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| 32 | 25 | 1 | Contact point in international agency | Name: Ms. Vladimira Kantorova Agency: Population Data Unit, Population Division DESA  Title: Population Affairs Officer  E-mail: [kantorova@un.org](mailto:kantorova@un.org)  Website: <https://www.un.org/development/desa/pd/>  Agency: United Nations Population Fund (UNFPA)  Website: <https://www.unfpa.org> |
| 32 | 25 | 2 | International agreed definition | Definition:  The percentage of women of reproductive age (15-49 years) currently using a modern method of contraception among those who desire either to have no (additional) children or to postpone the next pregnancy. The indicator is also referred to as the demand for family planning satisfied with modern methods.  Concepts:  The percentage of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods is also referred to as the proportion of demand satisfied by modern methods. The components of the indicator are contraceptive prevalence (any method and modern methods) and unmet need for family planning.   Contraceptive prevalence is the percentage of women who are currently using, or whose partner is currently using, at least one method of contraception, regardless of the method used. Unmet need for family planning is defined as the percentage of women of reproductive age who want to stop or delay childbearing but are not using any method of contraception. The standard definition of unmet need for family planning includes women who are fecund and sexually active in the numerator, and who report not wanting any (more) children, or who report wanting to delay the birth of their next child for at least two years or are undecided about the timing of the next birth, but who are not using any method of contraception. The numerator also includes pregnant women whose pregnancies were unwanted or mistimed at the time of conception; and postpartum amenorrheic women who are not using family planning and whose last birth was unwanted or mistimed. Further information on the operational definition of the unmet need for family planning, as well as survey questions and statistical programs needed to derive the indicator, can be found at the following website of the USAID Demographic and Health Surveys Program: http://measuredhs.com/Topics/Unmet-Need.cfm.  For analytical purposes, contraceptive methods are often classified as either modern or traditional. Modern methods of contraception include female and male sterilization, the intra-uterine device (IUD), the implant, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), lactational amenorrhea method (LAM), emergency contraception and other modern methods not reported separately (e.g., the contraceptive patch or vaginal ring). Traditional methods of contraception include rhythm (e.g., fertility awareness-based methods, periodic abstinence), withdrawal and other traditional methods not reported separately.  Comments and limitations:  Differences in the survey design and implementation, as well as differences in the way survey questionnaires are formulated and administered can affect the comparability of the data. The most common differences relate to the range of contraceptive methods included and the characteristics (age, sex, marital or union status) of the persons for whom contraceptive prevalence is estimated (base population). The time frame used to assess contraceptive prevalence can also vary. In most surveys there is no definition of what is meant by “currently using” a method of contraception.  In some surveys, the lack of probing questions, asked to ensure that the respondent understands the meaning of the different contraceptive methods, can result in an underestimation of contraceptive prevalence, in particular for traditional methods. Sampling variability can also be an issue, especially when contraceptive prevalence is measured for a specific subgroup (by age-group, level of educational attainment, place of residence, etc.) or when analyzing trends over time.  When data on women aged 15 to 49 are not available, information for married or in-union women is reported. Illustrations of base populations that are sometimes presented are: married or in-union women aged 15-44, sexually active women (irrespective of marital status), or ever-married women. Notes in the data set indicate any differences between the data presented and the standard definitions of contraceptive prevalence or unmet need for family planning or where data pertain to populations that are not representative of women of reproductive age. |
| 32 | 25 | 3 | Method of computation | The indicator consists of indicator 32a which refers to non-estimated national data while, indicator 32b contains estimates from UN Population Division. For the non-estimated national data, the numerator is the percentage of women of reproductive age (15-49 years old) who are currently using, or whose partner is currently using, at least one modern contraceptive method. The denominator is the total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning). Estimates are with respect to women who are married or in a union.  *Demand satisfied by modern methods = Number of women who are currently using a modern method of contraception / Number of women who are using any method of contraception of are having an unmet need for family planning.*  Indicator 32b contains estimates from UN Population Division. In order to generate regional and global estimates for any given reference year, the Population Division/DESA uses a Bayesian hierarchical model, described in detail in:  Alkema L., V. Kantorová, C. Menozzi and A. Biddlecom (2013). 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. Vol. 381, Issue 9878, pp. 1642–1652.  Kantorová V., M. Wheldon, P. Ueffing., A. N. Z. Dasgupta (2020). Estimating progress towards meeting women’s contraceptive needs in 185 countries: A Bayesian hierarchical modelling study. PLoS Medicine 17(2):e1003026.  Country-level, model-based estimates are only used for computing the regional and global averages. Information from surveys that only provide data on contraceptive use (and have no information on unmet need for family planning) is considered as well. The model is providing estimates of the indicator for countries and years without direct survey data by extrapolating underlying trends determined using data across all countries. The model implicitly weights observations from other countries such that higher weights are given to observations from more similar countries. The fewer the number of observations for the country of interest, the more its estimates are driven by the experience of other countries, whereas for countries with many observations the results are determined to a greater extent by those empirical observations.  Rationale:  The proportion of demand for family planning satisfied with modern methods is useful in assessing overall levels of coverage for family planning programmes and services. Access to and use of an effective means to prevent pregnancy helps enable women and their partners to exercise their rights to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. Meeting demand for family planning with modern methods also contributes to maternal and child health by preventing unintended pregnancies and closely spaced pregnancies, which are at higher risk for poor obstetrical outcomes. Levels of demand for family planning satisfied with modern methods of 75 per cent or more are generally considered high, and values of 50 per cent or less are generally considered as very low.  Disaggregation:  Age, sex, geographic location, depending on the data source and number of observations. |
| 32 | 25 | 4 | Importance of the indicator in addressing gender issues and its limitation | Access to and use of an effective means of contraception to prevent pregnancy enables women and their partners to exercise their rights to decide freely and responsibly the number and spacing of their children. Shortfalls in women’s empowerment are closely intertwined with shortfalls in reproductive rights. Gender discrimination can negatively influence health systems, for instance, so that women cannot access the reproductive health services and information, including family planning, and might be limited in their choices of types of contraception. At the household level, when women are not involved in household decision-making or are subjected to gender-based violence, they may have little control over their reproductive life, including use of contraceptives. Meeting demand for family planning with modern methods also contributes to preventing unintended pregnancies, which are at higher risks of poor maternal and child health outcomes. |
| 32 | 25 | 5 | Sources of discrepancies between global and national figures | Some published national data have been adjusted by the Population Division to improve comparability. Notes are used in the data set to indicate when adjustments were made and where data differed from standard definitions. Surveys might differ in the classification of modern and traditional methods. To improve comparability of data over time and across countries, method classifications used in some survey are adjusted to follow the classification described above. The global indicator represents all women of reproductive age. Some survey estimates represent women who are married or in a union and this is indicated in a note. |
| 32 | 25 | 6 | Process of obtaining data | This indicator is calculated from nationally representative household survey data. Multi-country survey programmes that include relevant data for this indicator are: Contraceptive Prevalence Surveys (CPS), Demographic and Health Surveys (DHS), Fertility and Family Surveys (FFS), Reproductive Health Surveys (RHS), Multiple Indicator Cluster Surveys (MICS), Performance Monitoring and Accountability 2020 surveys (PMA), World Fertility Surveys (WFS), other international survey programmes and national surveys.  For information on the source of each estimate, see United Nations, Department of Economic and Social Affairs, Population Division (2021). World Contraceptive Use 2021. (https://www.un.org/development/desa/pd/data/world-contraceptive-use)  For surveys with microdata sets available, the indicators are calculated following the definitions and concepts described above. These results are compared with the indicators published in survey reports, SDG national reporting platforms, or obtained from ad hoc queries. In some cases of discrepancies, the results are consulted with the national institutions that conducted the survey.  For model-based estimates and projections, out-of-sample validation methods are described in Kantorová V., M. Wheldon, P. Ueffing., A. N. Z. Dasgupta (2020). Estimating progress towards meeting women’s contraceptive needs in 185 countries: A Bayesian hierarchical modelling study. PLoS Medicine 17(2):e1003026. |
| 32 | 25 | 7 | Treatment of missing values | * At country level   There is no attempt to provide estimates for individual countries or areas when country or area data are not available. For the analytical and comparative purposes, the country-level model-based estimates and projections are generated using a Bayesian hierarchical model.   * At regional and global levels   Estimates for any given reference year are prepared using a Bayesian hierarchical model (see Computation method). |
| 32 | 25 | 8 | Data availability and assessment of countries’ capacity | Data for the percentage of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods are available for 133 countries or areas for the 2000-2020 time period. For 108 countries or areas, there are at least two available data points. |
| 32 | 25 | 9 | Expected time of release | Data collection:  Data are compiled in the period from October to January.  Data release:  in March of each year as a comprehensive compilation of data and model-based annual estimates and projections up to 2030 at the national, regional and global level.  See:   * United Nations, Department of Economic and Social Affairs, Population Division (2021). World Contraceptive Use 2021. New York: United Nations. (https://www.un.org/development/desa/pd/data/world-contraceptive-use) * United Nations, Department of Economic and Social Affairs, Population Division (2021). Estimates and Projections of Family Planning Indicators 2021. New York: United Nations. (https://www.un.org/development/desa/pd/data/family-planning-indicators) * The data are also available in the interactive data portal of the Population Division (https://population.un.org/dataportal/home) |
| 32 | 25 | 10 | Data source | Data extracted from SDG database, <https://unstats.un.org/sdgs/indicators/database/>  (on 28 May 2021)  Metadata extracted from SDG database, https://unstats.un.org/sdgs/metadata/files/Metadata-03-07-01.pdf (on 10 July 2021) |