FP2030 Measurement Framework

Contents

FP2030 Measurement Framework 1

Introduction 3

FP2030 Vision 3

Vision-level Results Statement 3

Current Results Framework 4

2030 Results Framework (in progress) 4

Geographic Scope of Reporting 5

Reporting Process 7

Indicators 8

Modern contraceptive prevalence (MCP) 8

Reporting Note: highlighting traditional contraceptive prevalence (TCP) 9

Percentage of women estimated to have an unmet need for modern methods of contraception 10

Percentage of women estimated to have their demand for family planning met with a modern method of contraception 11

Total number of users of modern contraceptive methods 12

Contraceptive Method Mix 13

Contraceptive Discontinuation Rates and Method Switching 14

Contraceptive method switching 14

Method Information Index Plus 16

Percentage of women who received family planning information during a contact with a health service provider 17

Percentage of facilities stocked out, by method offered, on the day of assessment 18

Percentage of primary SDPs that have at least 3 modern methods of contraception available on day of assessment 19

Percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment 20

Couple Years of Protection (CYPs) 21

Percent of current modern contraceptive users who last obtained their family planning method from each source 22

Annual expenditure on family planning from government domestic budget 24

Adolescent Birth Rate and Supplemental Indicators on Adolescents and Youth 25

Number of unintended pregnancies 27

Percent of births that are unintended 28

Number of unintended pregnancies averted due to modern contraceptive use 30

Number of unsafe abortions averted due to modern contraceptive use 31

Number of maternal deaths averted due to modern contraceptive use 32

Percentage of women who decided to use family planning alone or jointly with their husbands/partners 33

Communicating Uncertainty in Estimates 34

Recommendations for Country-Specific Measurement 35

Countries should select additional indicators specific to their context that will help them monitor progress towards their FP2030 commitments and the FP2030 vision. 35

Areas of Future Work 36

1. Indicators to measure Social and Behavioral Change efforts [Still under review] 37

2. Identifying measures at supportive environment level for policy, financing, and accountability [Still under review] 37

3. Better understanding of fertility intentions and desire to use contraception 37

[Still under review] 37

4. Improving Measurement of Rights and Empowerment Principles for Family Planning, Including but not limited to: 37

a) Improving monitoring of quality of care, including facility measures and client-perspectives of quality. [Still under review] 37

b) Improving measurement of empowerment, agency and autonomy [Still under review] 37

4c. Improving measurement of equity in family planning 38

Data Dependencies 40

Sources for Data/Indicators 40

Introduction

As part of FP2020's efforts to establish a foundation for the next phase of the partnership, the Performance Monitoring & Evidence (PME) Working Group is developing a proposed measurement framework to track country progress from 2021 to 2030 and report on progress toward the overall FP2030 vision.

This framework is grounded by a *results statement* that draws from the overall *vision* for the next phase of the partnership. The results statement articulates three levels of measurement required to effectively monitor progress toward reaching the vision.

The next measurement framework builds on FP2020's current results framework and core indicators, which countries use to monitor aspects of the enabling environment for family planning, the process of delivering services, the output of those services, expected outcomes, and the impact of contraceptive use. The annual process of countries analyzing their family planning data, holding stakeholder consultations on monitoring progress, and reporting on core indicators has led to increased capacity for data analysis, more regular conversations on progress, greater transparency on family planning measures, and more opportunities for the use of data for decision making. Based on these successes, the PME Working Group has aimed for a degree of consistency with the existing framework, while also proposing some changes and areas for continued work in the next partnership's measurement agenda.

FP2030 Vision

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

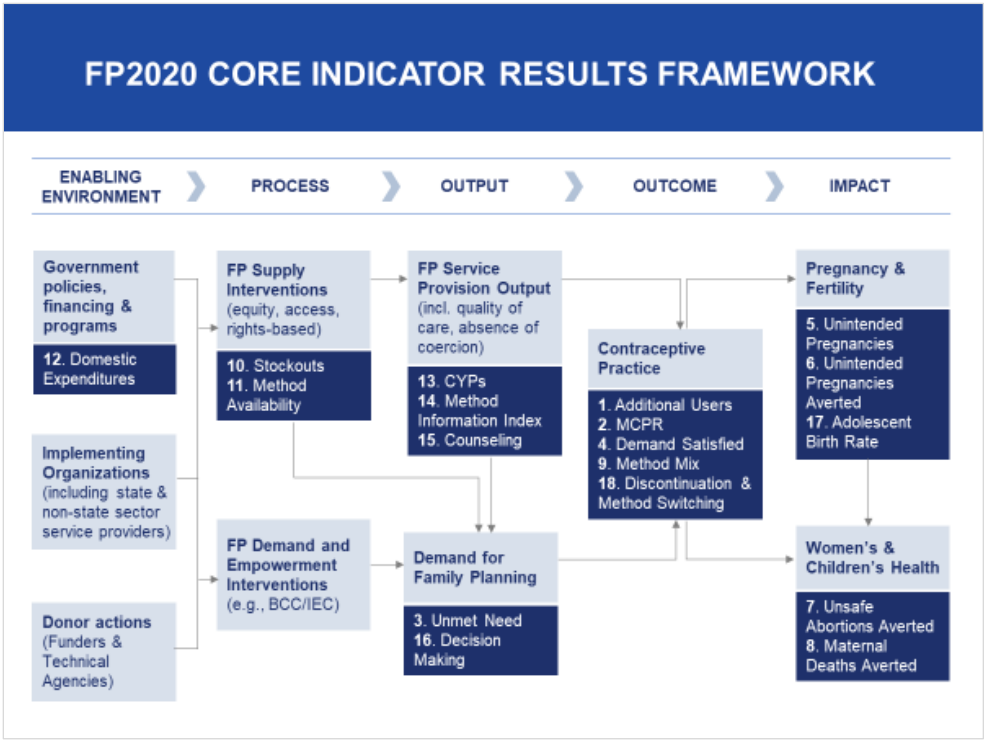
Vision-level Results Statement

Voluntary modern contraceptive use by everyone who wants it, achieved through individuals' informed choice and agency, responsive and sustainable systems providing a range of contraceptives, and a supportive policy environment.

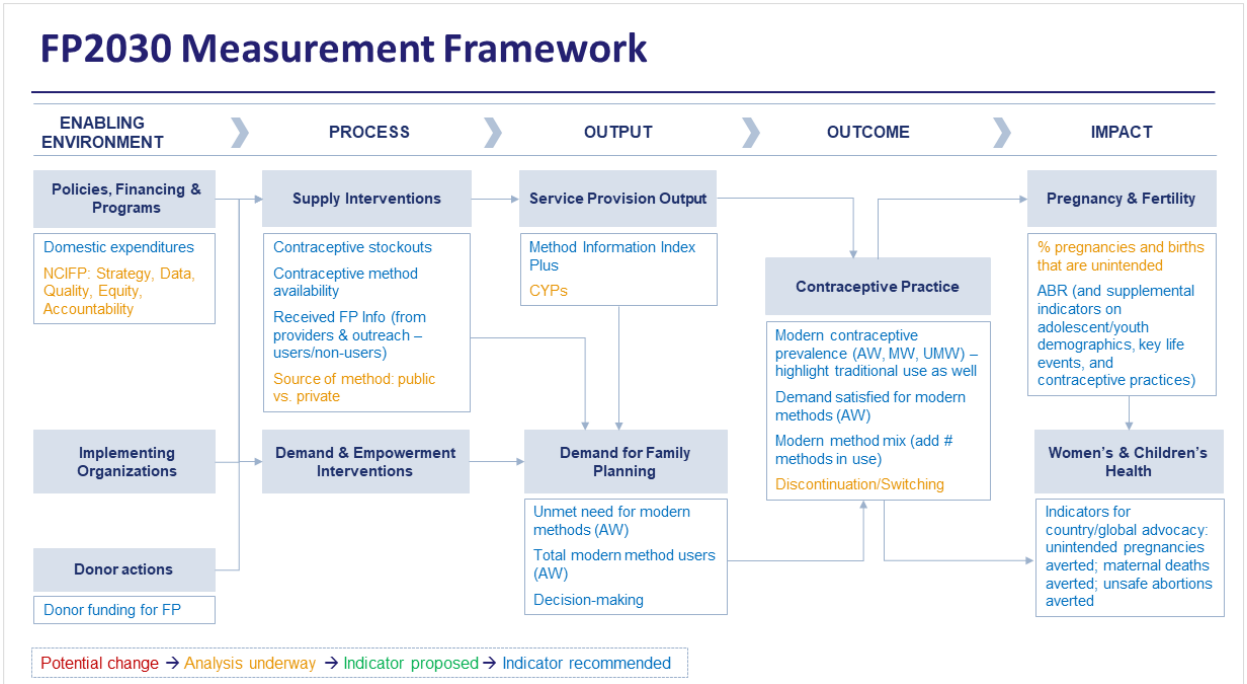
This results statement highlights aspects of progress toward the vision that will be monitored through the FP2030 measurement framework, including whether:

- **Individuals** have information about methods and side effects for a range of contraceptive choices and the ability to exercise their right to determine whether, when and how many children they want to have.
- **Responsive health systems** equitably and sustainably provide high quality services and supplies for a range of contraceptive methods.
- Countries and partners have **supportive** policy, financing, and accountability **environments** that enable voluntary contraceptive use.

Current Results Framework



2030 Results Framework (in progress)



Geographic Scope of Reporting

From 2012-2020, FP2020 reported Core Indicator estimates for the 69 poorest countries in the world, based on Gross National Income (GNI) per capita in 2010. As we transition to FP2030, the partnership will no longer only focus solely on the FP2020 69 focus countries, but rather will be open for any country to make a commitment. As a starting point for tracking family planning progress, FP2030 will annually report on a set of core indicators for all Low-Income and Lower-Middle Income countries using the World Bank's GNI per capita classifications as of 2018.

There is significant overlap between the FP2020 69 focus countries and the Low-Income and Lower-Middle Income countries. In the table below, non-FP2020 countries are marked in red.

LICs	**LMICs**	
Afghanistan	Angola	Myanmar
Burkina Faso	Algeria	Nepal
Burundi	Bangladesh	Nicaragua
CAR	Benin	Nigeria
Chad	Bhutan	Pakistan
DRC	Bolivia	Papua New Guinea
Eritrea	Cabo Verde	Philippines
Ethiopia	Cambodia	Sao Tome and Principe
Gambia	Cameroon	Senegal
Guinea	Comoros	Solomon Islands
Guinea-Bissau	Congo, Republic of	Sri Lanka
Haiti	Cote d'Ivoire	Tanzania
Korea	Djibouti	Timor-Leste
Liberia	Egypt	Tunisia
Madagascar	El Salvador	Ukraine
Malawi	Eswatini	Uzbekistan
Mali	Ghana	Vanuatu
Mozambique	Honduras	Viet Nam
Niger	India	West Bank and Gaza

Rwanda	Kenya	Western Sahara
Sierra Leone	Kiribati	Zambia
Somalia	Kyrgyz Republic	Zimbabwe
South Sudan	Lao PDR	
Sudan	Lesotho	
Syria	Mauritania	
Tajikistan	Micronesia	
Togo	Moldova	
Uganda	Mongolia	
Yemen	Morocco	

Indonesia, which was among the original 69 FP2020 focus countries and a commitment maker is in the Upper-Middle Income group. South Africa made a commitment at the 2012 London Summit but was not within the FP2020 69.

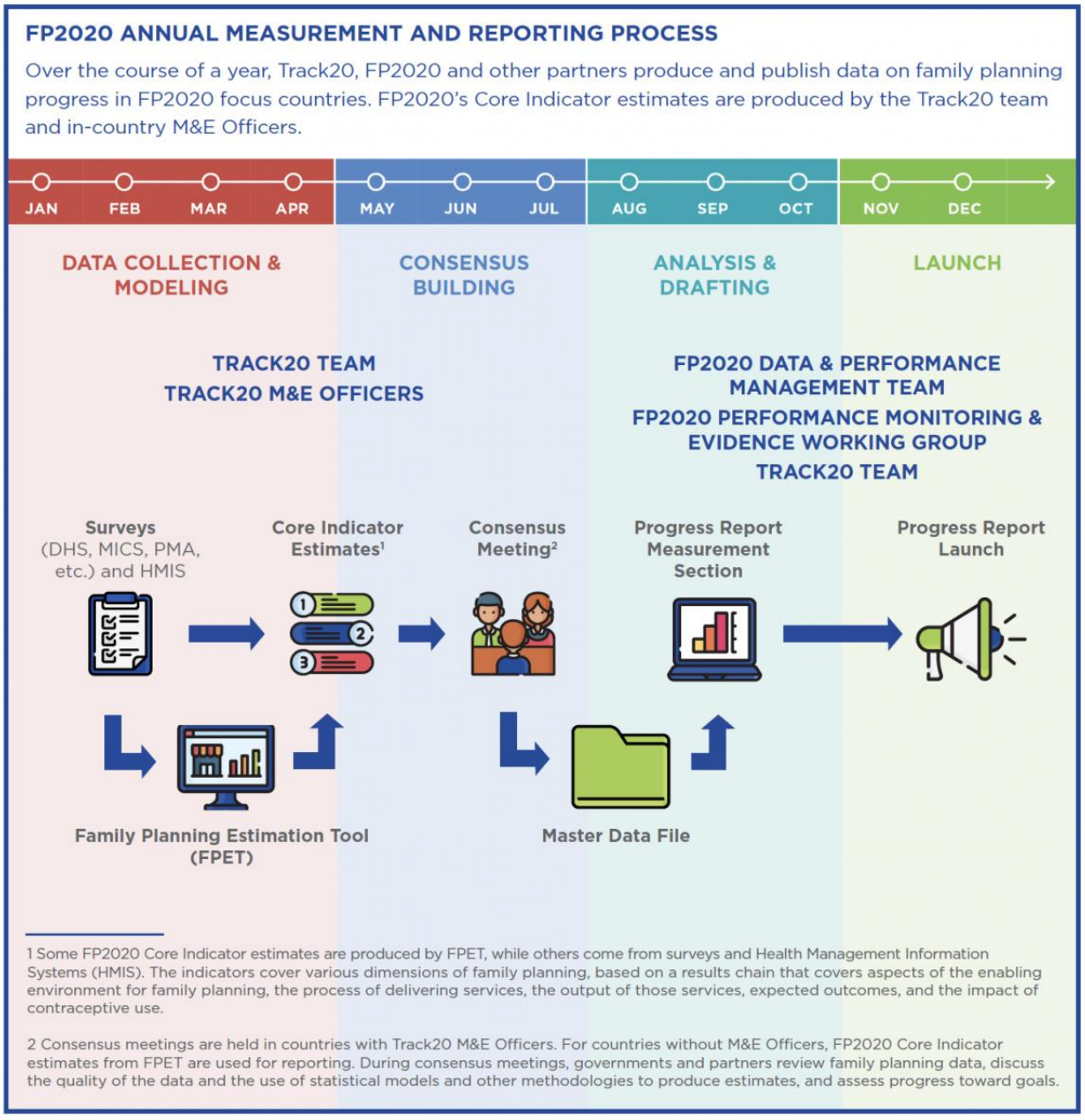
Among the Low Income and Lower-Middle Income Countries there may be a few countries, particularly small-island and fragile states, for which very little data is available and regular reporting of family planning data may be challenging.

As Upper-Middle Income countries make FP2030 commitments the geographic scope of the progress report and the process for data review and reporting will be reassessed to determine how to include these additional countries. Furthermore, if the data sources and information systems for these countries does not align with the FP2030 measurement framework, future adaptations will be considered.

Reporting Process

While some changes will be made to indicators, the reporting process will remain the same. In FP2030 commitment-making countries, the government family planning program will convene in-country stakeholders to review the annual family planning data. These consensus meetings are critical for ensuring that the process remains country-driven, and that stakeholders dedicate time to review and understand the data, take stock of progress, and adjust their strategies as necessary.

This approach also makes transparent the data and methodologies that influence decision making in-country and internationally. Beyond these annual reviews, governments collaborate with Track20 throughout the year to identify weaknesses in their data systems and make changes or adopt tools that can help them better use their available data to actively assess progress.



Indicators

The results framework is comprised of the indicators presented below. Each indicator is defined, and its calculation is described, including any disaggregation. Data sources are also listed, along with frequency of data and any relevant notes.

Modern contraceptive prevalence (MCP)

Rationale: This indicator gives a sense of contraceptive coverage, or what proportion of the population of women of reproductive age is using a modern contraceptive method, the primary behavior of interest noted in the FP2030 results statement. Trends in MCP can indicate whether coverage is being maintained, expanded or contracting. However, because it is an aggregate measure at a particular point in time, it does not capture the underlying contraceptive dynamics of individuals starting, stopping, or continuing contraceptive use over time for various reasons.

Definition: The percentage of all women of reproductive age (women 15-49 years of age) who are using (or report their partner is using) a modern contraceptive method in a specific year at a particular point in time. The following are considered modern methods: female sterilization, male sterilization, Intrauterine Device (IUD), injectable, implants, pill, emergency contraception, male condom, female condom, other vaginal methods (foam, jellies/spermicide, diaphragm) Standard Days Method (SDM), Lactational Amenorrhea Method (LAM).

Calculation: (# of women 15-49 using a modern contraceptive method / total # of women 15-49) x 100. This indicator is calculated using Track20's Family Planning Estimation Tool (which uses a Bayesian, hierarchical approach), and includes all available surveys in a country, such as historic and recent DHS, MICS, PMA and other national survey data. Based on these data, FPET produces estimates for MCP among all women, married women, and unmarried women.

Inclusion of routine data in FPET

Some countries that work with Track20 to produce their annual estimates for MCP have the option of including country-specific service statistics data in FPET. Incorporating recent routine data from health management information systems into FPET allows the model to produce estimates with recent data capturing any change in trends in contraceptive use, particularly when the most recent survey data are out of date. Countries with service statistics data (on commodities to clients, commodities distributed to facilities, users, or number of visits for contraceptives) that meet criteria related to reporting rates, consistency and quality can include this data in their FPET calculation.

Incorporating service statistics into FPET requires entry of at least three years of data so that a trend can be established. It is understood that there is inherent bias in service statistics data, so there is no expectation that values for Estimated Modern Use (EMU) from service statistics will be the same as the MCP values from surveys. In the FPET model, what is influential is the trend that service statistics data generate rather than the absolute value of the EMU from service statistics.

Disaggregation: The FPET estimates of unmet need will be disaggregated by married women and unmarried women. FPET does not provide disaggregated estimates by other characteristics. Disaggregated estimates for various demographic characteristics are available from the most recent survey and can be found for the DHS from Statcompiler, from country reports for MICS, and on PMA's Data Lab.

Data Source(s): Estimated using FPET with input data from surveys such as the DHS, MICS, PMA, RHS and other nationally representative surveys, and service statistics.

Data Frequency: Estimated annually

Reporting Note: highlighting traditional contraceptive prevalence (TCP)

For countries where TCP is 5% or higher, annual estimates of TCP will be reported.

Definition: The percentage of all women of reproductive age who are using (or whose partner is using) a traditional contraceptive method at a particular point in time. The following are considered traditional methods: rhythm (periodic abstinence), withdrawal, prolonged abstinence, breastfeeding, douching, and folk methods.

Calculation: (# of women 15-49 using a traditional contraceptive method / total # of women 15-49) x 100. This indicator is calculated using Track20's FPET tool, which includes a country's historic and recent DHS, MICS, PMA and other national survey data.

Percentage of women estimated to have an unmet need for modern methods of contraception

Rationale: This indicator estimates the amount by which modern contraceptive prevalence would increase if stated fertility preferences were fully realized using modern methods. It does not capture women's actual desire to use contraception, but rather is based on an algorithm that considers fertility preferences, risk of unintended pregnancy and use of less effective traditional methods of contraception. Unmet need along with MCP may be used as indicators for measuring the total potential demand for family planning at an aggregate or population level, since women who are estimated to have an unmet need have expressed a desire to space or limit births and are not using a modern contraceptive method.

Definition: The percentage of fecund women of reproductive age who want no more children or to postpone having the next child but are not using a contraceptive method. In addition, women who are currently using a traditional method of family planning and women who are pregnant with or postpartum amenorrheic after an unintended pregnancy are also added to the estimate of women who have an unmet need for modern contraception.

Calculation: FPET, as described for MCP, is used to estimate unmet need for a modern method. The actual calculation of unmet need in surveys is complex and more detail can be found in the Family Planning and Reproductive Health Indicators Database.

Disaggregation: The FPET estimates of unmet need will be disaggregated by married women and unmarried women. Disaggregated estimates for various demographic characteristics are available from the most recent survey and can be found for the DHS from Statcompiler, from country reports for MICS, and on PMA's Data Lab.

Data Sources(s): Estimated using FPET with input data from surveys such as the DHS, MICS, PMA, RHS and other nationally representative surveys, and service statistics. FPET does not provide disaggregated estimates for other characteristics. Disaggregated estimates for various demographic characteristics are available from the most recent survey and can be found for the DHS from Statcompiler, from country reports for MICS, and on PMA's Data Lab.

Data Frequency: Estimated annually

Percentage of women estimated to have their demand for family planning met with a modern method of contraception

Rationale: This is a progress indicator for Sustainable Development Goal Target 3.7. Similar to MCP, this indicator is an aggregate or population-based measure of contraceptive coverage, estimating how much of total potential demand for modern contraception is covered by current use. Like unmet need, the 'demand' does not reflect women's stated desire to use modern contraception, but rather is derived by combining modern contraceptive use and unmet need. Also, the term "satisfied" in the common name for this indicator, "demand satisfied" does not reflect women's satisfaction with their method; but rather could be interpreted as the total potential demand met by modern contraceptive use.

Definition: The percentage of women of reproductive age who want no more children or to postpone childbearing who are currently using (or their partners are using) a modern contraceptive method. The indicator assumes that all couples currently using modern contraception want to avoid a pregnancy and thus have their demand for modern contraception satisfied/met.

Calculation: Modern contraceptive prevalence (MCP)/total demand (where total demand = MCP + unmet need for modern methods) *100). FPET is used to estimate MCP, unmet need, and the percentage of women estimated to have their demand met with a modern method. FPET produces estimates for all women as described above for MCP.

Disaggregation: The modelled estimates will be disaggregated by married women and unmarried women. Disaggregated estimates for various demographic characteristics are available from the most recent survey and can be found from the DHS at Statcompiler, from country reports for MICS, and on PMA's Data Lab.

Data Source(s): Estimated using data from surveys such as the DHS, MICS, PMA, RHS and other nationally representative surveys; modeling using surveys and service statistics

Data Frequency: Estimated annually

Total number of users of modern contraceptive methods

Rationale: This indicator captures the scale of modern contraceptive use in absolute terms at a point in time. Increases in the total number of users may reflect an increase in MCP or a maintenance of MCP at steady levels depending on population growth rates, but in either case it amounts to an increase in contraceptive services and commodities provided to contraceptive users. Like MCP, it is an aggregate measure of contraceptive use, so this indicator does not capture the dynamics of contraceptive use over time as women and their partners move in and out of episodes of contraceptive use.

Definition: The total number of women (or their partners) currently using a modern contraceptive method at a defined point in time.

Calculation: All women MCP in a particular year is multiplied by the population of women of reproductive age at the mid-point of the year. Population data is obtained from the UNPD World Population Prospects or country-specific population projections.

Disaggregation: None

Data Source(s): FPET is used for estimation of MCP and UNPD World Population Prospects estimates of population by age and sex are used for population data.

Data Frequency: Estimated annually

Contraceptive Method Mix

Rationale: This indicator sheds light on the diversity and distribution of contraceptive methods being used. 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 prevalence of modern contraceptive use, which may be a result of a more active family planning program as well as increased method choice. Method skew (where one method makes up a disproportionate percent of the method mix) can be indicative of individual preferences and socio-cultural norms promoting or discouraging particular methods. Skew toward a method may also be strongly driven by the health care system, contraceptive availability, and how and where women access contraceptives.

Definition: The percent distribution of contraceptive or family planning users by modern method of contraception at a defined point in time.

Calculation: Method mix is calculated by dividing the method specific modern contraceptive prevalence by the total modern contraceptive prevalence. Method mix data for each country are obtained from the most recent DHS, MICS, PMA or national cross-sectional survey report.

Modern methods of contraception include pill, injectable, IUD, implant, condom (male), condom (female), LAM, sterilization (male), sterilization (female), and the Standard Days Method. Other modern methods, including emergency contraception (EC)/diaphragm/foam/jelly, are grouped into an 'other' category. Traditional methods are not included in the method mix.

Disaggregation: None though some limited disaggregation may be available from the DHS at Statcompiler, from country reports for MICS, and on PMA's Data Lab.

Data Source(s): Surveys such as the DHS, MICS, PMA, RHS, and other nationally representative surveys; service statistics

Data Frequency: varies, depending on when new survey findings are released.

Notes: In addition to the percentage of women using each method, the number of methods in use, defined as the number of methods for which greater than 5% of users are relying on that method will be reported. Method mix is currently limited to those methods captured in household surveys but the availability of data on new contraceptive methods may increase over time, including DMPA-SC and whether it is administered through self-injection or by a provider. In addition, contraceptive multipurpose prevention technology (MPT) will likely emerge in the coming years, including dual prevention pills that combine PrEP and oral contraception as well as others.

Contraceptive Discontinuation Rates and Method Switching

Rationale: The **contraceptive discontinuation rate** can help contextualize MCP and the total number of modern contraceptive users by illustrating the churn of users in and out of episodes of use, and by highlighting the effort required to maintain, let alone increase, contraceptive prevalence. The contraceptive discontinuation rates for different methods can also draw attention to the changing needs of women and potential issues with method provision that may be limiting choice. **Contraceptive method switching** provides additional insights on contraceptive dynamics, including the frequency of women stopping the use of one method and switching to another one.

Definition Contraceptive Discontinuation Rates: Among all women of reproductive age who began an episode of contraceptive use 3 -- 62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use, by reason for discontinuation, according to specific method.

Reason categories**:**

- *Contraceptive Discontinuation while in need*: Method failure, health concerns or side effects, wanted a more effective method, method inconvenient to use, lack of access/too far, costs too much, husband opposed, other reasons
- *Contraceptive Discontinuation when not in need***:** Wanted to become pregnant, infrequent sex/husband away, marital dissolution/separation, difficult to get pregnant/menopausal
- *Total contraceptive discontinuation*: Discontinuation while in need plus discontinuation when not in need, excluding switching.
- Contraceptive method switching: See below for more information.

Calculation: Contraceptive discontinuation rates are calculated using data from the DHS contraceptive calendar in the women's questionnaire. More information on the calculation can be found in the Guide to DHS Statistics.

Disaggregation: by method

Data Source(s): DHS surveys in select years

Data Frequency: varies, depending on when new survey datasets including the contraceptive calendar are released

Contraceptive method switching

Definition: Among women of reproductive age who began an episode of contraceptive use 3-62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use and use of a different method begins within two months of discontinuation of the previous method (see note below).

Switching indicates that either:

a) an episode of use of one method that is discontinued is immediately followed by an episode of use of another method or
b) discontinuation of one method due to "wanting a more effective method," is followed by a gap of one month of non-use before beginning a different contraceptive method (regardless of whether it is more or less effective than the original method).

Calculation: **Contraceptive method switching is calculated using data from the DHS contraceptive calendar in the women's questionnaire. More information on the calculation can be found in the Guide to DHS Statistics .**

Disaggregation: by method

Data Source(s): DHS surveys in select years

Data Frequency: varies, depending on when new survey datasets including the contraceptive calendar are released

Method Information Index Plus

Rationale: This indicator illustrates the information women received when they obtained a modern method of contraception. It provides insights on dimensions of rights and empowerment: informed consent, method choice, and the quality of care received by family planning providers. A low score may indicate a lack of provision of basic information on a routine basis and suggests a need for further investigation into the quality of care of services and choice of methods offered.

Definition: Among current users, an index measuring the extent to which women currently using a method report they received specific information from a family planning service provider when they began that family planning method.

Calculation: The index is composed of four questions:

1) At that time (when you first started using CURRENT METHOD), were you told about side effects or problems you might have with the method?
2) Were you told what to do if you experienced side effects or problems?
3) At that time, were you told about other methods of family planning that you could use?
4) At that time, were you told that you could switch to another method if you wanted to or needed to?

These questions are asked of all women who are using select modern methods at the time of the interview (questions are asked slightly differently for women who report female sterilization and are not asked for women who report male sterilization, LAM, or traditional method use). The reported value is the percent of women who responded "yes" to all four questions.

- *Numerator:* the number of women responding "yes" to all four questions
- *Denominator:* the number of women of reproductive age currently using a contraceptive method responding with a valid answer to all four questions.

Disaggregation: by method

Data Source(s): DHS, PMA

Data Frequency: varies, depending on when new survey findings are released

Percentage of women who received family planning information during a contact with a health service provider

Rationale: This indicator is one measure of access to FP-related information and services. It must be interpreted in context however, as not all women want or need family planning information, and information may be provided by other channels, including media, schools, and social networks. Though it does not assess the content of information provided, this indicator is associated with contraceptive use and, among nonusers, the intention to use contraception.

Definition [still under review]: The percent of women who received information on family planning at the time of contact with a health service provider (fieldworker or staff member at health facility). The contact could occur in either a clinic or community setting in the last 12 months.

Calculation: The percent of women who received FP information is based on the following different questions from PMA and DHS surveys:

PMA Questionnaire

> In the last 12 months, were you visited by a fieldworker who talked to you about family planning?
>
> In the last 12 months, have you visited a health facility or camp for care for yourself or your children?
> If Yes → Did any staff member at the health facility speak to you about family planning methods?

DHS Questionnaire

> In the last 12 months, were you visited by a fieldworker?
> If yes → Did the fieldworker talk to you about family planning?
>
> In the last 12 months, have you visited a health facility for care for yourself/or your children?
> If yes → Did any staff member at the health facility speak to you about family planning methods?

If a respondent said "yes" to either of those questions, she was considered to have received FP info in the last year.

- *Numerator:* the number of women who received FP information during a visit from a fieldworker or during a visit to a health facility.
- *Denominator:* Women who either 1) were visited by a family planning worker or 2) visited a health facility for any reason.

Disaggregation: by wealth quintile, contraceptive use/non-use

Data Source(s): DHS, PMA surveys in select years

Data Frequency: varies, depending on when new survey findings are released

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

Rationale: This indicator signals potential deficiencies in the supply chain for modern contraceptives, and lack of access to methods particularly when stockout rates of commonly used methods are high.

Definition: Percentage of facilities stocked out of each type of contraceptive offered, on the day of assessment

Calculation [still under review]

Disaggregation: By method

Data Source(s): Data for this indicator are obtained from UNFPA Supplies Surveys, SPA, SARA, other National Surveys and LMIS Reports, GHSC-PSM Quarterly Reports of stockouts by method.

Data Frequency: Varies, depending on when new survey findings or reports are released or when other data are available

Percentage of primary SDPs that have at least 3 modern methods of contraception available on day of assessment

Rationale: This indicator provides insight into the availability of contraceptive methods at lower levels of the health system, which can affect access and ultimately use.

Definition: The percentage of primary service delivery points that have at least 3 modern methods of contraception available on the day of the assessment. This indicator considers distinct methods (such as injectables or pills), not products (such as the 3 month or 6 month injectable) or brands.

The determination of which health facilities are defined as "secondary" or "tertiary" will be made at the country level, based on existing classifications. Typically, primary facilities are the first point of care. Country programs should keep a record of how health facilities have been classified for this indicator (e.g., primary, secondary, or tertiary; and whether community health workers are included).

Calculation [still under review]

Disaggregation: None

Data Source(s): Data for this indicator are obtained from UNFPA Supplies Surveys, SPA, SARA, other National Surveys and LMIS Reports, GHSC-PSM Quarterly Reports of stockouts by method.

Data Frequency: Varies, depending on when new survey findings are released or when other data are available

Percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment

Rationale: This indicator provides insight into the availability of contraceptive methods at higher levels of the health system, which can affect access and ultimately use.

Definition: The percentage of secondary and tertiary service delivery points that have at least 5 modern methods of contraception available on the day of the assessment. This indicator considers methods (such as injectables), not products (such as the 3 month or 6 month injectable) or brands.

The determination of which health facilities are defined as "secondary" or "tertiary" will be made at the country level, based on existing classifications. Secondary facilities tend to be referral facilities, such as hospitals. Tertiary facilities tend to be more highly specialized hospitals. A rule of thumb can be to consider hospitals, as well as other SDPs that provide maternity services, to be secondary-level facilities. The same rules could apply for NGO and commercial-sector facilities, which may be more difficult to classify because in-country documentation to classify them may not exist.

Calculation [still under review]

Disaggregation: None

Data Source(s): Data for this indicator are obtained from UNFPA Supplies Surveys, SPA, SARA, other National Surveys and LMIS Reports, GHSC-PSM Quarterly Reports of stockouts by method.

Data Frequency: Varies, depending on when new survey findings are released or when other data are available

Couple Years of Protection (CYPs)

Rationale: As the only indicator to come directly from routine data systems, CYPs serve as a proxy for the importance of investing in Health Management Information Systems and using routine data in countries. CYP data and particularly trends from year to year should not be interpreted without additional information, as there are often factors that may explain large variations between years.

Definition: The estimated protection provided by family planning services during a one year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.

Calculation: 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. Countries reporting CYPs used standard USAID conversion factors, which are available on the Family Planning and Reproductive Health Indicators Database.

Disaggregation: None

Data Source(s): Health Management Information Systems (HMIS)

Data Frequency: varies depending on availability of HMIS data

Percent of current modern contraceptive users who last obtained their family planning method from each source

Rationale: This indicator measures to what extent women rely on private, public or other facilities for contraceptives and can shed light on the market dynamics within a country, including what percentage of users pay for contraceptives and where certain methods are most often accessed.

Definition: The percentage of women using modern contraception who obtained their current method from each source (private, public and other). If a woman is currently using more than one method, this indicator refers to the most effective method she is using.

Private sector sources include private pharmacies or drug shops, general shops or markets, private clinics, and NGOs/FBOs. Public sources are any government facilities.

Private	**Private clinical**	Private hospitals, clinics, doctors, nurses, midwives, health centers, maternity homes, other private medical
	Private pharmacy or drug shop	Pharmacy, drug shop, dispensary, chemist
	Private shop or market	Shop, market, bar, disco, vending machine, gas station, grocery store, guest house/hotel, warehouse, other private
	NGO/FBO	Mission hospital, mission health center/clinic, church, mosque, religious institution, NGO health facility, mobile clinics, fieldworkers
Public	**Public**	Government hospitals, health centers, clinics, and CHWs, can be disaggregated into public hospitals vs. public other.
Other	**Other/Don't know/missing**	Friend, relative, partner, parent, traditional healer, traditional birth attendant, school, the respondent herself, "other," don't know, missing data

Calculation: (Total number of women currently using the FP method who reported obtaining their FP method from a particular supply sector/Total number of women currently using that FP method) x 100. DHS, PMA, and MICS questions differ slightly with DHS asking about the source of their most recent supply and MICS and PMA asking about the source of their first supply of the method. Progress reporting will indicate these differences. Questions asked in each survey are listed below.

DHS

"Where did you obtain (CURRENT METHOD) the last time?"

MICS

"CP8. Who prescribed the contraceptive method for you that you or your husband are using currently?"

"CP9.Where did you get the method contraceptive that you or your husband are on currently using?"

PMA

"You first started using [CURRENT] in [DATE FROM 316]. Where did you or your partner get it at that time?"

Disaggregation: By method

Data Source(s): DHS, PMA, MICS surveys in select years

Data Frequency: Varies, depending on when new survey findings are released

Annual expenditure on family planning from government domestic budget

Rationale: Domestic government expenditures reflect a government's commitment to its family planning program and indicate the prospects for its long-term financial sustainability.

Definition: The total amount of public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.

Calculation: **Methodology specific to each source**

Disaggregation: None

Data Source(s): Data for this indicator are obtained either directly from a country's government, a series of surveys conducted by UNFPA, the World Health Organization's System of Health accounts country reports, or from Track20's Family Planning Spending Assessment (FPSA).

Data Frequency: Varies depending on when new survey findings are released

Adolescent Birth Rate and Supplemental Indicators on Adolescents and Youth

Rationale: Adolescent birth rate is a progress indicator for Sustainable Development Goal Target 3.7. Reducing adolescent fertility and addressing the multiple factors underlying it are essential for improving sexual and reproductive health and the social and economic well-being of adolescents. Women who become pregnant and give birth very early in their reproductive lives are subject to higher risks of complications or even death during pregnancy and birth and their children are also more vulnerable. The adolescent birth rate is affected by differences or changes in the number or percent of adolescents exposed to the risk of pregnancy. Thus, changes in the rate may provide misleading information regarding the impact of family planning programs on fertility when other factors affecting risk of pregnancy are changing (for example, when age at marriage is rising quickly for the 15-19 age group).

Definition: **The number of births to adolescent females (ages 15-19) occurring during a given reference period per 1,000 adolescent females. The indicator is analogous to the age-specific fertility rate (ASFR), a component of the total fertility rate (TFR), for 15-19 year olds.**

Calculation: **Values for this indicator are obtained from the DHS survey report. The value is taken from the table displaying age-specific fertility rates. Specifically, the value for respondents 15-19 is used.**

Disaggregation: None

Data Source(s): DHS surveys in select years

Data Frequency: Varies depending on when new survey findings are released

Supplemental Indicators: **In order to better understand and monitor adolescent and youth sexual and reproductive health, FP2030 will aggregate the following supplemental indicators annually from various sources including DHS, MICS, and PMA. More indicator definitions for these supplemental indicators can be found on the FP2030 website.**

Adolescents & Youth Population

- Women of reproductive age (15-49)
- Young adolescents (10-14)
- Older adolescents (15-19)
- Older youth (20-24)
- Youth (15-24)

Key Life Events

- Median age at first marriage (25-29)[1]
- Median age at first sex (25-29)[1]
- Median age at first birth (25-29)[1]
- % of 15-19 year olds who are married
- % of 20-24 year olds who are married

[1] For a median to be calculated, 50% of the women need to have had experienced the event. Hence, all the medians are calculated for women aged 25-29 on the day of the survey as most of them have already experienced the event.

- % of 15-24 year olds who are married
- % of 20-24 year olds who were married before 18
- % of 25-29 year olds who were married before 18

Adolescents & Youth FP Use

- Modern Contraceptive Prevalence Rate (MCP) for married women aged 15-49
- % of married women aged 15-49 using a traditional method
- Unmet need for married women aged 15-49
- % of women who have never had intercourse (15-19)
- % of women who have never had intercourse (20-24)
- % of women who were sexually active in the four weeks preceding the survey (15-19)
- % of women who were sexually active in the four weeks preceding the survey (20-24)
- % of women who were sexually active in the year preceding the survey (15-19)
- % of women who were sexually active in the year preceding the survey (20-24)
- MCP for unmarried sexually active** older adolescents (15-19)
- MCP for unmarried sexually active** older youth (20-24)
- MCP for married older adolescents (15-19)
- MCP for married older youth (20-24)
- MCP for married youth (15-24)
- % of unmarried sexually active** older adolescents aged 15-19 using a traditional method
- % of unmarried sexually active** older youth aged 20-24 using a traditional method
- % of married older adolescents aged 15-19 using a traditional method
- % of married older youth aged 20-24 using a traditional method
- % of married youth aged 15-24 using a traditional method
- Unmet need: 15-19 year olds – married
- Unmet need: 20-24 year olds – married
- Unmet need: 15-24 year olds – married
- Unmet need: 15-49 sexually active** – unmarried
- Unmet need: 15-19 sexually active** – unmarried
- Unmet need: 20-24 sexually active**– unmarried
- Unmet need: 15-24 sexually active**– unmarried
- Condom use during last sex: 15-24 year olds

Number of unintended pregnancies

Rationale: 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).

Definition: 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.

Calculation: This indicator is calculated in two steps.

1. First, the number unintended births is calculated by multiplying the total number of live births (usually from the UNPD) by the % of births for which the pregnancy is reported as wanted later or not at all (usually from DHS or a regional average).
2. Next, miscarriages and abortions are added to this number to get to the total number of unintended pregnancies that occurred. For abortions, a regional estimate from the Guttmacher Institute of the % of unintended pregnancies terminated by abortion is used, and, for miscarriages a global estimate of 13% is used.

Disaggregation: None

Data Source(s): Estimated using modeling

Data Frequency: Estimated annually

Percent of births that are unintended

Rationale: The percent of births that are unintended helps conceptualize the percent of births that women report to being mistimed or unwanted. Unlike *the Number of Unintended Pregnancies* indicator, this indicator lends itself to be comparable across countries.

Definition: Percent distribution of births to women age 15-49 in the 5 years preceding the survey (including current pregnancies), by planning status of the birth (wanted then, wanted later, not wanted). Those wanted later and not wanted are defined as unintended.

Calculation: This indicator is calculated by separating births and current pregnancies reported as unintended or intended and then dividing the unintended by the total number of births and pregnancies reported in the 5 year preceding the survey.

- **Numerator**: The number of women who report their previous births and current pregnancies as mistimed (wanted later) or unwanted.
- **Denominator**: Total number of births and pregnancies in the 5 years preceding the survey**.**

DHS

When you got pregnant, did you want to get pregnant at that time (Yes/No)? If answered "no" and has had one or more live births: did you want to have a baby later on or did you not want any more children (Later/No More or None)? If answered "no" and has had no live births: did you want to have a baby later on or did you not want any children (Later/No More or None)?

If previous live birth: when you got pregnant with (NAME), did you want to get pregnant at that time (Yes/No)? If previous did not end with a live birth: when you got pregnant with the pregnancy that ended in (…), did you want to get pregnant at that time (Yes/No)? If no to either question: Did you want to have a baby later on, or not at all (Later/Not at all)?

MICS

When you got pregnant with (name), did you want to get pregnant at that time (Yes/No)? If only one previous birth: Did you want to have a baby later on, or did you not want any children (Later/No More or None)? If more than one previous birth: Did you want to have a baby later on, or did you not want any more children (Later/No More or None)?

Now I would like to talk to you about your current pregnancy. When you got pregnant, did you want to get pregnant at that time? If only one previous birth: Did you want to have a baby later on, or did you not want any children (Later/No More or None)? If more than one previous birth: Did you want to have a baby later on, or did you not want any more children (Later/No More or None)?

PMA

Now I would like to ask a question about your last birth. At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any / any more children at all (Then/Later/Not at all/ No response)?

Now I would like to ask a question about your current pregnancy. At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any / any more children at all (Then/Later/Not at all/ No response)?

Disaggregation: None

Data Source(s): DHS, MICS, PMA surveys in select years

Data Frequency: Varies, depending on when new survey findings are released

Number of unintended pregnancies averted due to modern contraceptive use

Rationale: This indicator contextualizes the value of accessible modern contraception, by showing how many couples are avoiding unintended pregnancy by using modern contraception.

Definition: The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.

The indicator assumes that all couples currently using contraception want to avoid a pregnancy and that if they did not have access to modern contraception they would be at risk of an unintended pregnancy. Unintended pregnancies that result due to method failure are subtracted from this calculation – so in places where more effective contraceptive methods are used, a relatively larger number of pregnancies will be averted.

Calculation: This indicator is calculated based on the total number of modern contraceptive users in each country, which is calculated by multiplying the MCP by the total number of women of reproductive age (WRA) in each year. From here, two additional calculations are needed:

1. First, it is necessary to estimate the number of pregnancies that would have occurred if those currently using modern contraception had not been using contraception. To get this number, the number of women using modern contraception is multiplied by 41%, which is the globally estimated annual pregnancy rate of women who are not actively trying to get pregnant and are not using contraception.
2. Second, it is necessary to subtract from this the number of pregnancies that occurred due to method failure (these pregnancies are assumed to be unintended). To get the number of pregnancies occurring due to method failure, you multiply the method-specific failure rates by the number of women using each method (based on the most recent method mix data available), and then add up the resulting unintended pregnancies from each method.

Disaggregation: None

Data Source(s): Estimated using modeling

Data Frequency: Estimated annually

Number of unsafe abortions averted due to modern contraceptive use

Rationale: This indicator estimates the positive impact of contraceptive use on maternal health, beyond preventing unintended pregnancies.

Definition: The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.

Calculation: This indicator is calculated in two steps:

1. First, the number of unintended pregnancies averted due to contraceptive use, is multiplied by the percent of unintended pregnancies that end in an induced abortion. The data for this is for most countries a country-level modeled estimate based on work published by the Guttmacher Institute and WHO (% of unintended pregnancies terminated by abortion).
2. Second, the value from step one is multiplied by the percentage of abortions that are unsafe which is available at a geographically aggregated level (region/subregion) and is available from WHO.

Disaggregation: None

Data Source(s): Estimated using modeling

Data Frequency: Estimated annually

Number of maternal deaths averted due to modern contraceptive use

Rationale: This indicator estimates the positive impact of contraceptive use on maternal health, beyond preventing unintended pregnancies.

Definition: The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.

Calculation: This indicator is calculated in two steps:

1. First, all of the different outcomes of unintended pregnancies averted are calculated: unintended births averted, abortions averted (split into safe and unsafe), and miscarriages averted. The number of unintended births averted is equal to the number of pregnancies averted minus abortions averted, and minus miscarriages averted. The number of miscarriages averted is based on a global miscarriage rate of 13%.
2. Next, maternal deaths averted are calculated from each of these unintended pregnancy outcomes. The number of live births averted is multiplied by the live-birth only Maternal Mortality Ratio (MMR) to estimate the number of maternal deaths averted from averting live births. The live-birth MMR is calculated from the published MMR, adjusting for the mortality due to other pregnancy outcomes. Unsafe abortions averted are multiplied by an unsafe abortion mortality ratio, which is calculated as the country MMR x regional ratio of unsafe abortion mortality to MMR to estimate maternal deaths averted from averting unsafe abortions. This calculates a country specific unsafe abortion estimate that is relative the overall MMR in each country. The number of safe abortions averted is multiplied by a global safe abortion mortality ratio (2 deaths per 100,000 safe abortions). Finally, miscarriages averted are multiplied by the full MMR to estimate the number of maternal deaths resulting from miscarriages.

Disaggregation: None

Data Source(s): Estimated using modeling

Data Frequency: Estimated annually

Percentage of women who decided to use family planning alone or jointly with their husbands/partners

Rationale: This indicator provides some insight into women's participation in contraceptive decision making. While it likely does not capture many of the challenges related to decision making that contraceptive users face, it can highlight limitations in women's autonomy, or signal barriers to voluntary, rights-based family planning, free of discrimination, coercion, or violence.

Definition: The percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner.

Calculation: This indicator is calculated from the responses to the question: *Would you say that using contraception is mainly your decision, mainly your (husband's/partner's) decision, or did you both decide together?*

- **Numerator**: the number of women who report making decisions on contraceptive matters either by themselves or based upon consensus joint decision-making with their husband/partner/provider.
- **Denominator**: the number of women of reproductive age currently married or in union responding with a valid answer to a survey question on FP decision-making.

Disaggregation: By wealth quintile

Data Source(s): DHS, PMA surveys in select years

Data Frequency: Varies, depending on when new survey findings are released

Communicating Uncertainty in Estimates

In the 2018-2019 Progress Report, the PME Working Group "urged FP2020 and family planning partners to advance toward communicating uncertainty intervals around estimates." In response, FP2020 and Track20 published uncertainty ranges for as many indicators as possible in the 2019–2020 Progress Report. Uncertainty ranges allow countries to understand changes in key family planning indicators and evaluate if country-level efforts (policy and programs) are supporting their progress on goals. Additionally, reporting uncertainty ranges improves data transparency and can lend more credibility to our methods, which have improved since the inception of FP2020.

In developing a measurement framework for the next phase of the partnership, the Working Group recommends continued improvements in the communication of uncertainty, including:

- Showing uncertainty ranges for all indicators when available;
- Continuing to work with Track20 Monitoring and Evaluation Officers/technical leads in countries to socialize the definition and interpretation of uncertainty ranges; and
- Increasing the understanding of uncertainty in indicators among the FP2030 Transition Oversight Group, Regional Hubs, etc., along with an understanding of how uncertainty impacts the measurement of progress.

Recommendations for Country-Specific Measurement

The Core Indicators in this document were selected with existing country data systems and monitoring efforts in mind, and were designed to capture information that is comparable across countries on contraceptive use, method choice, quality, availability, and other key aspects of family planning. The list was kept short to focus on only those indicators with global relevance, leaving space for countries to identify their own additional indicators to track specific strategies and priorities.

Countries should select additional indicators specific to their context that will help them monitor progress towards their FP2030 commitments and the FP2030 vision.

Areas of Future Work

Over the last eight years FP2020 partners have worked to improve and align on family planning measurement in many areas, including advancing modeling of contraceptive use, improving the tracking of FP financing, and aligning on stockout indicators. The framework above reflects these advances. The PME Working Group recognizes, however, that beyond the indicators in this document, there is still a need for improved measurement in many aspects of family planning. Looking ahead to the FP2030 family planning partnership, the measurement agenda should include efforts toward:

1. Indicators to measure Social and Behavioral Change efforts
2. Identifying measures at supportive environment level for policy, financing, and accountability
3. Better understanding of fertility intentions and desire to use contraception
4. Improving Measurement of Rights and Empowerment Principles for Family Planning, including but not limited to:
    a) Improving monitoring of quality, including facility measures of quality and client-perspectives of quality
    b) Improving measurement of empowerment, agency and autonomy
    c) Improving measures of equity

1. Indicators to measure Social and Behavioral Change efforts [Still under review]

2. Identifying measures at supportive environment level for policy, financing, and accountability [Still under review]

3. Better understanding of fertility intentions and desire to use contraception [Still under review]

4. Improving Measurement of Rights and Empowerment Principles for Family Planning, Including but not limited to:

a) Improving monitoring of quality of care, including facility measures and client-perspectives of quality. [Still under review]
b) Improving measurement of empowerment, agency and autonomy [Still under review]

4c. Improving measurement of equity in family planning

Justification/Rationale: The FP2020 partnership recognized 10 rights and empowerment principles of family planning; of these, one was focused on equity and non-discrimination. This focus on equity will remain critical to the vision of the FP2030 partnership. Inequities in health are avoidable, unnecessary, and unjust (Whitehead, 1992). According to a recent High Impact Practices publication, "Equity for family planning implies that all groups have the same access to information and services, and to all available methods of contraception, and that they are able to make decisions about their fertility and their use of contraception and act on those decisions."

What is the measurement challenge/issue? To understand if inequities exist in access to family planning information and services, researchers can assess three widely accepted dimensions of inequities – economic, social, and environmental. Economic inequities are related to wealth status (and can also impact social inequities). Social inequities are related to sex, age, education, marital status, race/ethnicity, language, sexual orientation, gender identity, disability, employment, intra-household bargaining, etc. Finally, environmental inequities are related to geographic location, humanitarian setting, etc.

Reviewing inequities in a single country at a point in time is feasible through existing survey sources for certain indicators (e.g., method information index, modern contraceptive use, attitudes about family planning, receiving family planning information through family, radio, tv, health provider, or community health worker, etc.) and for certain elements of the three dimensions (e.g., wealth, geographic location, sex, age, or education). However, available data have limitations related to (1) equity dimensions and outcome indicators considered and (2) comparability across settings.

Data on equity dimensions are limited; certain socio-demographic characteristics such as sexual orientation, gender identity, race/ethnicity, disability, and intra-household access to income/assets are not consistently measured across surveys and not all current survey sources include data for never-married women, an important social inequity that should be examined.

Outcome measures are limited too; while current surveys do measure access to family planning information, they do not adequately capture data on if women have **access** to services (including different methods).

Comparing wealth inequities in family planning over time and across countries can be complicated because the standard wealth index in surveys measures relative differences in the economic status of households in that country at the time of the survey only. Data during crisis periods, e.g. from humanitarian settings, seldom exist.

What actions can be taken to advance measurement in this area? Despite these challenges it is crucial that the family planning community make measurement improvements that will help decision-makers diagnose inequities in country-specific contexts and compare across different countries. The FP2030 partnership should consider several of the following as they continue to work to improve equity-focused indicators:

Related to data collection:

1. Are there questions existing surveys lack that would better capture inequities in family planning, related to capturing inequities in access, as well as inequities in domains that are currently not captured? Can projects such as PMA or individual studies pilot new questions?
2. Can other data sources such as HMIS data be used to assess inequities?

Related to data use:

1. How can countries best monitor inequity in family planning? Are there certain elements (e.g. age, wealth, etc.) in each dimension (e.g. economic, social, geographic) that should be consistently measured for family planning?
2. How should progress in reducing inequities be measured? Should modeling be considered to provide annual estimates for equity-focused indicators, since surveys are only periodically available?
3. How can targets for reducing inequities be set?

The family planning community has already made considerable gains in socializing the importance of understanding inequities in family planning programs; it has also tried to overcome measurement challenges through proposing standard family planning indicators (e.g. family planning information) through an equity lens. Even with these gains, the community needs to harmonize on which aspects of equity are critical to annually monitor for family planning programs and identify the best way forward for improving measurement.

Data Dependencies

FP2020's measurement framework and agenda depend on a variety of data sources, which in turn rely on investments by many partners. Changes to the measurement framework should take these dependencies and the family planning data landscape into account.

Sources for Data/Indicators

Source	Data/Indicators
Surveys	
DHS	MCP, unmet need, demand satisfied, unintended pregnancies, modern method mix, Method Information Index Plus, FP information, FP decision making, ABR, Discontinuation & Switching, source of method,
MICS	MCP, unmet need, demand satisfied, unintended pregnancies, modern method mix, ABR
PMA	MCP, unmet need, demand satisfied, unintended pregnancies, modern method mix, Method Information Index Plus, FP information, FP decision making
UNFPA Facility Surveys	Stockouts, method availability
NCIFP	Strategy, Data, Quality, Equity, Accountability
Models	
UNPD: World Population Prospects	Population estimates, MCP, unmet need, demand satisfied
Track20: FPET	MCP, unmet need, demand satisfied
Guttmacher Institute/WHO	Unintended pregnancies averted, maternal deaths averted, unsafe abortions averted
Routine Data	
HMIS (e.g. DHIS2); LMIS	CYPs, MCP(FPET); Stockouts by method
FP Financing	
KFF (Kaiser Family Foundation)	Donor government disbursements
OECD DAC	Donor government disbursements
Track20: Family Planning Spending Assessments	Domestic government expenditures
UNFPA	Domestic government expenditures
WHO: System of Health Accounts	Domestic government expenditures

GHSC-PSM	Contraceptive commodity expenditures; Stockouts by method
Various Sources (Track20, RHSC, Guttmacher, NIDI, PMA, Others)	Out of pocket expenditures