INDICATOR ANALYSIS

PROPORTION OF WOMEN OF REPRODUCTIVE AGE (15-49) WHO HAVE THEIR NEED FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS

ANALYSIS CONDUCTED BY FRANCOIS DAUDELIN & VAL PERCIVAL

FOR THE LANCET-SIGHT COMMISSION ON PEACEFUL SOCITIES THROUGH HEALTH AND GENDER EQUALITY

How is the indicator calculated?	*Definition:* The percentage of women of reproductive age (15–49 years) who desire either to have no (additional) children or to postpone the next child and who are currently using a modern contraceptive method *Calculation:* Modern contraceptive prevalence rate (mCPR) divided by the total demand for modern methods of contraception x 100 • mCPR is calculated as the number of women of reproductive age using a modern method of contraception divided by the total number of women of reproductive age x 100 Total demand for modern methods is calculated as mCPR + unmet need for modern methods (1).

GLOBAL TRENDS	
What are the global patterns for this indicator?	Globally, the proportion of women of reproductive age (15 – 49 years) who have their need for family planning satisfied with modern contraceptive methods increased slightly, from 74% in 2000 to 76% in 2019. The same figure is just 55% in sub Saharan Africa and Western Asia, and 51% in Oceania (excluding Australia and New Zealand) (2).

UTILITY	
What does the indicator measure?	This indicator measures if the use of family planning is keeping up with the desire to prevent pregnancy (2).
What does it NOT measure - what does it miss?	This indicator does not measure the effectiveness of modern contraceptive methods and if and in some countries, may only include married women.
If and how does the indicator relate to interface/relationship among health, gender and fragility/stability	Women in fragile settings are at higher risks of pregnancy-related morbidity and mortality. Access to contraceptives helps reduce unwanted pregnancy and can help reduce the number of complications in areas where there is limited care available (3).

AVAILABILITY

Sources for indicator (CRVS, DHS etc - include links)	Surveys: 1. Demographic and Health Surveys (DHS); 2. Reproductive Health Surveys (RHS); 3. Multiple Indicator Cluster Surveys (MICS). Indicator data are available from the following sources: 1. WHO's Global Health Observatory (country level 2009-2018): https://www.who.int/data/gho/data/indicators/indicator-details/GHO/demand-for-family-planning-satisfied---modern-methods-(-) 2. World Bank Data Bank (country and regional levels 1990-2019) Bankhttps://data.worldbank.org/indicator/SH.FPL.SATM.ZS 3. UN's Global SDG indicators Database (country and regional levels 2000-2021): https://unstats.un.org/sdgs/indicators/database/
Dates available	Data is available on the World Bank Databank for 1990-2019.
Availability across geographic areas	Available in many countries; however, frequency of data collected varies.
Availability in conflict affected settings	Limited, depends on the ability to conduct household surveys. When surveys are collected, coverage may be inadequate. Data in conflict affected settings varies by country (Years with data available from World Bank Data Bank): Yemen (2013); South Sudan (No Data); Libya (2014); Somalia (No Data), DRC (2014), Afghanistan (2015).

GRANULARITY	
Disaggregation at national level	
Data disaggregated by sex;	While some constituent tracer indicators are disaggregated by sex, data of the final output of the coverage index is not disaggregated by sex (2).
Data disaggregated by identity group (race, ethnicity);	No.
Data disaggregated by income	No. But wealth quintile breakdown available in limited countries.
Data disaggregated by citizenship;	No.
Data disaggregated by migration background;	No.

Disaggregation at sub-national level	
Data disaggregated by geographic region;	No. But urban/rural breakdown available in limited countries.
Data disaggregated by identity group (race, ethnicity);	No.
Data disaggregated by income.	No. But wealth quintile breakdown available in limited countries.

SOURCES OF BIAS	
What bias can exist with these data?	There is the possibility of selection bias when using survey methods to collect data. Additionally, data and information platforms may employ different measurement approaches. Historically, many surveys did not include questions about contraception for unmarried women (4).

VALIDITY	
Clear and accepted international standards for indicator;	Clear standards have been followed in collecting data for this indicator from married women. The inclusion of unmarried women is becoming more common, but it is not yet standardized.
Validity of measurement of indicator generally accepted;	Validity will depend on the coverage and accuracy of the data source, as well as the methodology used. Data sources that have low coverage may be less valid due to selection bias (5). Surveys that include unmarried women will have greater validity.

RELIABILITY	
Reliability of indicator generally accepted;	Reliability of the indicator is limited by the quality and method of data collection. Given the recent inclusion of unmarried women, results are likely to vary.

COMPLEXITY	
Enables analysis across time and location.	Yes, this indicator does enable for analysis across time and location as there is no geographic or time-related limitation explicitly identified within its definition. Modeled data are useful for comparing populations with different access to and preferences of contraception across time and space (2).

OTHER REFLECTIONS	
Are indicator values imputed/modelled?	Values at the country level from the WHO's Global Health Observatory, the Global SDG indicators' database and the World Bank are not imputed or modelled.
	For estimates from the three sources at the regional and global level, a Bayesian hierarchical model is used to model the indicator based on countries with available data (6). *Uncertainty bounds are not included with regional and global estimates. As such, caution should be exercised when comparing values through space and time.*
	The model is described in more detail in Alkema L., V. Kantorová, C. Menozzi and A. Biddlecom (2013) (7).

References

1. UNDESA. Estimates and Projections of Family Planning Indicators 2020 [Internet]. 2020 [cited 2021 Sep 17]. Available from: https://www.un.org/en/development/desa/population/theme/family-planning/cp_model.asp

2. Population Division of the United Nations Department of Economic and Social Affairs. Global progress in satisfying the need for family planning. 2019.

3. Austin J, Guy S, Lee-Jones L, McGinn T, Schlecht J. Reproductive health: a right for refugees and internally displaced persons. Reproductive health matters. 2008;16(31):10–21.

4. Short Fabric M, Jadhav A. Standardizing Measurement of Contraceptive Use Among Unmarried Women. Global Health: Science and Practice. 2019;7(4):564–75.

5. Pan American Health Organization. Health Indicators: Conceptual and Operational Considerations [Internet]. 2018 [cited 2020 Feb 12]. Available from: https://www.paho.org/hq/index.php?option=com_content&view=article&id=14401:health-indicators-conceptual-and-operational-considerations-section-1&Itemid=0&limitstart=4&lang=en

6. United Nations Statistics Division. Indicator 3.7.1: Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods [Internet]. United Nations Statistics Division; 2021. Available from: https://unstats.un.org/sdgs/metadata/files/Metadata-03-07-01.pdf

7. Alkema L, Kantorova V, Menozzi C, Biddlecom A. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. The Lancet. 2013;381(9878):1642–52.