

Indicator description	Number of additional women using modern methods of family planning through DFID support
Type of indicator	Cumulative
Overview	<p>This outcome indicator measures DFID's contribution to the number of additional women using modern methods of family planning in each country.</p> <p>Country offices with reproductive health programmes, or which provide general or health sector budget support, should report results against this indicator.</p> <p>For each year, the total number of family planning users is estimated by applying the contraceptive prevalence rate (CPR) to the number of women aged 15–49 years. The difference between this figure and the total number of family planning users in the previous year gives the number of additional women using family planning. DFID attributed results are based on funding share. The results for each year are summed to generate the cumulative total over the DFID results framework (DRF) period of 5 years from financial year 2010/11 to financial year 2014/15.</p>
Technical definition summary	<p>Modern methods of family planning include the pill, female and male sterilisation, intra-uterine device (IUD), injectable, implant, male and female condom, diaphragm, and emergency contraception.</p> <p>CPR is the percentage of women aged 15–49 years who are using, or whose partners are using, a modern method of contraception.</p> <p>To illustrate how the metric <i>additional family planning users</i> differs from <i>new users</i>, suppose that the total family planning users in year 1 is 100. Of these, 75 continue using contraception into year 2, and 25 stop using contraception. Suppose in year 2, there are 50 new users who were not using contraception in year 1.</p> <p>The total family planning users in year 2 comprises continuers and new users, $75 + 50 = 125$.</p> <p>The additional users between year 2 and year 1 is the difference between the total number of users in these years, $125 - 100 = 25$</p>

	<div data-bbox="395 230 1362 801" data-label="Figure"> <p>Total family planning users</p> <table border="1"> <thead> <tr> <th>Year</th> <th>Continuers</th> <th>Stoppers</th> <th>Starters</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Year 1</td> <td>100</td> <td>0</td> <td>0</td> <td>100</td> </tr> <tr> <td>Year 2</td> <td>75</td> <td>25</td> <td>25</td> <td>125</td> </tr> </tbody> </table> </div> <p>The methodology set out in this note is used to calculate results obtained through our bilateral programmes. Published results against this indicator also include results from our multilateral and regional programmes, and civil society organisations, where the risk of double counting can reasonably be eliminated.</p>	Year	Continuers	Stoppers	Starters	Total	Year 1	100	0	0	100	Year 2	75	25	25	125
Year	Continuers	Stoppers	Starters	Total												
Year 1	100	0	0	100												
Year 2	75	25	25	125												
<p>Rationale</p>	<p>Unmet need for family planning is a major barrier to development. This indicator is an outcome metric which is understood and used internationally to track progress towards meeting global unmet need for family planning following commitments at the family planning summit in 2012. The indicator takes account of maintaining supplies to existing users of family planning as well as reaching new users.</p>															
<p>Data calculation and guidance</p>	<p>Total family planning users = number of women aged 15–49 years X CPR</p> <p>Additional users = Difference in total family planning users between years</p> <p>DFID result = DFID attributable fraction X additional users</p> <p>Results are calculated for the whole country for each financial year 2010/11, 2011/12, 2012/13, 2013/14, and 2014/15.</p> <p>If DFID is supporting only a specific geographical region within a country, the same method should be used, with CPR and population data corresponding to the specific geographical region.</p> <p>For years in which information on the number of women aged 15–49 years is not yet available, any reasonable method may be used to estimate it pending the publication of new population estimates: for example projections based on historical trend.</p> <p>For years in which there is no information on CPR, any reasonable method may be used to estimate it pending the results of the next survey: for example projections based on historical trend, or linearly interpolating between the most recent known rate and the target value.</p> <p>Age group and marital status should be consistent between CPR and population</p>															

	<p>estimates. Ideally, calculations are based on the total number of women aged 15–49 years, whether married or unmarried. However, household surveys sometimes report CPR only for married women or women ‘in union’.</p> <p>If particular shocks occur within a country affecting supplies of contraceptives, it is acceptable to estimate additional family planning users as the difference between intervention and counterfactual (business as usual) scenarios. Justifications for assumptions, with evidence, should be given.</p> <p>DFID’s attributable fraction is its donor share of family planning results. This is usually estimated from inputs, such as budget share. For sector budget support, either the overall health budget or the reproductive health budget is used, corresponding to DFID’s contribution. DFID’s attribution will vary from year to year as DFID, partner government or other donor spending changes. Where a substantial proportion of a country’s family planning services are delivered in the private sector, it may not be possible to reliably estimate funding share.</p> <p>In countries where population data are unavailable or unreliable, the funding share is unknown, or the main DFID financing modality is direct funding to service delivery programmes, this indicator is estimated from programme data or management information.</p> <p>DFID reports results in UK financial years (April to March). Where country data relate to calendar years or some other division, the closest period to DFID’s financial year should be used without adjustment. For example, 2013 calendar year data would be reported under DFID’s 2013/14 financial year.</p>
Data sources	<p>CPR is available from household surveys, such as the Demographic and Health Surveys, Multiple Indicator Cluster Surveys and contraceptive prevalence surveys.</p> <p>Population data can be obtained from official national statistics or United Nations (UN) Population Division.</p> <p>Information on DFID funding allocation is available from approved business cases.</p> <p>Information on the total government health budget is available from the annual progress report of the health sector or directly from the ministry of health. Where possible, actual expenditure rather than planned expenditure should be used.</p>
Reporting roles	<p>Country offices should provide twice-yearly returns of achieved results for financial years 2010/11, 2011/12, 2012/13, 2013/14, and 2014/15, updating previous estimates as new information on population, CPR or DFID attribution becomes available.</p>
Worked examples	<p>1. Standard methodology</p> <p>Official statistics recorded 100,000 women aged 15–49 years for the baseline year 2009, as shown in the table. The historical trend was used to estimate the equivalent population in each subsequent year pending new data. The most recent household survey reported CPR of 40% in 2009. The reproductive health programme is intended to increase CPR to 50% by 2014. Estimates of CPR are linearly interpolated for intervening years pending new survey data. DFID supported 10% of the country’s health budget in 2010, 8% in 2011 and 5% in subsequent years.</p>

Year	Baseline 2009	2010	2011	2012	2013	Target 2014
Number of women aged 15–49 years	100,000	105,000	110,000	115,000	120,000	125,000
CPR	40%	42%	44%	46%	48%	50%
Total family planning users	40,000	44,100	48,400	52,900	57,600	62,500
Additional family planning users		4,100	4,300	4,500	4,700	4,900
DFID attributable fraction		10%	8%	5%	5%	5%
DFID result		410	344	225	235	245

2. Intervention versus counterfactual methodology

Official statistics recorded 100,000 women aged 15–49 years for the baseline year 2009, as shown in the table. The historical trend was used to estimate the equivalent population in each subsequent year pending new data. The most recent household survey reported CPR of 40% in 2009. The reproductive health programme is intended to increase CPR to 50% by 2014. Estimates of CPR under the intervention scenario are linearly interpolated for intervening years pending new survey data. DFID and other donors prevented a national stock-out of contraceptives in 2010. Under the counterfactual scenario, CPR is assumed to drop to 35% in 2010 then increase in line with regional trends. DFID supported 10% of the reproductive health programme in 2010, 8% in 2011 and 5% in subsequent years.

Year	Baseline 2009	2010	2011	2012	2013	Target 2014
Number of women aged 15–49 years	100,000	105,000	110,000	115,000	120,000	125,000
CPR with DFID intervention	40%	42%	44%	46%	48%	50%
Total family planning users with DFID intervention	40,000	44,100	48,400	52,900	57,600	62,500
CPR without DFID intervention	40%	35%	36.5%	37%	38.5%	40%
Total family planning users without DFID intervention	40,000	36,750	40,150	42,550	46,200	50,000
Additional family planning users		7,350	8,250	10,350	11,400	12,500
DFID attributable fraction		10%	8%	5%	5%	5%
DFID result		735	660	518	570	625

DFID's results for each year, pending updated population and CPR data, are entered in the DRF return. The annual results are added together to give the cumulative total for the DRF period.

Baseline data

Country offices can determine the most suitable baseline for this indicator, depending on the timing of their reproductive health programmes and the availability of survey data.

	<p>A baseline estimate of total family planning users is required for the calculation of this indicator under the standard methodology, as results are expressed in relation to the previous year.</p> <p>Baseline data on population and CPR will be useful to monitor progress under the intervention-versus-counterfactual methodology.</p>
Return format	<p>Results are returned via a template on the DRF teamsite.</p> <p>Calculations, data sources and assumptions should be clearly explained in a supporting spreadsheet.</p>
Data disaggregation	<p>As yet, most countries' data collection systems are unable to support age or wealth disaggregation in DRF reporting. Where disaggregation is possible, results should be given separately for adolescents aged 15–19 years and those in the bottom two wealth quintiles.</p> <p>The Guttmacher Institute provides disaggregated estimates of CPR and unmet need among the youngest and poorest in DFID focus countries, to enable us to monitor equity in DFID's reproductive health programming.</p>
Data availability	<p>In some countries there will be difficulties obtaining the required data to measure results against this indicator. In these situations, results should be estimated at the output level, using management information or programme data.</p>
Time period/lag	<p>There may be a considerable lag in verifying achieved results, as surveys only take place every 3–5 years.</p>
Quality assurance measures	<p>There are four layers of quality assurance (QA) in place, not including any processes put in place by partners or implementers.</p> <ol style="list-style-type: none"> 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 in the DRF, and provide a link to the calculations spreadsheet. 3. Policy Division check the DRF return and the 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	<p>Caution should be exercised in the interpretation of results, as year-to-year changes in the number of additional users of family planning through DFID support may be driven by a combination of country-specific factors.</p> <p>A result greater than zero for additional users is likely to indicate DFID programming having successfully increased a country's CPR. However, positive results may also be due to an increase in population.</p> <p>Conversely, a negative number of additional users may indicate an underperforming programme; but could also be due to project completion or decreasing population.</p> <p>Variations in DFID's donor share will cause results to increase or decrease.</p>
Data quality	<p>This outcome level indicator is considered highly relevant for measuring global access to contraceptives, because it takes account of maintaining supplies to existing users as well as reaching new users. It is an internationally coherent metric which is used to track progress towards meeting global unmet need for family planning following commitments at the family planning summit in 2012. Sixteen DFID country offices, one multilateral programme, one regional</p>

	<p>programme and two civil society organisations contribute towards this indicator from reproductive health programmes or general/health budget support. Results are considered to be moderately accurate overall. Accuracy is good in countries with recent demographic and health surveys (DHS), reliable population estimates and where DFID's share of funding for family planning can be established. The indicator is much more difficult to measure, and likely to be inaccurate, where these things are not in place. Where results are based on surveys which only take place every three to five years, there may be long time lags in obtaining data. Coherence is problematic where country offices or partners are unable to effectively measure the required indicator, and therefore use a proxy such as new users. There are no concerns in terms of cost or confidentiality.</p>
Additional comments	<p>Using new users as a proxy for additional users will overestimate the required indicator because it does not take account of those continuing or stopping contraception.</p>
Variations from the standard methodology	<p>Alternatives to the standard methodology are an intervention-versus-counterfactual methodology, or using management information or programme data to measure results.</p>