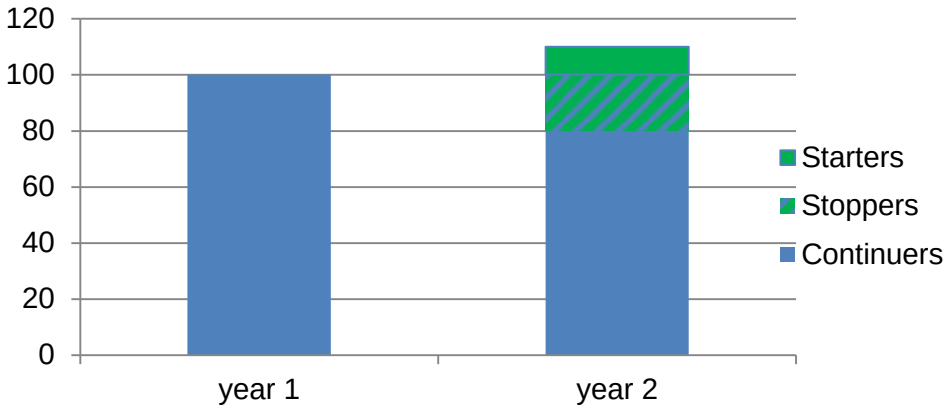
Indicator description	**Family Planning Indicators:** **1.Total Users:** Number of women & girls using modern methods of family planning through DFID support. **2. Additional Users:** Number of *additiona*l women using modern methods of family planning through DFID support.
Type of indicator	**Total Users: Non-cumulative,** results are not aggregated over years. This avoids the double-counting of users supplied with long-acting methods of contraception. **Additional Users: Cumulative**
DFID commitment	At the 2017 London Summit on Family Planning, the UK committed to spending an average of £225 million each year for the next 5 years. To monitor progress and report on the impact of this spend DFID will report Family Planning results using a basket of indicators that include total and additional users. Further information is available here.
Rationale	DFID funds a wide range of programmes that contributes to family planning: from budget support for family planning & health systems strengthing (eg. training health workers) to financing commodity supply chains & full service delivery (eg. family planning clinics). These indicators are applicable to each of these programmes. The indicators not only take into account maintaining support to existing users of family planning but also account for reaching new users of contraception.
Technical definitions	**1. Modern Methods of Family Planning**: These include contraceptives such as the pill, female and male sterilisation, intra-uterine device (IUD), injectable, implant, male and female condom, other hormonal or barrier methods, and emergency contraception. **2. Women of Reproductive Age (WRA)**: This refers to the number of all women aged 15–49 years. **3. Modern Contraceptive prevalence rate (mCPR)**: This is the percentage of WRA who are using, or whose partners are using, modern contraceptives. It may be reported for all women or just for a subset of women who are 'married or in union'. **4. Total Users**: This is estimated by multiplying the mCPR to the number of WRA. **5. Additional Users**: This is the difference in total users between 2 years. [Note: this indicator does not apply to individuals and is measured at a population level]. **6. New User**: This term applies to the individual level. It has multiple definitions: first-time user of contraception; new to a provider; new to a contraceptive method (eg. switching methods) and/or; not recently using a method (eg. lapsed user). Using new users interchangeably with additional users is incorrect and it should not be used as a "proxy" **7. Difference between Additional and New Users (Figure 1):**. • There are a 100 total users (existing users) in a country in year 1. Between year 1 and year 2, 20 women stop using contraception. 80 women continue using contraception into year 2. • In year 2, there are **30 new users to contraception** (first-time

	users / starters). Therefore, in year 2, total users comprises of existing users (continuers) and new users, 80 + 30 = 110. • The **additional users** is the difference between the total number of users in year 1 and 2: 110 - 100 = 10. • If we "proxy" new users for additional users, we would not be taking into account discontinuation (stoppers). We would incorrectly over-estimate that there are 30 additional users between years. **Fig 1: Total family planning users**  **8. DFID Attribution:** This is the number of total and additional users of family planning in a country that are attributable to DFID support. Typically this is determined by DFID's share of family planning spending in a country.

Data calculation and guidance	**1. Calculation**
	
	Total Users
	• Step 1- Calculate Total Users Nationally:
	  ○ *WRA X mCPR*
	• Step 2 – Calculate DFID Attributable Fraction:
	  ○ *(DFID Spend) / (National Spend + DFID Spend)*
	• Step 3 – Calculate Total Users Supported by DFID:
	  ○ *(Step 1) X (Step 2)*
	
	Additional Users
	• Step 1- Calculate Total Users Nationally:
	  ○ *WRA X mCPR*
	• Step 2 – Calculate Additional Users Nationally:
	  ○ *Difference in Total Users between years*
	• Step 3 – Calculate DFID Attribution Fraction:
	  ○ *(DFID Spend) / (National Spend + DFID Spend)*
	• Step 4 – Calculate Additional Users Supported by DFID:
	  ○ *(Step 2) X (Step 3)*
	
	2. Guidance
	• Results are calculated at the country level.
	• Only use mCPR
	• Use mCPR and population estimates for all women of

	reproductive age (WRA), if possible.
	• mCPR and women of WRA data should be consistent. Eg. do not apply mCPR for married women to all women population estimates.
	• Always use the mCPR from a most recently available national survey. Then the following options can be used to project for intervening years where mCPR is not available:
	  ○ Use national estimates/goals/projections for mCPR if available or;
	  ○ Base projections on historical trends or;
	  ○ Consult international projections for mCPR (eg. Track 20 and/or UN Population Division projections) If for example, Track 20 predicts that mCPR will increase year on year by an average of 2%, consider using this increase in projections.
	• Always use the population of WRA from the most recently available national estimates. Then the following options can be used to project for intervening years where estimates are not available
	  ○ Use national estimates / projections if available or;
	  ○ Project based on historical trends or;
	  ○ Consult international population projections (eg. UN Population Division).
	• DFID's attribution fraction is its proportional share of national family planning spending. National spend comprises of DFID spending in country; government spending and; other donor spend. DFID's attribution will vary from year to year as DFID, government or other donor spending changes. This is a key variable for claiming DFID's results, therefore it is important to always include comprehensive data for national spending to avoid over-estimating DFID's attribution and results.
	  ○ For government spend, either the overall health budget or the family planning or reproductive health budget can be used.
	  ○ For other donor spend, consult data available in country and/or the OECD-DAC, CRS database.
	• DFID reports results in UK financial years (April to March).Where country data relate to calendar years or some other division, an appropriate overlapping period should be identified and used consistently.
	• If DFID's main funding is for service delivery programmes, consult point 3 in the section "Variation from Standard Methodology".

Data sources	**Suggested sources** (this is not an exhaustive list): **1. mCPR**: available from household surveys eg. the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys and contraceptive prevalence surveys or in-country household surveys / national statistics offices. **2. Population of WRA**: National Census data, or United Nations (UN)

	Population Division or estimates from in-country national statistics offices. **3. DFID attribution**: This typically comprises of DFID spend and national spend • DFID Spend: is available from DFID's internal spend tracking systems (eg. AMP/DFID Analytics) • National Spend: Information on family planning budgets, total government health budget is available from the annual progress reports of the health sector in-countries or directly from the ministry of health. Where possible, actual expenditure rather than planned expenditure should be used. Other donor spend on health / family planning is available from the OECD-DAC database
Reporting roles	DFID country offices/spending departments have primary responsibility for ensuring adequate baseline data is available and that programmes meet the requirements for ongoing monitoring. They should provide results returns as commissioned by DFID headquarters, updating previous estimates as new information on population of WRA, mCPR or DFID attribution becomes available.
Worked example	Table 1 presents a worked example: • **Population of WRA:** Official statistics recorded 100,000 women aged 15–49 years for the baseline year. We use the historical trend from official statistics records to estimate the equivalent population in each subsequent year pending new data. • **mCPR:** The DHS reported mCPR of 40% in the baseline year. A national mCPR goal has been set for 50% in year 5. Pending new data, we consult international projections. We find that the country is on track to reach its goal and mCPR will increase each year by 2%. We apply this increase in our projection. • **DFID attribution**: Data is available for DFID spend, government spend and other donor spend for family planning for this country. We therefore use the following formula to obtain DFID's attributable fraction: *(DFID Spend) / (National Spend + DFID Spend).* We work out that DFID will support 10% of the entire family spend in the country for year 1, 8% in year 2 and 5% in subsequent years. This is DFID's attribution fraction. • **DFID Result:** ○ Total Users**:** *(DFID Attribution fraction) X (Total users national*) eg. In year 1 this is 10% X 44,100 etc… ○ Additional users**:** *(DFID Attribution fraction) X (Additional users national)* eg. In year 1 this is 10% X 4,100 etc…

	<table><tr><th>Year</th><th>Baseline</th><th>year 1</th><th>year 2</th><th>year 3</th><th>year 4</th><th>year 5</th></tr><tr><td>Number of women aged 15–49 years</td><td>100,000</td><td>105,000</td><td>110,000</td><td>115,000</td><td>120,000</td><td>125,000</td></tr><tr><td>mCPR</td><td>40%</td><td>42%</td><td>44%</td><td>46%</td><td>48%</td><td>50%</td></tr><tr><td>Total users (national)</td><td>40,000</td><td>44,100</td><td>48,400</td><td>52,900</td><td>57,600</td><td>62,500</td></tr><tr><td>Additional users (national)</td><td></td><td>4,100</td><td>4,300</td><td>4,500</td><td>4,700</td><td>4,900</td></tr><tr><td>DFID Attribution fraction</td><td></td><td>10%</td><td>8%</td><td>5%</td><td>5%</td><td>5%</td></tr><tr><td>DFID result – total users</td><td></td><td>4,410</td><td>3,872</td><td>2,645</td><td>2,880</td><td>3,125</td></tr><tr><td>DFID result – additional users</td><td></td><td>410</td><td>344</td><td>225</td><td>235</td><td>245</td></tr></table>
Baseline	The baseline is calendar year 2012 or UK financial year 2012–13. because the FP2020 commitment relates to the whole period 2012–2020.Historical results should be updated as new survey or population information becomes available.
Return format	Calculations should be contained and maintained in a supporting spreadsheet. The spreadsheet must contain: • Clealy presented calculations; • Names and links to data sources; • Clearly presented & explained assumptions. Eg. rationale underlying mCPR & WRA projections; • Clear presentation of the components of spend data included in the calculation of DFID's Attribution fraction. Please do not include a final percentage or fraction only; • Calculations, raw data and explainations underlying DFID's Attribution fraction if alternate methods are used(i.e. non-spend data); • Descriptions and relevant calculations of alternate methodology (i.e. if option 3 under "variations in standard methodology" is being used). • Document any changes in assumptions that underlie calculations and contain up to date calculations to reflect new data releases and/or changed assumptions.
Data dis-aggregation	Where disaggregation is possible, results should be reported separately for adolescents aged 15–19 years and those in the bottom two wealth quintiles. [Note: we will provide better guidance on this for Spring 2017]
Quality assurance measures	There are four layers of quality assurance (QA) in place, not including any processes put in place by partners or implementers. 1. Country offices assess data quality during annual reviews and project completion reviews. 2. Country offices comment on the quality of their data being reported to DFID headquarters, and provide a link to the calculations spreadsheet. 3. Policy Division check results returns and calculations, and record any issues in a QA log. 4. Finance and Corporate Performance Division review the QA log to ensure resolution of issues.

Interpretation of results	Caution should be exercised in the interpretation of results, as year-to-year changes in the number of total and additional users of family planning through DFID support may be driven by a combination of country-specific factors and survey variation. For example: • Successful programming, population increase, secular trends and an increasing donor share will each by themselves generate increased results or; • Conversely, an underperforming programme, shocks, contraceptive stock-outs, decreasing population and decreasing donor share may each cause lower results (potentially negative results for additional users).
Data quality	Given the range of data sources used, the accuracy of the results data varies and is subject to the quality of the underlying data source. In many cases DFID uses survey data collected by others (eg partner country governments, international organisations) and has limited control over the quality of the data. There are challenges to collecting data in developing countries including constraints due to security risks. This can jeopardise the completeness and the accuracy of total and additional user estimates. To help mitigate some of the effects, we have in place four layers of quality assurance (QA), in addition to any processes put in place by partners or implementers as detailed under "Quality Assurance Measures" section.
Data issues	Family planning results are reported from all forms of DFID's funding including bilateral, regional, multilateral and civil society programmes. When aggregating the results from different forms of funding, double counting in countries receiving more than one aid modality is avoided by discounting an appropriate proportion of the multilateral, regional and/or civil society results. DFID HQ double counting methodology is recorded in Vault ID 15514293
Additional comments	Using new users as a proxy for additional users is not allowed. This will be an overestimate because it does not take account of those discountinuing contraception.
Variations from the standard methodology	There are 3 circumstances under which country offices / spending departments might want to deviate from standard methodology: **1. Data unavailability:** Data on 3 key variables are required for calculations for methodology described under "data calculation and guidance": mCPR; Population of WRA and; DFID Attribution fraction. • mCPR & population of WRA not available: DFID programmes operate in countries that have a DHS/MICS household survery and UN Population Division estimates. If there are considerable time-lags between data rounds, the office should consult international projections and historical trends for these variables and apply to calculations. • DFID Attribution fraction cannot be calculated using spend: This is likely to happen, as not all partner country governments track family

	planning spending or a substantial proportion of family planning services are delivered in the private sector, where spend data is hard to obtain. In this situation, alternate methods of claiming attribution can be used. Eg. Applying DFID's proportional share of contraceptives supplied to a country to the national total and additional user estimates to calculate DFID's result. It is important to clear this alternate method with DFID HQ before applying it to calculations. **2. DFID supports a specific geographical region only:** There are two options to calculate results: • Option 1: Use methodology in "data calculation and guidance" with regional level variables (if available) • Option 2: Use methodology with national level variables as described under "Data calculation and guidance". DFID programmes typically operate in regions which are harder to service (i.e. cost per result is higher than elsewhere in a country). Since DFID operates in these regions, other national funding is likely available to operate in the remaining, easier to service regions. Option 1 will measure the number of women DFID directly services in the region it works in. Option 2 will allow DFID to count all of the women reached under option 1 plus include a small proportion of women indirectly reached in the areas not serviced by DFID. This is reasonable, because these other women are likely reached only because DFID provided funding in harder to service regions. While either option is fine, it is recommended to use option 2 (standard methodology). **3. Service delivery programmes:** DFID funds a wide range programmes that contributes to total and additional users: from budget support that do not directly work with beneficiaries to service delivery (i.e. family planning clinics) that work directly with beneficiaries. The methodology under "Data calculation and guidance" is designed to measure total and additional users from the entire range of programming. However, service delivery programmes, are often able to directly measure the number of total and additional users supported in a country with DFID funds. Therefore, if DFID's main funding in a country is for this type of programming *and* partners use a robust methodology it may be acceptable to use their estimates instead of the standard methodology. Robust methodology includes using the MSI Impact 2 calculator. Spending departments should seek DFID HQ approval before they use methodology from service delivery programmes. Note: It is often the case that Centrally Managed Programmes (CMPs) are full service delivery and would like to use the MSI Impact 2 calculator instead. CMPs should consult DFID HQ for advice before going forward, so that steps can be taken to avoid double counting results from country office programmes. Along with details for methodology, CMPs will need to provide DFID HQ with: the list of countries they operate in; the amounts spent on the programme in each country and; the number of total and additional users reached in each country