Indicator description	**Number of additional women using modern methods of family planning through DFID support**
Version	Quest version 2.1 DATE: 18/06/2013 This replaces version 1.9 of the note (used for reporting rounds up to and including September 2012).
Changes since last version	Substantial changes in 15/02/2013 version to make the note clearer and clarify that: • there are exceptions to the main methodology including use of base and intervention scenarios, programme information where country data are unavailable or unreliable and regional information where appropriate. • country offices do not need to return actual information where no new survey data are available Minor changes in 18/6/13 version to change the type of indicator to cumulative and make suitable for publication.
Type of indicator	Variable
Methodological summary	The indicator measures the number of <u>additional</u> users of modern methods of family planning through DFID support. Measuring additional users is difficult because women change and stop their methods of contraception frequently. Data from family planning service providers is often unreliable or unavailable. This is particularly the case for social marketing programmes. A reasonable proxy for the number of additional users in each country is the difference between the absolute number of women using family planning between the baseline and the reporting period. This will not be the same as the number of <u>new</u> users since they will be different cohorts of women. The absolute number of women using family planning can be measured by applying the Contraceptive Prevalence Rate (measured from household surveys) to population estimates. For most countries, DFID's support should be calculated by taking a share of the additional users in the country, based on DFID's funding share. <u>Exceptions</u> 1) **Geographic regions.** If DFID is only supporting a specific geographical region within a country, the same method should be used. In this case the CPR should be applied to the population estimates in that specific geographical region. 2) **Use of base and intervention scenarios.** Some countries may choose to assume a base scenario and an intervention scenario and forecast the number of additional users as the difference between the two. This would be appropriate when particular shocks are expected in the country which will affect the likely users of family planning. In this case the additional users of family planning would be measured by comparing the actual number of users at a point in time with the expected base scenario (or counterfactual). 3) **Use of programme information.** In some countries, especially post-conflict

| | countries, population based data are unavailable or unreliable. In these circumstances, and when the main DFID financing modality for family planning is direct funding to service delivery programmes, it is more appropriate to estimate the annual number of new users serviced through these programmes (for example number of new users collected by a non-state service provider).

Exceptions should be agreed with Human Development Department.

Country offices are not <u>required</u> to submit numbers of results achieved every year. Because the methodology relies on household surveys which are only usually conducted every 3-5 years, DFID has contracted the Guttmacher Institute to calculate an aggregate annual estimate across all 28 DFID focus countries. This will provide estimates of progress for publication in the DFID Annual Report until sufficient country household survey information is available to generate reliable estimates. **Countries should still submit estimates of progress when new survey data become available.** These are important for triangulation with the Guttmacher estimates.

Countries should also update their <u>forecasts</u> when DFID's share of funding changes. |
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| Rationale | Internationally, progress towards family planning goals is now measured by tracking the number of additional users of family planning. The 2010 '*handtohand'* campaign, and the global movement, FP 2020, are using the number of additional users as the indicator to measure progress in family planning interventions. |
| Country Office Role | Country offices with family planning programmes, General Budget Support or Sector Budget Support should provide through the DFID Results Framework data collection system:

- forecasts of additional users by 2014/15

- estimates of achieved results when household survey data become available.

Calculations, data sources and assumptions should be clearly explained in a supporting spreadsheet. This should be saved in Quest, and the Quest number added to the DRF return. |
| Data sources | Data on the Contraceptive Prevalence Rate (CPR) are available from household surveys, notably the Demographic and Health Surveys, Multiple Indicator Cluster Surveys and contraceptive prevalence surveys. These are usually available only every 3-5 years.

Population data are available from official national population estimates. If these are not available, UN Population Division estimates can be used http://esa.un.org/wpp/unpp/Panel_profiles.htm

Where appropriate, data on new users can be sourced from programme monitoring systems.

Source for funding figures
Information on DFID funding allocation is available from approved Business Cases. Information on the total government health budget should be available from the Annual Progress Report of the Health Sector or directly from the Ministry of Health. For estimates of progress, actual expenditure should be used rather than planned expenditures, wherever possible. |

Reporting organisation	DFID
Data included	**The Contraceptive Prevalence Rate (CPR)** This is the percentage of women of reproductive age (15-49) who are practising, or whose partners are practising, a modern method of contraception. Modern methods of contraception are: male and female condoms, male and female sterilization, hormonal contraceptives (oral pills, injectables and implants), intrauterine devices, diaphragms and spermicides. **Total number of women of reproductive age** Population estimates of women of reproductive age (age 15-49) are required for the baseline year (see below). Actuals for later years are required as they become available. Forecasts are required for 2014/15. Note that the age group and marital status must be consistent between the CPR and the population estimates. Ideally, where data are available, the calculations would be based on the total number of women of reproductive age (whether married or unmarried). Household surveys sometimes report the CPR only for married women or women 'in union'. If this is the case, the population estimates for the number of married women aged 15-49 are likely to be the most appropriate. **DFID's contribution to the country's budget** Contributions for the total Health budget or the Reproductive, Maternal and Neonatal Health budget are needed, depending on the attribution method used (see below). These should be for the most recent year. **The country's overall planning budget** This should either be the total Health budget or the Reproductive, Maternal and Neonatal Health budget, depending on the DFID contribution figures used. **Programme data on new users** Where appropriate, the number of new users can be measured from programme monitoring systems.
Data calculations	For most countries The indicator measures the total additional users of modern methods of family planning. This is calculated from the number of users at the reporting period (or forecasting period) less the number of users at the baseline. (This is different from the indicator 'number of births attended by a skilled professional' which measures the cumulative number of births attended by skilled professional, counting repeated events (births) over the 4 years.) **The baseline.** The baseline year will vary across countries depending on family planning programmes that are operating in country. The baseline number of women using modern methods of family planning should be calculated by multiplying the contraceptive prevalence rate (CPR) in the baseline year by the number of women of reproductive age in the same year. Since household surveys are not conducted every year, it is likely that the CPR for the baseline will need to be estimated by projecting forward to the baseline from

the most recent previous survey. This should be done based on past trends or another suitable assumption.

The forecast. The forecast of additional women using modern methods of family planning should be calculated from the expected number of women using family planning in 2014/15 less the baseline number. The expected number in 2014/15 should be calculated by multiplying the expected CPR in 2014/15 by the expected number of women of reproductive age in 2014/15.

The expected CPR may be available from the country's own forecasts or can be predicted from past trends. Alternatively the CPR from the most recent household survey may be the most appropriate assumption for the likely CPR in 2014/15.

Population forecasts may be available from national statistics offices or UN Population Division. If not, they should be forecast based on previous trends.

Table 1 illustrates how the forecast is calculated.

Forecasts should be updated when the DFID attribution rate changes (see below) or when new CPR estimates become available from household surveys.

Estimates of actual progress. These should be provided when new CPR estimates become available from household survey data. They should be calculated by multiplying the latest CPR estimate by the number of women of reproductive age in the same time period, less the baseline estimate. See table 2**.**

Exceptions
1) **Geographic regions**. If DFID is only supporting a specific geographical region within a country, the same method should be used. In this case the CPR should be applied to the population estimates in that specific geographical region.

2) **Use of base and intervention scenarios.** Some countries may choose to assume a base scenario and an intervention scenario and forecast the number of additional users as the difference between the two. This would be appropriate when particular shocks are expected in the country which will affect the likely users of family planning, such as internal or external conflicts, stock-outs of family planning commodities or very rapid population growth. In this case a base scenario (or counterfactual) should be estimated using the expected future CPR with no family planning interventions. Then the additional users of family planning would be measured by comparing the actual number of users at a point in time with the expected base scenario at the same point in time. Justifications for assumptions, with evidence, should be given. This methodology is illustrated in tables 3 and 4.

3) **Use of programme information.** In some countries, especially post-conflict countries, population based data are unavailable or unreliable. In these circumstances, and when the main DFID financing modality for family planning is direct funding to service delivery programmes, it is more appropriate to estimate the annual number of new users serviced through these programmes (for example number of new users collected by a non-state service provider). Country offices are advised to work with implementers to estimate the expected number of new users served through these programmes by 2015, and the actual number of new users served annually. This would not be possible for social marketing programmes.

Exceptions should be agreed with Human Development Department.

DFID attribution
There are different ways of estimating DFID's attribution depending on the type of family planning programme operating in country. In most cases taking a share of the country's progress based on DFID's share of funding will be appropriate. So, if Country X had 500,000 more couples using modern methods between the baseline in 2009/10 and 2012/13, and DFID funds accounted for 10% of contraceptive services in Country X in that period, then DFID would be responsible for 50,000 couples adopting modern methods.

DFID's share of funding could either be its share of funding to Reproductive, Maternal and Neonatal Health programmes or to the health sector as a whole. Where DFID provides general budget support or sector budget support, it is more appropriate to take the share of the health budget.

DFID's attribution will vary from year to year as DFID or partner government spending changes. The funding share should be calculated for each year by dividing DFID's funding in a particular year by the country's expenditure (or budget if actual expenditure is not known) in the same year. This methodology is illustrated in table 5.

For further guidance please see the document entitled 'General guidance for Completion of the Results Template – including approach to attribution and contribution'. This is available on the DRF teamsite. http://teamsite/sites/fcpd/AEandVfM%20Dept/CP/CorpResultsFramework/Lists/RkyvLinks/AllItems.aspx

Illustrative tables

Table 1 illustrates how the forecast number of additional users of family planning is calculated. It uses an illustrative baseline year of 2009/10.

	Number of women aged 15-49	CPR	Number of women using family planning
2009/10 actual[1]	50,000	20%	10,000
2014/15 forecast	55,000	24%	13,200
Difference			3,200

[1] This may need to be projected forward from the previous household survey.

In this example there is an expected increase in CPR of 1 percentage point per year between 2009/10 and 2014/15 from 20% to 24%. The population of women aged 15-49 is forecast to rise from 50,000 to 55,000.

The expected number of additional users of family planning is **3,200.**

Table 2 illustrates how the estimates of progress are calculated.

	Number of women aged 15-49	CPR	Number of women using family planning	Additional users
2009/10 actual[1]	50,000	20%	10,000	
2010/11 actual	51,000	20.5%	10,455	455
2011/12 actual	52,000	21%	10,920	465
2012/13 actual	53,000	21.5%	11,395	475
2013/14 actual	54,000	22%	11,880	485

[1] This may need to be projected forward from the previous household survey.

In this example a household survey was conducted in 2013/14 which recorded a CPR of 22%, an increase from 20% in 2009/10. CPR is estimated for the intervening years. The number of women aged between 15 and 49 increased from 50,000 in 2009/10 to 54,000 in 2013/14. The number of women using modern methods of family planning is estimated each year, and the difference between years provides the number of additional users.

Table 3 illustrates how the 'base scenario' and 'intervention scenario' can be used to forecast the additional users of family planning.

		Base scenario		Intervention scenario	
	Number of women aged 15-49	CPR	Number of women using family planning	CPR	Number of women using family planning
2009/10 actual[1]	50,000	20%	10,000	20%	10,000
2014/15 forecast	55,000	18%	9,900	20%	11,000
Difference					1,100

[1] This may need to be projected forward from the previous household survey

In this example the country is expected to suffer from internal conflict and the CPR is forecast to fall from 20% in the baseline year 2009/10 to 18% by 2014/15. Under the intervention scenario, family planning programmes are expected to ensure that the CPR remains constant at 20%.

Then the expected impact of the family planning programmes is 11,000 less 9,900 = **1,100**.

Table 4: In the same way, the actual progress would need to be measured against the expected progress from the base scenario.

		Base scenario		Actual observed	
	Number of women aged 15-49	CPR	Number of women using family planning	CPR	Number of women using family planning
2009/10 actual[1]	50,000	20%	10,000	20%	10,000
2010/11 actual	51,000	19.5%	9,945	20%	10,200
2011/12 actual	52,000	19%	9,880	20%	10,400
2012/13 actual	53,000	18.5%	9,805	20%	10,600
2013/14 actual	54,000	18%	9,720	20%	10,800

[1] This may need to be projected forward from the previous household survey

	In this example there is an actual increase in the number of users of family planning of 800 between 2009/10 and 2013/14, but since the base scenario was predicting a fall, the number of additional users of family planning due to the family planning programmes operating in country is the difference between 10,800 and 9,720 = **1,080.**
	Table 5 illustrates the annual calculation of attribution.
	<table><tr><td></td><td>Additional users in country X</td><td>DFID share of funding</td><td>DFID contribution to additional users</td></tr><tr><td>2011/12</td><td>1,100</td><td>10%</td><td>110</td></tr><tr><td>2012/13</td><td>1,300</td><td>10%</td><td>130</td></tr><tr><td>2013/14</td><td>1,700</td><td>5%</td><td>85</td></tr><tr><td>2014/15</td><td>2,500</td><td>5%</td><td>125</td></tr><tr><td>Total</td><td></td><td></td><td>450</td></tr></table>
	In this example, DFID's funding share is 10% in 2011/12 and 2012/13. The partner government substantially increases its funding for reproductive health in 2013/14, resulting in a reduction of DFID's funding share to 5%. The correct proportion is applied to the number of additional users in each year to give DFID's contribution in each year. The number of additional users of family planning that can be attributed to DFID is **450**.

Calculations, data sources and assumptions should be clearly explained in a supporting spreadsheet. |
| Good performance | The target is 10 million additional women using modern methods of family planning through DFID support. This will be met through funding to the bilateral programme and multilateral and civil society organisations.

A separate note sets out the methodology to assess DFID contribution toward the target from multilateral programmes, such as UNFPA Global Programme for Reproductive Health Commodity Security, and civil society programmes. |
| Return Format | Forecasts and estimates of progress should be made to FCPD via the templates on the DFID Results Framework teamsite. Spreadsheets containing the data calculations, sources and assumptions should be made available to Human Development Department. Quest numbers should be noted in the FCPD Template. |
| Data disaggregation | **No disaggregations are required from country offices.** The Framework for Results for Reproductive, Maternal and Newborn Health commits DFID to monitor and achieve progress in the poorest 40% and among adolescents aged 15-19. This will be monitored separately by the Guttmacher Institute.

If DFID is supporting a specific geographical region rather than the whole country then the CPR should be applied to the population estimates for that specific geographical region. |
| Data availability | Household surveys, such as Demographic and Health Surveys, Multiple Indicator Cluster Surveys and contraceptive prevalence surveys, are generally conducted every three to five years and are available for the majority of developing countries through the DHS and MICS.

Population data can be found from the latest population estimates of the relevant |

	country or from the UN population estimates.
Quality assurance measures	The forecasts and estimates should be double checked by a second adviser before being submitted.
Data issues	Data issues and how they should be addressed are outlined in 'data calculations' section above.
Country Office/Spending Department variation	
Bangladesh	Cumulative
Ethiopia	Peak year
Ghana	Cumulative
India	Cumulative up to 2010/11 inclusive: peak year thereafter
Indonesia	Peak year
Malawi	Peak year
Rwanda	Peak year
Sierra Leone	Peak Year
Uganda	Peak Year
Zambia	Peak Year