Chapter IV

GLOSSARY

*United Nations Secretariat**

The expansion of the field of family planning evaluation research has brought about an increased number of technical terms and specialized expressions that are not defined in some of the texts using them. Furthermore, specific concepts are sometimes expressed by different terms, while, on the other hand, the same term may be used to refer to different concepts. In the light of these considerations, the members of the Third Expert Group on Methods of Measuring the Impact of Family Planning Programmes on Fertility recommended that a glossary of terms commonly found in the literature of contraception and programme evaluation should be included in this *Addendum* to *Manual IX*. Despite some overlapping, this glossary is intended to complement the existing *Multilingual Demographic Dictionary* and sum up, without being fully comprehensive, the current state of the evaluation terminology. Most, although not all, of the definitions are drawn or paraphrased from the literature cited in the sources. Attention has been given only to definitions of concepts, and computational procedures to quantify them have thus been omitted. Each term or expression listed in the glossary is listed in an alphabetical index for easy reference. Some of the terms listed have other meanings in ordinary discourse; this glossary gives only the special meanings of these terms when they are used in discussions of family planning evaluation.

A. Family planning

1. **Birth regulation** refers to measures taken by couples to space or limit the number of their children, excluding abortion. **Birth control** refers to all methods used to space or limit the number of children, including abortion. **Contraception** refers to measures taken by couples to prevent conception, including sterilization, but excluding artificial interruption of pregnancy (abortion). A **contraceptor** is a user of a contraceptive method.

2. The concept **motivation for family planning,** although general enough to refer to motivation for both spacing and limiting births, was often resorted to only in connection with the latter meaning. Motivation for family planning was empirically assessed on the basis of certain criteria, for instance: (*a*) when the **potential output of children** is larger than the **demand for children**; or (*b*) when the number of surviving children has reached or exceeded the desired number of children; or (*c*) when a couple states explicitly that no more children are wanted. **Potential output of children** refers to the number of children a typical couple would have under conditions of natural fertility and of prevailing life expectancy to adulthood. **Demand for children** may be represented by various concepts, such as the total desired number of children, or the number of children a couple expects to have, or the number of additional children already born (or surviving) plus the number of additional children wanted. There is no consensus on the operationalization of this concept.

3. **Contraceptive accessibility** depends upon how much effort (in terms of distance, travel time or cost, for instance) is required to obtain an available contraceptive method. **Perceived accessibility** refers to accessibility as reported or perceived by respondents. **Actual accessibility** refers to the actual measured distance, travel time or cost of travel and/or services, to a contraceptive services outlet. Usage sometimes includes the notion of contraceptive availability in the concept of accessibility. For **contraceptive availability**, a contraceptive is available in a country if it is marketed or distributed and can be obtained through some realistically feasible effort; it is sometimes used synonymously with **accessibility**. A distinction between **actual** and **perceived availability** is also made.

4. **The cost of fertility regulation** is often decomposed into different concepts. **Psychological cost** refers to reservations, displeasure and anxieties associated with the use of birth regulation devices. **Social cost** refers to the social constraints—conjugal, family, and peer pressures as well as religious prohibitions and taboos and other negative norms—which discourage adoption of birth regulation methods. **Health cost** refers to health risks and medical side-effects resulting from use of birth regulation methods. **Economic cost** refers to the monetary and time cost necessary to obtain information and use a contraceptive method.

5. **Demand for family planning** refers to the number or proportion of (married) women or couples with an apparent motivation to prevent or delay a pregnancy. Demand for family planning is sometimes used synonymously with **demand for contraception. Unmet need for family planning** refers to the proportion of reproductive-aged sexually active (or married) women or couples who are apparently motivated to prevent or delay a pregnancy but who are not practising contraception. Alternatively, **unmet need** may reflect an outside

* Population Division of the Department of International Economic and Social Affairs, with the assistance of John A. Ross, Center for Population and Family Health, Columbia University, New York, who acted as consultant.

standard of need, as in areas with excessive mortality and fertility levels. Proposed measures of unmet need have varied considerably, depending in part upon the criteria used to measure motivation to control fertility and those used to identify current exposure to risk of pregnancy. Sometimes measures have tried to reflect unmet need among couples wishing to increase birth spacing as well as unmet need among couples desiring no more children, and sometimes only the latter motivation has been considered. Sometimes users of relatively ineffective methods of contraception have been counted as having unmet need. Although measures of unmet need most frequently focus on exposure to risk of an unintended pregnancy at a particular time, some estimates have attempted to allow for the number of couples who are likely to be in need in the near future, although they are temporarily not at risk of pregnancy. The most prominent illustration of this subgroup is women currently pregnant.

B. Contraceptive acceptance and use

6. **Contraceptive acceptor** refers to a couple, woman or man who accepts a contraceptive method with the intention of using it for delaying or preventing the next conception. Those who receive a birth regulation method but never use it, or who abandon it immediately, are acceptors but are not users. **Contraceptive users** are acceptors who do not abandon use of a birth regulation method immediately after acceptance and who are actively using it at interview or cut-off point. Contraceptive users trying to delay the next birth are referred to as **birth-spacers;** users trying to prevent the next birth are referred to as **birth-limiters** (or **spacers** and **limiters,** for short). **Never-users** are women or couples who have never used any contraceptive method in their entire life, up to the time of the interview. **Current users** are women or couples who are using a contraceptive method at the time of the interview. **Past users** are couples or women who have used a contraceptive method in the past but are not using any method at the time of the interview. **Ever-users** are couples or women who have used in the past and/or are currently using a contraceptive method. Each of these last four concepts can in turn be subdivided into **single-method users** if pertaining to a single or particular contraceptive method; and **multi-method users,** if pertaining to two or more contraceptive methods. Hence, **single-method** and **multi-method current users, single-method** and **multi-method past users** and **single-method** and **multi-method ever-users. Current non-users** are women or couples who are not using a contraceptive method at the time of the interview. **Programme acceptor** refers to an acceptor who initiates contraceptive use from the programme. **Programme users** are couples who utilize a contraceptive method provided by the family planning programme. When the contraceptive methods are provided by the private sector, one refers to **non-programme acceptors** and to **non-programme users. Potential users** sometimes refers to couples motivated for family planning but not yet using. Potential users are defined as **potential spacers** if they state that they wish to delay the next pregnancy and as **potential limiters** if they state that they want to prevent all further pregnancies. See **motivation for family planning.** A distinction between **all acceptors** and **new acceptors** of a given contraceptive method is also used to separate those adopting a particular method offered by the programme for the first time from those who receive additional supplies of a previously adopted method. Monthly reports on programme activity typically list these separately. A new pill acceptor may be entirely new to the programme or may be a former intra-uterine device (IUD) acceptor. To avoid such ambiguities, a further distinction is needed between **new programme acceptors** and **former** or **"old" programme acceptors.** A contraceptor can thus be a new pill acceptor but an "old" programme acceptor. This distinction, however, is so far rare in practice.

7. **Contraceptive prevalence** refers to the proportion of couples (or married or sexually active women) of reproductive age using a contraceptive method at a given time or during a short interval of time. A **Contraceptive Prevalence Survey (CPS)** is a specialized survey directed to, among other things, identifying the past and current use of different types of traditional and modern birth regulation methods by couples of reproductive age and the extent of availability of or accessibility to such methods. A **KAP Survey** is a survey undertaken to collect information on women's (or sometimes couples') knowledge about, attitude towards and practice of family planning. Its purpose is to inform policy planners about what the relevant population knows about birth regulation and what proportion approves it, practises it etc. Some KAP surveys also include questions relating to fertility; and KAP surveys also provide contraceptive prevalence data, by method, age and other characteristics, as do CPS surveys.

8. A **segment** (of contraceptive use) is a period during which a particular contraceptive method is used without interruption. In the case of the intra-uterine devices, a segment of use begins with insertion of the device and ends when the device is removed or expelled (even if another device is inserted immediately), or upon occurrence of an unintended pregnancy. For other methods, a segment of use ends upon occurrence of a contraceptive failure, a change to another contraceptive method or interruption of contraceptive use for a specified period of time, such as one month. In life-table analysis of contraceptive continuation and contraceptive failure, a distinction is often made between **first** and **later** segments of use.

C. Fertility and fecundity

9. **Fertility** refers to actual reproductive performance rather than to its capacity; production of a live birth. **Infertility** is the opposite of fertility; it refers to the absence of children and is sometimes synonymous with **childlessness.** Infertility can be voluntary (contraception or abortion) or involuntary (infecundity). **Fecundity** refers to the ability to produce a live birth. **Infecundity** refers to the inability to conceive; it is similar to **sterility,** which may be **primary** (inability from puberty ever to produce a live birth) or **secondary** (appearing after at least one birth). **Natural fertility** refers to the fertility rate a group of women would have in the absence of deliberate birth control.

10. **Fecundability** refers to the probability of conceiving during a menstrual cycle or month. **Physiological fecundability** (or **total fecundability**) takes into consideration all conceptions, including those usually not detected (some of which occur and end before menses return.) **Recognizable fecundability** excludes pregnancies ending within two weeks after conception. **Apparent fecundability** refers to a fecundability estimate based on all conceptions that are recognized and declared by a woman. **Effective fecundability** includes only those pregnancies that end in a live birth. **Residual fecundability** (or **controlled fecundability**) refers to the probability of conception during a menstrual month in the presence of contraception, as opposed to **natural fecundability**, the probability of conceiving in the absence of contraception. The term **fecundability** used without qualifiers is generally synonymous with **natural fecundability**.

11. **Conception** is the beginning of a pregnancy. **Conception rate** refers the proportion of women conceiving each month among those who have not conceived at the beginning of the month (conditional monthly probability).

12. **Exposed women** refers specifically to women exposed to the risk of conception. This includes all women of reproductive ages currently in a marital union, from which are excluded all pregnant women, naturally sterile women, amenorrhoeic women, deliberately sterilized women and women who though in a union are not currently cohabiting. This concept can still be used in cases where data are not available for certain subcategories (amenorrhoeic women or non-cohabiting women) provided the nature of the measurement is made explicit.

D. Contraceptive evaluation

13. **Contraceptive effectiveness** is the proportionate reduction in the probability of conception due to contraceptive use. Four types of effectiveness are commonly distinguished:

(*a*) **Theoretical effectiveness** (or physiological or biological effectiveness) refers to effectiveness of a contraceptive under ideal laboratory conditions, with no human error. Any conceptions are therefore **method failures**;

(*b*) **Use-effectiveness** (or clinical effectiveness) refers to effectiveness of contraception under conditions of ordinary use, allowing for unintended conceptions due to incorrect or careless use as well as for method failures;

(*c*) **Extended use-effectiveness** refers to effectiveness of contraceptive use regardless of interruption and discontinuation of use, as well as switching between methods. It counts all conceptions, regardless of whether they occur while contraception is actually employed. In order to estimate contraceptive effectiveness, the observed rate of unintended conceptions among contraceptive users, **accidental pregnancies**, is compared with an estimate of the pregnancy rate the contraceptive users would have experienced in the entire absence of contraception. Usage is not completely consistent; sometimes the term **contraceptive effectiveness** has been applied to rates of **contraceptive failure**;

(*d*) **Demographic effectiveness** is similar to extended use-effectiveness but uses live birth as the end-point of interest, ignoring all conceptions with other outcomes.

14. **Contraceptive failure** describes the occurrence of an involuntary (or accidental) pregnancy while contraception is being used. **Contraceptive failure rates** relate the number of unintended conceptions to the duration of exposure to the risk of conceiving. **Method failure** or **theoretical failure** occurs when an involuntary conception takes place while the contraceptive method is being used properly, and a **method failure rate** represents the number of method failures in relation to the period of proper use. **Use failure rates** relate the number of involuntary conceptions that occur under conditions of ordinary use to the duration of contraceptive use. Conceptions due to incorrect or careless contraceptive practice are included, as well as method failures. **Extended use-failure** expands the notion of failure to include all unintended conceptions following the start of contraceptive use, including conceptions during interruption of use or occurring after use was entirely discontinued. Contraceptive failures can also be classified according to the reason contraception was employed: **delay failure** represents the occurrence of a pregnancy sooner than was intended; **prevention failure** represents the occurrence of a pregnancy to a woman who intended to have no more children at any time. The most common measures of rates of contraceptive failure are:

(*a*) **Cumulative failure rate**, which equals the proportion of women who become unintentionally pregnant within a given time (e.g. one year) of the beginning of a segment of contraceptive use (see **segment**). This measure is calculated using life-table methods. It can be either **gross** or **net**. The **gross rate** is hypothetical, by assuming that the group followed never terminate contraception unless a pregnancy intervenes; the **net rate** retains the confounding effects of contraceptive termination for reasons other than pregnancy (see **gross rate, net rate**).

(*b*) **Pearl pregnancy rate**, which is the number of involuntary pregnancies per 100 years of exposure (calculated by dividing the observed number of involuntary pregnancies by the observed months of exposure for a group of women and multiplying the result by 1,200). This measure is distorted, however, by the length of the observation period, because failure rates per month are higher near the beginning of a segment of contraceptive use than at longer durations. The **improved Pearl index** refers to a Pearl pregnancy rate based on the experience of a group of women each of whom is observed for a fixed amount of time, such as one year. A one-year improved Pearl index is closely related to a one-year life-table failure rate.

Measures of contraceptive failure are sometimes referred to as measures of **contraceptive effectiveness**, although the latter term is more often reserved for estimates of the proportionate reduction in the probability of conception attributable to contraceptive use. (See **contraceptive effectiveness**.)

15. **Continuation** (contraceptive) refers to the continuing use of a birth regulation method. One can distinguish between **first-method continuation** and **all-**

method continuation. The first expression refers to the continuous use of the same contraceptive method during a specified period of time. The second expression implies changes in the type of contraceptive method after acceptance and refers to acceptors who are still using any method (with no intervening pregnancy) after a specified period of time since acceptance. **Continuation rate** refers to the proportion of acceptors who are still using after a given period of time such as one year; one can distinguish between **first-method continuation** rates and **all-method continuation** rates. **Retention rate** is the term usually used in life-table analysis with respect to the continuing use of the intra-uterine device. The retention rate can be computed either with or without reinsertion of the intra-uterine device. It refers generally to **annual rates**. Complement to the termination rate. (See also **discontinuation**.)

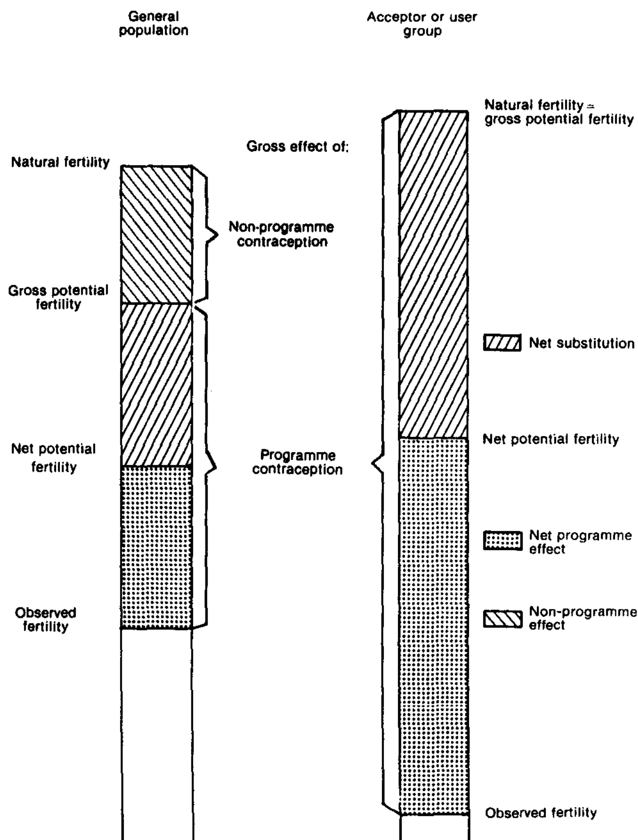
16. **Contraceptive discontinuation** refers to the cessation of use of a contraceptive method. Discontinuation is measured by a **discontinuation rate** which consists, in general, of the complement to 1.0 of the continuation rate. In life-table analysis of the intra-uterine device continuation, the term **termination** rather than discontinuation is generally encountered. Termination of use of an IUD occurs as a result of the **expulsion** or **removal** of an IUD or of an **accidental pregnancy**. In IUD evaluation, termination is measured by a **termination rate**, which is the sum of the net rates of expulsion, removal and accidental pregnancy. Such rates are usually measured by **segment**. In intra-uterine device analysis, **expulsion** refers to complete expulsion of the intra-uterine device or partial expulsion requiring removal. **Expulsion rate** is the life-table measurement of intra-uterine device expulsions over a specified period of time. Expulsion rates are sometimes subdivided into **first expulsion rates** and **later expulsion rates. Removal** refers to the removal of the intra-uterine device for medical and non-medical reasons. **Removal rate** is the life-table measurement of intra-uterine device removals over a specified period of time. **Accidental pregnancy** includes all conceptions occurring while using a contraceptive method; it is synonymous with **contraceptive failure**. The **accidental pregnancy rate**, in IUD evaluation, is also a life-table measurement of unwanted pregnancies over a specified period of time. See also **failure rate. Loss to follow-up** is a concept commonly used in connection with the analysis of intra-uterine device life table analysis; in analysis of clinic data, it includes women overdue *n* months or more for a scheduled visit to a family planning clinic and for whom no information for that overdue period was obtained. The grace period for "overdue" classification may vary.

Expulsion rates, removal rates and accidental pregnancy rates, when computed through life-table analysis, can be expressed as **gross rates** or as **net rates**. The **gross rate** is the rate computed as in a single-decrement life table, assuming no competing risks by other types of terminations. A **net rate** is the rate computed while making allowance for the effects of competing risks and is calculated using a multiple-decrement life table. Thus, a net rate might have been higher except for the effect of competing risks. The net IUD rates of expulsion, removal and accidental pregnancy add up to the rate of termination for all causes combined.

E. FAMILY PLANNING PROGRAMME EVALUATION

17. The **potential fertility** of a group of (married) women or of contraceptive users is the fertility this group would have experienced in the absence of a family planning programme (or alternatively of a particular contraceptive method). One can distinguish **net potential fertility**, which is the fertility that would have prevailed if there had never been a family planning programme (and if couples who entered the programme would have resorted to non-programme contraception) (see figure VIII). **Gross potential fertility** refers to the fertility that would prevail if all use of programme contraception were eliminated and if there were no **net substitution**. If the reference population is a group of family planning programme acceptors, their gross potential fertility is higher than the natural fertility in the general population, since the latter contains a sterile subgroup. If the reference population is the general population, gross potential fertility falls below natural fertility, since the presence of non-programme contraceptive use depresses the latter (see figure VIII). In some applications, however, the potential fertility of users is set equal to the actual (prevailing) fertility of the general population of married women of reproductive ages.

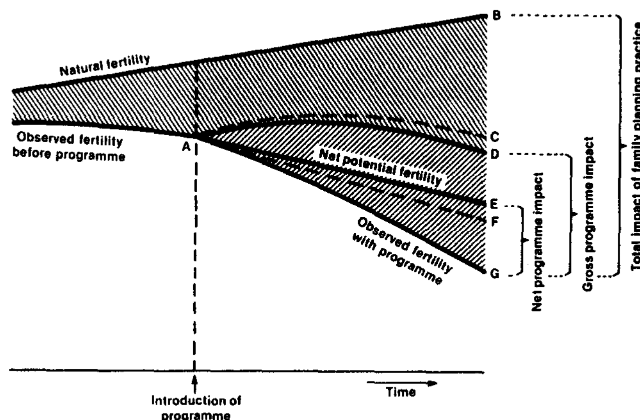
Figure VIII. Relationships between natural, gross and net potential fertility in the general population and in a group of acceptors



Source: Bongaarts (1985), p. 42.

18. **Catalytic effect** is the use of contraception in the private sector that was induced by the activities of the organized family planning programme. **Spill-over** means the same as **catalytic effect. Substitution** refers to couples using programme contraception who would have used non-programme contraception had the programme not existed. **Net substitution** is the combined results of **substitution** and **catalytic** effects; it accounts for the difference between gross and net programme impact (see figure IX). **Net (family planning) programme impact**: programme effect estimated on the basis of net potential fertility; the net impact equals the gross impact less substitution plus the catalytic effect. (See figures VIII and IX.) **Gross (family planning) programme impact** is the programme effect estimated on the basis of gross potential fertility (see figure IX). **Total family planning practice impact** is the estimated effect of all birth regulation practice, by both **programme** and **non-programme users** (see figure IX). **Family planning programme impact** refers to the amount of change in fertility that can be attributed to the policies, measures and activities purposely undertaken to reach a specific fertility level. Theoretically, the impact of the programme is measured by the difference between the fertility level observed in a given calendar year and the level of fertility that would have prevailed in the same period had no family planning programme been undertaken. In practice, the impact of the programme is measured as the difference between the **observed** and the **potential fertility** of the general population or of a group of **programme users**. (See figure VIII.)

Figure IX. Fertility trends in presence or absence of a family planning programme



Source: Bongaarts (1982), p. 262.

NOTE:

A = Observed fertility at beginning of programme;
B = Natural fertility;
CD = *EF* = catalytic effect;
ED = Net substitution effect;
D = Gross potential fertility;
E = Net potential fertility;
G = Observed fertility;
DG = Gross programme impact;
DE = Net substitution effect;
EG = Net programme impact;
CE = *DF* = substitution effect;
BG = Total fertility decline;
BD = Non-programme fertility reduction.

19. **Family planning programme effort or input** refers to the sum of policies adopted and implemented and the activities carried out to provide knowledge, attitudinal change, supplies and services that help achieve the objectives of organized family planning programmes. **Family planning programme output** refers to a specific outcome of a family planning programme, as a result of specific input. Programme-induced levels of contraceptive prevalence, for instance, constitute a programme output.

SOURCES OF GLOSSARY

Bongaarts, John (1982). A note on the concept of potential fertility and its application in the estimation of the fertility impact of family planning programmes. In *Evaluation of the Impact of Family Planning Programmes on Fertility: Sources of Variance*. New York: United Nations, 261-262.
Sales No. E.81.XIII.9.

_______ (1985). The concept of potential fertility in evaluation of the fertility impact of family planning programmes. In *Studies to Enhance the Evaluation of Family Planning Programmes*. New York: United Nations, 40-49.
Sales No. E.84.XIII.9.

_______ and Robert G. Potter (1983). *Fertility, Biology and Behavior: An Analysis of the Proximate Determinant*. New York: Academic Press, 3, 65-66.

Chayovan, Napaporn, Albert I. Hermalin and John Knodel (1984). *Measuring Accessibility to Family Planning Services: Exploring Alternative Measures with Data from Rural Thailand*. Population Studies Center Research Report. Ann Arbor: University of Michigan.

Easterlin, Richard A. (1975). An economic framework for fertility analysis. *Studies in Family Planning* 6(3):54-56.

Economic Commission for Asia and the Far East. *Report of the Expert Group on Assessment of Acceptance and Use-effectiveness of Family Planning Methods*. Asian Population Studies Series, No. 4.
Sales No. E.69.II.F.15.

Economic and Social Commission for Asia and the Pacific (1984). Report of the First Study Director's Meeting of the Pilot Study on the Role of Community Communication Networks in the Acceptance and Continuation of Family Planning Practice. Draft.

Hermalin, Albert I. (1983). Fertility regulation and its costs: a critical essay. In Rodolfo A. Bulatao and Ronald D. Lee, eds., with Paula E. Hollerbach and John Bongaarts, *Determinants of Fertility in Developing Countries*, vol. 2, *Fertility Regulation and Institutional Influences*. Report of the National Research Council Committee on Population and Demography, Panel on Fertility Determinants. New York: Academic Press, 1-53.

Laing, John E. (1984). Natural family planning in the Philippines. *Studies in Family Planning* 15(2):49, 51-52.

Leridon, Henri (1977). *Human Fertility: The Basic Components*. Trans. by Judith F. Helzner. Chicago: University of Chicago Press, 22-24, 96-97, 120-123.

Mauldin, W. Parker (1967). Retention of IUDs: an international comparison. *Studies in Family Planning* 1(18, supplement):3.

_______ and Robert J. Lapham (1982). Measuring the input of family planning programs. In Albert I. Hermalin and Barbara Entwisle, eds., *The Role of Surveys in the Analysis of Family Planning Programs*. Proceedings of a seminar organized by the International Union for the Scientific Study of Population. Liège: Ordina Editions, 216, 222.

Morris, Leo and John E. Anderson (1982). The use of contraceptive prevalence survey data to evaluate family planning program service statistics. In Albert I. Hermalin and Barbara Entwisle, eds., *The Role of Surveys in the Analysis of Family Planning Programs*. Proceedings of a seminar organized by the International Union for the Scientific Study of Population. Liège: Ordina Editions, 149.

——— and others (1981). *Contraceptive Prevalence Surveys: A New Source of Family Planning Data*. Population Reports, series M, No. 5. Baltimore, Maryland: Population Information Program of The Johns Hopkins University.

Nag, Moni (1985). Some cultural factors affecting costs of fertility regulation. In *Population Bulletin of the United Nations, No. 17-1984*. New York: United Nations, 17-38.
Sales No. E.84.XIII.13.

Nortman, Dorothy L. and Gary L. Lewis (1984). A time model to measure contraceptive demand. In John A. Ross and Regina McNamara, eds., *Survey Analysis for the Guidance of Family Planning Programs*. Proceedings of a seminar organized by the International Union for the Scientific Study of Population. Liège: Ordina Editions, 37-46.

Paulet, C. (1977). L'évaluation d'un programme de planification familiale en terme de continuation. Document No. 1, série A. Bucarest: Centre ONU-Roumanie.

Ross, John A., ed. (1982). *International Encyclopedia of Population*. New York: The Free Press, vol. 1.

Ryder, Norman B. (1973). Contraceptive failure in the United States. *Family Planning Perspectives* 5(3):133-134.

Schirm, A. L. and others (1982). Contraceptive failure in the United States: the impact of social, economic and demographic factors. *Family Planning Perspectives* 14(2):71.

Tietze, Christopher (1967). Intra-uterine contraception: recommended procedures for data analysis. *Studies in Family Planning* 1(18, supplement):1.

——— and Sarah Lewit (1968). Statistical evaluation of contraceptive methods: use-effectiveness and extended use-effectiveness. *Demography* 5(2):931-935.

——— (1970). Evaluation of intrauterine device: ninth progress report of the cooperative statistical program. *Studies in Family Planning* 1(55):1-40.

Trussell, James and Jane Menken (1982). Life table analysis of contraceptive failure. In Albert I. Hermalin and Barbara Entwisle, eds., *The Role of Surveys in the Analysis of Family Planning Programs*. Proceedings of a seminar organized by the International Union for the Scientific Study of Population. Liège: Ordina Editions, 537-538.

van de Walle, Etienne (1982). *Multilingual Demographic Dictionary*. 2nd ed., adapted by van de Walle from the French section edited by Louis Henry. A publication of the International Union for the Scientific Study of Population. Liège: Ordina Editions.

World Fertility Survey (1977). *Guidelines for Country Report No. 1*. Basic Documentation; WFS/TECH. 573. Voorburg, The Netherlands: International Statistical Institute.

Glossary index*

Acceptor
  non-programme, 6
  programme, 6
    all, 6
    former, 6
    new, 6
    old, 6
Accessibility
  actual, 3
  perceived, 3
Accidental pregnancy, 13, 16
  rate, 16
Availability
  actual, 3
  perceived, 3
Birth
  control, 1
  limiters, 6
  regulation, 1
  spacers, 6
Catalytic effect, 18
Conception, 11
  rate, 11
Continuation
  all method, 15
    rate, 15
  contraceptive, 15
    rate, 15
  first method, 15
    rate, 15
Cost
  of fertility regulation, 4
  psychological, 4
  economic, 4
  health, 4
  social, 4
Contraception, 1
Contraceptive
  acceptor, 6
  accessibility, 3
    actual, 3
    perceived, 3
  availability
    actual, 3
    perceived, 3
  continuation, 15, 16
    all method, 15
      rate, 15
    first method, 15
      rate, 15
  discontinuation, 16
    rate, 16
  effectiveness, 13, 14
    biological, 13
    clinical, 13
    demographic, 13
    extended use, 13
    physiological, 13
    theoretical, 13
    use, 13
  failure, 13, 14
    cumulative rate, 14
      gross, 14
      net, 14
    delay,14
    extended-use, 14
    method, 13, 14
      rate, 14
    prevention, 14
    rate, 14, 16
    theoretical, 14
    use, 14
      rate, 14
  prevalence, 7
    survey, 7
  retention, 15
  termination, 16
    rate, 16
  user, 6
Contraceptor, 1
Current non-users, 6
Current user, 6
Demand
  for children, 2
  for contraception, 5
  for family planning, 5
Discontinuation, 16
  rate, 16
Ever-users, 6
Exposed women, 12
Expulsion, 16
  first, 16
  gross rate, 16
  later, 16
  net rate, 16
  rate, 16
Failure, 13, 14
  contraceptive, 13, 14
  cumulative rate, 14
  delay, 14
  extended use, 14
  method, 14
  prevention, 14
  rate, 14
    gross, 14, 16
    net, 14, 16
  theoretical, 14
  use, 14
Family planning
  non-programme impact, 18
  programme effort, 19
  programme impact, 18
    gross, 18
    net, 18
    total, 18
  programme input, 19
  programme output, 19
  unmet need for, 5
Fecundability, 10
  apparent, 10
  controlled, 10
  effective, 10
  natural, 10
  physiological, 10
  recognizable, 10
  residual, 10
  total, 10
Fecundity, 9
Fertility, 9
  natural, 9
  observed, 18
  potential, 17, 18
    gross, 17
    net, 17
Gross rate, 14, 16
Infecundity, 9
Infertility, 9
KAP survey, 7
Limiters, 6
  potential, 6
Loss to follow-up, 16
Motivation
  for family planning, 2
Multi-method user, 16
  current, 6
  ever-, 6
  past, 6
Net rate, 14, 16
Never-user, 6
Natural fertility, 9
Non-programme user, 6
Pearl
  improved index, 14
  pregnancy rate, 14
Past user, 6
Potential
  fertility, 17, 18
    gross, 17
    net, 17
  limiter, 6
  output of children, 2
  spacer, 6
  user, 6
Programme impact
  family planning, 18
    gross, 18
    net, 18
    total, 18
Programme
  effort, 19
  input, 19
  output, 19
  users, 6
Removal, 16
  gross rate, 16
  net rate, 16
  rate, 16

* Each term or expression is followed by the number of the glossary paragraph in which it can be found.

Retention
  rate, 15
Segment, 8, 14, 16
  first, 8
  later, 8
Single-method user, 6
  current, 6
  ever-, 6
  past, 6
Spacers, 6
  potential, 6
Spill-over effect, 17
Sterility, 9
  primary, 9
  secondary, 9
Substitution, 18
  net, 18
Termination, 16
  rate, 16
Unmet needs for contraception, 5
User
  contraceptive, 6
  current, 6
  current non-, 6
  ever-, 6
  multi-method, 6
    current, 6
    ever-, 6
    past, 6
  never-, 6
  non-programme, 6, 18
  past, 6
  potential, 6, 12
  programme, 6, 18
  single-method, 6
    current, 6
    ever-, 6
  past, 6

كيفية الحصول على منشورات الأمم المتحدة

يمكن الحصول على منشورات الأمم المتحدة من المكتبات ودور التوزيع في جميع أنحاء العالم . استعلم عنها من المكتبة التي تتعامل معها أو اكتب إلى : الأمم المتحدة ، قسم البيع في نيويورك أو في جنيف .

如何购取联合国出版物

联合国出版物在全世界各地的书店和经售处均有发售。请向书店询问或写信到纽约或日内瓦的联合国销售组。

HOW TO OBTAIN UNITED NATIONS PUBLICATIONS

United Nations publications may be obtained from bookstores and distributors throughout the world. Consult your bookstore or write to: United Nations, Sales Section, New York or Geneva.

COMMENT SE PROCURER LES PUBLICATIONS DES NATIONS UNIES

Les publications des Nations Unies sont en vente dans les librairies et les agences dépositaires du monde entier. Informez-vous auprès de votre libraire ou adressez-vous à : Nations Unies, Section des ventes, New York ou Genève.

КАК ПОЛУЧИТЬ ИЗДАНИЯ ОРГАНИЗАЦИИ ОБЪЕДИНЕННЫХ НАЦИЙ

Издания Организации Объединенных Наций можно купить в книжных магазинах и агентствах во всех районах мира. Наводите справки об изданиях в вашем книжном магазине или пишите по адресу: Организация Объединенных Наций, Секция по продаже изданий, Нью-Йорк или Женева.

COMO CONSEGUIR PUBLICACIONES DE LAS NACIONES UNIDAS

Las publicaciones de las Naciones Unidas están en venta en librerías y casas distribuidoras en todas partes del mundo. Consulte a su librero o diríjase a: Naciones Unidas, Sección de Ventas, Nueva York o Ginebra.

Litho in United Nations, New York
40520—September 1986—6,250
ISBN 92-1-151160-7

00800

United Nations publication
Sales No. E.86.XIII.4
ST/ESA/SER.A/66/Add.1