A Review of and Reflection on Demand-Side Measures of Family Planning

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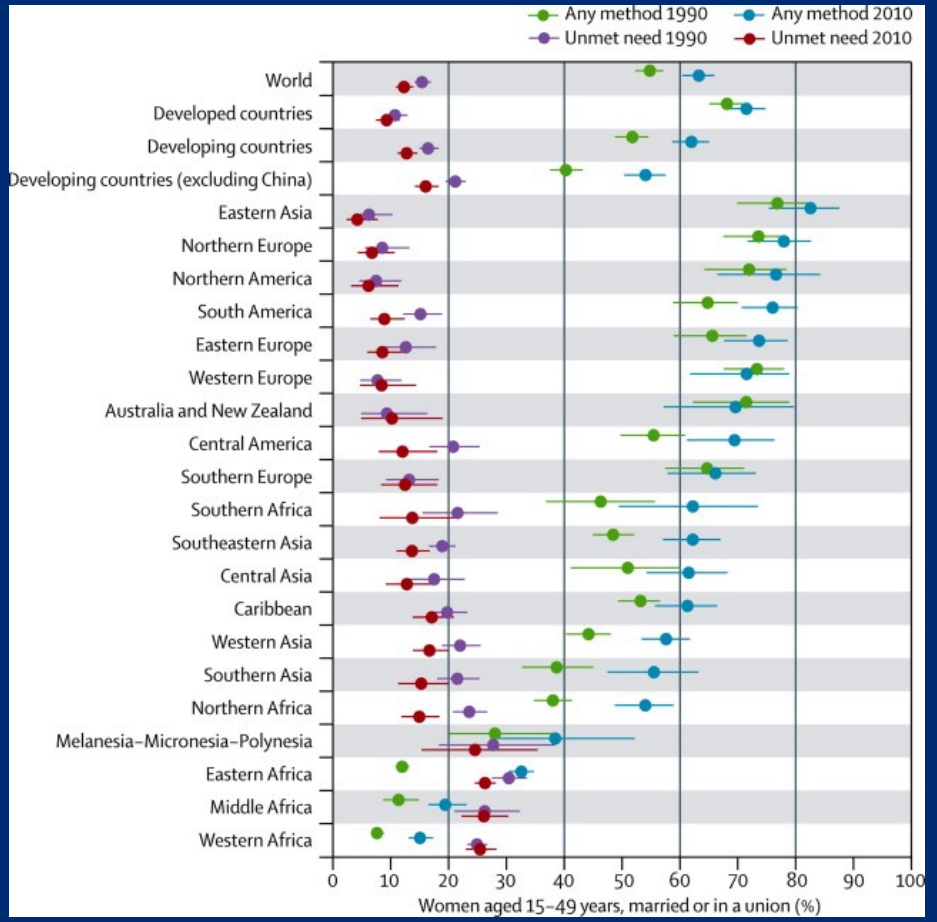
May 31, 2023

Points covered

- Half a century of strong measurement of family planning demand
- Largely driven by interests in fertility outcomes
- Focus of frameworks driving measurement have changed over time
- Sources of family planning data are largely unchanged
- A new framework will require broad consensus and buy-in and better data

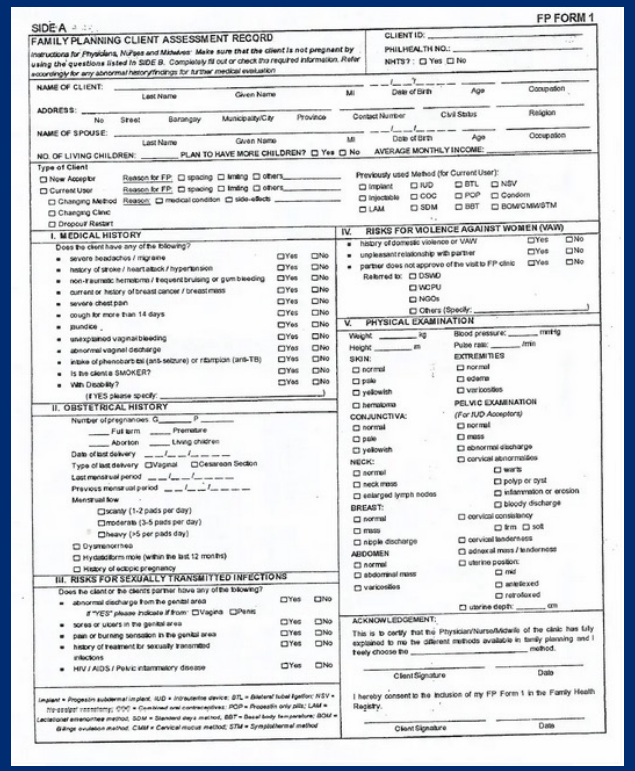
What is unique about the history of FP measurement (in LMICs)?

- It's predominantly been household survey-based
  - Face-to-face interviews with samples of women of reproductive age
- It measures FP as contraceptive use, abortion use less reliably
- It's been largely population-based
  - Supports international donor monitoring



Source: Alkema et al., Lancet, 2013

Three main sources of FP data



SIDE A FP FORM 1

FAMILY PLANNING CLIENT ASSESSMENT RECORD

CLIENT ID:

PHILHEALTH NO.:

NHTS? ☐ Yes ☐ No

Instructions for Physicians, Nurses and Midwives: Make sure that the client is not pregnant by using the questions listed in SIDE B. Completely fill out or check the required information. Refer accordingly for any abnormal history/findings for further medical evaluation.

NAME OF CLIENT: Last Name Given Name MI Date of Birth Age Occupation

ADDRESS: No Street Barangay Municipality/City Province Contact Number Civil Status Religion

NAME OF SPOUSE: Last Name Given Name MI Date of Birth Age Occupation

NO. OF LIVING CHILDREN: PLAN TO HAVE MORE CHILDREN? ☐ Yes ☐ No AVERAGE MONTHLY INCOME:

Type of Client

☐ New Acceptor Reason for FP: ☐ spacing ☐ limiting ☐ others

☐ Current User Reason for FP: ☐ spacing ☐ limiting ☐ others

☐ Changing Method Reason: ☐ medical condition ☐ side-effects

☐ Changing Clinic

☐ Dropout/ Restart

Previously used Method (for Current User):

☐ Implant ☐ IUD ☐ BTL ☐ NSV

☐ Injectable ☐ COC ☐ POP ☐ Condom

☐ LAM ☐ SDM ☐ BBT ☐ BOM/CMM/STM

I. MEDICAL HISTORY

Does the client have any of the following?

- severe headaches / migraine ☐Yes ☐No
- history of stroke / heart attack / hypertension ☐Yes ☐No
- non-traumatic hematoma / frequent bruising or gum bleeding ☐Yes ☐No
- current or history of breast cancer / breast mass ☐Yes ☐No
- severe chest pain ☐Yes ☐No
- cough for more than 14 days ☐Yes ☐No
- jaundice ☐Yes ☐No
- unexplained vaginal bleeding ☐Yes ☐No
- abnormal vaginal discharge ☐Yes ☐No
- intake of phenobarbital (anti-seizure) or rifampicin (anti-TB) ☐Yes ☐No
- Is the client a SMOKER? ☐Yes ☐No
- With Disability? ☐Yes ☐No

(If YES please specify: _____)

II. OBSTETRICAL HISTORY

Number of pregnancies: G_____ P_____

_____ Full term _____ Premature

_____ Abortion _____ Living children

Date of last delivery: __/__/____

Type of last delivery: ☐Vaginal ☐Cesarean Section

Last menstrual period: __/__/____

Previous menstrual period: __/__/____

Menstrual flow

☐scanty (1-2 pads per day)

☐moderate (3-5 pads per day)

☐heavy (>5 per pads day)

☐ Dysmenorrhea

☐ Hydatidiform mole (within the last 12 months)

☐ History of ectopic pregnancy

III. RISKS FOR SEXUALLY TRANSMITTED INFECTIONS

Does the client or the client's partner have any of the following?

- abnormal discharge from the genital area ☐Yes ☐No

If "YES" please indicate if from: ☐Vagina ☐Penis

- sores or ulcers in the genital area ☐Yes ☐No
- pain or burning sensation in the genital area ☐Yes ☐No
- history of treatment for sexually transmitted infections ☐Yes ☐No
- HIV / AIDS / Pelvic inflammatory disease ☐Yes ☐No

Implant = Progestin subdermal implant; IUD = Intrauterine device; BTL = Bilateral tubal ligation; NSV = No-scalpel vasectomy; COC = Combined oral contraceptives; POP = Progestin only pills; LAM = Lactational amenorrhea method; SDM = Standard days method; BBT = Basal body temperature; BOM = Billings ovulation method; CMM = Cervical mucus method; STM = Symptothermal method

IV. RISKS FOR VIOLENCE AGAINST WOMEN (VAW)

- history of domestic violence or VAW ☐Yes ☐No
- unpleasant relationship with partner ☐Yes ☐No
- partner does not approve of the visit to FP clinic ☐Yes ☐No

Referred to: ☐ DSWD ☐ WCPU ☐ NGOs ☐ Others (Specify: _____)

V. PHYSICAL EXAMINATION

Weight: _____ kg Blood pressure: _____ mmHg

Height: _____ m Pulse rate: _____ /min

SKIN: ☐ normal ☐ pale ☐ yellowish ☐ hematoma

EXTREMITIES ☐ normal ☐ edema ☐ varicosities

CONJUNCTIVA: ☐ normal ☐ pale ☐ yellowish

PELVIC EXAMINATION (For IUD Acceptors) ☐ normal ☐ mass ☐ abnormal discharge ☐ cervical abnormalities ☐ warts ☐ polyp or cyst ☐ inflammation or erosion ☐ bloody discharge

NECK: ☐ normal ☐ neck mass ☐ enlarged lymph nodes

BREAST: ☐ normal ☐ mass ☐ nipple discharge

ABDOMEN ☐ normal ☐ abdominal mass ☐ varicosities

☐ cervical consistency ☐ firm ☐ soft

☐ cervical tenderness

☐ adnexal mass / tenderness

☐ uterine position: ☐ mid ☐ anteflexed ☐ retroflexed

☐ uterine depth: _____ cm

ACKNOWLEDGEMENT:

This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

_____ Client Signature _____ Date

I hereby consent to the inclusion of my FP Form 1 in the Family Health Registry.

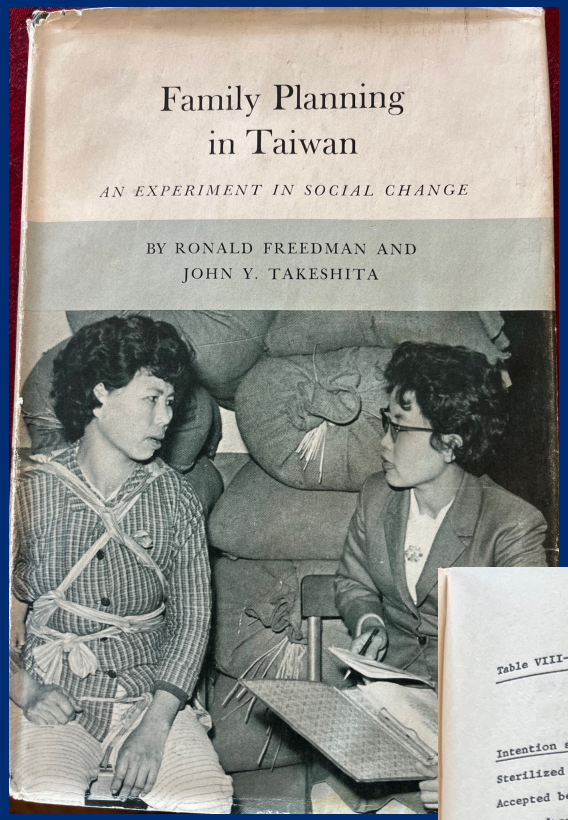
_____ Client Signature _____ Date

Philippine health system
FP client record

1. Client and facility records (MIS)
2. Commodities (purchases and consumption)
3. Sample surveys
   - Female respondents of reproductive age
   - Some male respondent samples

UNFPA Kenya

FP Experiment in Taiwan, 1963-66



Intentions to Accept Family Planning

Table VIII-3. Cumulative Acceptance Rates to End of Each of Four Time Periods, by Initial Acceptance Intention

Intention status	Number in base group	Cumulative acceptance rate to end of: Experimental period: Within 30 days of home visit	Experimental period: Feb. 1963–Mar. 1964	Extension period: Apr. 1964 Dec. 1964	Free insertion period: Jan. 1965–July 1965
Sterilized or believes self sterile	1,839	*	1	2	2
Accepted before home visit	226	100	100	100	100
Accepted on home visit	374	100	100	100	100
Stated intention to accept:					
soon	1,703	13	38	41	44
eventually	4,307	1	8	11	15
Total intending to accept	6,010	4	16	19	23
Stated intention never to accept because:					
already using contraception	1,779	2	14	16	19
ambivalent or undecided	573	3	18	21	24
opposed to general idea and others	448	1	6	10	12
Total intending never to accept	2,800	2	14	16	19
Total intending never to accept excluding those already using	1,021	2	13	16	19
Indeterminate	144	–	100	100	100
Total (Sample A)[a/]	11,393	6	18	21	24
Total (Sample B)[a/]	8,810	4	15	18	22
Total (Sample C)[a/]	7,031	4	16	19	23

[a/] Sample A includes all home-visited cases; Sample B excludes the sterilized or believes self sterile, those accepting before or on home visit, and the indeterminate cases; Sample C further excludes those not intending to accept because already using contraception.

* Less than 1 per cent.

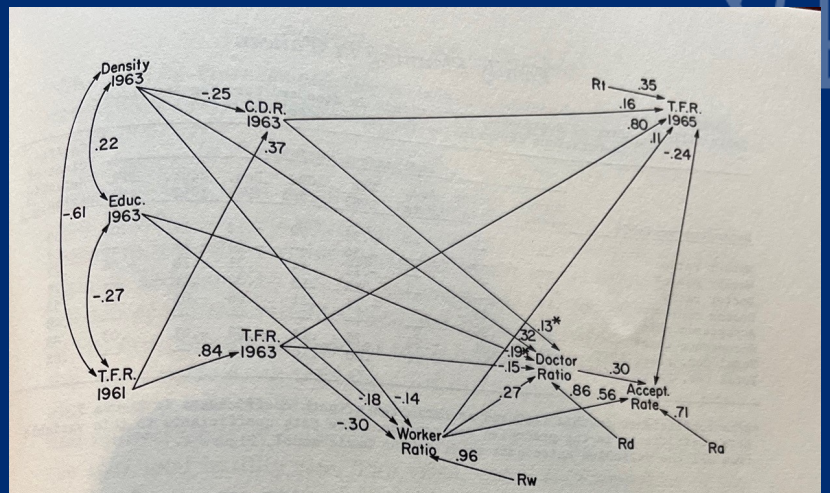


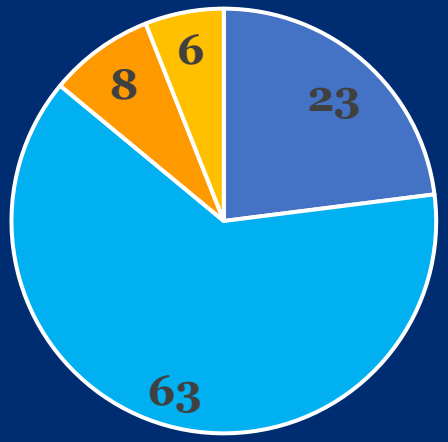
Figure 5. Path Diagram of Factors Affecting 1965 Total Fertility in 78 Urban Areas

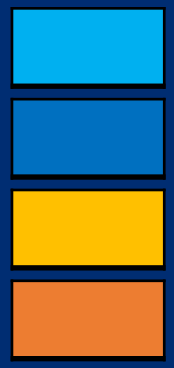
Note: The paths Rw, Rd, Ra, and Rt represent residual paths, which encompass all other influences on the variable in question. The expression (1-square of the residual path) gives the proportion of variance accounted for by the variables with direct paths to the variable in question.

* Path coefficient is less than twice the standard error of the Beta coefficient.

Source: Freedman and Takeshita, FP in Taiwan, 1969

Intention to accept among married women 20-39 not using satisfactory contraception: Taichung (Taiwan) experiment, c. 1963-66





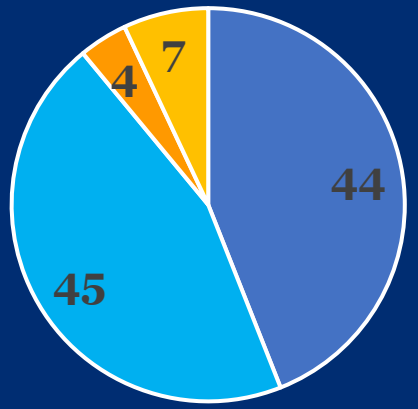
Intend to accept soon

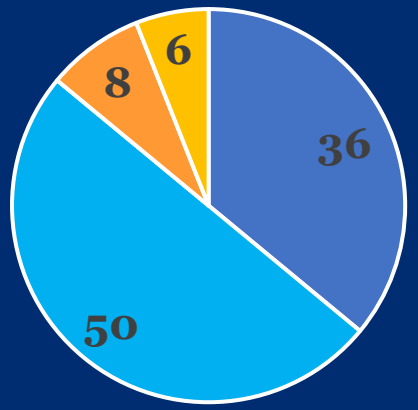
Intend to accept eventually

Do not intend to accept -ambivalent

Do not intend to accept-other reaasons

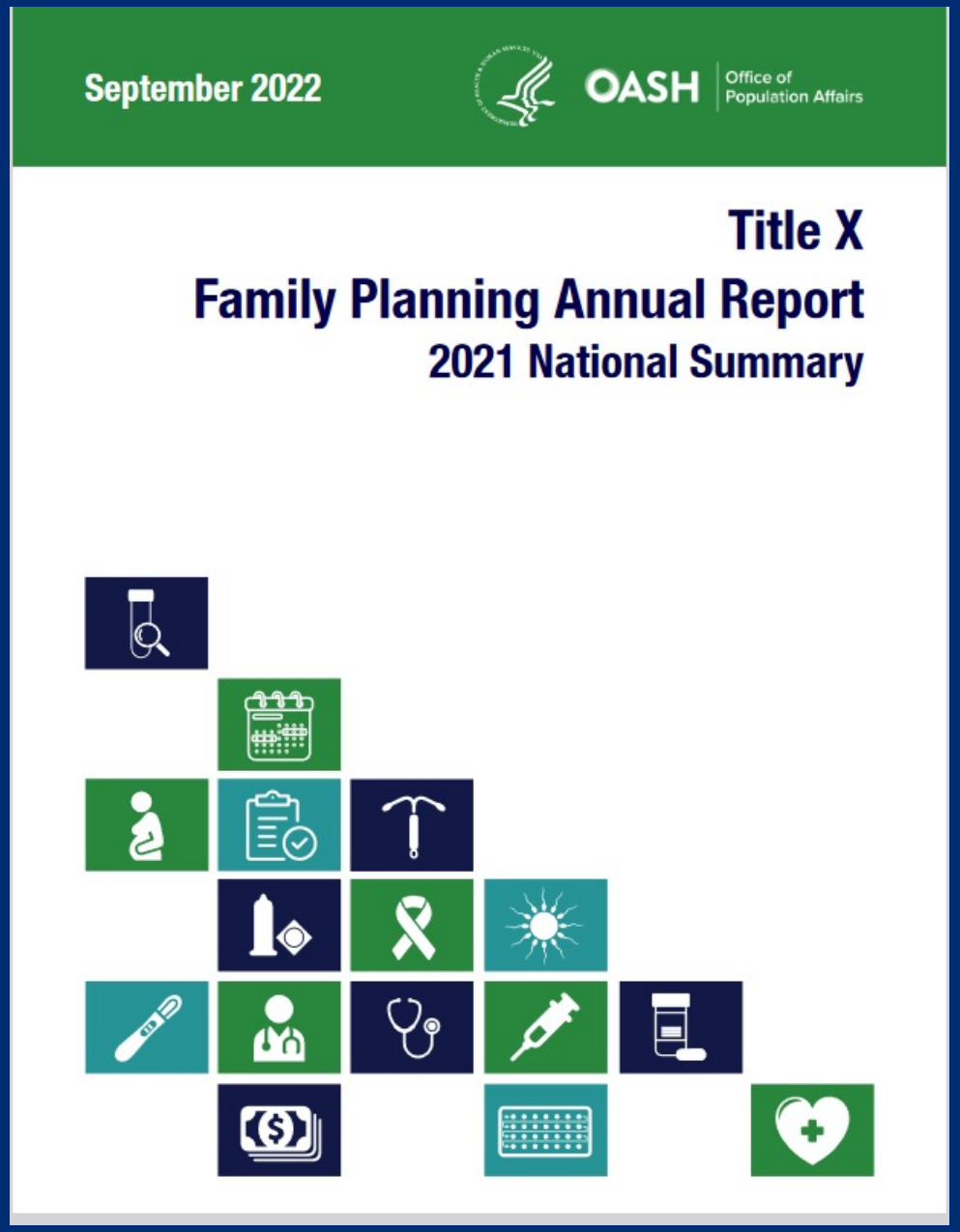
Past user, prior abortion





Past user, no prior abortion

Source: Freedman and Takeshita, FP in Taiwan, Table VIII-7



US Title X FP Reporting

Terms used

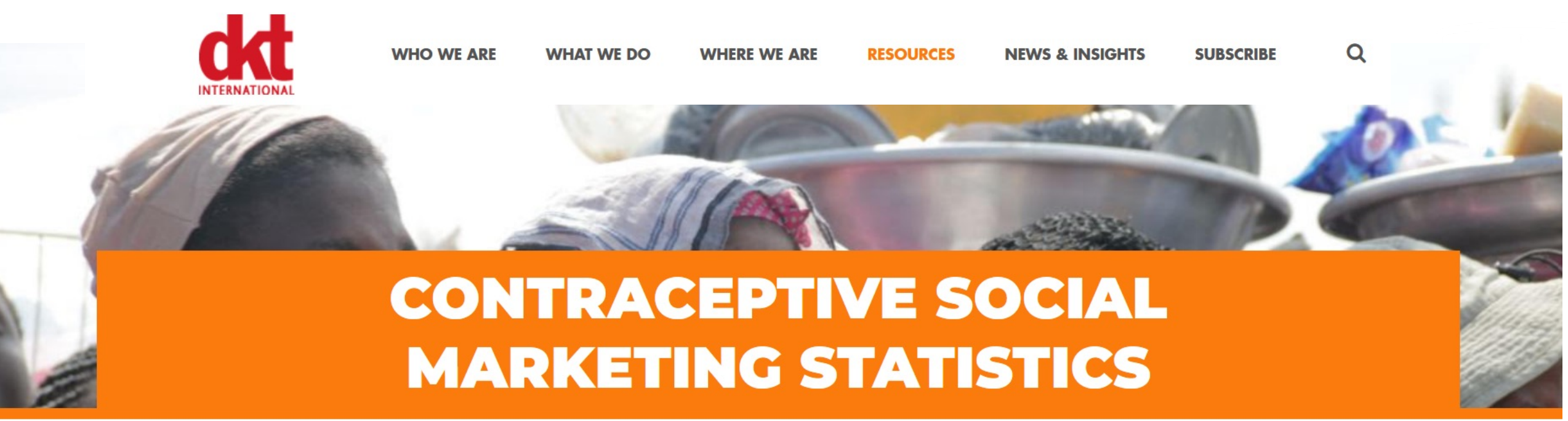
- Family planning user
- Family planning encounter
- FP service provider
- FP service site
- Client records

Example of a Commodities-based Indicator

Couple-Years of Protection (CYP) is the estimated protection provided by family planning (FP) methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. This includes permanent methods, such as sterilization, and the lactational amenorrhea method (LAM)

Examples	
Method	**CYP conversion factor**
Sterilization	10 CYP per procedure
5-year implant	3.8 CYP per implant
Hormonal IUD	4.8 CYP per insertion
Depoprovera	0.25 CYP per does
Combined OC	0.0667 CYP per 28-pill pack
Emergency contraception	0.05 CYP per dose

https://www.usaid.gov/global-health/health-areas/family-planning/couple-years-protection-cyp

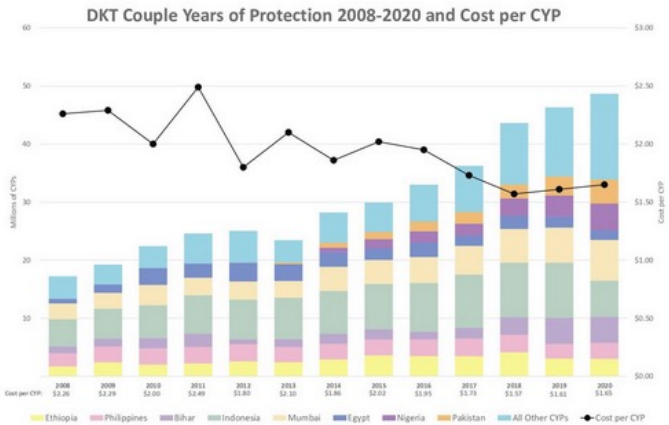


CONTRACEPTIVE SOCIAL MARKETING STATISTICS

DKT International publishes statistics for Contraceptive Social Marketing programs that report their sales data to DKT. These reports contain sales results from social marketing programs that generate 10,000 CYPs or more. To learn about CYPs and how DKT counts them, refer to our Resources page.

For Contraceptive Marketing Statistics sales data from 1991 to present in Excel format, download this file.

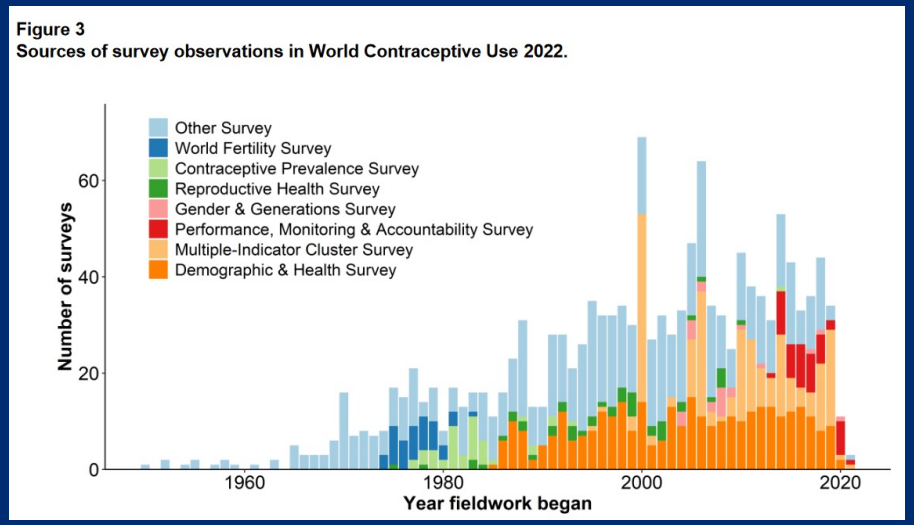
Contraceptive Social Marketing Statistics, 1991-Present



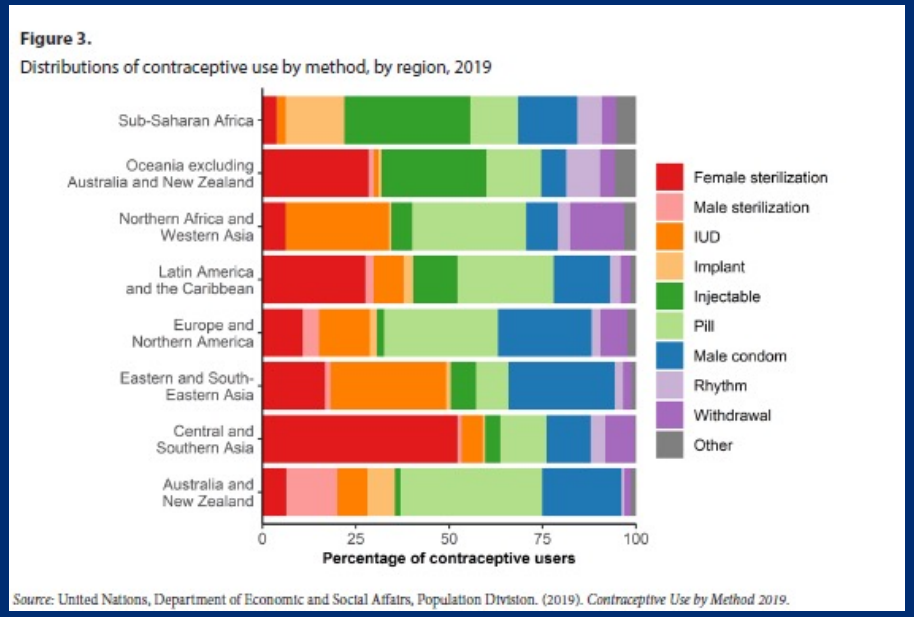
https://www.dktinternational.org/contraceptive-social-marketing-statistics/

In this half century of strong measurement of family planning demand…

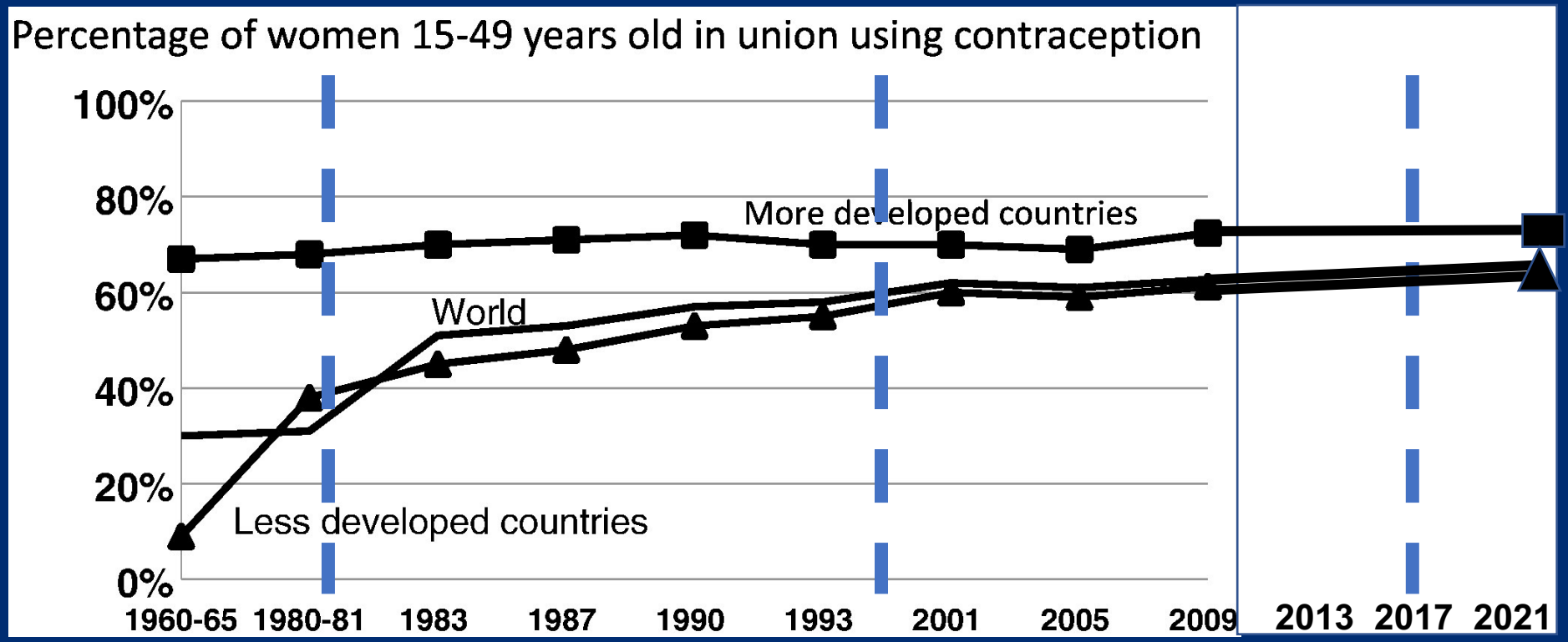
- KAP surveys in the 1970s
- World Fertility Surveys 1972- 1984
- Contraceptive Prevalence Surveys 1978-1984
- Reproductive Health Surveys 1978-2016
- Young Adult Reproductive Health Surveys 1987-2002
- Demographic and Health Surveys 1984-
- Other survey programs (MICS, PapChild)
- Periodic national surveys



Source: UN Methodoloogy Report, WCU 2022



As contraceptive prevalence increased, content focus for measurement shifted.



Knowledge-Attitude-Practice

Supply-Demand (access, quality, ideation)

Unmet need and satisfied demand

Reproductive empowerment

Role of conceptual frameworks

- Visualization of causal pathways
- Identify determinants and outcomes
- Enable measurement and operationalization
- Support hypothesis testing

The role of conceptual frameworks in driving measurement

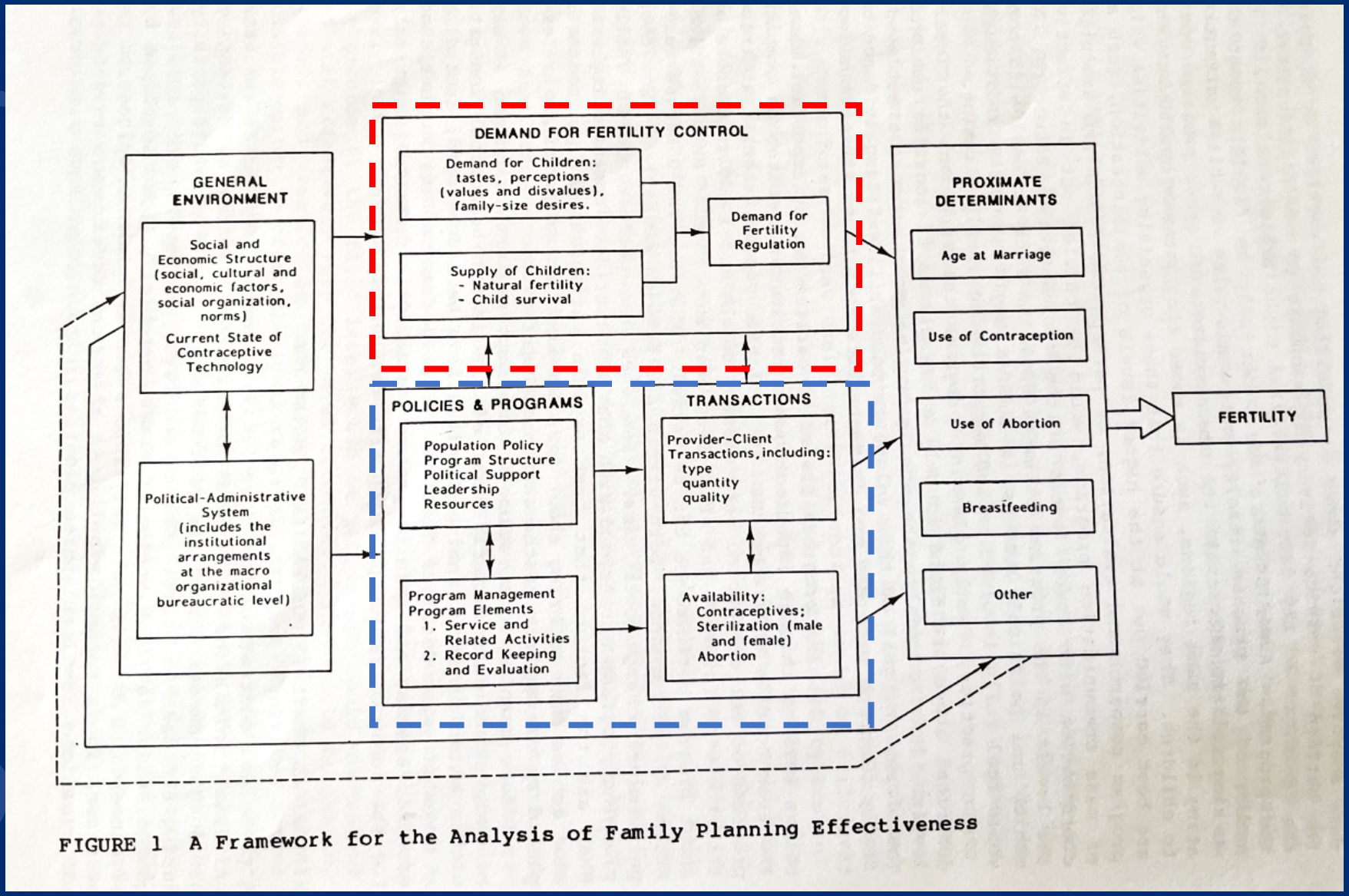
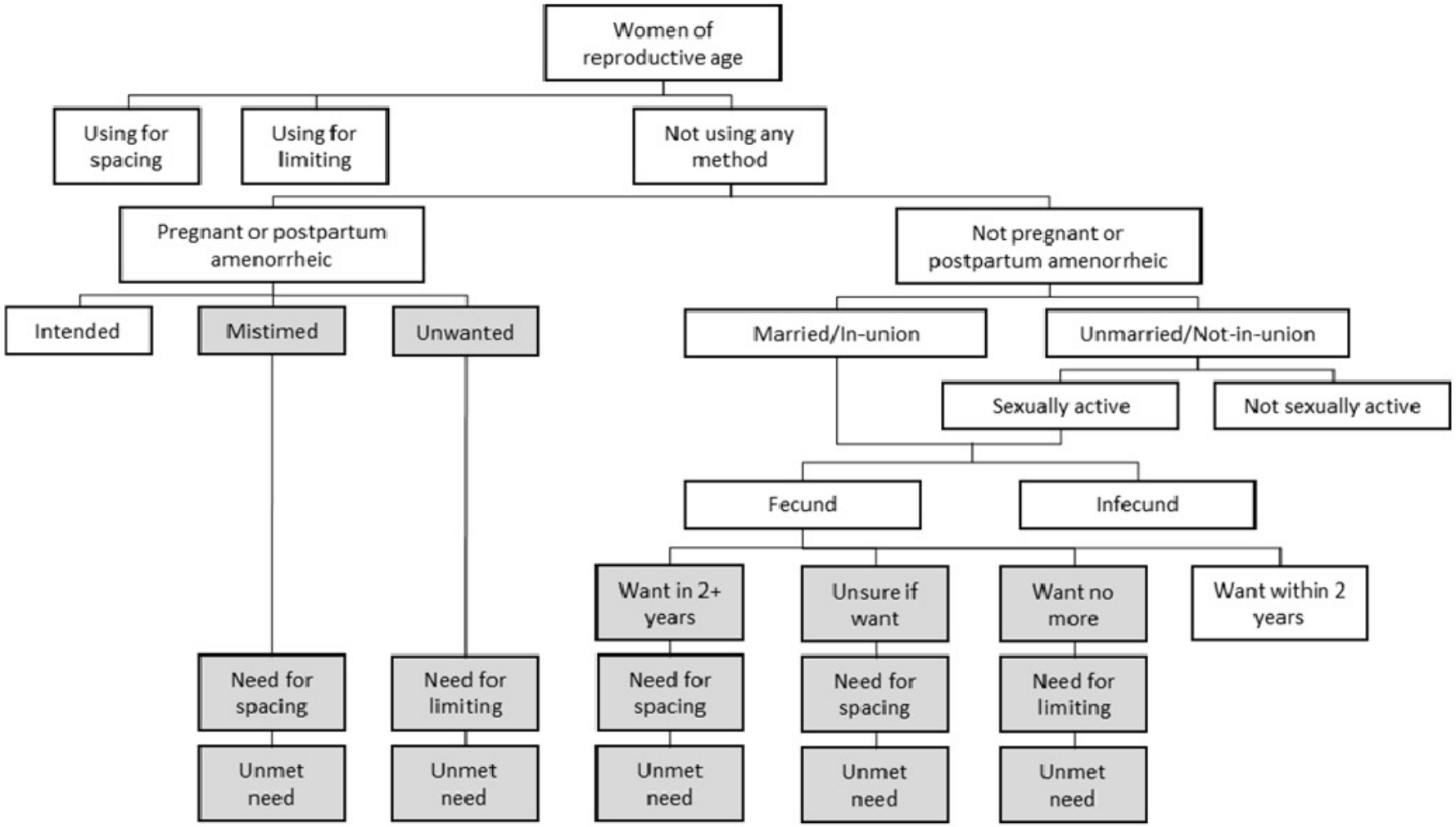


FIGURE 1 A Framework for the Analysis of Family Planning Effectiveness

Source: Lapham and Simmons, Organizing for Family Planning Effectiveness, 1987

Unmet need for family planning framework and algorithm

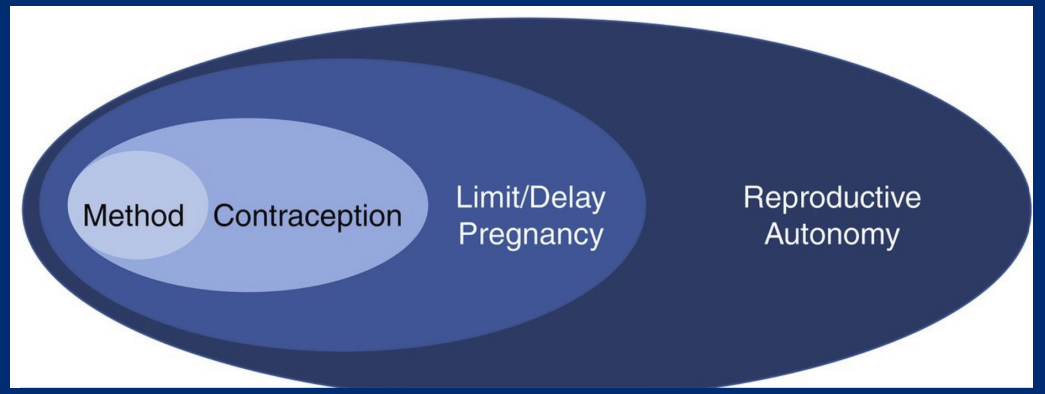
2012 DHS revised definition of the unmet need for family planning indicator.



Source: Based on Bradley and others (2012). Revising Unmet Need for Family Planning. DHS Analytical Studies No. 25, Calverton, Maryland: ICF International.

Unmet Need for Contraception

- KAP-GAP, originator concept
- Early framing by Westoff, revision by Bradley
- Demand satisfied as composite of mCPR/(CPR+Unmet Need)
- Exposure issues behind “Need” (Bradley and Casterline, 2014; Bell and Bishai, 2017)
  - Sexual activity
  - Fecundity
  - Marital status
  - Pregnancy and postpartum amenorrhea
- Demand – For what? (Fabic, 2022)



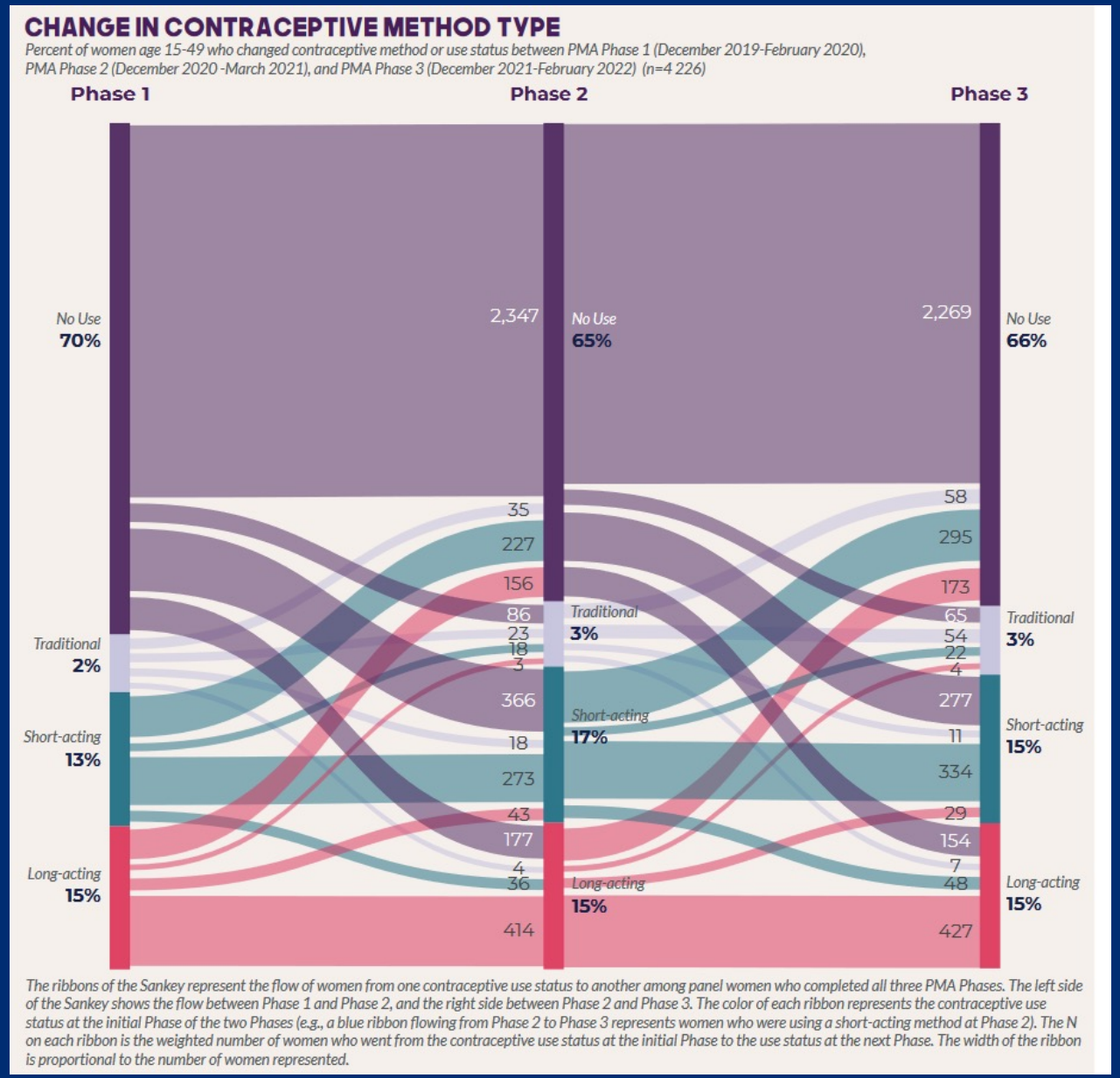
Demand for fertility and contraception are multi-dimensional but not equivalent.

Fertility/Pregnancy	Demand for	Contraception/Abortion
Preferences Desired family size Ideal family size	Fertility ≠ Contraception	Preferences Method features (mode of administration, user control, permanence)
Motivations Desire for (more) children		Motivations Sexual frequency Pregnancy avoidance
Intentions Timing Intensity		Intentions Intention to (continue) use
Satisfaction Happiness Value of children		Satisfaction Reasons for stopping Switching
Incidence Pregnancies/births		Incidence Adoption Duration of use (coverage/prevalence)

Contraceptive use dynamics

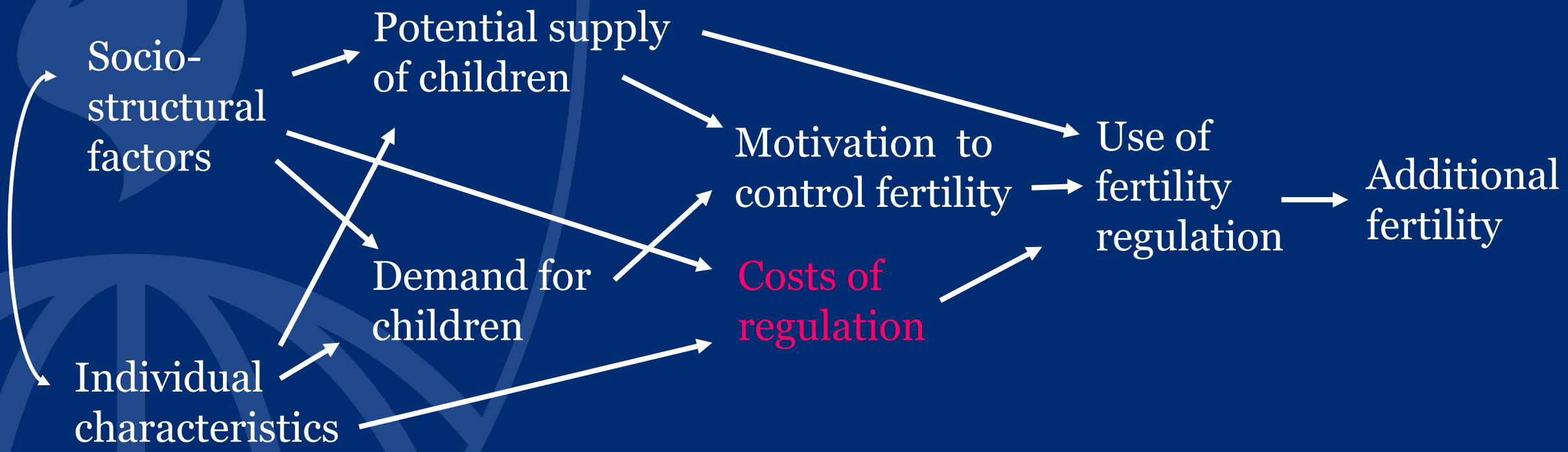
Micro-level dynamics belie modest change at aggregate level

Example: Burkina Faso PMA Longitudinal Surveys 2019-2022



Thinking forward with the past

“Basic model of factors determining additional fertility”



Source: Hermalin, Fertility Regulation and Its Costs, 1983

Subjective costs--Threats to:

Cultural norms

- Nonconformity with religious and moral beliefs
- Social disapproval and fear of sanctions

Social adjustment

- Disharmony in extended family
- Unconventional communication about sex between spouses
- Discord between spouses
- Undermining family status or security

Personal adjustment

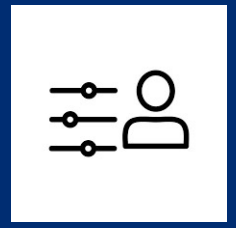
- Adoption of inner control or efficacy
- Change of self-perception and family role
- Loss of enjoyment of children
- Threat to sexual adjustment

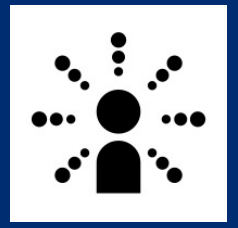
Psychic threats to physical and mental health

- Temporary discomfort
- Fear of permanent damage to health
- Fear of infant death
- Shyness toward gynecological examination
- Anxiety over contraceptive failure

Psychologistics

- Perceived accessibility of contraception





In sum,

Continuing importance of

- Conceptual frameworks (old and new) to guide measurement and validation
- Multi-disciplinary perspectives
- Indicator validation through different types of data (qualitative, longitudinal, dynamic, financial) and analyses
- Evidence-based consensus-building

Thank you.

If it's not measured,
it's not monitored.

If it's not monitored,
progress is unknown.

If progress is unknown, there is no accountability.