MEASUREMENT

MEASURING PROGRESS
As a time-bound initiative with ambitious goals, FP2020 is committed to measuring progress since the 2012 London Summit. By improving the infrastructure and capacity to generate and use more frequent, high-quality data for decision making, FP2020 and its partners are transforming the monitoring of family planning.

The FP2020 annual progress report reflects countless efforts at multiple levels: from the women agreeing to respond to questionnaires, to the country-level technical working groups tracking progress, to the global-level efforts to align indicators and measures across surveys. The results of these efforts are comparable annual estimates on key dimensions of family planning across the 69 FP2020 focus countries: the FP2020 Core Indicators.
The annual process of producing and reviewing data, building consensus, and reporting at national and global levels is one of the true successes of the FP2020 partnership, and is helping countries, donors, and civil society organizations better use the wealth of family planning data that exists for program decisions and investments. At the same time, this process is identifying data gaps and the need for continued improvements in data systems and measurement.

**CORE INDICATORS**

The FP2020 Core Indicators are based on a results framework designed to measure aspects of the enabling environment for family planning, the process of delivering services, the output of those services, expected outcomes, and the impact of contraceptive use. Together, this complementary and interrelated set of indicators provides a foundation for monitoring family planning progress across the 69 FP2020 focus countries. In addition to the FP2020 Core Indicators, countries track additional measures—specific to their context and data systems—to improve and expand their family planning programs.

Our aim is that the analyses and indicator estimates presented in this report will spark productive conversations about progress and what can be done differently, highlight what we are still struggling to measure, and inspire action that accelerates progress toward FP2020 goals, the *Every Woman Every Child Global Strategy*, and ultimately the Sustainable Development Goals.
PROGRESS ON CONTRACEPTIVE USE AND NEED

The number of women and girls using modern methods of contraception in the 69 FP2020 focus countries continues to rise, and as of July 2018 had reached more than 317 million. Core indicator 1, the most direct measure of progress toward achieving the goal of 120 million additional modern users by 2020, estimates that there are 46 million additional users of modern contraception compared to 2012. This growth is approximately 30% greater than the historic trend.
An increase in additional users of modern contraception implies that a country is not only maintaining its existing base of users (as of 2012), but is also attracting new or returning users.
The number of additional users of modern methods can increase in two ways. One is through population growth, without a change in the proportion of women who choose to use contraception. As of 2018, there are 924 million women of reproductive age (15–49) in the 69 FP2020 focus countries, compared to 834 million in 2012: an increase of 90 million, or 11%. Half of this population growth is from just five countries (India, Nigeria, Pakistan, Ethiopia, and Bangladesh). In these countries, just keeping up with population growth means that even with no change in contraceptive prevalence, many more women are now using a modern method.

The other way to increase additional users is through increasing the proportion of women who choose to use modern contraception; that is, increasing the contraceptive prevalence rate.

Changes in contraceptive use are influenced by a variety of factors within countries, including levels of current contraceptive use, fertility intentions, sexual activity (both within and outside of marriage), and demand for contraception. The 69 FP2020 focus countries were selected because they were the poorest in 2012, but these countries are quite diverse in terms of their contraceptive prevalence, levels of unmet need, and investment in family planning programs prior to the FP2020 initiative. Because of these diverse starting points, generalizing about progress across all 69 focus countries is difficult. Change can, however, be meaningfully explored when looking at individual countries or subgroups of countries.

Examining progress from a regional perspective helps to illustrate different patterns and trends and contextualize the changes that are occurring. Core Indicator 1 is largely driven by the population dynamics of countries, with more than half of the 46 million additional users of contraception in Asia (26 million). Asia includes four of the five most populous FP2020 focus countries: India, Indonesia, Pakistan, and Bangladesh. Because of their size, progress in Asian countries has a large influence on progress toward the overall FP2020 goal of 120 million additional users.
Core Indicator 2. The modern contraceptive prevalence rate (MCPR) among all women of reproductive age, indicates the proportion of women and girls using a modern method. There are significant regional variations in this indicator and the pace at which it moves. Although FP2020 focus countries are only a subset of the countries in each region, their patterns tend to reflect the larger regional picture. In FP2020 focus countries in Asia, 38% of all women of reproductive age are using a modern method as of July 2018, and growth is just 0.2 percentage points per year. In contrast, the pace of MCPR growth in FP2020 focus countries in Africa has been much faster over the last several years. As of July 2018, 24% of women of reproductive age in these countries are using a modern method; growth is 1.1 percentage points per year in Eastern and Southern Africa and 0.7 percentage points per year in West Africa.

Looking at progress from a country perspective provides additional insight into the variability of growth in contraceptive use. Figure 6 shows both the weighted regional averages in annual percentage point change in MCPR and the degree to which countries are dispersed around that average. Using West Africa as an example, the graph shows a regional average of 0.7 percentage point growth per year, with four countries falling below the average and 11 countries either equal to or above the average. Because this average is weighted by the size of each country’s female population of reproductive age, large countries that are growing slowly will have a disproportionate effect on growth. In the case of West Africa, the population of women of reproductive age in Nigeria makes up roughly half of all women of reproductive age in the region. Although Nigeria’s MCPR is growing at approximately the average rate of FP2020 focus countries as a whole (0.3 percentage points per year), it is the second slowest growing country in its region. Without Nigeria included, the growth rate for West Africa is 1 percentage point per year, almost the same as Eastern and Southern Africa.
Another way of looking at progress is by examining a graphic of the S-Curve pattern of MCPR growth, which is based on historical patterns and illustrates different rates of growth at different levels of contraceptive use. As depicted in Figure 7, countries with lower MCPR tend to have slow growth, countries in the middle tend to have higher rates of growth, and countries with higher MCPR tend to grow slowly.
The S-Curve concept provides a guide for countries to assess priorities and contextualize expectations for growth in contraceptive prevalence. Although each country will have a unique S-Curve pattern, the overall journey from low to high MCPR will be similar. In general, countries with lower prevalence (bottom of the S-Curve) should prioritize demand generation and shifts in social norms, while ensuring and expanding access to family planning services. The middle part of the S-Curve is when growth accelerates and there is an opportunity to maintain higher growth over time. Countries at this stage should ensure that high quality services are available to support an expanded range of contraceptive choices. As countries transition to higher prevalence (top of the S-Curve), priorities should be shifted to further focus on expanding method choice, reducing inequity, and ensuring sustainability through domestic financing options for their family planning programs. These options include engaging the private sector, ensuring national health insurance coverage of contraceptives, and securing financing for domestic procurement of contraceptives.
FIGURE 13
S-CURVE PATTERN OF MCPR GROWTH
The S-Curve pattern of MCPR growth helps countries examine and understand their current growth rates. The S-Curve is based on historical patterns and suggests that countries grow at different rates based on their levels of contraceptive use.

LOWER PREVALENCE: SLOW GROWTH
When MCPR is very low, countries tend to see slow annual growth in MCPR. Efforts are needed to change social norms around family planning, stimulate demand, and establish the infrastructure and providers to deliver quality family planning services.

PERIOD WHERE RAPID GROWTH CAN OCCUR
As demand grows and contraceptive use becomes more common, countries can enter into a period of rapid growth by focusing on ensuring availability of an expanded range of contraceptive methods, high-quality services, and continued demand generation.

HIGHER PREVALENCE: GROWTH SLOWING AND LEVELING OFF
Finally, when contraceptive use becomes very common and unmet need declines, MCPR growth slows. Programs at this stage need to focus on long-term sustainability, continued improvements in service quality, expanding the range of methods available, and striving to reach underserved groups.

FIGURE 14
HIGHEST AVERAGE ANNUAL MCPR GROWTH, 2012–2018
This graphic shows the 10 FP2020 countries with the highest average annual percentage point increase in MCPR (among all women) over the 2012-2018 period.
FP2020 COUNTRIES WITH THE FASTEST MCPR GROWTH

In 2018, there were 15 FP2020 countries with growth in contraceptive use among all women of reproductive age greater than one percentage point per year.1 Of these 15 countries, 13 are FP2020 commitment making countries. Mozambique has had the highest MCPR growth over the last 3 years. The majority of these countries are in the middle part of the S curve where rapid growth should be supported by strategic investments that match opportunities and ensure that high quality family planning services are available throughout the country.

Countries are increasingly using data to assess and adjust their family planning programs, and there are now 10 countries2 who are within reach of achieving the goals for mCPR growth they established as part of their FP2020 commitments or in their Costed Implementation Plans. Four of these are among the fastest growing list: Mozambique, Liberia, Kenya, and Zimbabwe.

1 Uganda’s average annual percentage point MCPR growth over the 2012–2018 period is 1.04, but is rounded to 1.0 in Figure X for consistency.

2 Ghana, Kenya, Liberia, Mali, Mauritania, Mozambique, Nepal, Somalia, Viet Nam and Zimbabwe
Among lower prevalence countries, where growth in the short term is expected to be slow, progress can sometimes better be measured by looking at changes in unmet need: **Core Indicator 3**. An increase in unmet need (the percentage of women who want to delay or limit pregnancies, but who are not currently using a modern method) can be a sign of changes in social norms, reflecting a greater desire to delay or limit pregnancies and rising demand for contraception.
Unmet need includes women not currently using a modern method as well as those using traditional methods, who are considered to have an unmet need since modern methods are more effective at preventing pregnancy. Unmet need should not be interpreted as a direct measure of lack of access. There are many potential reasons why a woman who does not want to become pregnant would not use modern contraception. These include limited access to modern methods as well as a wide range of other issues, such as perceived health side effects or social disapproval. Understanding the barriers to use within each country’s context is important to ensure that programs can address the needs of women across different settings and situations.

**Core Indicator 4**, demand satisfied with modern contraception, takes a wider view to assess the degree to which governments and the broader family planning community are meeting the commitment to make family planning services accessible to all who want them. **Core Indicator 4** is also an indicator for the Sustainable Development Goals (SDG) target 3.7, which includes ensuring universal access to family planning by 2030.

**Core Indicator 4** is constructed based on MCPR and unmet need for modern methods, with total demand assumed to encompass current modern users and those with unmet need for modern methods. The proportion of these women using a modern method is termed “demand satisfied,” and is also affected by the dynamics of unmet need. Generally, countries have a high proportion of total demand satisfied with modern methods when modern contraceptive use is high and unmet need is low. Countries with low levels of contraceptive use and low unmet need, however, can also have a relatively high proportion of demand satisfied.
There is still much work to be done for countries to successfully meet the suggested SDG target of at least 75% demand satisfied with modern methods. Among the 69 FP2020 focus countries, 15 are currently on track to meet this target by 2020 if current trends continue. Regionally, there is great variation in terms of progress toward satisfying existing demand. The greatest change since 2012 is seen in Eastern and Southern Africa, where the high growth in MCPR has driven a nine percentage point increase in demand satisfied. Central and West Africa have also seen increases, but in these regions the growth in MCPR is accompanied by increasing levels of unmet need—a complex dynamic that represents both changing fertility intentions and improvements in family planning programs. Asia has seen marginal change, as is expected at higher levels of prevalence.

The regional averages in Figure 8 provide a high-level snapshot of progress toward achieving the FP2020 goal of 120 million additional women and girls using modern contraception by 2020. However, it is important to remember that these aggregate numbers belie the complexity of country dynamics. Additional data on each country and reports on progress toward their commitments are available online through the FP2020 country pages: familyplanning2020.org/countries.


34 Women who are currently pregnant or postpartum amenorrheic whose pregnancy/last births were wanted at the time are considered not to be in need. However, pregnant or postpartum amenorrheic women whose pregnancy/last births were wanted later or not at all are considered to have an unmet need.
CONTRACEPTIVE METHOD CHOICE

Multiple factors can affect the decision-making process: an individual may have to consider questions of cost, effectiveness, and side effects of the various methods, along with partner and family pressure, societal norms, and religious prohibitions on specific methods or on contraceptive use in general. Further constraints include stock-outs at accessible facilities, limited information on the full range of methods, a lack of trained providers, and prohibitive local and national policies on family planning.

Access to complete information and a full range of contraceptive methods is a fundamental element of FP2020’s Rights and Empowerment Principles for family planning. While no one indicator can completely measure full, free, voluntary, and informed choice, FP2020 annually monitors several indicators linked to these principles as they relate to method choice. These indicators measure different dimensions of rights-based family planning and offer perspective on the complexities of the decisions facing women, girls, and couples when choosing to use a method of contraception.

ACCESSIBLE

Health care facilities, trained providers, and contraceptive methods need to be both available and accessible. Barriers such as cost, distance, limited provider training, and stock-outs may limit the ability of women to access services to meet their family planning needs and choose from a full range of available methods. **Core Indicator 10** (stock-outs) and **Core Indicator 11** (method availability) reflect the availability of individual methods and the range of available methods at a facility at a point in time (the day of a facility survey), providing an indication of supply-side barriers to women’s ability to access contraception. Stock-outs refer to the temporary unavailability of contraceptive commodities (or supplies and/or trained staff in the case of sterilization) at a health facility where the method or service is offered. Method availability measures the number of methods available at primary and secondary/tertiary facilities respectively.

Stock-outs have the effect of restricting choice; when a woman arrives at a facility to access family planning services, her options are limited to what is available that day. This may result in a woman choosing a method that is not as well suited to her needs and preferences, or simply leaving without a method. Ensuring that a minimum number of methods are available at various levels of the health care system guarantees that individuals and couples have multiple options to choose from when selecting contraception.
FIGURE 16  PERCENT OF FACILITIES STOCKED OUT OF OFFERED METHOD (CORE INDICATOR 10)

This graphic shows the percentage of facilities in each country that were stocked out of methods they offer on the day of assessment.

VISUAL KEY

- % of facilities stocked out
- Most common method in use

- No data
- % equal to zero

PERMANENT  LONG-ACTING  SHORT-TERM

- Benin
- Bolivia
- Burkina Faso
- Burundi
- Cameroon
- Côte d’Ivoire
- Ethiopia
- Guinea-Bissau
- Guinea
- Haiti
- Honduras
- Indonesia
- Kenya
- Lao PDR
- Madagascar
- Malawi
- Mauritania
- Myanmar
- Nepal
- Niger
- Nigeria
- Philippines
- Rwanda
- Sao Tome and Principe
- Tanzania
- Togo
- Zambia
- Zimbabwe
Among the 28 countries providing stock-out data by method for 2017, the level of stock-outs ranged widely: from Benin, Burundi, Nigeria, and Sao Tome and Principe, where fewer than 10% of facilities were stocked out of a given method on the day of assessment, to Haiti and Cameroon, where more than 80% of facilities were stocked out of all of the 9 assessed methods on the day of assessment (Figure 9). Stock-outs may be particularly problematic for the most popular or commonly-used methods, especially short-term methods that require frequent revisits to maintain protection against unintended pregnancy. In Mauritania, for example, around 10% of married women (which constitutes two-thirds of modern contraceptive users) rely on pills as their method of contraception. Yet 53% of facilities were stocked out of pills on the day of assessment in 2017, meaning that many women who came for pills on that day could not access their method of choice.

Stock-outs in 2017 of the most common method in use ranged from very low levels (1% of facilities stocked out of pills in Lao PDR and 2% of facilities stocked out of implants in Burkina Faso) to extremely high levels (93% of facilities stocked out of condoms in Cameroon and 89% of facilities stocked out of injectables in Haiti). In the aggregate, stock-outs of the most commonly used method are relatively low, with a median of 8% of facilities stocked out of the most common method across the 28 countries. This may suggest that many countries are successfully monitoring key commodities within supply chains to ensure access to the most commonly used and in-demand methods, but it could also indicate that stock availability is driving method choice.
Across the FP2020 focus countries with data on method availability (Core Indicator 11) in 2017, availability was relatively high, with an average of 78% of primary level facilities offering 3+ methods and having them in stock on the day of assessment, and 79% of secondary/tertiary facilities offering 5+ methods and having them in stock on the day of assessment. At the primary level, only four countries saw fewer than 50% of facilities with 3+ methods available on the day of assessment: Cameroon, Lao PDR, Liberia, and Mauritania. Three countries—Bolivia, Côte d'Ivoire, and Mauritania—saw fewer than 50% of secondary and tertiary facilities with 5+ methods available on the day of assessment. In contrast, nine countries saw more than 90% of primary facilities offering 3+ methods, and 10 countries saw more than 90% of secondary/tertiary facilities offering 5+ methods. These data do not indicate the availability of specific methods or method types (short vs. long-acting or permanent methods), but do suggest that in some countries, women’s ability to choose from a full range of contraceptive methods may be constrained at various levels of the health care system.

**INDIVIDUALS SHOULD BE EMPOWERED TO MAKE THEIR OWN DECISIONS ABOUT WHETHER AND WHICH METHOD TO USE**
Women and girls must be free to make their own decisions about their reproductive health care and to seek contraceptive services without risk of discrimination, coercion, or violence. Across the 40 FP2020 focus countries with available data, on average 90% of women report that the decision to use family planning was made on their own or jointly with their partners: **Core Indicator 16**. The data show women’s participation in contraceptive decision making among contraceptive users is high in many countries, including upwards of 98% of women using a method in Egypt, Myanmar, and Rwanda. (There are a few outliers: in Comoros, for example, almost 30% of contraceptive users did not participate in the decision to use family planning.)

Indicator 16, however, paints an incomplete picture of contraceptive decision making and is a limited measure of empowerment. Given that the indicator scores are high and vary little across countries and years, the indicator may not be capturing many of the challenges that women face in deciding to use contraceptives and selecting a method. Furthermore, Indicator 16 only measures the decision-making power of women who are currently using a method, and gives no insight into the experiences of women who are not using a method and how that decision was made. Data on contraceptive decision making among non-users should be available in the near future as a result of updates to the DHS women’s questionnaire, and may shed more light on the decision-making dynamics women face in making their own choices about their reproductive health care and family planning.

**QUALITY CARE SHOULD SUPPORT INDIVIDUALS TO MAKE AN INFORMED CHOICE**
To ensure that women and girls can determine the contraceptive method that best meets their needs, health care workers must provide appropriate information about the full range of contraceptive options as well as counseling on those options. **Core Indicator 14**, the Method Information Index (MII), measures the extent to which women are informed about side effects and alternate methods. The index is based on three questions asked of current contraceptive users: (1) Were you informed about other methods? (2) Were you informed about side effects? (3) Were you told what to do if you experienced side effects?
Across the 39 FP2020 focus countries with available data since 2012, the highest MII score was in Zambia, where 72% of respondents answered positively to all three questions. The lowest MII score was seen in Pakistan, where only 14% of respondents reported receiving information on other methods and side effects when choosing their current method. 

Looking at the individual question scores across countries, a greater percentage of women reported receiving information on other methods (average across countries of 64%) than being informed about side effects (57%) or how to handle them (52%).

On average, users of implants and IUDs have the highest total MII values (56% and 58% respectively), while users of female sterilization have the lowest (33%). Understanding the context is important in interpreting these values. For example, newly introduced or revitalized methods, such as implants, may be accompanied by recent provider training that is associated with higher quality counseling. In such cases, users of implants would be expected to report higher MII scores. Conversely, users who received their current method several years ago (such as the copper IUD or female sterilization) may report lower MII scores because the quality of counseling at that time did not reflect current standards of care. The average MII of 43% across the 39 FP2020 focus countries with data indicates substantial room for improvement in counseling and quality of care. These are crucial aspects of rights-based family planning, and improvements in quality of care are strongly linked to higher rates of contraceptive use.37

OUTCOMES OF CONTRACEPTIVE CHOICE: CONTRACEPTIVE DISCONTINUATION AND SWITCHING, AND MODERN CONTRACEPTIVE METHOD MIX
Contraceptive Discontinuation & Method Switching

The right to full, free, voluntary, and informed choice includes the right to switch contraceptive methods as needed or to discontinue contraceptive use entirely. As women move through their reproductive lives, contraceptive discontinuation is expected: during attempts to get pregnant, during periods of infrequent sex or a partner’s absence, following a marital separation, or when a woman determines that she is infertile or has completed menopause. Method discontinuation can also be indicative of barriers to free and informed choice, especially when women discontinue for reasons other than lack of need. Health concerns and side effects, inconvenience of using a method, lack of access, and opposition from a husband are just a few of the reasons that women report for discontinuation.

In 2017, FP2020 added an indicator for Contraceptive Discontinuation and Method Switching (Core Indicator 18) to reflect the churn of contraceptive use (as women and their partners start using contraception, stop for various reasons, and switch methods) and draw attention to potential issues with method provision that may result in discontinuation. Discontinuation rates are only available from the DHS and are calculated from data on episodes of contraceptive use from the contraceptive calendar. Across FP2020 focus countries with available data on discontinuation, the highest rates of first year discontinuation are generally seen among short-term methods: on average 37% for injectables, 42% for pills, and 40% for condoms.
Analysis of 32 FP2020 focus countries with survey data since 2012 shows average rates of discontinuation of short-term methods while in need that are greater than 20%, meaning that more than a fifth of episodes of use of these methods stopped within 12 months, despite the user still potentially needing contraception. These rates may point to challenges women face in accessing methods that require resupply, may point to their dissatisfaction with these methods, or may be related to side effects, among other possible reasons. Rates of discontinuation while in need of long-acting reversible contraceptives are generally lower, with an average of 12% of IUD episodes of use and 8% of implant episodes of use stopped within the first year of use. This may indicate higher satisfaction or better counseling associated with these methods, but could also point to limitations on access to IUD and implant removal.

Rates of method switching can provide other insights. A woman may decide to stop using a particular method in favor of one she prefers or that has fewer side effects, or she may switch from a less effective short-term method to a more effective long-term method that offers better protection from unintended pregnancy. In these instances, method switching reflects a woman's right to choose from a broad range of methods. Very low rates of method switching could suggest that women are more satisfied with the given method, but could also suggest that women may not able to act on their preferences to change methods or that method availability is limited. The highest rates of method switching are seen with short term methods; an average of 11% of condom use episodes, almost 10% of pill use episodes, and 8% of injectable use episodes end with a switch to another method within the first year of use. Lower rates of switching are seen with long-acting reversible contraceptives: an average of approximately 5% of IUD episodes and 3% of implant episodes end with a switch in method within the first year.

Modern Contraceptive Method Mix
Modern contraceptive method mix presents the distribution of modern contraceptive users by the method they use, based on the most recent survey data available. **Core Indicator 9** illustrates the cumulative outcome of all the factors involved in each woman’s contraceptive choice. These include enabling factors, such as method availability and receipt of full information on contraceptive methods and side effects, and limiting factors, such as policies, social norms, and stock-outs.

While there is no “right” or “ideal” method mix, there is consensus that a wide variety of methods should be available to meet the varied and changing needs of individuals and couples, including short-term, long-acting reversible, and permanent methods. Based on modern method mix data, an estimated one-third (23) of FP2020 focus countries have 5 or more modern methods in use, representing at least one permanent, one long-acting reversible, and one short-term method. In 8 of the 69 FP2020 focus countries, both types of long-acting reversible contraception (IUDs and implants) are used by more than 5% of modern users, indicating some level of availability and choice in reversible methods. Expanding the number of methods available increases the likelihood that individuals and couples can choose a method that meets their needs as they move through the reproductive life cycle, including reversible methods to delay or space pregnancies and permanent methods once desired fertility has been reached.
Modern contraceptive method mix varies greatly across the FP2020 focus countries, reflecting both individuals’ and couples’ preferences and the diverse contexts in which they live. Among the 69 FP2020 focus countries, injectables are the most common method in use in 26 countries, followed by pills in 17 countries, male condoms in 9 countries, and IUDs in 8 countries. Female sterilization is the most common method in use in 6 countries (Honduras, India, Nepal, Nicaragua, Solomon Islands, and Sri Lanka), ranging from 32% of modern contraceptive use in Sri Lanka up to 75% in India.

Substantial method skew, where one method makes up 60% or more of the method mix—as seen in India with female sterilization, or in Ethiopia, where 63% of modern contraceptive users rely on injectables—can be indicative of individual preferences as well as socio-cultural norms that promote or discourage particular methods. Skew toward a particular method may also be strongly driven by the health care system, contraceptive availability, and how and where women access contraceptives. Limited health infrastructure or a shortage of health care providers may send women to shops and pharmacies, where they are generally limited to pills and condoms, while public sector implementation of task-sharing may dramatically expand access and use of methods like implants and injectables.
Across FP2020 focus countries there have been shifts in method mix since 2012, with implants assuming a greater portion of modern use and female sterilization declining in proportion to other modern methods across nearly all countries with available data. Despite these shifts, the most common method in use in each country has remained largely unchanged over time. For women and girls across the 69 FP2020 focus countries, the decision to use a contraceptive method is complex and influenced by a wide range of factors, some of which are in response to short-term changes and interventions (stock-outs, method availability, quality counseling) and some of which are slower to change (individual preferences, fertility desires, and community norms). Changes in method mix can indicate where those programmatic changes and interventions are successfully expanding access to information and increasing the availability of a broad range of methods, but lack of change shouldn't necessarily be interpreted as a lack of progress. In many countries, the most common method in use may continue to be popular because it best meets the needs of women in that specific country context. Understanding how these many determinants of contraceptive choice fit together is best done with an understanding of country context and dynamics.

SUMMARY
Measuring full, free, voluntary, and informed contraceptive choice among individuals and couples across the 69 FP2020 focus countries is a complicated endeavor. A range of factors—from the availability of different methods to the provision of quality counseling to the involvement of partners or healthcare providers in decision making—may simultaneously encourage and inhibit the ability of women and girls to make decisions about their reproductive health and choose a method that best meets their needs. While no one metric can fully capture all the dimensions of contraceptive choice, FP2020 is working to monitor key elements and enabling factors of rights-based family planning. It is essential that these measurement efforts continue and grow as the community improves its understanding of the interconnected drivers of contraceptive choice. The process of monitoring these indicators draws attention to progress, and lack thereof, among FP2020 focus countries and helps to ensure that the rights of women and girls are central to family planning programming. In addition, the emphasis on rights-based family planning and ensuring women and girls have access to a full range of contraceptive methods is fundamental to countries’ ability to reach their goals of increasing contraceptive prevalence. Global analysis has shown that increasing the number of methods available and expanding women’s access to a broad range of methods have significant potential to increase contraceptive use. Successful family planning programs must continue to strive to fulfill the right to full, free, voluntary, and informed contraceptive choice.

COUNTRY EXAMPLE: NEPAL

The example of Nepal shows how information can help program designers understand some key challenges and opportunities for improving contraceptive choice.
Data from UNFPA indicate that a basic range of contraceptive methods is generally available to women in Nepal, with nearly 90% of primary-level facilities offering at least three methods of contraception. Performance is slightly lower at secondary and tertiary-level facilities, where 67% had five or more methods available on the day of assessment. In 2017, Nepal saw relatively low levels of stock-outs across most methods (<10% of facilities stocked out on the day of assessment). The exception is LARCs: 42% of facilities were stocked out of IUDs and 39% stocked out of implants, meaning that in 4 out 10 facilities, on the day of assessment, women coming in for family planning would not have access to one or both LARCs. While LARCs are only used by about 11% of contraceptive users in Nepal, implant use has grown nearly 400% over the past 10 years (from .6% to 2.6% AW prevalence). This growth may be hampered if stock-outs persist. Last year approximately 40% of facilities were also without the supplies or staff to provide female sterilization, the most common method in Nepal, or male sterilization. There has been a substantial improvement this year and only 8% of facilities were without supplies or staff to provide permanent methods on the day of assessment.

Methods assessed for stock-outs were: female sterilization, male sterilization, IUD, implant, injectable, pill, male condom, female condom, and emergency contraception.


39 “Methods in use” is defined here as methods representing greater than 5% of modern use (>5% of users using). Methods included are: female sterilization, male sterilization, IUD, implant, injectable, pill, male condom, female condom, lactational amenorrhea method (LAM), diaphragm, foam or jelly, standard days method (SDM), and emergency contraception (EC). Note that no country had greater than 5% of users using female condom, diaphragm, foam or jelly, SDM, or EC. “Other modern methods” was excluded as it represents an aggregate of individual methods.


SPECIAL ANALYSIS: UNDERSTANDING DATA ON ADOLESCENTS AND YOUTH

Empowering young people with the tools they need to thrive is central to achieving both FP2020 goals and the Sustainable Development Goals (SDGs). The youth population comprises a large proportion of the total number of women and men of reproductive age in the 69 FP2020 focus countries. Population pyramids for FP2020’s focus countries in Africa and Asia, shown in Figure X, suggest the importance of the sexual and reproductive health of young people for national development as well as individual well-being. Youth aged 15–24 make up 41% of all men and women of reproductive age in FP2020 focus countries in Africa and 34% of those in Asia.
Understanding the lives of young people and their information and service needs is critical for developing effective health programs. Research on adolescents suggests that many patterns related to lifelong health behaviors around diet, exercise, alcohol, tobacco use, and sex are established during adolescence. The choices made and the patterns of behavior that young people develop today will affect the entire trajectory of their lives.

Many young people are not yet sexually active, while some have had sex and are only sporadically sexually active, some are currently sexually active and not yet married, and some are married and have begun childbearing. Each of these groups has different sexual and reproductive health needs, which necessitates a range of nuanced indicators. Unfortunately, the information to examine these nuances is often not available.

A number of FP2020 partners are working to address the gaps in adolescent and youth data, including among very young adolescents (10–14) for whom little data exist. Here we report on a selection of indicators recommended by FP2020’s Performance, Monitoring, and Evidence Working Group for tracking country progress. These indicators include the adolescent and youth population size, the percentages who are married and who are unmarried and sexually active, and patterns of key life events: age at marriage, first sex, and first birth. These indicators also include current levels of contraceptive use and unmet need among married and unmarried sexually active women aged 15–19 and 20–24, as these data help countries better understand the desire among these age groups to limit or space births and the progress toward meeting that contraceptive demand. The indicators reviewed here are not comprehensive, and countries should develop a longer list of national and sub-national adolescent and youth indicators within their own country and local contexts.
The adolescent birth rate, **Core Indicator 17**, tracks progress toward reducing teen births, a priority for FP2020 and the SDGs. Over the last two decades adolescent birth rates have been slowly declining worldwide. But while the adolescent birth rate is important for tracking a critical development outcome, it does not help countries understand the different sexual and reproductive health behaviors of young people nor their contraceptive needs. About half of pregnancies among adolescent women aged 15–19 in developing countries are unintended, and about half of these end in abortion, most under unsafe conditions. Adolescent birth rates may change because of declines in early marriage, delay of first sexual activity, increases in contraceptive use, or increased abortion rates.
FIGURE X  YOUTH POPULATION IN FP2020 COUNTRIES IN ASIA

This graphic shows the population distribution of FP2020 countries in Asia, by five-year age groups, it also shows the percentage of the population of reproductive age (ages 15-49) comprised of youth.
FIGURE X  YOUTH POPULATION IN FP2020 COUNTRIES IN AFRICA

This graphic shows the population distribution of FP2020 countries in Africa, by five-year age group. It also shows the percentage of the population of reproductive age (ages 15-49) comprised of youth.

PATTERNS AND TRENDS IN THE KEY LIFE EVENTS OF YOUNG PEOPLE
FIGURE 21: MEDIAN AGE AT KEY LIFE EVENTS AMONG WOMEN

The median age represents the age by which 50% of women ages 25-29 had experienced their first marriage, sexual intercourse and birth.

VISUAL KEY
- First Marriage
- First Sex
- First Birth

Note: figures based on Demographic and Health Surveys (DHS) since 2012.
The life trajectories of young people differ greatly across countries—and even within countries, according to income, education, ethnicity, and geography—with considerable variation in the timing and sequence of key events: the age they first have sex, get married, and/or give birth. Examination of available data on the median age of key life events from FP2020 focus countries reveals the diversity of these patterns, and when shown on a timeline can illustrate opportunities for different interventions (Figure X).

While priorities may differ depending on country context, in all countries and for all young people there is a need to share culturally sensitive, age-appropriate information and education related to sexual and reproductive health.
In some countries, the general pattern is for a young person to get married, have their first sexual activity, and then have their first birth. In other countries, the general pattern is for a young person to begin having sex some time during adolescence, get married, and then have their first birth. These distinctions highlight the importance of understanding local patterns and developing approaches that are context-specific, timely, and effective. For example, looking more closely at Ghana and Haiti, we see the long period between the median age at first sex and the median age at first marriage, highlighting the importance of widespread access to health services and health education for adolescents and youth. In other countries, such as Chad, Niger, and Bangladesh, early marriage is common, and more than half of women are married by the age of 16. Efforts to delay marriage and delay first birth are critical in these contexts for a host of reasons, including improvements in maternal health outcomes, increasing girls' education, and empowering women. In Afghanistan, India, and Indonesia, the median age of marriage is later and precedes first sex, with first birth following soon after. This suggests that programs should prioritize the integration of maternal health and family planning services, including postpartum and post-abortion family planning, to reach adolescents and youth. While priorities may differ depending on country context, in all countries and for all young people there is a need to share culturally sensitive, age-appropriate information and education related to sexual and reproductive health.

THE CHALLENGES OF MEASURING SEXUAL ACTIVITY AND BEHAVIORS AMONG UNMARRIED YOUTH
Many of the gaps in understanding the sexual behaviors and health needs of young people are related to challenges in measuring sexual activity, irrespective of age or marital status. In many countries, particularly in Asia and North Africa, unmarried women (including those aged 15-24) are excluded from surveys about sexual and reproductive health due to sensitivities about sexual activity outside of marriage. Many unmarried youth may also be reluctant to report sexual activity, particularly when interviewed in their home setting.

In countries that do collect data among unmarried sexually active men and women, the classifications of sexual activity used in standard reporting may obscure understanding of youth contraceptive use. In most survey analyses of contraceptive use, unmet need, and demand satisfied, an unmarried person is only considered to be sexually active if they’ve had sex within the last month; in contrast, all married women are considered sexually active regardless of how recently they’ve had sex. Yet in many countries the percentage of youth who have had sex but not in the last month is equal to or greater than the percentage of youth who are currently sexually active. For example, in the Democratic Republic of Congo (DR Congo), shown in Figure X, only 12% of unmarried women aged 15–19 are currently sexually active, whereas an additional 7% were sexually active in the last 2–3 months and an additional 5% were sexually active in the last 4–12 months. One can also see the rapid transition that takes place between the ages of 15–19 and 20–24. Among women aged 15–19 almost half have never had sex, whereas among women aged 20–24 only 9% have never had sex. These data suggest that women who are not currently sexually active should be examined together with those who are currently sexually active to better understand the behaviors and needs of unmarried women for developing effective programs.

**FIGURE 22  DRC YOUTH MARITAL STATUS, SEXUAL ACTIVITY, CONTRACEPTIVE USE AND NEED**
CONTRACEPTIVE USE AND UNMET NEED AMONG YOUNG PEOPLE

Of the FP2020 focus countries with DHS data collected since 2012, 25 have sufficient DHS data to examine contraceptive use among women aged 15–19 and 27 have sufficient DHS data for women aged 20–24.
For unmarried sexually active women aged 15–19, contraceptive use ranges from a low of 11% MCPR in Rwanda to nearly 70% in Lesotho. Contraceptive use is typically slightly higher for unmarried sexually active women aged 20–24. With a few exceptions, contraceptive use among unmarried sexually active women is far higher than among married women of the corresponding age group. Unmet need for family planning is also higher. In 22 of 25 countries, unmet need is greater among unmarried sexually active women aged 15–19 than among married women of the same age. The data suggest that the motivation to avoid pregnancy is very high among unmarried sexually active youth, leading to higher rates of contraceptive use. In most countries, however, the majority of unmarried sexually active youth are still not using a contraceptive method.

Contraceptive use among married women aged 15–19 ranges from 1% in Nigeria to 53% in Myanmar. Contraceptive use among married women aged 20–24 is generally higher, ranging from 4% in Chad to almost 64% in Zimbabwe. Low rates of contraceptive use among young married women suggest the social importance in many countries of bearing children early in the marriage. Despite these social norms, unmet need among married women aged 15–19 and 20–24 is in most cases higher than the national average, suggesting there is a desire and opportunity among youth to delay or space births.
One way to better recognize the youth interventions that are needed is to look at the sexual activity and contraceptive use of the entire youth population of a specific country. Figure X for the DR Congo shows a series of stacked bars of the entire population of women aged 15–19 and 20–24, arranged by marital status and sexual activity, and then looks more deeply at the contraceptive use and unmet need among married youth and unmarried sexually active youth, respectively, in the subsequent two graphics. Together these graphics illustrate not just rates of contraceptive use among different segments of the population, but also the relative size of each of these populations in relation to the overall population of women aged 15–19 and 20–24. In DR Congo, among the 12% of unmarried women aged 15–19 who are currently sexually active, almost half (48%) have an unmet need for any contraception (meaning they are not using any method and do not want to have a child in the next two years) and a quarter are relying on traditional methods. Patterns are similar for the unmarried 20–24 age group, though a far larger percentage is sexually active by this age. These data suggest that a large portion of young people are not getting the information and services they need to delay sexual debut and avoid sexual exploitation, coercion, and abuse as well as unintended pregnancies and sexually transmitted infections.

In DR Congo there is also considerable unmet need among the 21% of women aged 15–19 and the 60% of women aged 20–24 who are married. In each of these groups approximately a third of women have an unmet need. The data suggest opportunities for family planning counseling and services related to delaying first birth among married youth as well as opportunities for postpartum family planning. Nor should programs overlook the many women who want to get pregnant (almost exclusively married women) and who should be reached with integrated maternal health and family planning services to ensure that they understand the importance of adequate birth spacing for maternal and child health.
Download estimate tables with adolescent/youth indicator data.

SUMMARY

Understanding demographics, patterns of key life events, and behaviors related to sexual and reproductive health and combining these data with information on the methods youth are using, where they are accessing services, and what policy barriers exist will help programs assess priorities and effectiveness and make decisions about future investments. At the same time, continued investments to improve data collection and analysis related to youth’s contraceptive access and choice will further our understanding. Enabling all adolescents and youth (married and unmarried, and those with and without children) to avoid unintended pregnancy will reap savings in maternal and child health care, boost young women’s educational and economic prospects, and give them the opportunity to reach their full potential.

COUNTRY EXAMPLE: INDIA

Dramatic Changes in Early Marriage in India
India’s National Family Health Survey 4 (NFHS-4) in 2015-2016, the first Demographic Health Survey in a decade, revealed a dramatic decline in child marriage in India. Defined as the marriage of a girl under age 18 or a man under age 21, child marriage was prohibited by law with the Child Marriage Restraint Act of 1929 and the Prohibition of Child Marriage Act in 2006. Yet in the 2005–06 DHS, 45% of women aged 20–24 reported that they were married before 18. Ten years later, the NFHS-4 showed 25% of women aged 20–24 reporting that they were married before 18—a decline of more than 20 percentage points. This rapid decline in the rate of early marriage is unprecedented in India’s history.

There is still wide variation in rates of child marriage across Indian states. In Bihar, Jharkhand, Rajasthan, and West Bengal, 35–40% of women aged 20–24 reported they were married before 18. Fewer than 10% of women aged 20–24 reported they were married before 18 in Goa, Himachal Pradesh, Jammu and Kashmir, Kerala, and Punjab. Despite this wide variation, almost all states experienced dramatic declines over the past decade.


The convention in the literature is to use “women” rather than “girls” when discussing the data for these age groups, and we have followed that convention here. “Unmarried sexually active” throughout this section refers to women who reported sexual activity within the last month.
METHODOLOGY

The data presented in this report reflect methodological choices that we believe yield the most accurate and relevant information for tracking progress toward FP2020 goals. As a time-bound initiative with an urgent goal, we measure progress from the 2012 London Summit until now (2018), taking into account all available and serviceable data. Using modeling, we produce annual estimates of critical indicators and we re-estimate the trend of additional contraceptive users on an ongoing basis. This section provides more detail on the methodology behind the data in an effort to increase understanding, promote transparency, and support mutual accountability.

TIME PERIODS COVERED IN THIS REPORT

The estimates presented in this report measure annual progress, and for Indicators 1–8, represent the value as of the mid-point of each year (e.g., the 2018 estimates for Indicators 1 and 2 show additional users and MCPR as of July 2018). The baseline year of 2012 is presented as the mid-point of 2012, or July 2012, when the London Summit took place. This 2018 Progress Report marks year six of the FP2020 initiative.

FAMILY PLANNING ESTIMATION TOOL (FPET)
The Family Planning Estimation Tool (FPET) is a Bayesian hierarchical statistical model that produces annual estimates of MCPR, unmet need, and demand satisfied. Traditionally, countries have relied on estimates for MCPR and unmet need that are taken from population-based surveys, such as the Demographic and Health Survey (DHS). However, most countries do not conduct such surveys annually. In addition, although routine family planning service statistics and/or data on contraceptive commodities distributed are available in most countries through Health Management Information Systems (HMIS), they tend to not be used to monitor progress or make decisions at a program level.

FPET incorporates all available historical survey data for a country as well as service statistics (where determined to be of sufficient quality) to produce estimates of contraceptive prevalence and unmet need, which are in turn used to calculate demand satisfied. By using all available data, and regional and global patterns of change, FPET is producing better estimates of current levels of MCPR, unmet need, and demand satisfied for each FP2020 country than have been traditionally available for assessing changes in family planning.

**ROLLING BASELINE: RE-ESTIMATING THE TREND**

Estimates of the number of additional users of modern methods of contraception are calculated using a “rolling baseline,” meaning we recalculate annual estimates (starting with the baseline year, 2012) on an ongoing basis as new data become available. Each year we compare the total number of users to the number of users in 2012, and the difference between the two totals is the number of additional users.

\[
\text{Additional Users}_2018 = \text{Total Users}_2018 - \text{Total Users}_2012
\]
Continuously incorporating new data improves our ability to monitor progress, so that by 2020 our estimates for all years (2012 to 2020) will represent the most comprehensive and accurate data available. Calculations of the number of total users—and thus additional users—depend on MCPR and the population of women of reproductive age (WRA).

\[ \text{Total Users} = \text{MCPR} \times \text{WRA} \]

There is often a lag time of a year, and sometimes longer, before the surveys used to calculate MCPR are released. In addition, updated population estimates (including WRA) often include retrospective modifications of past estimates based on newly released census data and other sources. The estimates in this report are based on the United Nations Population Division’s “2017 Revision of World Population Prospects.”

Consequently, as new data become available, they affect not only current year estimates but those calculated in previous years as well. The advantage of using rolling estimates is seen by comparing the estimate of the number of users of modern contraception that was calculated for the London Summit on Family Planning in 2012 (258 million) to the updated estimate for 2012 that we use now (271 million).

Our revised baseline calculation incorporates new surveys that give us a better sense of the current mCPR in a country as well as what the mCPR was in 2012. These mCPR estimates are combined with UN Population Division population estimates to produce estimates of the number of users of modern contraceptives for the current year and for previous years. As a result, we now consider the total number of contraceptive users in 2012 to be 13 million more than originally estimated in 2012. Were we to use the old estimate for 2012, this discrepancy could be misconstrued as 13 million additional users on top of the actual 46.4 million additional users.
Not only is our 2012 estimate updated, but so are our 2013–2018 estimates. This means that the number of additional users that we estimated for these years in our last report has also been re-estimated. Because of these changes, it is important not to compare numbers in this report to numbers in previous reports. Instead, this report publishes the entire 2012 to 2018 trend based on the most recent data, enabling comparison of changes over time.

More information on the methodology for the rolling baseline can be found on the Track20 website.

**IMPACT MODEL UPDATES**

Since 2014, the Strengthening Evidence for Programming on Unintended Pregnancy (STEP UP) consortium of experts has been working to harmonize modeling approaches for estimating impacts of modern contraceptive use. Based on new studies STEP UP agreed to revisions to impact model inputs which affect this year's estimates of unintended pregnancies, as well as unintended pregnancies, unsafe abortions and maternal deaths averted due to modern contraceptive use (Core Indicators 5–8). More detail on these changes can be found here [HYPERLINK TO STEP UP BRIEF], and include:

- **Unintended pregnancies (Core Indicator 5):** based on new data, the pregnancy rate of non-users with an unmet need for family planning has been updated from 31% to 41%. This change results in higher estimates of the number of unintended pregnancies. In last year's report, we estimated 42 million unintended pregnancies across FP2020 countries from July 2016 to July 2017. This year's estimate for the same period (July 2016 to July 2017) is 48 million unintended pregnancies.
• **Unintended pregnancies averted (Core Indicator 6):** the updated pregnancy rate of non-users with an unmet need for family planning also results in higher estimates of the number of unintended pregnancies averted due to modern contraceptive use. In last year’s report, we estimated that 84 million unintended pregnancies were averted across FP2020 countries from July 2016 to July 2017. This year’s estimate for the same period (July 2016 to July 2017) is 115 million unintended pregnancies averted.

• **Unsafe abortions averted (Core Indicator 7):** updated estimates of the proportion of unintended pregnancies ending in abortion and the proportion of abortions that are safe versus unsafe have an effect on estimates of the number of unsafe abortions averted by contraceptive use. The effect varies by country and region, but in the aggregate the effect is a lower number of unsafe abortions averted due to modern contraceptive use in FP2020 countries. In last year’s report, we estimated 26 million unsafe abortions averted in FP2020 countries between July 2016 and July 2017; this year’s estimate for the same period is 20 million.

• **Maternal deaths averted (Core Indicator 8):** similarly, the new data on the proportion of unintended pregnancies ending in abortion and the proportion of abortions that are safe versus unsafe affect estimates of the number of maternal deaths averted, with the effect varying by country and region. The aggregate effect is a higher estimate of the number of maternal deaths averted in FP2020 countries: 125,000 estimated for the July 2016 to July 2017 period in last year’s report, versus 131,000 estimated for the same period in this year’s report.

**DATA RECENCY**
New data from surveys and service statistics become available over the course of the year, and 15 FP2020 focus countries have new data available since last year’s report. Due to variations in data sources, the strength and “recency” (how old the data are) of estimates differ by indicator and country. The most recent data source for countries ranges from 2002 to 2017 and for indicators 1-8 is classified accordingly in the estimate tables: “old” (before 2012), “recent” (2012–2015.5) and “new” (2016 to the present). For indicators 9–18, the year of the data source is given.
USING SERVICE STATISTICS TO IMPROVE ESTIMATES

Track20 uses service statistics to inform MCPR trend estimates for FP2020 focus countries where these data meet the following criteria:

- Consistent levels of reporting over time (with at least 60% of facilities reporting data), so that changes in the volume of service statistics do not represent more facilities reporting, rather than an increase in services delivered;

- At least three years of consistent data, with at least one year overlapping with a survey so that the model can calibrate the two trends; and

- At least one year of service statistics reported after the most recent survey; if a survey is the most recent data point, the survey will be used to inform the MCPR trend.

In 2018, MCPR estimates for 13 countries were informed by service statistics (see Country Information Estimate Table).

In addition to informing estimates of MCPR and unmet need through FPET, service statistics such as commodities distributed to clients are converted into couple-years of protection (CYPs)—Core Indicator 13—using conversion factors. CYPs allow for comparison of the pregnancy prevention delivered through the provision of different contraceptive methods. This is necessary because providing one IUD and one condom generate very different levels of protection against pregnancy for the clients receiving them. The CYP measure adjusts for these differences and shows the total years of protection that will result from the services/products provided each year.
The CYP estimates presented in this report are based on data from countries' routine data systems. This information is vital for monitoring health system performance, forecasting inventory stocks to ensure adequate supplies are available, and tracking progress over time. Because countries need to have robust health information systems to report on CYPs, this indicator serves as a proxy for the importance of investing in these systems. Since 2012, an increasing number of countries have been able to use service statistics to report on CYPs. This year’s report features CYP data from 24 countries, up from 14 countries in last year’s report (see Core Indicator 13 Estimate Table).

ESTIMATE TABLES

FP2020’s 18 Core Indicators are the foundation of our measurement agenda and strive to capture different dimensions of family planning, including availability, quality, equity, informed choice, use, and empowerment. Together they present a varied family planning landscape, across and within the 69 FP2020 focus countries. Though these indicators are reported in a standardized way across the focus countries, it is important to understand nuances between the indicators and the way they are presented in this report.
Some indicators are reported for all women (number of additional users and MCPR), while others are currently reported for married or in-union women (unmet need and demand satisfied), with the ultimate aim of reporting these indicators for all women as we develop a sound methodology for doing so. Some indicators are derived annually from modeling (Indicators 1–8), while others are based on the most recent survey (Indicators 9–11 and 14–18). In addition, we present some indicators disaggregated by age, urban/rural residence, and wealth quintile, to highlight disparities in contraceptive use, unmet need, and demand satisfied. The disaggregated data, however, are only available from the most recent surveys for married women, and so may not match with the annual modeled estimates for these indicators.

The full data set for all indicators is available for download below. This data is also available on the FP2020 and Track20 websites, which have country-specific pages with information and downloadable data on each of the 69 FP2020 focus countries.

**ALL ESTIMATE TABLES**

The files below contain estimates for the 18 FP2020 Core Indicators, estimates for total users of modern contraception, modern contraceptive prevalence rate for married women, and disaggregated estimates for MCPR, unmet need and demand satisfied. In addition, the files contain information on data sources used for modeling in the Family Planning Estimation Tool (FPET). For Core Indicators 1-8, estimates are reported for 2012-2018. For indicators that depend on a survey, the estimates come from the most recent survey.

**CORE INDICATORS**
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<th>Description</th>
<th>Measurement Unit</th>
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<td>MODERN CONTRACEPTIVE PREVALENCE RATE</td>
<td>All women</td>
<td></td>
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<tr>
<td>UNMET NEED</td>
<td>Married or in-union women</td>
<td></td>
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<tr>
<td>DEMAND SATISFIED</td>
<td>Married or in-union women</td>
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