Goal Setting:
Identifying Opportunities

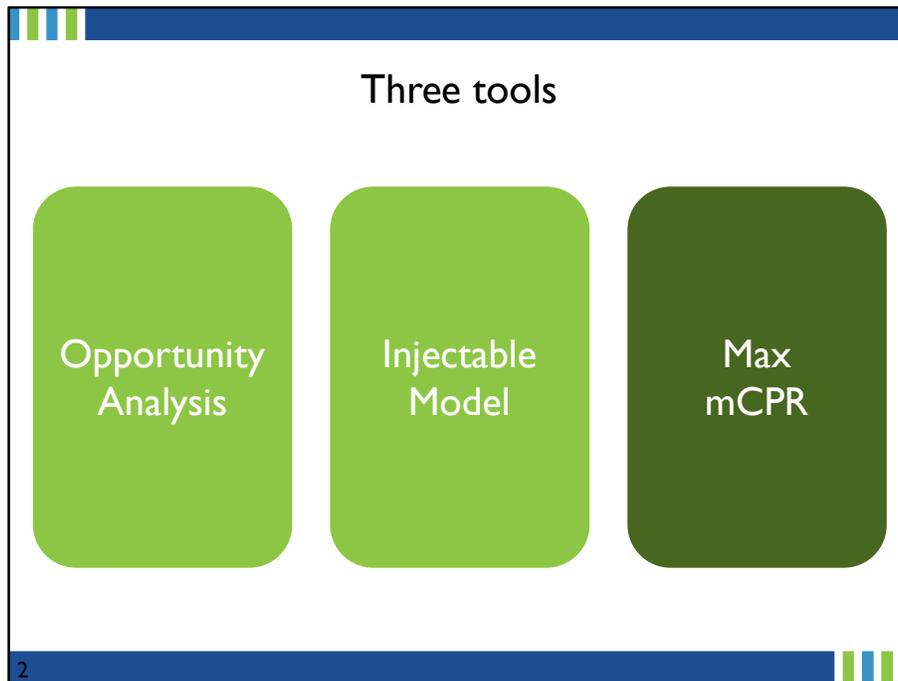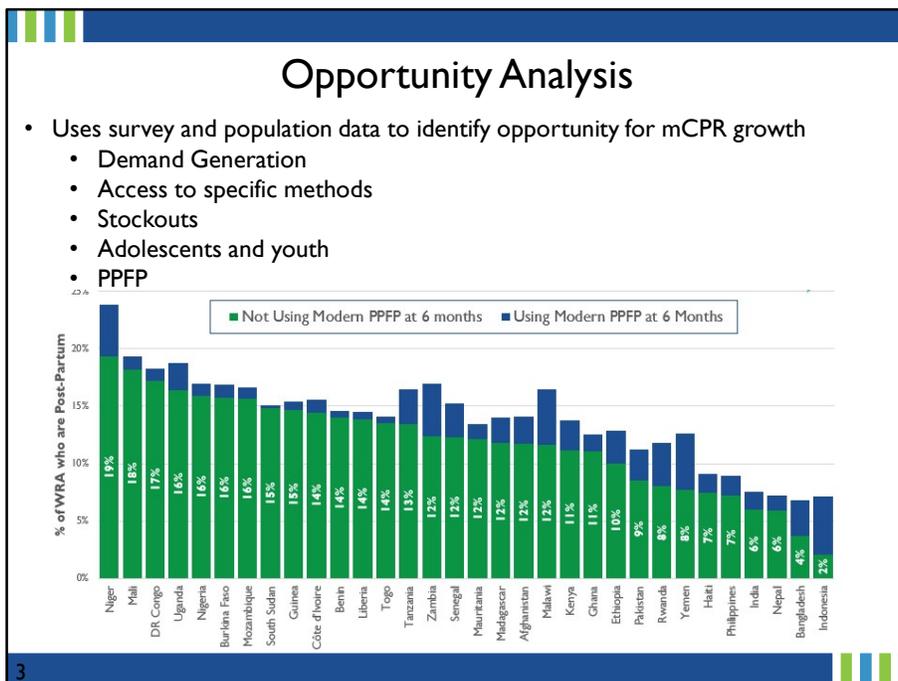| Year	Avg.	Total
2010	2.0	1.3 M
2015	2.2	1.5 M
2020	2.5	1.9 M

2021

Goals can be set based on identified opportunities for growth in mCPR. This approach is sometimes used when national priorities have already been set or data analysis shows that focus on a specific intervention or sub-set of women presents an opportunity for substantial growth.

We will briefly look at 3 tools that fall into this category. The first, Opportunity Analysis, combines High Impact Practices with population segmentation. The second, the Injectable Model, looks at the estimated impact of fully scaling up sub-cutaneous injectables and self injection. The third, the Maximum mCPR model, estimates the highest level of mCPR a country can achieve based on other fertility related factors, including fertility preferences.
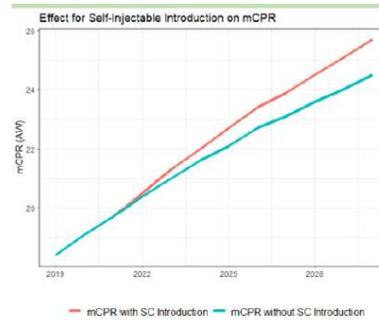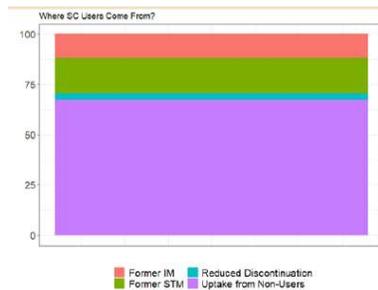
There are many ways to approach identifying opportunities for contraceptive growth in a country. The approach described here will focus on analysis that can be done with globally available data. Looking at High Impact Practices, there are 5 different opportunities that can be quantified: demand generation, access to specific methods, stockouts, adolescent and youth, and post-partum family planning.

This slide uses postpartum family planning as an example. This approach uses data on the size of the postpartum population as well as current of a modern method among postpartum women. In this graphic, the height of bars (both the green and the blue) is the percentage of women of reproductive age that are postpartum. Looking at the first bar, which is Niger, we see that about 24%, or almost 1 in 4, women of reproductive age are postpartum. We then look at just the green part of the bar and see that the majority of these postpartum women are not using a modern method. We see that about 19%, or almost 1 in 5, women of reproductive age are postpartum and not using a modern method. In this example, a postpartum intervention would reach a large proportion of women of reproductive age. The graphic organizes countries with the biggest opportunity on the left and the smallest on the right.

It is often interesting to repeat this analysis at the subnational level within a country. It is helpful to see where countries should prioritize specific interventions.

Focusing on a Specific Method:
Injectable Model

- Projecting Subcutaneous (SC) and Self-Injectable (SI) Use Model estimates the number of potential SC and SI users annually through 2030.
- Includes estimates of switching from DMPA and other short-term methods and growth from non-users

This approach quantifies the opportunity presented by a specific method. The model looks at the impact, both in terms of changes in mCPR and method mix, of scaling up subcutaneous injectables through the health system and through self injections. The impact is based both on uptake from non-users and from women switching from another method. The impact will be greater in countries that do not already have widespread availability of these methods.

The graphic on the left shows where growth in contraceptive use is coming from. The bottom of the graph, the purple part, is uptake from women who were not using contraceptives. The top two categories, the red and green parts, show women who switched from using IM injectables or other short acting methods. The last color, the blue, shows women who continued using SC injectables who would have otherwise discontinued IM injectable. Research shows that SC injectables have a lower discontinuation rate compared to IM injectables.

The graphic on the left shows the change in mCPR with the introduction of SC injectables- the red compared to the blue line. These are examples of the outputs from the model.

The maximum mCPR tools can be used to help contextualize a goal. To help determine if the goal is too ambitious or unachievable. The tool uses data from DHS to determine a country's highest potential contraceptive prevalence rate based on ideal number of children and key demographic life events. Helpfully, it is also disaggregated for spacing and limiting.

The graphic compares the contraceptive prevalence, for spacing and limiting, from the last DHS with the maximum mCPR output by the model. The bars on the left are from the latest DHS, showing a prevalence or 43%, breaking down to 19.8% using for spacing and 23.2% using for limiting. Based on the country specific data related to demographic life events and fertility desires, both of these have room for increases. The bar on the right shows that the total mCPR could go up to 50.1%. mCPR for spacing could increase by about 4 percentage points and mCPR for limiting by about 3 percentage points.

Unless there are plans to change fertility desires, which often takes a long time, an mCPR goal should not exceed 50%.

Model Availability

- Opportunity Analysis Briefs
  http://www.track20.org/pages/data_analysis/in_depth/opportunities/overview.php

Interactive Tools:
- Injectable Model
  http://www.track20.org/pages/track20_tools/self_injectable_use.php

- Maximum CPR Model
  http://www.track20.org/pages/track20_tools/maximum_cpr.php

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All of the tools, models, and approaches discussed are available online. The Opportunity Analysis is available in brief format while the other two, the Injectable and Maximum CPR models are interactive online tools.