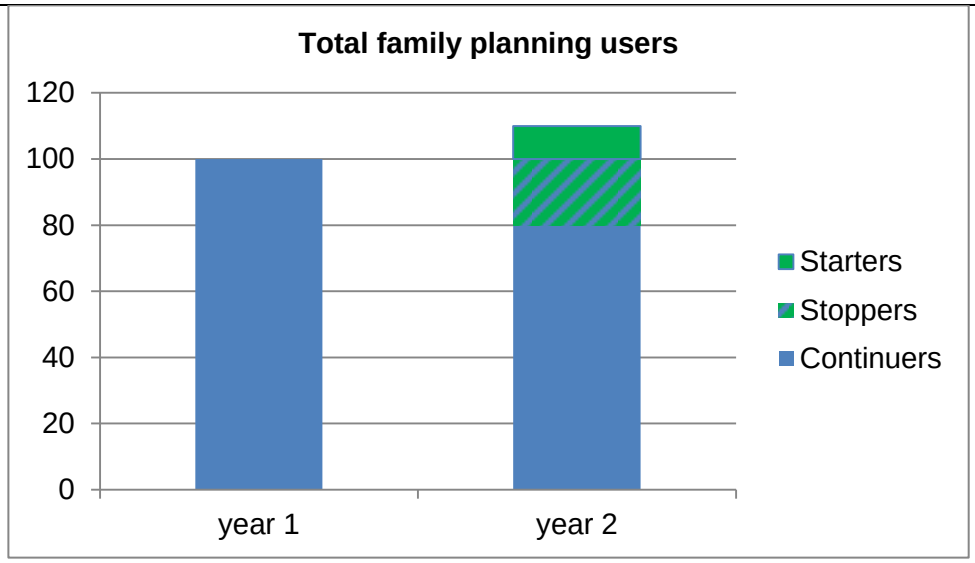
Indicator description	**Number of additional women using modern methods of family planning through DFID support**
Type of indicator	Cumulative
Rationale	Unmet need for family planning is a major barrier to development. This indicator is an outcome metric which is used internationally to track progress towards meeting global unmet need for family planning following commitments at the London Summit on Family Planning in 2012. The indicator takes account of maintaining supplies to existing users of family planning as well as reaching new users. This methodology note describes the measurement of DFID's contribution to the number of additional women using modern methods of family planning. It applies to country offices with reproductive health programmes, or which provide general or health sector budget support.
Technical definition	Modern methods of family planning include the pill, female and male sterilisation, intra-uterine device (IUD), injectable, implant, male and female condom, other hormonal or barrier methods, and emergency contraception. Contraceptive prevalence rate (CPR) is the percentage of women aged 15–49 years who are using, or whose partners are using, contraception. It may be reported for modern and traditional methods or just modern methods; and it may be reported for all women or just women 'married or in union'. The total number of family planning users is estimated by applying the CPR to the number of women aged 15–49 years. The difference in total family planning users between 2 years gives the number of additional women using family planning over the period. DFID attributed results are based on DFID's share of the country's results (see data calculations section below). To illustrate how the metric *additional family planning users* differs from *new users*, suppose that the total family planning users in year 1 is 100. Of these, 80 continue using contraception into year 2, and 20 stop using contraception. Suppose in year 2, there are 30 new users who were not using contraception in year 1. The total family planning users in year 2 comprises continuers and new users, 80 + 30 = 110. The additional users between year 2 and year 1 is the difference between the total number of users in these years, 110 - 100 = 10.

	
Data calculation and guidance	Total family planning users = number of women aged 15–49 years X CPR Additional users = Net Difference in total family planning users between years DFID result = DFID attributable fraction X additional users Results are calculated at the country level for each year. Please use the CPR for modern methods only and all women of reproductive age, where data are available. Age group and marital status should be consistent between CPR and population estimates. 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. If 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. Use existing official projections where available. If information on CPR is not yet available, any reasonable method may be used to estimate it pending the results of the next survey: for example linearly interpolating between the most recent known rate and the target value, using modelled estimates or projections based on historical trend. 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. DFID's attribution will vary from year to year as

<table>
<tr><td></td><td>DFID, partner government or other donor spending changes.

DFID reports results in UK financial years (April to March); although the international FP2020 commitments are tracked by calendar year. Where country data relate to calendar years or some other division, an appropriate overlapping period should be used consistently and without adjustment.</td></tr>
<tr><td>Data sources</td><td>CPR is available from household surveys, such as the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys and contraceptive prevalence surveys.

Modelled estimates of CPR are available from United Nations (UN) Population Division.

Population data can be obtained from official national statistics or United Nations (UN) Population Division.

Information on DFID funding allocation is available from approved business cases.

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.</td></tr>
<tr><td>Reporting roles</td><td>DFID country offices/spending departments have primary responsibility for ensuring adequate baseline data is available and that programmes include suitable indicators and requirements for ongoing monitoring. They should provide results returns as commissioned by DFID headquarters, updating previous estimates as new information on population, CPR or DFID attribution becomes available.</td></tr>
<tr><td>Worked example</td><td>Official statistics recorded 100,000 women aged 15–49 years for the baseline year, as shown in the table. The historical trend was used to estimate the equivalent population in each subsequent year pending new data. The DHS reported CPR of 40% in the baseline year. The reproductive health programme increased CPR to 50% by year 5. Estimates of CPR are linearly interpolated for intervening years pending new survey data. DFID is supporting 10% of the country’s health budget in year 1, 8% in year 2 and 5% in subsequent years.

<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>Target 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>CPR</td><td>40%</td><td>42%</td><td>44%</td><td>46%</td><td>48%</td><td>50%</td></tr>
<tr><td>Total family planning users</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 family planning users</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 attributable fraction</td><td></td><td>10%</td><td>8%</td><td>5%</td><td>5%</td><td>5%</td></tr>
</table>
</td></tr>
</table>

	DFID result		**410**	**344**	**225**	**235**	**245**
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, data sources and assumptions should be clearly explained in a supporting spreadsheet.						
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.						
Data availability	In some countries there will be difficulties obtaining the required data to measure results against this indicator: for example where there is no recent DHS, or population data are unavailable or unreliable. Where a substantial proportion of a country's family planning services are delivered in the private sector, it may be challenging to reliably estimate funding share.						
Time period/lag	There may be a considerable lag in verifying achieved results, as surveys only take place every 3–5 years.						
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 additional users of family planning through DFID support may be driven by a combination of country-specific factors and survey variation. Successful programming, population increase, secular trends and an increasing donor share will each by themselves generate positive results on this indicator. Conversely, an underperforming programme, shocks, contraceptive stock-outs, decreasing population and decreasing donor share may each cause low or negative results on this indicator.						
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 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 the results estimates.						

	There are four layers of quality assurance (QA) in place relating to the DFID calculations, in addition to 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 HQ, 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.
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.
Additional comments	Using new users as a proxy for additional users is not recommended. It will overestimate the required indicator because it does not take account of those stopping contraception.
Variations from the standard methodology	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 may be estimated from programme data or management information.