



FP2030 Measurement Framework

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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

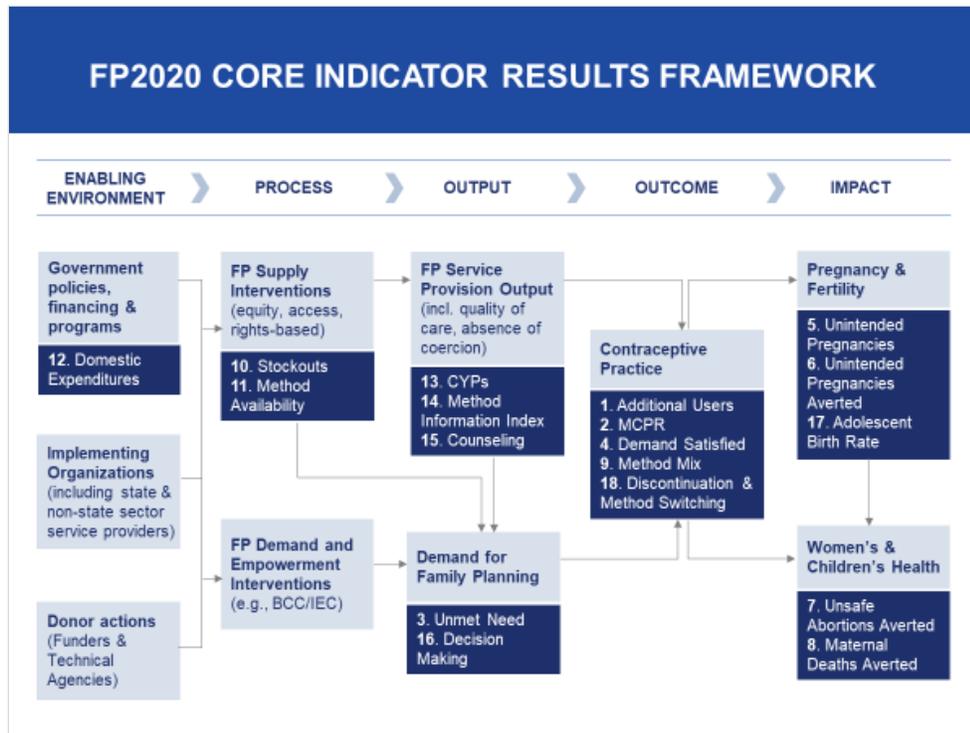
Voluntary modern contraceptive use by everyone who wants it, achieved through individuals' informed choice and agency, responsive and sustainable systems providing a range of contraceptives, and a supportive policy environment.

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

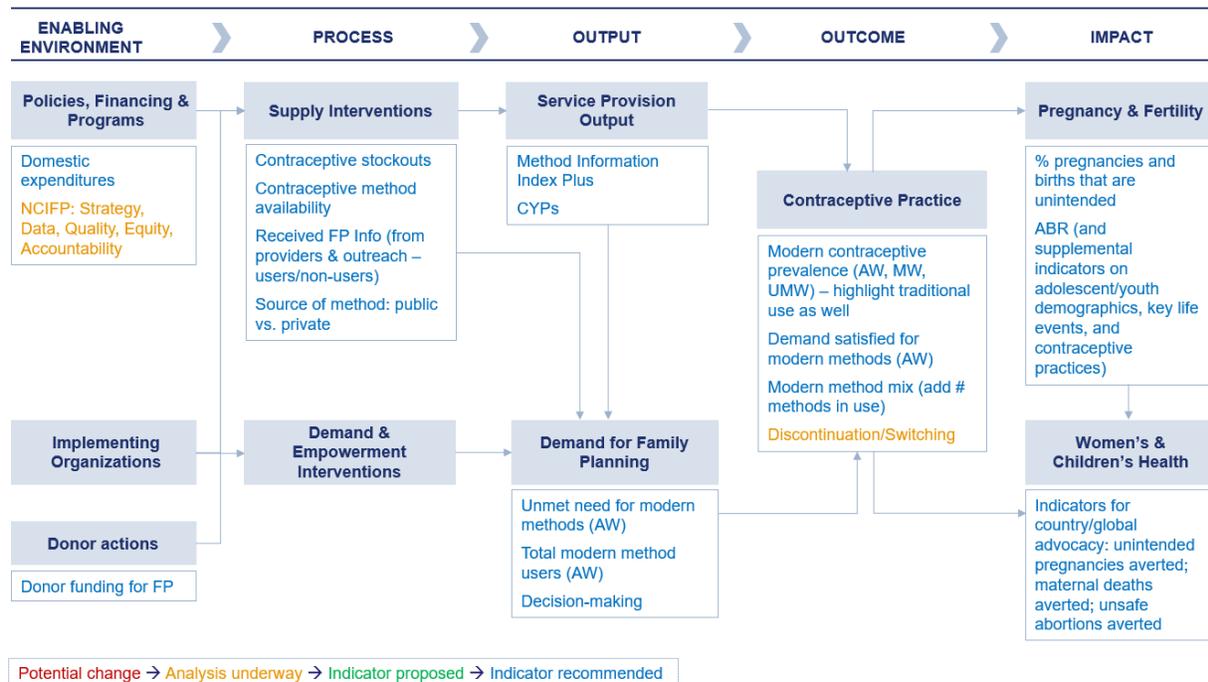
- **Individuals** have information about methods and side effects for a range of contraceptive choices and the ability to exercise their right to determine whether, when and how many children they want to have.
- **Responsive health systems** equitably and sustainably provide high quality services and 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 | Algeria | Mauritania |
| Burkina Faso | Angola | Federated States of Micronesia |
| Burundi | Bangladesh | Mongolia |
| Central African Rep. | Belize | Morocco |
| Chad | Benin | Myanmar |
| DR Congo | Bhutan | Nepal |
| Eritrea | Bolivia | Nicaragua |
| Ethiopia | Cabo Verde | Nigeria |
| Gambia | Cambodia | Pakistan |
| Guinea | Cameroon | Papua New Guinea |
| Guinea-Bissau | Comoros | Philippines |
| DPR Korea | Congo | Samoa |
| Liberia | Cote d'Ivoire | Sao Tome and Principe |
| Madagascar | Djibouti | Senegal |
| Malawi | Egypt | Solomon Islands |
| Mali | El Salvador | Sri Lanka |
| Mozambique | Eswatini | State of Palestine |
| Niger | Ghana | Tajikistan |



| | | |
|--------------|-------------|-------------|
| Rwanda | Haiti | Tanzania |
| Sierra Leone | Honduras | Timor-Leste |
| Somalia | India | Tunisia |
| South Sudan | Indonesia | Ukraine |
| Sudan | Iran | Uzbekistan |
| Syria | Kenya | Vanuatu |
| Togo | Kiribati | Viet Nam |
| Uganda | Kyrgyz Rep. | Zambia |
| Yemen | Lao PDR | Zimbabwe |
| | Lesotho | |

South Africa made a commitment at the 2012 London Summit but was not within the FP2020 69.

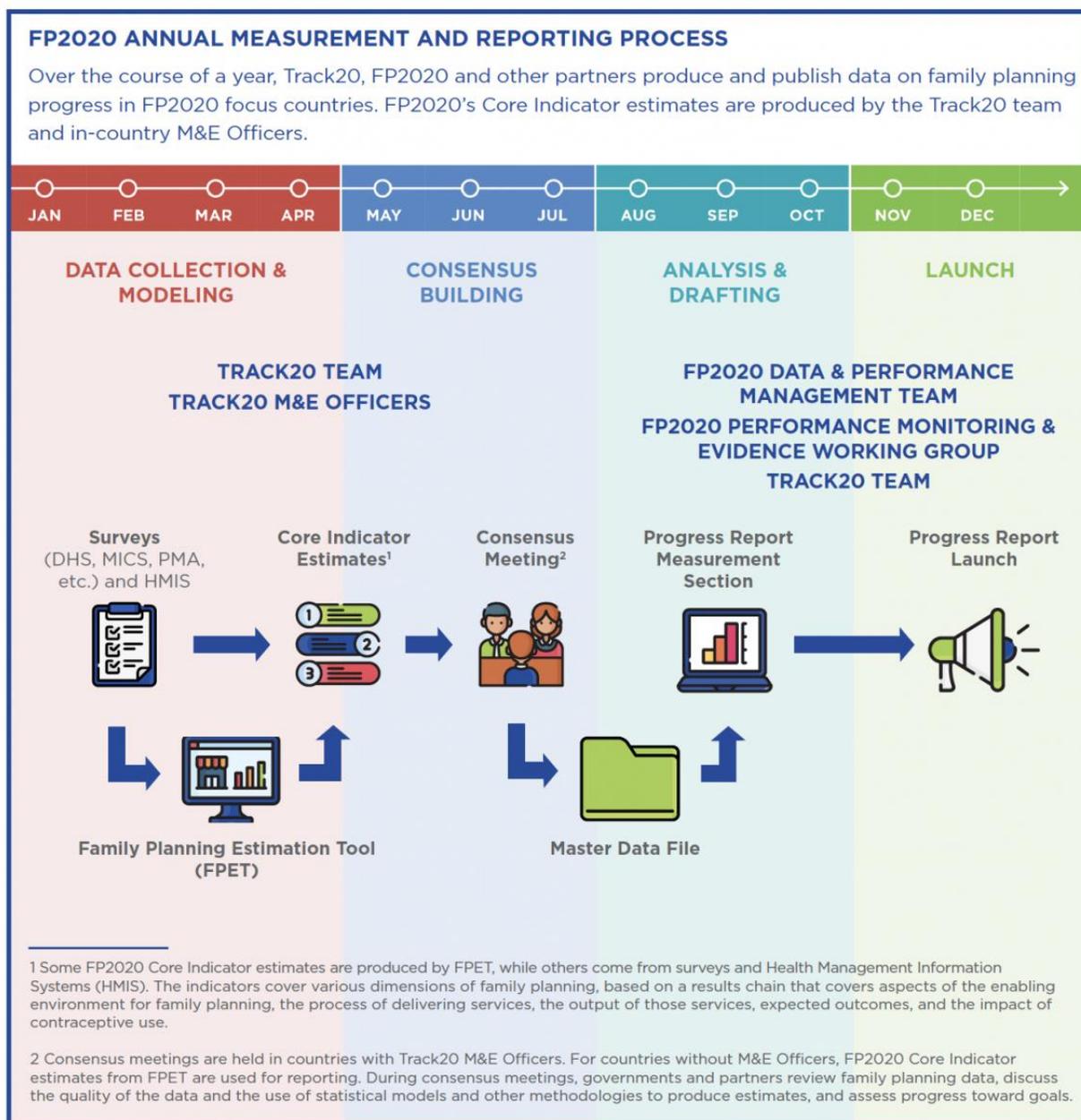
Among the Low Income and Lower-Middle Income Countries there may be a few countries, particularly small-island and fragile states, for which very little data is available and regular reporting of family planning data may be challenging.

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 had interactions with the health care system and among those women, the percentage that received family planning information during contact with a health service provider

Rationale: This indicator is one measure of interactions with the health care system (via facility, fieldworker, or both) and FP-related information and services during these interactions. 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.

Definition: The percent of women who had interactions with the health care system (via a fieldworker, health facility, or both). Among these women, the percent who received information on family planning at the time of contact with a health service provider (fieldworker, staff member at health facility, or both). The contact could occur in a clinic, community setting, or at both locations 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 community health worker 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?

In the last 12 months, visited by fieldworker or community health worker (only available in newer DHS and not PMA)

- **Numerator:** The number of women responding “yes” to being visited by a fieldworker in the last 12 months.
- **Denominator:** All women of reproductive age in the survey

At fieldworker or community healthcare visit, heard about FP information

- **Numerator:** The number of women responding “yes” to being told about FP information during fieldworker or community health worker visit
- **Denominator:** The number of women of reproductive age that were visited by fieldworkers or community health workers in the last 12 months

In the last 12 months, visited a health facility

- **Numerator:** The number of women responding “yes” to having had visited a health facility in the last 12 months.
- **Denominator:** All women of reproductive age in the survey

At health facility, heard about FP information

- **Numerator:** The number of women responding “yes” to being told about FP information during health facility visit
- **Denominator:** The number of women of reproductive age that visited a health facility in the last 12 months

In the last 12 months, visited by fieldworker and visited a health facility

- **Numerator:** The number of women responding “yes” to being visited by a fieldworker or community health care worker AND visited a health facility in the last 12 months.
- **Denominator:** All women of reproductive age in the survey

At both interactions, heard about FP information

- **Numerator:** The number of women responding “yes” to being told about FP information at both interactions—when visited by fieldworker or community health care worker AND visiting a health facility in last 12 months
- **Denominator:** All women of reproductive age that were visited by a fieldworker or community health care worker AND visited a health facility in the last 12 months

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

- **Numerator:** Number of assessed facilities that were stocked out of the offered family planning product/method at the time of the most recent facility assessment visit, or according to the ending balance of the most recent logistics report¹
- **Denominator:** Total number of assessed facilities that offer² the product/method and for which stock data were available at the time of the most recent facility assessment visit or logistics report

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 Annual and 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

¹ If possible, for comparison purposes, the last quarter logistics report on stockouts in a calendar year, Oct-December should be used for Indicator 10 as it aligns with the time when UNFPA Supplies Surveys are carried out across countries. However, the choice of the time period should always be validated during country consensus meetings, as many countries use the LMIS standard of average stockouts in the last 12 months (typically the last calendar year)

² Offer of product has been interpreted in many ways. The strictest standard and most relevant to programme management is facilities required to offer the product based on national protocols and guidelines. The less strict standard, is offer by facilities based on *regular and normal service delivery* which excludes facilities that may not regularly offer a method to clients or have trained providers to provide service. Both measures of offer are assessed in UNFPA Supplies Surveys. Recent changes by the USAID GHSC-PSM project also use a less restrictive definition of offer and now only calculate stockouts for facilities that are *active*. (For further information see the Active Site rule <https://www.ghsupplychain.org/news/improving-family-planning-stockout-data-quality-and-reporting>)

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:

- **Numerator:** Number of assessed primary – level SDPs that had at least three methods³ available at the time of the most recent facility assessment visit, or according to the ending balances of the most recent logistics report
- **Denominator:** Total number of assessed primary – level SDPs for which data were available at the time of the most recent facility assessment visit or logistics report

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, annually through LMIS or HMIS and when new surveys are released

³ Methods not products

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

- **Numerator:** Number of assessed secondary and tertiary – level SDPs that had at least five methods⁴ available at the time of the most recent facility assessment visit, or according to the ending balances of the most recent logistics report
- **Denominator:** Total number of assessed secondary and tertiary – level SDPs for which data were available at the time of the most recent facility assessment visit or logistics report

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

⁴ Methods not products, should be used for this indicator. For example having two types of implants should not be counted as two methods in stock but as one method in stock, towards the total of five methods in stock.

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.

Public sources are any government facilities. Private sector sources typically include private pharmacies or drug shops, general shops or markets, private clinics, and NGOs/FBOs. However, what is considered a private source could change depending on the country for which it is reported. For example, in some countries, pharmacies or NGOs or shops are included in the “Other” category. Please refer to the survey reports to understand what is included under the “Private” versus “Other” categories.

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

“Who prescribed the contraceptive method for you that you or your husband are using currently?”

“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)⁵
- 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

⁵ 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

Justification/Rationale Two indicators: women’s fertility desires and intention to use contraception were not part of the 18 Core Indicators of FP2020 but are critical to assess jointly to understand if and how women’s fertility desires 1) change over time and 2) predict the use of contraception. The indicator on fertility desires is used to calculate unmet need and demand satisfied— both of which will remain part of the FP2030 measurement framework. Furthermore, recent studies have suggested that including intention to use contraception can provide a more accurate assessment of gaps in contraceptive use and further contextualize unmet need (Moreau et al., 2019).

What is the measurement challenge/issue? Current surveys typically measure fertility intentions through questions that ask about women’s desire to have more children, which women answer: 1) yes, 2) no, or 3) don’t know. Women that want additional children are then asked, how long they want to wait. Women that want to wait less than two years are classified as wanting children “soon,” those that want to wait more than two years are classified as wanting to have children “later,” and those unsure of timing are classified as “undecided about timing.” For women who are currently pregnant, this desire for children question is asked in terms of desire for another child after the current pregnancy. Current surveys such as the DHS measure intention to use contraception by asking women who are currently not using a method if they will use a contraceptive method in the future and women answer by indicating 1) yes, 2) no, or 3) don’t know. While these data are critical to understand point-in-time estimates, they don’t capture the changing fertility intentions or the interrelationships between fertility desires and contraceptive use. PMA collects longitudinal panel data for intention to use, and also asks women when they might start using a method and which method they might use, thereby permitting measurement of changing fertility intentions and the relationship with future contraceptive use.

Several longitudinal research studies have demonstrated that fertility desires are fluid (Moreau et al., 2013; Speizer et al., 2013; Srivastava et al., 2019; Mozumdar et al., 2020; Speizer et al., 2020). These studies have found that some women who at an earlier period reported wanting to delay a pregnancy two or more years or who do not want any more children rationalized their experienced pregnancies at follow-up as intended. The opposite was also found where some women who reported wanting a pregnancy at a first observation reported their experienced pregnancy as unintended at the later date. These studies also found that the desire to have no more children was a strong predictor of contraceptive use. Similarly, a recent analysis showed that adding a question about motivational strength to prevent pregnancy to fertility desires was a better predictor of subsequent contraceptive use for non-users and continued use among users.⁶ Other studies have demonstrated that some women are ambivalent about future childbearing and contraceptive use (Withers et al., 2011). The reasons for ambivalent fertility desires and intention to use contraception can vary by country context, life stage, personal circumstance, quality, and availability of family planning services, etc. – which make it difficult to understand if women are indeed in need of contraception or will use contraception when “in need” as captured in the standard indicator of “unmet need”. A study from Uganda found that women with an unmet need were slower to adopt contraception than those women without unmet need (Sarnak et al., 2020). Furthermore, another study in Uganda using longitudinal data found that women’s intentions to use contraception were a stronger predictor of adoption and discontinuation of contraception than fertility desires (Sarnak et al., 2021). While unmet need will remain integral to FP2030

⁶ Analysis presented by Aparna Jain (Population Council) at the IUSSP virtual workshop on methodologies for measuring pregnancy intention and unintended pregnancy and birth (2021). Full analysis is forthcoming.

progress monitoring, it's also critical to assess both women's fertility desires and intention to use contraception.

What actions can be taken to advance measurement in this area?

Surveys such as PMA have a longitudinal design, which allows FP2030 data partners to further analyze the varying fertility desires and their subsequent impact on contraceptive use. However, as the FP2030 data partners look towards the next decade of monitoring progress, they should consider:

1. Whether and how to quantify fluctuations in fertility desires, as well determine how these fluctuations affect key indicators like unmet need and demand satisfied? Additionally, what can be learned for informing policy and programming?
2. How do we better understand the motivations of women that respond with “undecided or don't know” about additional children or timing of children? Should questions on motivational strength to prevent pregnancy be added to surveys to understand these nuances to help better inform programs and policies to reach these?

Note: Although this brief focuses on contraceptive use among women for limiting or spacing their births based on their fertility desires, it is important to acknowledge that some women might want to have children to achieve their fertility desires but are unable to do so due to possible infertility issues.

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4a. Improving monitoring of quality of care, including facility measures and client-perspectives of quality. [Still under review]

4b. Improving measurement of empowerment, agency and autonomy

Justification/Rationale:

Women's empowerment is considered a critical factor affecting family planning behaviors and outcomes for women (Prata et al., 2017). It is defined as 'the expansion of people's ability to make strategic life choices in a context where this ability was previously denied to them' (Kabeer, 2001). Decision-making is a key indicator for measuring empowerment. It refers to the ability to meaningfully engage in the process through which decisions are made. This is helpful for measuring empowerment because the individual's autonomy in making the choice to include others in the decision-making process is critical to their empowerment (ICRW, 2018). Agency is referred to as a dimension of empowerment because it encompasses the reflection and action for power (Kabeer, 2001). It is the ability to exercise life choices and includes three main factors: choice, voice and power. Together these factors show the capacity and ability for action (Upadhyay et al., 2014; Eerdewijk et al., 2017). Moreover, full reproductive autonomy is a woman's ability to achieve her reproductive intentions (Upadhyay et al., 2014). The Reproductive Autonomy Scale uses the sub domains of decision-making, freedom from coercion, and communication to measure autonomy (ICRW, 2018). Measuring decision-making is instrumental for determining a women's empowerment and agency. Those two factors are necessary components to achieve reproductive autonomy.

To ensure rights-based principles and person-centered family planning were the cornerstone of the FP2020 partnerships efforts, FP2020 developed the "[Rights and Empowerment Principles](#)" and the "[Rights and Empowerment Checklist](#)" which includes empowerment as a dimension of family planning. Furthermore, since the 2012 progress report, FP2020 measured family planning decision-making as part of its 18 Core Indicators to assess the percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner. Additionally, equity is a core component of the sustainable development goals (SDGs) and advancing women's empowerment is formalized in [SDG 5 on gender equality](#). Research shows there is a correlation between women's empowerment and lower fertility, unintended pregnancies, and longer birth intervals (Upadhyay et al., 2014). As such, it is an important area of measurement to continue to improve and refine.

What is the measurement challenge/issue?

The Demographic and Health Surveys (DHS) and Performance Monitoring for Action (PMA) surveys measure family planning decision-making through questions that ask about women's decision to use contraception, which women answer: 1) it was mainly her decision, 2) it was mainly her husband or partner's decision, or 3) it was jointly her and her partner's decision. In the most recent FP2020 progress report, in all the countries with available survey data, over 70% of women report that they decided to use family planning alone or jointly with their husbands or partners (many countries are over 90%). FP2020 disaggregates this data by wealth quintile, but there is little variation between the poorest population group and the richest population group. Additionally, the results shown for married or in-union women do not capture decision-making for all or unmarried women.

While this data supports the goal of monitoring global indicators on women's empowerment and family planning use, the current survey questions have limitations which makes it harder to predict contraceptive use across all contexts. The questions are not specific to women's own interests and do not address the issue of how women's participation in decision-making influences the outcome (Kishor et al., 2008). In the study on empowerment of women in Egypt, Kishor argues that capturing empowerment requires the addition of indicators that measures the evidence of empowerment (Kishor, 2000). Additionally, there is room for further research on the interpretation of decision making. Peterman et al. suggest measures of agency such

as “the ability to define goals, perceive control and act on goals” to be more aligned with empowerment compared to measures of decision making. To assess contraceptive autonomy, additional questions related to informed, full, and free choice should be added to existing population-based surveys (Senderowicz, 2020).

Throughout studies, there are various scales used to help measure empowerment. The Reproductive Autonomy Scale measures reproductive autonomy using the sub domains of decision-making, freedom from coercion, and communication (Upadhyay et al., 2014). Measure Evaluation developed a multidimensional scale to standardize a measurement of reproductive empowerment among women in sub-Saharan Africa. The sub domains of this scale include those of the Reproductive Autonomy Scale, but it is more comprehensive in that it also includes domains on social support and norms. The scale was validated in Kenya, Zambia, and Nigeria. In all three case studies, the scale has potential to be a predictive measure of reproductive empowerment (Mandal et al., 2020). Although effective, the studies found it difficult to create a measure that can be used across sub-Saharan African countries due to the various ethnic, religious, and sociocultural groups. Household decision-making, economic, socio-cultural, familial, legal, political, and psychological dimensions of empowerment can also be used to explore the relationship between women’s empowerment and contraceptive use (Tadesse et al., 2013). The study by Measure Evaluation on Women’s Empowerment and Choice of Family Planning Methods demonstrates women’s empowerment in these dimensions has direct associations with contraceptive use (Do and Kurimoto, 2010). Although these scales and measures are helpful, they are not always standardized and consistently included in all surveys on women’s empowerment.

Empowerment of women and individuals can be fluid and change depending on life circumstances or situations. Researchers should consider including additional measures that are objective and can be relevant to women in local contexts to complement decision-making indicators (Peterman et al., 2020). For example, PMA conducted a study to examine women’s economic empowerment and its effect during the COVID-19 pandemic. The study uses longitudinal panel data collected from November 2019, before restrictions to June 2020, during restrictions. The findings show women who are reliant on their husbands for economic purposes became more reliant during the COVID-19 pandemic, which is associated with reduced decision-making (Anglewicz et al.) There is agreement that empowerment has a multitude of dimensions but there is not a clear consensus on the best way to operationalize indicators to various contexts (Peterman et al., 2020). For instance, measures of empowerment often leave out youth populations because they focus on dyadic relationships applicable only to married adults and include markers that are not relevant to the youth populations (MacQuarrie, 2021). Development of consistent measures for empowerment should involve validating a set of measures in diverse settings. A recent study looked at newly developed and validated measure of youth empowerment to facilitate the inclusion of young women’s empowerment. The study found that youth empowerment is negatively associated with ideal number of children and positively associated with young women’s intention to use contraception (MacQuarrie, 2021). Diversifying measures of empowerment will help the family planning community ensure consistent global measurement of empowerment and increase the ability to compare studies of contraceptive autonomy (Senderowicz, 2020).

What actions can be taken to advance measurement in this area?

As the FP2030 data partners look towards the next phase of monitoring decision making, they should consider:

1. How can we better measure empowerment? Is this one indicator sufficient to capture all aspects of empowerment that influence family planning decision making? Would it be helpful to have new indicators or to expand the questions to capture more aspects of empowerment?

2. Should there be a standard list of questions, measures, and/or scales validated to determine women's empowerment that can be comparable across all surveys?
3. Should measurement focused on family planning use and agency or reproductive autonomy also be considered alongside the decision-making indicator? Could the decision-making indicator be used for other purposes such as measurement of one's own health and that of family members?
4. Would the results be more advantageous if surveys included questions on empowerment for all women instead of just married women? Will having empowerment data on all women help gauge the number of women that feel empowered to use a method for herself and women that chose to use a method with a partner?

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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 |