	30.9%	29.6%	26.3%
Nepal	66.3%	28.9%	43.2%	58.3%	72.3%	78.3%	82.0%	83.8%
Niger	46.5%	34.9%	44.4%	52.2%	51.0%	54.7%	33.8%	21.6%
Nigeria	48.5%	13.9%	36.6%	45.6%	52.7%	54.4%	56.3%	53.4%
Pakistan	63.8%	41.0%	50.9%	58.5%	66.1%	69.3%	69.2%	70.7%
Philippines	75.9%	56.0%	69.7%	76.2%	80.9%	79.2%	77.6%	70.5%
Senegal	47.4%	37.5%	35.0%	52.6%	49.3%	56.9%	41.4%	44.6%
Sierra Leone	40.0%	20.1%	35.4%	38.5%	47.3%	40.9%	43.0%	42.5%
Tajikistan	55.0%	15.6%	26.1%	48.4%	61.1%	69.8%	67.6%	61.2%
Togo	37.1%	16.7%	30.6%	38.1%	37.9%	37.4%	45.0%	41.5%
Uganda	44.0%	24.4%	43.4%	48.3%	41.8%	45.6%	50.7%	41.5%
Yemen	53.8%	31.2%	46.5%	54.9%	58.4%	56.2%	59.1%	56.6%
Zambia	69.9%	59.9%	68.0%	73.5%	71.6%	69.2%	69.3%	67.0%
Zimbabwe	86.6%	81.6%	87.3%	89.6%	89.0%	87.3%	82.5%	74.2%

Country	Residence		Household wealth index				
	Urban	Rural	Lowest	Second	Middle	Fourth	Highest
Bangladesh	87.3%	82.6%	82.6%	85.3%	84.8%	82.0%	84.8%
Burkina Faso			25.2%	24.8%	29.1%	39.8%	46.6%
Cambodia	84.7%	81.4%	75.6%	83.2%	79.9%	84.2%	86.0%
Comoros	54.9%	28.4%	23.5%	33.5%	36.2%	45.3%	47.6%
DR Congo	52.2%	36.1%	31.1%	38.1%	37.2%	43.4%	58.1%
Egypt	83.8%	81.4%	78.4%	78.8%	84.3%	84.3%	84.8%
Ethiopia			49.1%	49.0%	55.5%	62.9%	77.9%
Gambia	34.8%	16.4%	16.1%	18.0%	18.6%	32.8%	41.2%
Ghana	48.0%	46.3%	41.6%	45.8%	44.6%	48.9%	53.5%
Guinea	25.3%	16.0%	12.2%	18.7%	17.5%	18.4%	27.2%
Haiti	51.0%	48.2%	47.0%	43.7%	51.7%	51.6%	51.6%
Indonesia	84.0%	84.9%	80.6%	86.3%	86.1%	85.3%	83.3%
Kenya	82.4%	73.2%	52.0%	71.5%	78.7%	84.7%	85.5%
Kyrgyzstan	70.5%	65.1%	70.6%	67.5%	63.8%	59.8%	73.4%
Lesotho	82.7%	73.6%	67.3%	71.0%	78.3%	78.3%	83.0%
Liberia	44.0%	33.7%	27.8%	34.7%	40.4%	47.3%	46.6%
Mali	48.8%	21.1%	12.1%	17.3%	17.5%	33.0%	50.6%
Nepal	69.5%	65.6%	62.8%	65.9%	67.4%	67.3%	67.5%
Niger	62.6%	41.7%	35.8%	36.3%	39.3%	48.9%	61.9%
Nigeria	64.2%	33.6%	10.4%	24.9%	39.8%	55.2%	73.9%
Pakistan	72.4%	58.8%	45.9%	56.1%	66.8%	68.8%	75.0%
Philippines	77.2%	74.7%	70.1%	77.7%	79.3%	78.0%	73.7%
Senegal	59.1%	34.6%	29.2%	34.4%	46.0%	57.6%	58.0%
Sierra Leone	50.4%	34.6%	34.4%	31.6%	33.6%	45.3%	53.0%
Tajikistan	60.0%	53.3%	48.2%	53.1%	52.9%	54.3%	64.8%
Togo	40.0%	35.3%	32.7%	35.7%	36.4%	35.1%	44.9%
Uganda			27.0%	36.0%	46.9%	48.0%	58.6%
Yemen	70.1%	45.2%	n/a	n/a	n/a	n/a	n/a
Zambia	77.2%	64.5%	60.5%	62.8%	67.5%	73.3%	83.1%
Zimbabwe	88.1%	85.9%	81.9%	84.8%	87.7%	88.9%	88.5%

DEMAND SATISFIED FOR A MODERN METHOD, MARRIED OR IN-UNION WOMEN (CONTINUED)

DISAGGREGATED FROM RECENT SURVEY

Country	Highest educational level				
	No education	Primary	Primary incomplete	Primary complete	Secondary or Middle/JSS
Bangladesh	85.7%		84.9%	84.4%	
Burkina Faso	28.1%	42.4%			49.4%
Cambodia	79.2%	81.1%			84.3%
Comoros	27.0%	36.5%			
DR Congo	29.2%	35.1%			
Egypt	81.0%	81.4%			
Ethiopia	52.7%	63.9%			74.5%
Gambia	19.5%	21.8%			
Ghana	38.8%	47.5%			47.4%
Guinea	17.2%	21.1%			
Haiti	46.3%	47.2%			
Indonesia	76.5%	83.4%			
Kenya	40.5%		69.8%	80.8%	
Kyrgyzstan					66.5%
Lesotho	54.5%		72.5%	71.2%	80.2%
Liberia	34.7%	36.3%			
Mali	23.6%	33.7%			
Nepal	74.5%	64.7%			58.0%
Niger	43.0%	53.8%			
Nigeria	15.2%	50.8%			
Pakistan	58.0%	68.1%			
Philippines	55.5%	74.7%			
Senegal	36.3%	59.0%			
Sierra Leone	36.8%	43.1%			
Tajikistan	44.4%	41.5%			
Togo	29.2%	39.8%			
Uganda	23.8%	41.9%			60.9%
Yemen	45.9%	59.7%			66.1%
Zambia	61.0%	66.9%			
Zimbabwe	69.2%	83.4%			87.9%

Country	Highest educational level (continued)				Survey
	Secondary incomplete	Secondary complete or higher	Higher	Secondary or higher	
Bangladesh	82.0%	84.1%			pDHS 2014
Burkina Faso			66.2%		PMA2020 2014 R1
Cambodia					2014 pDHS
Comoros				48.0%	2012 DHS
DR Congo				53.0%	2013-14 DHS
Egypt				82.9%	2014 DHS
Ethiopia				82.7%	2014 PMA2020 R2
Gambia					2013 DHS
Ghana				58.8%	2014 pDHS
Guinea				27.8%	2012 DHS
Haiti				53.3%	2012 DHS
Indonesia				85.6%	2012 DHS
Kenya				84.1%	2014 pDHS
Kyrgyzstan			71.0%		2012 DHS
Lesotho			84.6%		2014 pDHS
Liberia				47.5%	2013 DHS
Mali				55.0%	2012-13 DHS
Nepal			55.9%		MICS 2014
Niger				67.3%	2012 DHS
Nigeria				65.9%	2013 DHS
Pakistan				71.8%	2012-13 DHS
Philippines				76.5%	2013 DHS
Senegal				62.9%	2014 DHS
Sierra Leone				48.8%	2013 DHS
Tajikistan				55.7%	2012 DHS
Togo				44.8%	2013 DHS
Uganda			63.7%		PMA2020 2014 R1
Yemen			76.7%		pDHS 2013
Zambia				76.8%	2014 DHS
Zimbabwe			92.0%		MICS 2014

COUNTRY INFORMATION

	Sources for model-based estimates (Indicators 1-8)		
	Most recent survey used in FPET	Service statistics included in FPET	Source % pregnancies that are unintended (used for Indicator 5)
Afghanistan	MICS 2010-11		Regional Average
Bangladesh	pDHS 2014		2011 DHS
Benin	MICS 2014		2011-12 DHS
Bhutan	MICS 2010		Regional Average
Bolivia	DHS 2008		2008 DHS
Burkina Faso	PMA2020 R1 2014		2010 DHS
Burundi	PMS 2012	Yes	2010 DHS
Cambodia	pDHS 2014		2010 DHS
Cameroon	DHS 2011		2011 DHS
CAR	MICS 2010		1994-95 DHS
Chad	MICS 2010		2004 DHS
Comoros	DHS 2012		2012 DHS
Congo	DHS 2011-12		2011-12 DHS
Côte d'Ivoire	DHS 2011-12	Yes	2011-12 DHS
Djibouti	PAPFAM 2012		Regional Average
DPR Korea	RHS 2010		Regional Average
DR Congo	DHS 2013-14		2013-14 DHS
Egypt	DHS 2014		2008 DHS
Eritrea	DHS 2002		2002 DHS
Ethiopia	PMA2020 R2 2014		PMA2020 R2
Gambia	DHS 2013		Regional Average
Ghana	PMA2020 R3, pDHS 2014		2008 DHS
Guinea	DHS 2012		2012 DHS
Guinea-Bissau	MICS 2014		Regional Average
Haiti	DHS 2012		2012 DHS
Honduras	DHS 2011-12		2011-12 DHS
India	DLHS/AHL pooled 2012-13		2005-06 DHS
Indonesia	Susenas 2014		2012 DHS
Iraq	MICS 2011		Regional Average
Kenya	PMA2020 R2/pDHS 2014		2008-09 DHS
Kyrgyzstan	MICS 2014		2012 DHS
Lao PDR	DHS 2011-12		Regional Average
Lesotho	pDHS 2014		2009 DHS
Liberia	DHS 2013		2013 DHS
Madagascar	DHS 2008-9		2008-09 DHS
Malawi	MES 2013-14		2010 DHS

	Sources for model-based estimates (Indicators 1-8)		
	Most recent survey used in FPET	Service statistics included in FPET	Source % pregnancies that are unintended (used for Indicator 5)
Mali	DHS 2012-13		2012-13 DHS
Mauritania	MICS 2011		2000-01 DHS
Mongolia	SISS 2013		Regional Average
Mozambique	DHS 2011	Yes	2011 DHS
Myanmar	MICS 2009-10		Regional Average
Nepal	MICS 2014		2011 DHS
Nicaragua	National 2011-12		2006-07 RHS
Niger	DHS 2012		2012 DHS
Nigeria	DHS 2013	Yes	2013 DHS
Pakistan	DHS 2012-13		2012-13 DHS
Papua New Guinea	National 2006		Regional Average
Philippines	DHS 2013		2013 DHS
Rwanda	DHS 2010		2010 DHS
Sao Tome and Principe	DHS 2009-9		2008-09 DHS
Senegal	DHS 2014		2010-11 DHS
Sierra Leone	DHS 2013		2013 DHS
Solomon Islands	DHS 2006-7		Regional Average
Somalia	MICS 2006		Regional Average
South Africa	DHS 2003	Yes	1998 DHS
South Sudan	MICS 2010		Regional Average
Sri Lanka	DHS 2006-7		Regional Average
State of Palestine	MICS 2014		Regional Average
Sudan	MICS 2010		Regional Average
Tajikistan	DHS 2012		2012 DHS
Tanzania	DHS 2010		2010 DHS
Timor-Leste	DHS 2009-10		2009-10 DHS
Togo	DHS 2013-14		2013/14 DHS
Uganda	PMA2020 R1 2014		2011 DHS
Uzbekistan	MICS 2006		1996 DHS
Vietnam	MICS 2013-14		2002 DHS
Western Sahara			Regional Average
Yemen	pDHS 2013		1997 DHS
Zambia	DHS 2013-14		2013/14 DHS
Zimbabwe	MICS 2014		2010-11 DHS

Appendix

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Acronyms

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Acronyms

CPR	Contraceptive prevalence rate
CYP	Couple-years of protection
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
EC	Emergency contraception
FP	Family planning
FPET	Family Planning Estimation Tool
FPE	Family Planning Effort score or index
IUD	Intra-uterine device
LAM	Lactational amenorrhea method
LAPM	Long-acting permanent method of contraception
LARC	Long-acting reversible contraceptives
M&E	Monitoring and evaluation
mCPR	Modern contraceptive prevalence rate
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MII	Method Information Index
NCIFP	National Composite Index on Family Planning
PME WG	Performance Monitoring & Evidence Working Group
PMA2020	Performance Monitoring & Accountability 2020 (The Bill & Melinda Gates Institute for Population and Reproductive Health, Bloomberg School of Public Health)
RHS	Reproductive Health Survey
RHSC	Reproductive Health Supplies Coalition
SDM	Standard Days Method
SDP	Service delivery point
STM	Short-term method of contraception
LMIS	Logistics Management Information System
SHA	System of Health Accounts (WHO)

FP2020 Focus Countries, by region

CENTRAL AFRICA

Cameroon
Central African Republic
Chad
Congo
DR Congo
Sao Tome and Principe

EASTERN AND CENTRAL ASIA

DPR Korea
Kyrgyzstan
Mongolia
Tajikistan
Timor-Leste
Uzbekistan

EASTERN AND SOUTHERN AFRICA

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

LATIN AMERICA AND CARIBBEAN

Bolivia
Haiti
Honduras
Nicaragua

MIDDLE EAST AND NORTHERN AFRICA

Egypt
Iraq
South Sudan
State of Palestine
Sudan
Western Sahara
Yemen

SOUTH ASIA

Afghanistan
Bangladesh
Bhutan
India
Nepal
Pakistan
Sri Lanka

SOUTHEAST ASIA AND OCEANIA

Cambodia
Indonesia
Lao PDR
Myanmar
Papua New Guinea
Philippines
Solomon Islands
Vietnam

WESTERN AFRICA

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

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World Health Organization

Acknowledgements

FP2020 Commitment to Action Measurement Annex is a product of the collaborative effort of many individuals and organizations committed to improving and expanding family planning programs around the world.

We are profoundly grateful for the leadership and expertise provided by the co-leads of the Performance Monitoring & Evidence Working Group (PME WG), and for the insights generously shared by PME WG members, without whom this report would not be possible:

Co-lead: Dr. Zeba Sathar

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International Planned Parenthood Federation

Dr. Roy Tjiong

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This report was written by **Michelle Weinberger**, **Priya Emmart**, and **Shipra Srihari** (Track20), and **Nina Miller** and **Erika Studt** (FP2020 Secretariat). The authors wish to thank **Claire Manibog** (www.clairemanibog.com) for her great skill and artistry in data visualization and information design, and **Vanessa Saba** (www.vanessasaba.net) for contributing to the design of the report.

As ever, we are deeply grateful for the expertise, wisdom, and patience of Track20's director, **Emily Sonneveldt**, and for the efforts of the entire Track20 team, as well as the M&E officers who conducted country

data consensus workshops in 2015. We thank the reviewers from FP2020's Core Conveners – DFID, Bill & Melinda Gates Foundation, UNFPA, and USAID – for providing feedback to improve this product.

We thank **Selamawit Desta** for providing valuable information about PMA2020's efforts, and the many PMA2020 resident enumerators working to improve the timeliness, quality, and accessibility of family planning data in their countries. We are grateful to **John Stover** of Avenir Health for sharing his innovative work on tracking family expenditures in the 69 FP2020 focus countries.



FP2020

www.familyplanning2020.org

Family Planning 2020 (FP2020) is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multi-lateral 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 Secretariat, and hosted by the United Nations Foundation, FP2020 is based on the principle that all women, no matter where they live, should have access to lifesaving contraceptives. FP2020 is in support of the UN Secretary-General's global effort for women and children's health, Every Woman Every Child



United Nations Foundation

www.unfoundation.org

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 US public charity by entrepreneur and philanthropist Ted Turner, and now is supported by global corporations, foundations, governments, and individuals.

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