TRACK 20 FP2020

The National Composite Index for Family Planning (NCIFP): 2017 Global Report

Avenir Health

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NCIFP data, reports, and country briefs available at: http://www.track20.org/pages/data_analysis/policy/NCIFP.php

Executive Summary

The National Composite Index for Family Planning (NCIFP) is a measurement tool to help capture the enabling environment in which family planning (FP) programs are implemented by examining the levels and types of effort for a range of FP programmatic indicators. The first round of the NCIFP was conducted in 2014 in 89 countries and the second round took place in 2017 in 84 countries. This report presents the main findings of the 2017 NCIFP as well as comparisons to the 2014 NCIFP findings to illustrate change over time. Results of the 2017 round of the NCIFP have revealed improvements in the existence of policies and program implementation across all five dimensions: strategy, data, quality, equity, and accountability.

The total NCIFP score is the average of 35 individual item scores for each country. Items are organized under the following five dimensions: strategy, data, quality, equity, and accountability. The total possible score is 100. Results are presented globally, by region and by country which can be useful for informing policy judgements and resource allocations. At the country level, decision-makers can review the scores for specific items to identify areas for potential improvements.

The overall 2017 NCIFP score, averaged over all countries (unweighted) is 64, which indicates a strong effort on all criteria. For the five dimensions, the unweighted averages are 74 (strategy), 64 (data), 64 (quality), 61 (equity) and 60 (accountability), demonstrating a considerable range, with a 14-point gap between the highest and lowest scored dimensions. When comparing the 2014 and 2017 NCIFP scores among countries with data from both rounds (71 countries), we see that every dimension score increased between rounds. The scoring pattern remained the same over time with strategy scoring the highest (62 in 2014) and accountability scoring the lowest (39 in 2014). The overall score for countries with data from both rounds increased from 53 in 2014 to 64 in 2017.

Table 1: 2014 and 2017 NCIFP Scores by Dimension, for countries with data from both rounds (unweighted)

Dimension		2014 Score	2017 Score
Strategy		62	74
Data		53	64
Quality		53	64
Equity		58	61
Accountability		39	59
Total		53	64

Sub-regions differ considerably. Francophone and Anglophone sub-Saharan Africa (SSAF-F and SSAF-A) scored above other regions in total score and across all five dimensions. In order of descending total scores after SSAF-A and SSAF-F were Asia, Latin America, and the Caribbean (LAC), the Middle East and North Africa (MENA) and Eastern Europe and Central Asia (EECA). The ranking is almost the same when scores are weighted by population of women of reproductive age.

Despite large differences in total scores and dimension scores, the sub-regions generally follow similar patterns across the 35 individual items (Table 2). This suggests there are global similarities in the areas that FP programs prioritize effort.

Table 2: 2014 and 2017 NCIFP Scores by Dimension and Sub-region, for countries with data from both rounds (unweighted)

	2014					
	Strategy	**Data**	**Quality**	**Equity**	**Accountability**	**Total**
SSAF-A	69	60	56	60	46	58
SSAF-F	67	57	55	59	35	55
Asia	63	52	50	57	37	52
LAC	61	53	52	60	37	53
MENA	57	48	55	47	33	50
EECA	48	43	48	58	41	47
	2017					
	Strategy	**Data**	**Quality**	**Equity**	**Accountability**	**Total**
SSAF-A	83	74	68	67	69	72
SSAF-F	76	69	68	62	58	67
Asia	76	61	63	59	60	64
LAC	68	60	63	61	55	62
MENA	73	57	60	54	54	60
EECA	63	54	56	56	52	56

From 2014 to 2017, SSAF-F had the largest median point increase from 2014 to 2017 in total score, followed by SSAF-A, MENA, LAC, Asia and EECA (Figure 5). Overall, the dimension with the largest median point increase across sub-regions was accountability, and the lowest median point increases were found in the equity dimension.

From 2014 to 2017, half of the 35 items had a median point increase of 10 or more points and every item in the accountability dimension had a median point increase of at least 15 points (Figure 7). To further explore the variation across countries and individual scores, total scores are presented for each country and dimension scores for each country are presented in ranked order (Figures 8 and 9).

Additional analysis found that modern contraceptive use tends to be higher when the NCIFP total score is higher and when each NCIFP dimension score is higher. This analysis was separated by sub-Saharan African countries (SSA countries) and non-sub-Saharan African countries (non-SSA countries). The analysis could not be performed at the sub-regional level (SSAF-A, SSAF-F, Asia, LAC, MENA, EECA) because there were too few countries in each sub-regional grouping to produce meaningful results. Higher NCIFP scores were correlated with higher modern contraceptive use in both the SSA and non-SSA regional groupings, but the relationships were much stronger for the SSA regional grouping (Figure 10).

Further analyses found that a higher score for access to long-acting and permanent methods (LAPMs) was accompanied by greater LAPM use and modern use overall (Table 7). There was also a weak relationship between NCIFP items measuring equity for youth and modern contraceptive use among sexually active women ages 15-24 (Figures 12 and 13).

Finally, two other analyses are also included to provide a more in-depth look at the results of the 2017 NCIFP. These include a comparison of results based on yes/no responses (which were used in both NCIFP rounds) and responses measured on a 1-10 scale (added to all items in the 2017 NCIFP), and an analysis of response rates.

Introduction

The National Composite Index for Family Planning (NCIFP) was developed to support FP2020 measurement efforts to capture indicators related to an enabling policy environment and a rights-based approach to family planning (FP) services. FP2020 working groups, donors and various implementing partners collaborated with Avenir Health's Track20 Project in tool development and analysis. The NCIFP focuses on FP plans and structures, including data systems, that pertain to quality of care, choice, accountability, and equity.

The NCIFP builds on the National Family Planning Effort (FPE) index that has been regularly applied to developing countries since 1972 to measure the level of effort that goes into FP programs and to track changes over time. In 2014, the NCIFP questionnaire was added at the end of the FPE questionnaire, so data were gathered on both instruments at the same time in all countries. The intention was to build on the standard FPE questions, adding items to capture areas not fully covered by the FPE, particularly issues related to rights, quality, and accountability.

In 2017, a second round of NCIFP data collection took place to enable monitoring of these rights-based FP program efforts over time. Track20 built on the analysis, lessons learned and recommendations from the 2014 data collection to simplify the 2017 questionnaire.[1] A total of 89 countries participated in the 2014 round of the NCIFP and 84 countries participated in 2017. Two countries were dropped from the analysis due to concerns related to data quality. Of the remaining countries, 71 participated in both the 2014 and 2017 rounds. The following table shows a list of participating countries, by region.

Table 3: Countries by Regional Grouping (countries with data from 2014 are in bold font)

2017 Countries by Regional Grouping (countries with data from 2014 are in bold)					
Asia (ASIA)	Latin America and the Caribbean (LAC)	Middle East/ North Africa (MENA)	Anglophone Sub-Saharan Africa (SSAF-A)	Francophone Sub-Saharan Africa (SSAF-F)	Eastern Europe and Central Asia (EECA)
Afghanistan	**Bolivia**	**Egypt**	**Cameroon**	Benin*	**Armenia**
Bangladesh	Colombia	**Iraq**	**Eritrea**	Burkina Faso	**Azerbaijan***
Bhutan	**Dominican Rep.**	**Jordan**	**Eswatini**	**Burundi**	**Georgia**
Cambodia	**El Salvador**	**Morocco**	**Ethiopia**	CAR	**Kazakhstan**
India	**Guatemala**	State of Palestine	**Gambia**	**Chad**	**Kyrgyz Republic**
Lao PDR	**Haiti**		**Ghana**	**Congo**	**Moldova**
Malaysia	**Honduras**		**Kenya**	**Cote d'Ivoire**	**Romania**
Mongolia	**Jamaica**		**Lesotho**	**DR Congo**	**Russia**
Myanmar	**Mexico**		**Liberia**	Guinea	**Tajikistan**
Nepal	**Nicaragua**		**Malawi**	**Guinea-Bissau**	**Turkmenistan**
Pakistan	**Panama**		**Namibia**	**Madagascar**	**Ukraine**
Papua New Guinea	**Peru**		**Nigeria**	**Mali**	**Uzbekistan**
Philippines			**Rwanda**	**Mauritania**	
Sri Lanka			Sierra Leone	**Mozambique**	
Solomon Islands			Somalia	**Niger**	
Timor-Leste			**South Sudan**	Sao Tome & Principe	
Viet Nam			**Tanzania**	**Senegal**	
			Uganda	**Togo**	
			Zambia		
			Zimbabwe		

*removed from analyses due to data quality concerns

[1]For a more detailed description of the modifications made to the 2017 NCIFP, please see the 2014 NCIFP Report, which can be found on the Track20 website. http://www.track20.org/pages/data_analysis/policy/NCIFP.php.

Methodology

Study leaders of the 2017 NCIFP reached out to the 69 FP2020 priority countries (the world's poorest in 2012) and to around 30 other countries that participated in the 2014 FPE/NCIFP survey and earlier FPE data collection. The NCIFP uses a key informant approach, identifying experts in each country who have a comprehensive understanding of the family planning program. Importantly, respondents are instructed to leave questions blank if they are not confident of their response. Data collection at the country-level was managed by a local consultant who was familiar with the national FP program and could identify people who could gauge the effort levels of its various features. The consultant in each country instructed 10-15 local respondents in questionnaire completion and followed up to obtain the responses. Participants included individuals who were considered FP program leaders, experts, and observers. To obtain a variety of perspectives, respondents worked in four different capacities: inside the FP program, in local NGO organizations, in local academic or research organizations, and resident staff of international agencies.

The 2014 round of the NCIFP was comprised of mostly yes/no questions with a few 1-10 scale questions. However, data collection revealed several challenges related to asking mostly yes/no questions. First, the score for each question ended up simply representing the percent of respondents who said yes. Additionally, for some questions, a clear cut 'yes' or 'no' answer was not feasible because the question asked about multiple issues, or the answer fell into an intermediate place between a simple "yes" or "no" response. To address these issues, 1-10 scale responses were added after every yes/no question in the 2017 round to allow finer nuances in responses. Table 4 shows all 35 items of the 2017 NCIFP report, with 1-10 scale responses that were added in the 2017 round marked as "new." Future data collection and analysis will use only the 1-10 scale responses, but to allow for trend analysis between 2014 to 2017, the scores in this report are based on the 2014 approach which mainly used a yes/no format.[2] The scores for each country, converted into total and dimension scores, reflect the averages of responses given by FP experts.

Table 4: 2017 NCIFP Individual Items

Dimension	Question	Yes/No	1 to 10
Strategy	Does the National Family Planning Action plan include defined objectives over a 5-to 10-year period, including quantitative targets?	X	***new***
	Does the National Family Planning Action plan include objectives to reach the poorest and most vulnerable groups with quality FP information and services?	X	***new***
	Does the National Family Planning Action plan include projection of the resources (material, human and financial) required to implement the strategy, as well as sets forth a plan to secure the resources?	X	***new***
	Does the National Family Planning Action plan include a mechanism and funding to support meaningful participation of diverse stakeholders?	X	***new***
	High level of seniority of the director of the national family planning program and whether director reports to a high level of government.		X
	Extent to which import laws and legal regulations facilitate the importation of contraceptive supplies or extent to which contraceptives are manufactured locally.		X
Data	Does the government collect data to monitor special sub-groups?*	X	***new***
	Does the government collect data from the private sector on commodities?	X	***new***
	Is there a system of quality control for service statistics?	X	***new***
	Are data used to ensure that the poorest and most vulnerable women and girls have access to quality FP services?	X	***new***

[2]Note: All x's in Table 4 are consistent with the 2014 question format. There were 15 1-10 scale response items in the 2014 NCIFP, which were carried over to the 2017 round.

	Extent to which systems for client recordkeeping, clinic reporting and feedback of results are adequate.		**X**
	Extent to which program statistics, national surveys, and small studies are used by specialized staff to report on program operations and measure progress.		**X**
	Extent to which program managers use research and evaluation findings to improve the program in ways suggested by findings.		**X**
Quality	Are FP SOP in line with WHO and used for determining areas of need for quality improvement?	**X**	***new***
	Are there guidelines on task sharing of family planning services?	**X**	***new***
	Are indicators for quality of care collected and used for public sector family planning services?	**X**	***new***
	Are indicators for quality of care collected and used for private sector family planning services?	**X**	***new***
	Are there structures in place to address quality, including participatory monitoring or community/facility quality improvement activities?	**X**	***new***
	Does government collect information related to informed choice and provider bias?	**X**	***new***
	Extent to which training programs, for each category of staff in the family planning program, are adequate to provide personnel with information and skills necessary to carry out their jobs effectively.		**X**
	Extent to which the logistics and transport systems are sufficient to keep stocks of contraceptive supplies and related equipment available at all service points, at all times and at all levels (central, provincial, local).		**X**
	Extent to which the system of supervision at all levels is adequate (regular monitoring visits with corrective or supportive action).		**X**
	Extent to which clients adopting sterilization are routinely informed that it is permanent?		**X**
	Extent to which the entire population has ready and easy access to IUD removal.		**X**
	Extent to which the entire population has ready and easy access to implant removal.		**X**
Equity	Are there policies in place to prevent discrimination towards special sub-groups?*	**X**	***new***
	To what extent do service providers discriminate against special sub-groups?*		**X**
	Extent to which areas of country not easily serviced by clinics or other service points are covered by CBD programs for distribution of contraceptives (especially rural areas).		**X**
	Extent to which the entire population has ready access to LAPMs.*		**X**
	Extent to which the entire population has ready access to STMs.*		**X**
Accountability	Are there mechanisms in place at the national, subnational, and facility level to monitor whether or not access to voluntary, non-discriminatory FP information and services is being achieved?	**X**	***new***
	Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds (age, marital status, ability to pay), or coercion (including inappropriate use of incentives to clients or providers)?	**X**	***new***
	Are violations reviewed on a regular basis?	**X**	***new***
	Are there mechanisms in place at the facility level to solicit and use feedback from clients?	**X**	***new***
	Is there a system in place that encourages dialogue and communication between users and service providers/health officials about service availability, accessibility, acceptability, and quality?	**X**	***new***

* indicates composite score
Special subgroups include "Youth", "Unmarried Women", "Wealth Status", "Post-Abortion Clients", and "HIV Status"; LAPMs include Female Sterilization, Male Sterilization, IUDs, Implants; STMs include Condoms, Pills, and Injectables

Data were entered in Excel, with checks for consistency and data quality. The responses from each respondent in a country were averaged to obtain a country score for each individual question. The total score, and scores for each dimension were calculated from averaging across the individual questions. Analytic techniques included cross-tabulations, graphical and correlation approaches. Both unweighted and weighted regional totals are presented in the report. Weighted totals for 2017 are weighted by the number of women of reproductive age (15-19) in each country in 2017, based on the UN World Population Prospects (2019 Revision). Weighted totals for 2014 are weighted by the number of women of reproductive age in each country in 2015, based on the UN World Population Prospects (2012

Revision). In cases where the 2014 results and 2017 are compared directly in the report, analyses only include the 71 countries that have data for both rounds.

Results are presented globally, by region and by country which can be useful for informing policy judgements and resource allocations. At the country level, decision-makers can review the scores for specific items to identify areas for potential improvements. It is important to note that regional and global averages only represent the countries included in the survey, not all countries.

Results

The results section of this report is comprised of three subsections: summary of global and regional results, country variation, and patterns for the 35 individual scores by region. The first section provides an overview of dimension scores (strategy, data, quality, equity, accountability) overall and by region. Results are shown both weighted and unweighted, and 2017 scores are shown alongside 2014 scores to give a sense of change over time. The next subsection shows dimension scores and total scores by country. In the final subsection of the results, analysis is at the individual item level, rather than the dimension level. Regional averages for each individual item are shown (both weighted and unweighted), and the median difference in individual scores from 2014 to 2017 are presented.

Weighted scores take into account the number of women of reproductive age (WRA) living in each country. Table 5 shows the distribution of WRA within and between countries. For example, among countries included in the survey, WRA in Asia make up 57% of total WRA, and WRA in Afghanistan make up 1.5% of the WRA in Asia.

Table 5: Distribution of women of Reproductive age within and between regions

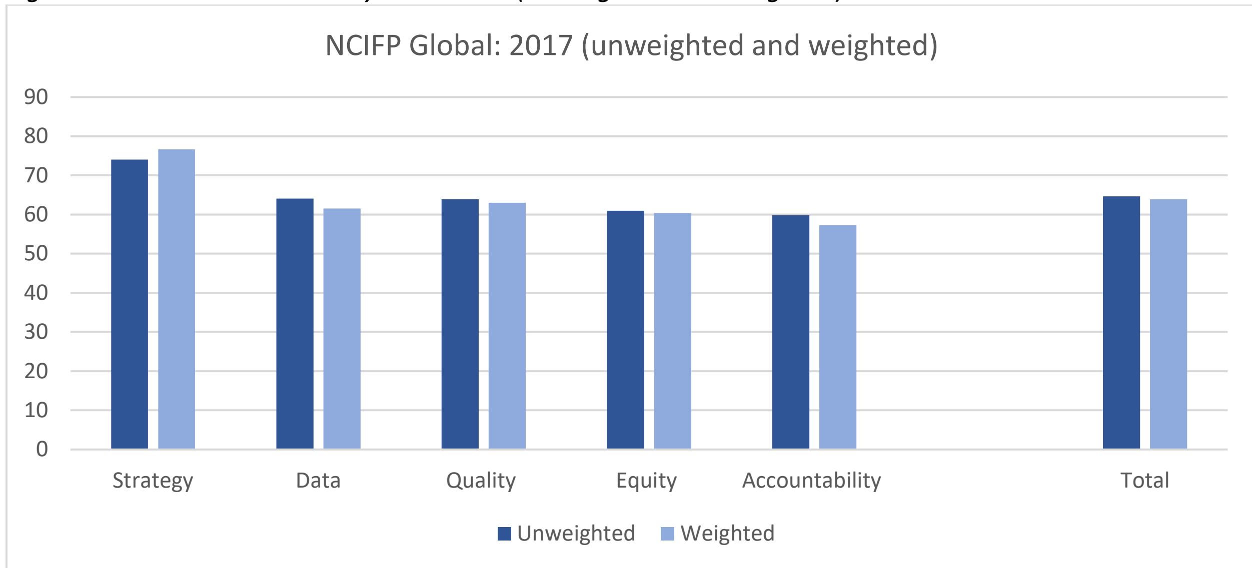
ASIA **WRA = 549,862,000** **(57% of total)**	**LAC** **WRA = 76,659,000** **(8% of total)**	**MENA** **WRA = 46,676,000** **(5% of total)**	**SSAF-A** **WRA = 144,544,000** **(15% of total)**	**SSAF-F** **WRA = 68,343,000** **(7% of total)**	**EECA** **WRA = 70,920,000** **(7% of total)**
Countries within each region (% of regional WRA)					
Afghanistan (1.5%)	Bolivia (3.7%)	Egypt (49.0%)	Cameroon (4.2%)	Burkina Faso (6.5%)	Armenia (1.1%)
Bangladesh (8.1%)	Colombia (17.3%)	Iraq (19.1%)	Eritrea (0.6%)	Burundi (3.7%)	Georgia (1.3%)
Bhutan (0.0%)	Dom. Rep. (3.6%)	Jordan (5.2%)	Eswatini (0.2%)	CAR (1.6%)	Kazakhstan (6.4%)
Cambodia (0.8%)	El Salvador (2.4%)	Morocco (19.0%)	Ethiopia (18.2%)	Chad (4.9%)	Kyrgyz Rep. (2.2%)
India (62.8%)	Guatemala (5.9%)	Palestine (2.4%)	Gambia (0.4%)	Congo (1.8%)	Moldova (1.5%)
Lao PDR (0.3%)	Haiti (3.8%)		Ghana (5.1%)	Cote d'Ivoire (8.6%)	Romania (6.4%)
Malaysia (1.5%)	Honduras (3.3%)		Kenya (9.1%)	DR Congo (26.4%)	Russia (48.6%)
Mongolia (0.2%)	Jamaica (1.0%)		Lesotho (0.4%)	Guinea (4.3%)	Tajikistan (3.2%)
Myanmar (2.7%)	Mexico (44.4%)		Liberia (0.8%)	Guinea-Bissau (0.7%)	Turkmenistan (2.2%)
Nepal (1.5%)	Nicaragua (2.3%)		Malawi (3.0%)	Madagascar (9.2%)	Ukraine (14.9%)
Pakistan (9.5%)	Panama (1.4%)		Namibia (0.4%)	Mali (6.0%)	Uzbekistan (12.3%)
PNG (0.4%)	Peru (10.9%)		Nigeria (30.8%)	Mauritania (1.5%)	
Philippines (5.0%)			Rwanda (2.1%)	Mozambique (10.0%)	
Sri Lanka (1.0%)			Sierra Leone (1.3%)	Niger (6.6%)	
Solomon Isl. (0.0%)			Somalia (2.3%)	Sao Tome & Prin. (0.1%)	
Timor-Leste (0.1%)			South Sudan (5.3%)	Senegal (5.5%)	
Viet Nam (4.6%)			Tanzania (9.0%)	Togo (2.7%)	
			Uganda (6.8%)		
			Zambia (2.8%)		
			Zimbabwe (2.6%)		

Summary of Global and Regional Results

Figure 1 provides an overview for the 82 countries that participated in the 2017 NCIFP, comparing weighted and unweighted scores for each dimension. The total score unweighted was 65 – about two-thirds of the maximum possible score of 100. Overall, the strategy dimension scored the highest (74)

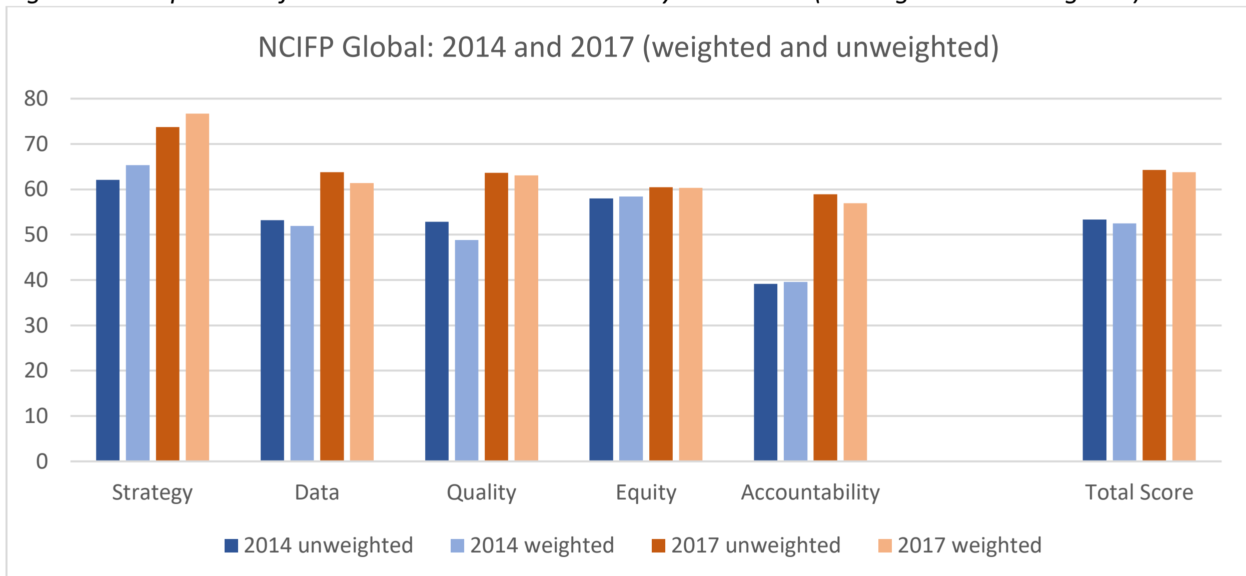
and accountability was the lowest (60). The data (64), quality (64) and equity (61) scores were quite close to one another.

Figure 1: 2017 Global Scores by Dimension (unweighted and weighted)



Looking only at the 71 countries with data in both 2014 and 2017, we see that every dimension score has increased since 2014. Figure 2 shows the unweighted 2014 and 2017 scores. The total score has increased by just over 10 points. Patterns have remained largely the same with strategy being the highest scoring dimension and accountability the lowest in both years. The accountability dimension saw the largest increase (from 39 to 59) and the equity dimension saw the smallest increase (from 58 to 61).

Figure 2: Comparison of 2014 and 2017 Global Scores by Dimension (unweighted and weighted)



Regional differences, by dimension are displayed in Figures 3, 4, 5 and 6. Anglophone sub-Saharan Africa (SSAF-A) scored the highest across all dimensions except quality, where Francophone sub-Saharan Africa

(SSAF-F) scored the highest, and accountability where the Middle East and North Africa (MENA) scored the highest. Eastern Europe and Central Asia (EECA) consistently scored the lowest in all dimensions. Strategy was the highest scoring dimension for all regions, but the lowest scoring dimension varied across regions. SSAF-A and MENA scored lowest in equity while SSAF-F, EECA, Asia, and Latin America and the Caribbean (LAC) scored the lowest in accountability.

Once weighted by population of WRA (Figure 4), SSAF-A scored the highest across all dimensions and EECA scored the lowest across all dimensions except equity, where MENA scored the lowest. Every region scored the highest in strategy, except for EECA which scored the highest in equity. Patterns for lowest scoring dimensions for each region were the same as the unweighted results.

Figure 3: 2017 NCIFP by Region and Dimension (unweighted)

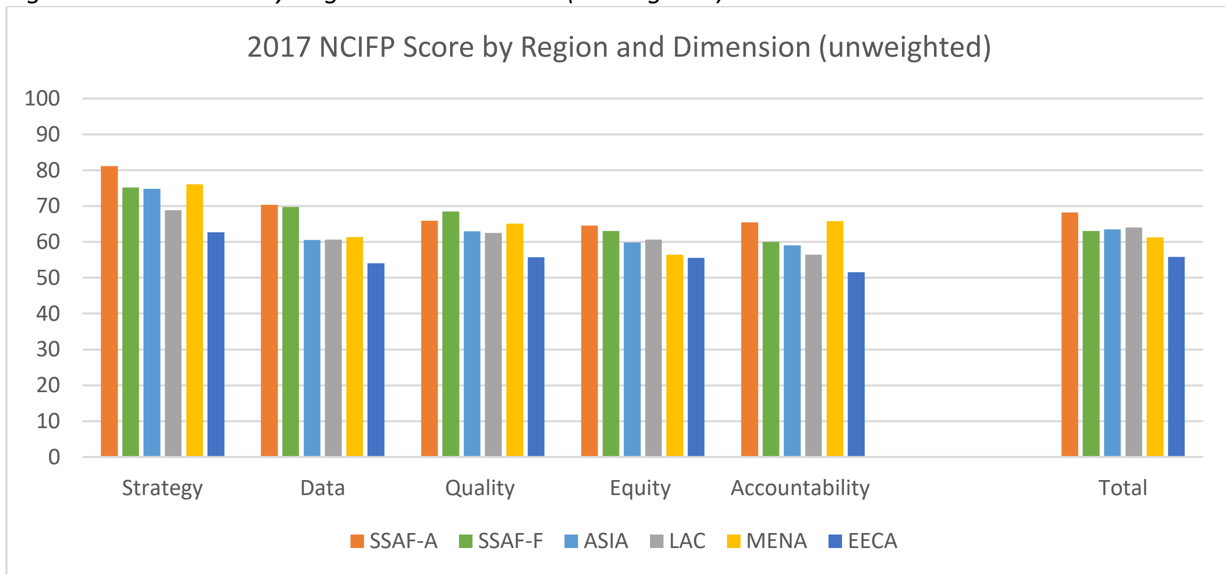
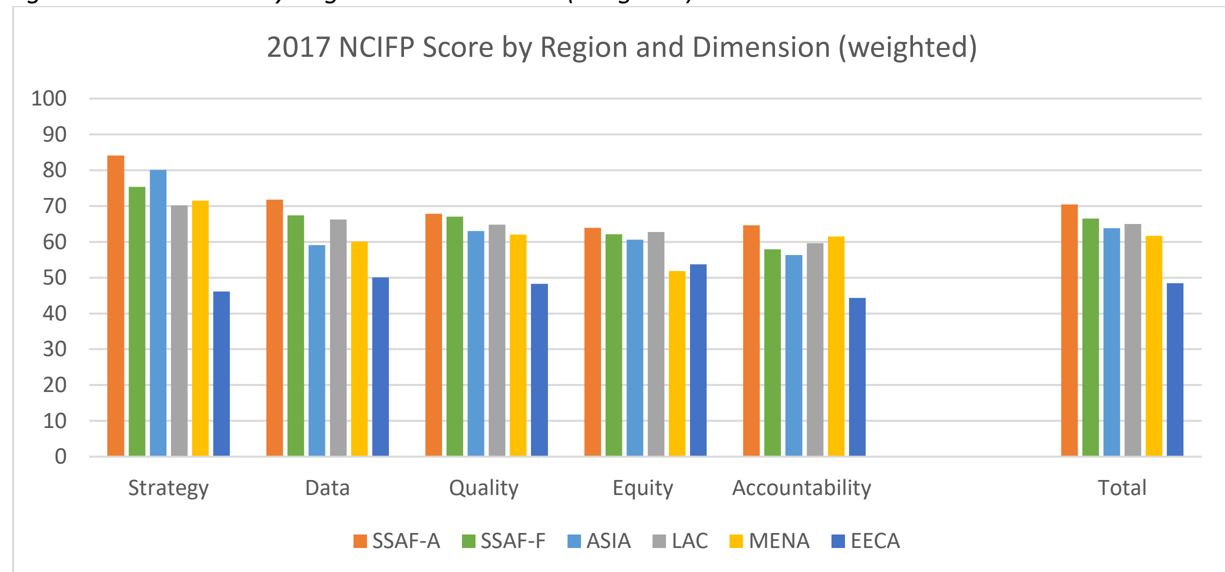


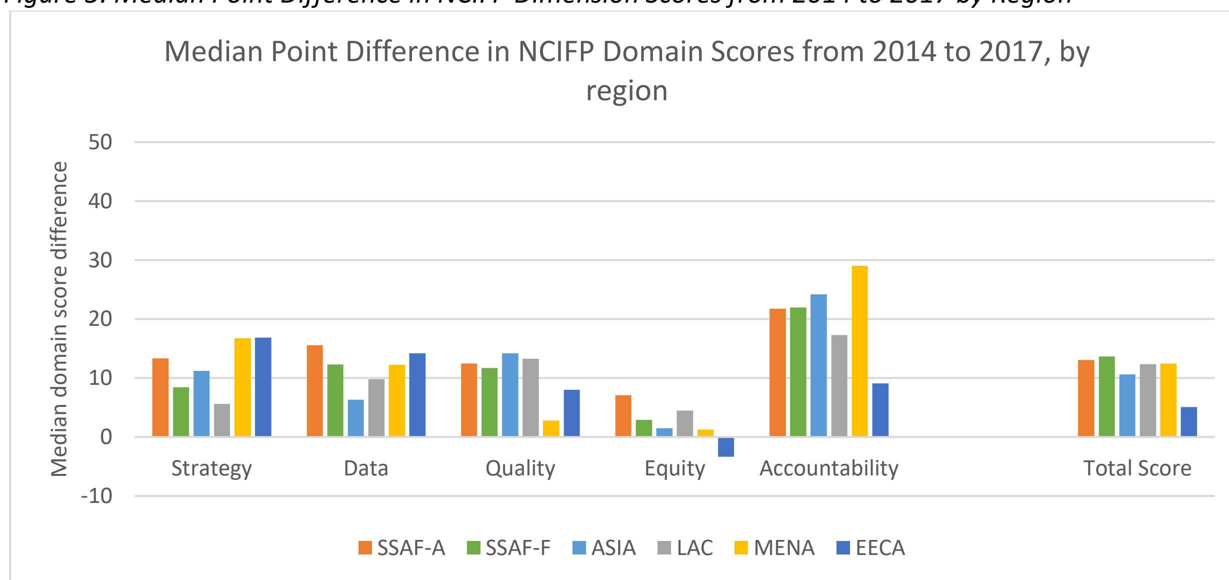
*Figure 4: 2017 NCIFP by Region and Dimension (weighted)**



*Note: Weighted averages only represent the countries included in the analysis for each region rather than all countries in the region. For example, the MENA region includes population weights for only Egypt, Iraq, Jordan, and Morocco.

Figure 5 shows the median point difference in dimension scores from 2014 to 2017 by region for countries with data in both 2014 and 2017. Every region except EECA saw the largest median point increase in the accountability dimension. For EECA, the largest increase was in the strategy dimension. For all regions, the smallest change was seen in the equity dimension. The equity score declined from 2014 to 2017 for EECA. In terms of the total score, SSAF-F saw the largest increase from 2014 to 2017 and EECA the smallest.

Figure 5: Median Point Difference in NCIFP Dimension Scores from 2014 to 2017 by Region



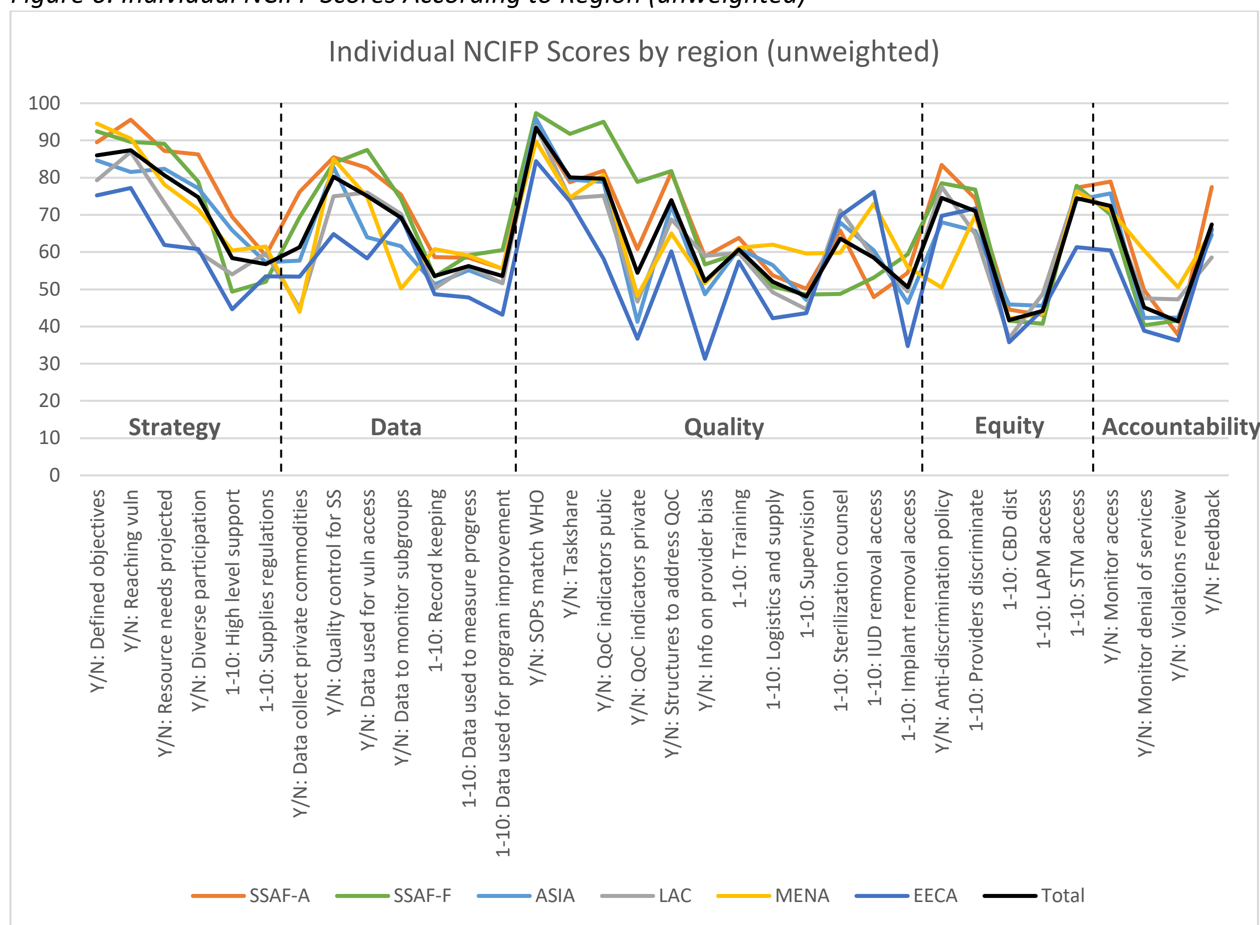
Patterns for the 35 Individual Scores by Region

Figure 6 clearly illustrates that regional lines rise and dip together, suggesting common experiences internationally. This figure suggests that programs exert stronger efforts in some of the 35 items than others. For four of the regions (SSAF-F, Asia, LAC and EECA), the highest scoring item was “Are FP Standard Operating Procedures in line with WHO and used for determining areas of need for quality FP improvement?”. In SSAF-A, the highest scoring item was “Does the national family planning action plan include objectives to reach the poorest and most vulnerable groups with quality FP information and services?”. MENA’s highest scoring item was “Does the national FP action plan include defined objectives over a 5 to 10-year period, including quantitative targets?”. There was less consistency in terms of the lowest scores by region. Lowest scores per region were as follows:

- SSAF-A: Are violations reviewed on a regular basis?
- SSAF-F: Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds or coercion?
- Asia: Are indicators for quality of care collected and used for private sector family planning services?
- LAC & MENA: Extent to which areas of the country not easily serviced by clinics or other service points are covered by CBD programs for distribution of contraceptives.
- EECA: Does government collect information related to informed choice and provider bias?

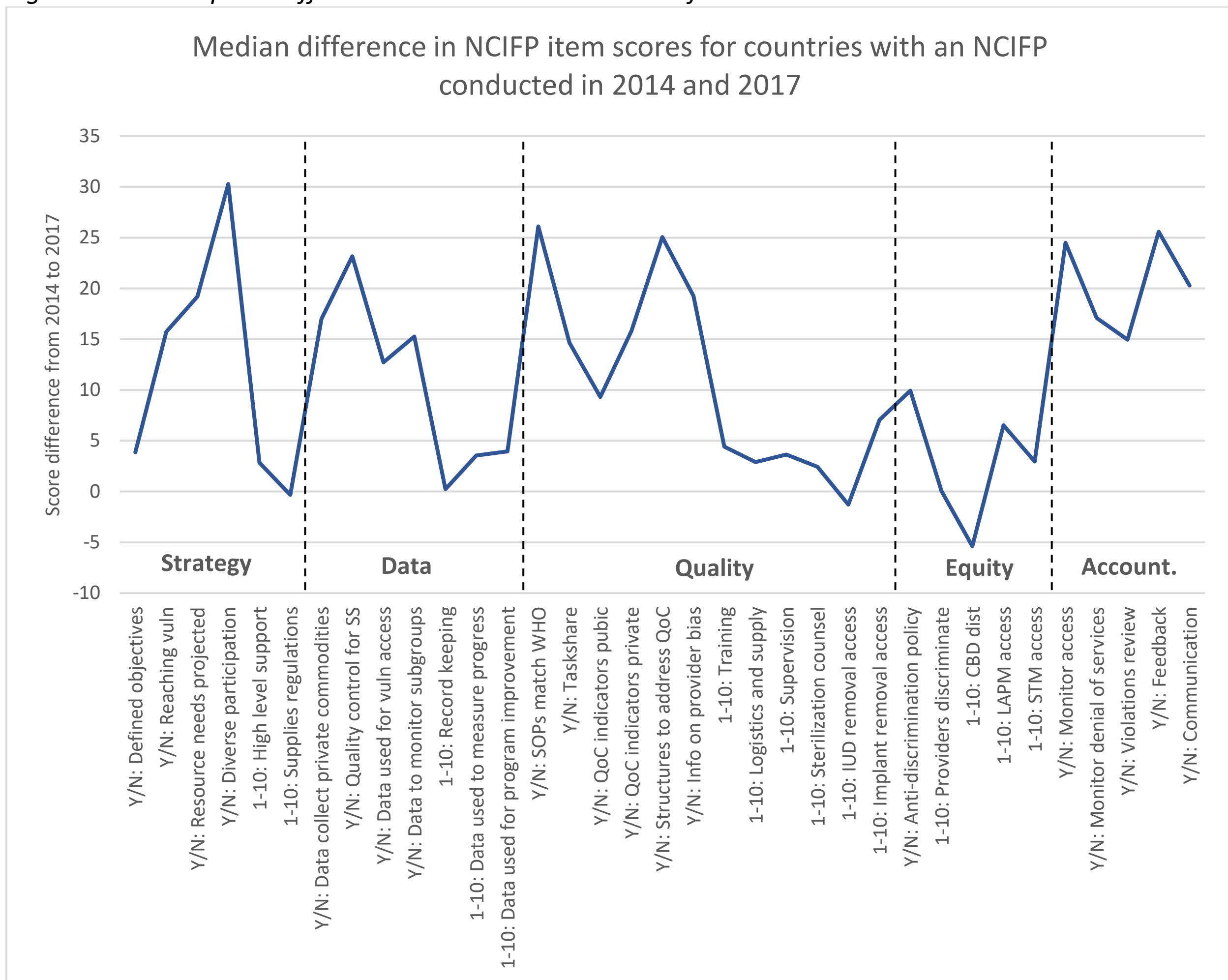
The lowest scoring item for SSAF-A and SSAF-F fell within the accountability dimension. For Asia and EECA, the lowest scoring item was in the quality dimension, and for LAC and MENA, the lowest scoring item fell within the equity dimension. None of the lowest scoring items fell within the strategy dimension.

Figure 6: Individual NCIFP Scores According to Region (unweighted)



Median point differences from 2014 to 2017 for the 35 individual items are shown in Figure 7. Again, this figure only shows scores for the countries that conducted an NCIFP in both 2014 and 2017. Among these countries, the largest median point increase was for the item "Does the National Family Planning Action Plan include a mechanism and funding to support meaningful participation of diverse stakeholders?" (30 points). For two items, the median point difference between 2014 and 2017 was negative: "Extent to which the entire population has ready and easy access to IUD removal" (-1 point) and "Extent to which areas of the country not easily serviced by clinics or other service points are covered by CBD programs for distribution of contraceptives (especially rural areas)" (-5 points). Half of the 35 items had an unweighted median point increase of 10 or more points. Every item in the accountability dimension had a median point increase of at least 15 points.

Figure 7: Median point difference in individual item scores from 2014 to 2017



Country Variation

Figure 8 shows the variation in total scores by country and region and Figure 9 shows dimension scores by country and region. Both figures include all 82 countries that participated in the 2017 NCIFP. These figures illustrate that there is large variation in scores, even across countries within the same region. EECA has the widest range of total scores – with Tajikistan as the highest score (87.9) and Romania as the lowest (30.0). Countries in MENA have the smallest range of total scores – from 74.7 for Jordan to 59.5 for Morocco. Among all regions, Rwanda has the highest score (91.6) and Romania the lowest.

Consistent with the previous figures, Figure 9 shows that for most countries, the highest dimension score is for strategy, and the lowest is for accountability. Patterns for dimension scores are relatively consistent in SSAF-F, SSAFA-A, MENA, and Asia but there is more inconsistency across dimension scores in LAC and EECA.

Figure 8: Total 2017 Scores by Country and Region

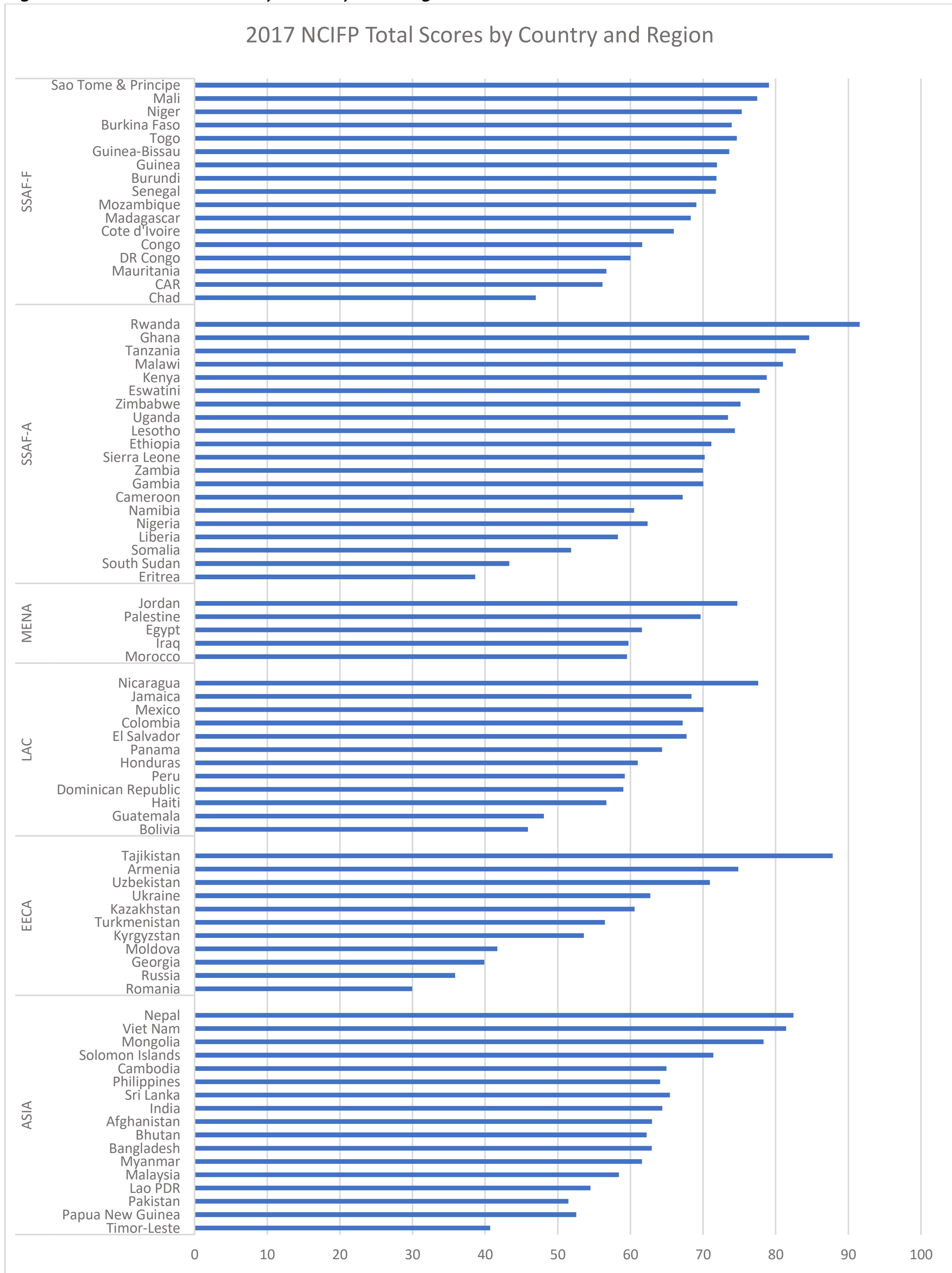
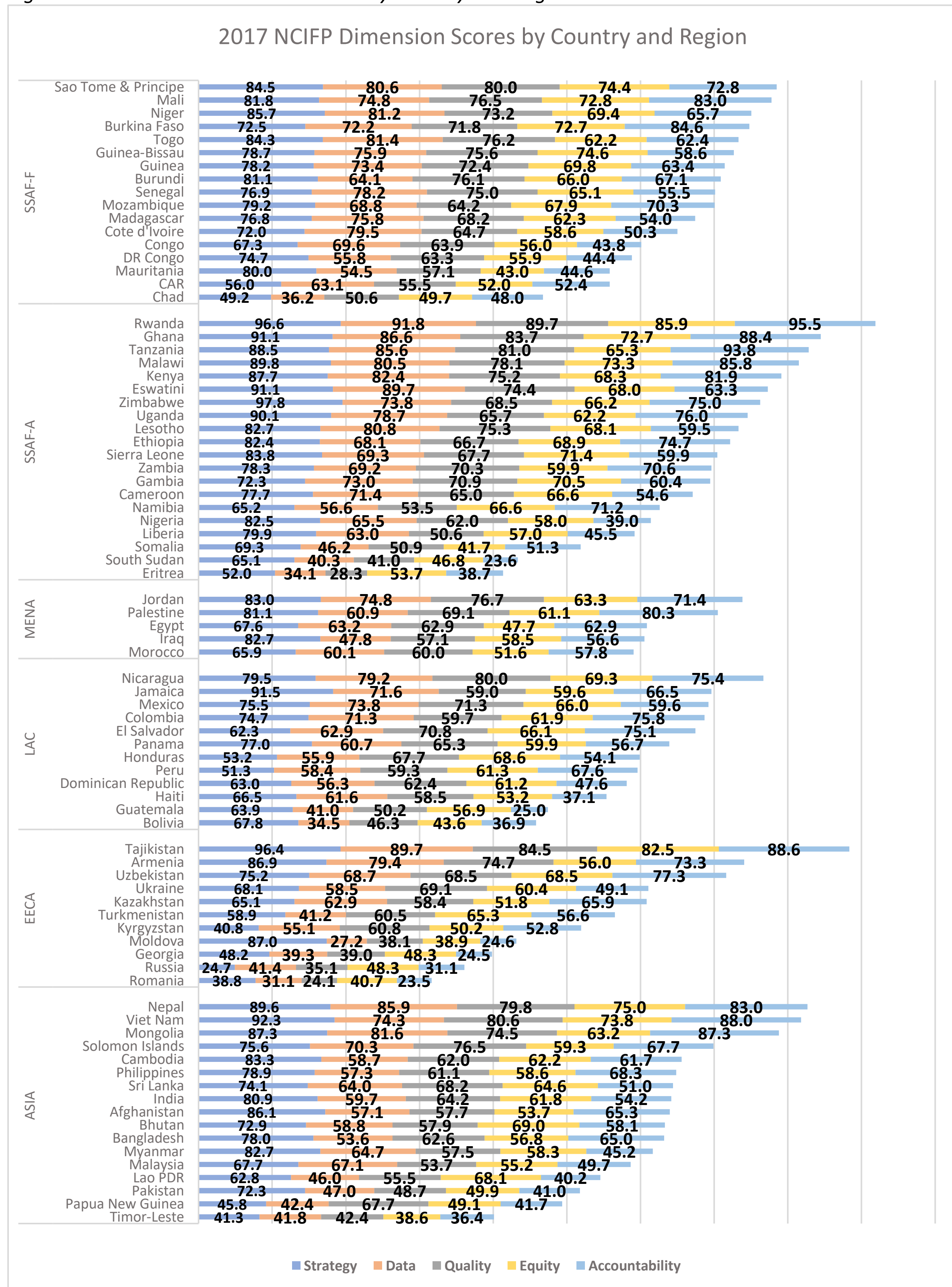


Figure 9: 2017 NCIFP Dimension Scores by Country and Region



Special Analysis

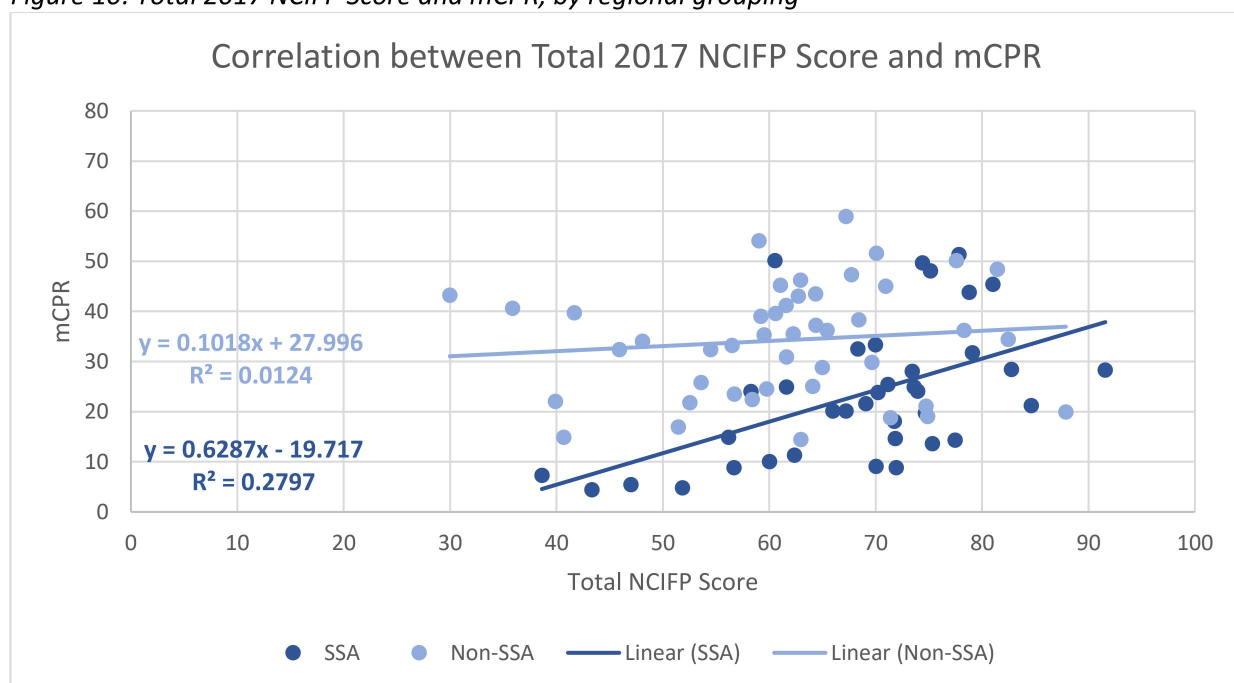
Correlation between NCIFP and Family Planning Indicators

Next, we look at key indicators such as modern contraceptive prevalence rate (mCPR) and total fertility rate (TFR), combining results of the 2017 NCIFP and data from external sources to provide a deeper understanding of the results. The following figures show correlations between different components of the 2017 NCIFP and key family planning indicators, separated by SSA and non-SSA countries. Of the 82 countries that participated in the 2017 NCIFP and are included in this analysis, 37 are in SSA and the remaining 45 are non-SSA countries. TFR and mCPR estimates are drawn from the UN Population Division World Population Prospects. R^2 values are provided to show the goodness of fit of the linear trend between variables.

TFR and mCPR estimates vary across the two regions, with SSA countries tending to have lower mCPR and higher TFR than Non-SSA countries. The average mCPR across SSA countries included in the analysis is 23.4%, with a minimum mCPR of 4.4% (South Sudan) and a maximum mCPR of 51.3% (Eswatini). The average TFR among SSA countries included in the analysis is 4.7, with a minimum of 3.0 (Eswatini) and a maximum of 7.0 (Niger). Among Non-SSA countries included in the analysis, the average mCPR is 34.2%, with a minimum of 14.4% (Afghanistan) and a maximum of 58.9% (Colombia). The average TFR among Non-SSA countries included in the analysis is 2.6, with a minimum of 1.3 (Moldova) and a maximum of 4.6 (Afghanistan).

Figure 10 shows the correlation between total NCFIP score and mCPR for sub-Saharan African countries (SSA) and non-SSA countries. For both SSA and Non-SSA regions, mCPR is positively related to total NCIFP score. A ten-point increase in total score is accompanied by a 6-point increase in mCPR in SSA and a 1-point increase in Non-SSA. The relationship between mCPR and NCIFP is much stronger among SSA countries (r=0.53) compared to Non-SSA countries (r=0.11).

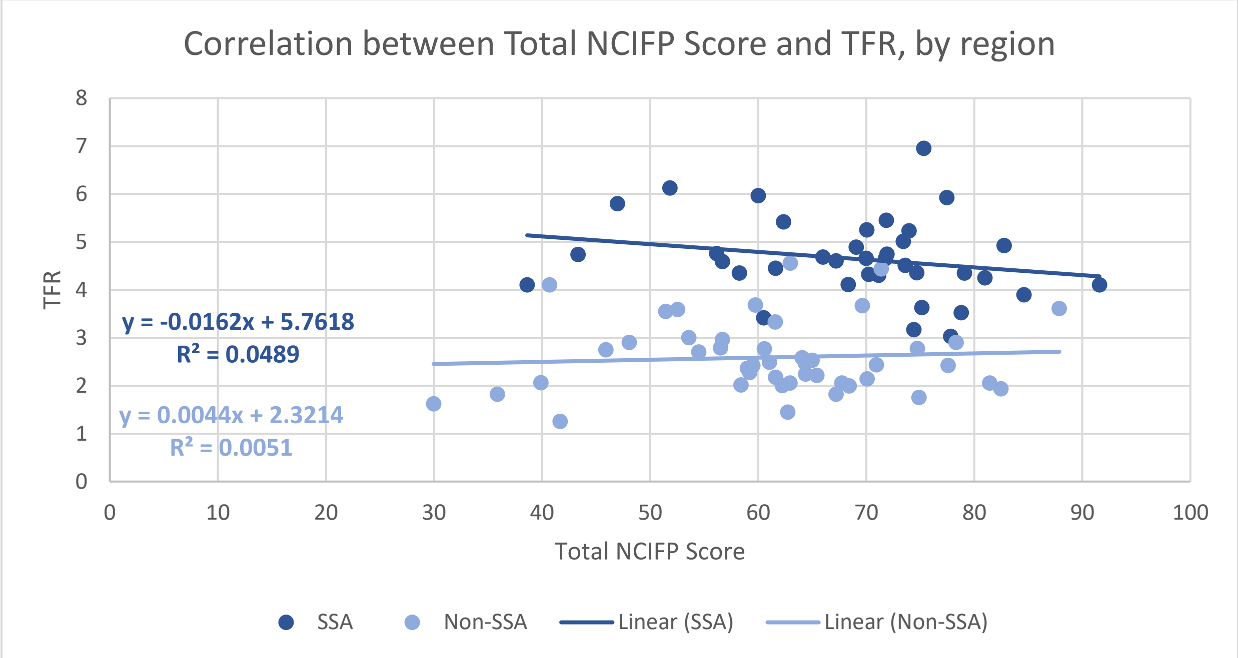
Figure 10: Total 2017 NCIFP Score and mCPR, by regional grouping



mCPR estimates are from UN Estimates and Projections of Family Planning Indicators 2020.

The relationship between NCIFP and TFR is much weaker than that for mCPR. This is not entirely surprising as TFR is not as directly impacted by programmatic efforts as mCPR. A ten-point increase in NCIFP score is accompanied by a 0.2-point decrease in TFR in SSA countries and no change in TFR in Non-SSA countries. As Figure 11 shows, TFR in Non-SSA countries tends to be lower than in SSA countries.

Figure 11: Total 2017 NCIFP Score and TFR, by regional grouping



TFR estimates are from the UN World Population Prospects 2019: Total fertility by region, subregion, and country, 1950-2100. TFR estimates for the 2015-2020 period were used in conjunction with the 2017 NCIFP scores.

The following table gives the "r" correlations for the total score and the five dimension scores with mCPR, by SSA and Non-SSA regional groupings:

SSA countries: mCPR correlates positively and substantially with the total and dimension scores. There is little variation across dimensions, with the data dimension having the highest correlation coefficient (0.55) and quality the lowest (0.41).

Non-SSA countries: mCPR is also positively correlated with the total and dimension scores in the Non-SSA region. However, correlations are low. Patterns for the relationship between each dimension and mCPR do not match those seen in the SSA region. In the Non-SSA region, the equity dimension had the highest correlation coefficient (0.26) and strategy the lowest correlation coefficient (0.02).

Table 6: Correlation between 2017 Dimension scores and mCPR by regional grouping

	Correlation between Dimension Scores and mCPR (all women)
	mCPR: SSA Countries
Total Score	r=0.53
Strategy	r =0.50
Data	r =0.55

Quality	r =0.41
Equity	r =0.47
Accountability	r =0.50
	mCPR: Non-SSA Countries
Total Score	r =0.11
Strategy	r =0.02
Data	r =0.10
Quality	r =0.09
Equity	r =0.26
Accountability	r =0.15

mCPR estimates are from UN World Population Prospects: Estimates and Projections of Family Planning Indicators 2020.

Table 7 shows the "r" correlations between NCIFP scores for access and different categories of contraceptive use. Within the equity dimension, there are two questions related to access of methods: "Extent to which the entire population has ready access to long-acting and permanent methods (LAPMs)" and "Extent to which the entire population has ready access to short-term methods (STMs)." In Table 7, these two items are shown separately and averaged together to create an indicator for "access to LAPMs and STMs." The correlation between these items and three different categories of contraceptive use (percent of contraceptive users who are using a LAPM, percent of contraceptive users who are using an STM, and total modern use) are shown. Data on LAPM and STM use for the relevant time period (2016-2018) were only available for 46 of the countries that conducted a 2017 NCIFP, so results were not broken down by regional grouping.

The relationship between the different access items and contraceptive use are all positive. The correlations between access to LAPMs and contraceptive use are much higher than those for access to STMs. This is not surprising, as provision of LAPMs (including implants, IUDs, and sterilization) requires a visit to a health facility and insertion/surgery by a medical professional. Ensuring access of these more technically complex methods requires more effort from the FP program.

Table 7: Correlation between 2017 NCIFP scores for access and different categories of contraceptive use

	Correlation between NCIFP scores for access and contraceptive use		
	% of contraceptive users using a LAPM	**% of contraceptive users using a STM**	**mCPR**
Access to LAPMs	r=0.58	---	r=0.48
Access to STMs	---	r=0.10	r=0.15
Access to LAPMs and STMs	---	---	r=0.35

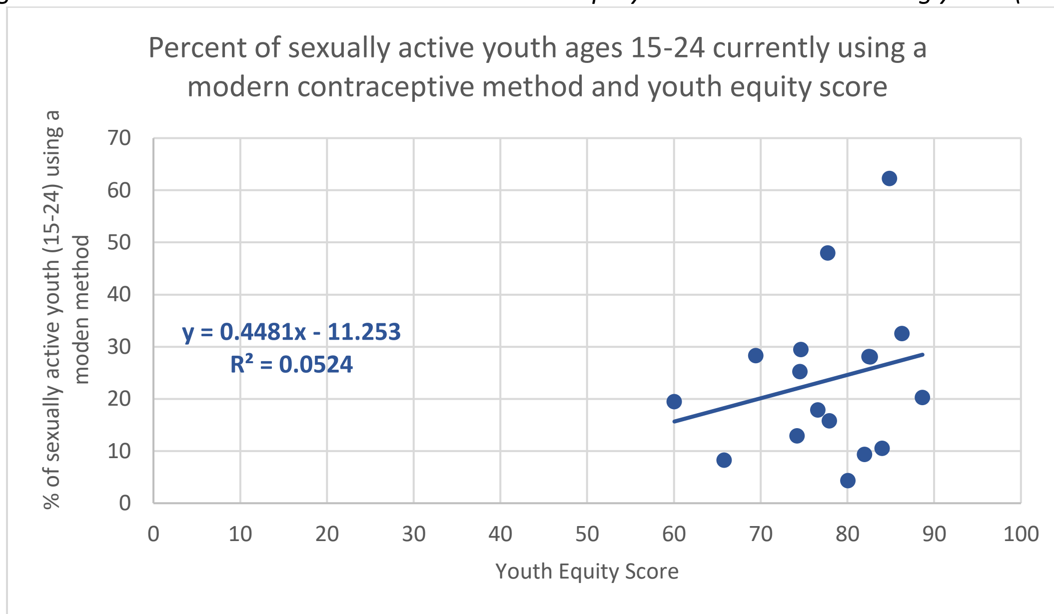
*LAPM and STM data are from UN World Contraceptive Use, 2020. LAPM and STM estimates include data from 2016-2018. Data are not modeled estimates, but compiled from a variety of sources (PMA, MICS, DHS, national surveys). mCPR estimates are from UN Estimates and Projections of Family Planning Indicators, 2020.

The equity dimension also has items to measure the FP program effort related to vulnerable subgroups based on age, wealth status, marital status, HIV status, and post-abortion status. Figure 12 shows the correlation between equity scores related to youth and modern contraceptive use among sexually active women ages 15-24. The "youth equity score" in this figure is an average of the two NCIFP items related to youth: "Extent to which service providers do not discriminate against youth," and "Are there policies in place to prevent discrimination towards youth?". Data for modern contraceptive use among sexually

active youth were drawn from DHS Surveys from 2015-2018 and were only available for 17 countries that participated in the 2017 NCIFP (Armenia, Burundi, Chad, Colombia, Ethiopia, Guatemala, Haiti, Malawi, Myanmar, Nigeria, Papua New Guinea, Philippines, Rwanda, Senegal, Tajikistan, Uganda, and Zimbabwe).

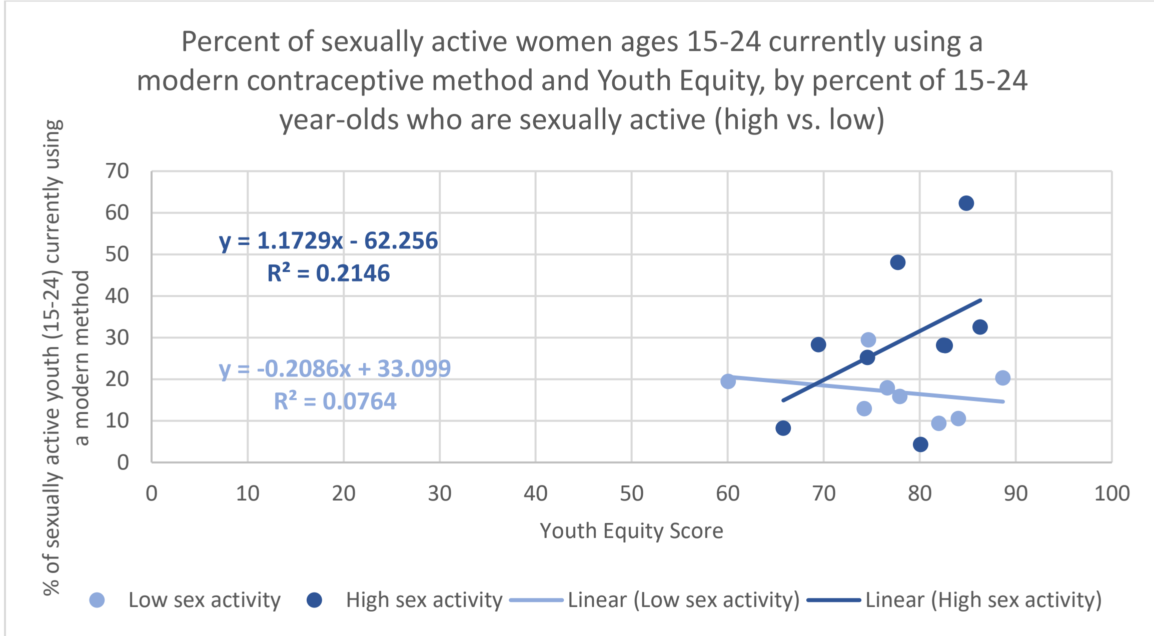
Youth contraceptive use is positively related to the NCIFP youth equity score. A ten-point increase in youth equity score is accompanied by a 4-point increase in youth mCPR. However, the “r” correlation coefficient is fairly small (0.23).

Figure 12: Correlation between 2017 NCIFP Youth Equity Score and mCPR among youth (15-24)



When we separate the data points by countries with “high” sexual activity among 15-24-year-olds (equal to or above the median for all 17 countries [29%]) and “low” sexual activity among 15-24-year-olds (below the median value of 29%), we see variation in the relationship between youth mCPR and the youth equity score. Figure 13 shows a negative correlation between youth mCPR and youth equity for countries with low youth sexual activity and a positive correlation for countries with high youth sexual activity. A 10-point increase in the youth equity score is accompanied by a 2-point decrease in mCPR among low youth sexual activity countries and a 12-point increase in mCPR among youth in high sexual activity countries. The “r” correlation coefficient is moderate for the relationship between youth equity score and high youth sexual activity countries (r=0.46) but low for the relationship between youth equity score and low youth sexual activity countries (r=0.28). Although these correlations were estimated for only 17 data points, it appears as though efforts to ensure policies and providers do not discriminate against youth may have a large impact on youth mCPR in countries where sexual activity among youth is relatively high.

Figure 13: Correlation between 2017 NCIFP Youth Equity Score and mCPR among sexually active youth (15-24), by youth sexual activity level



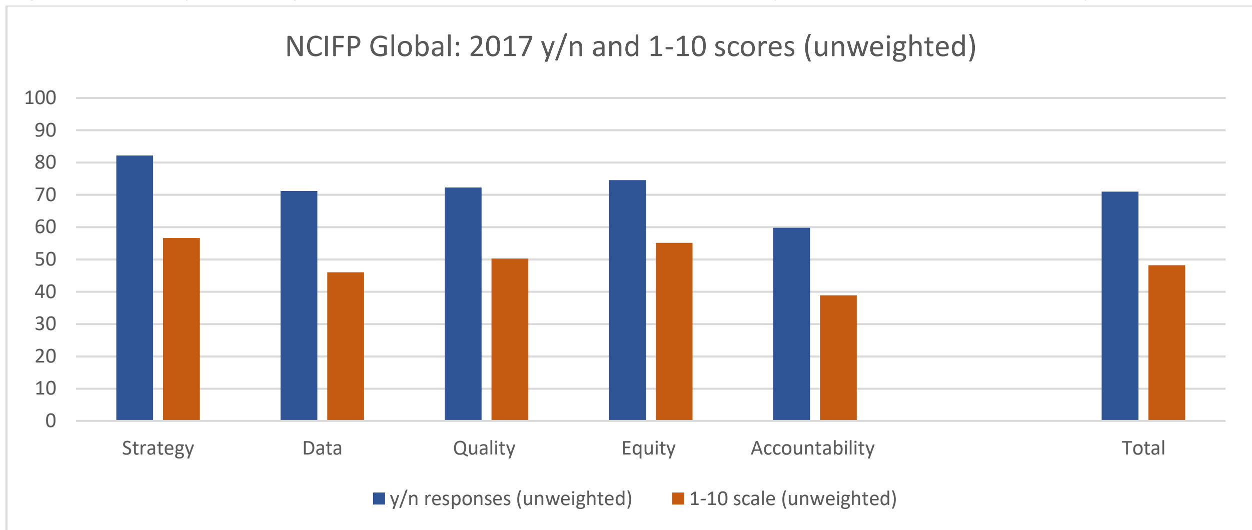
Comparison of 1-10 Score vs. Yes/No Responses

In the "Results" sections of this report, all 2017 NCIFP results were presented based on the 2014 approach, which mainly used a yes/no format to generate item scores. In 2017, the yes/no questions were followed by a 1-10 rating scale to address some of the challenges related to yes/no responses, which were revealed in the 2014 round of the NCIFP. First, the score for each question ended up simply representing the percent of respondents who said yes. Additionally, for some questions, a clear cut 'yes' or 'no' answer was not feasible because the question asked about multiple issues, or the answer fell into an intermediate place between the two responses. The 1-10 scale responses that were added after every yes/no question in the 2017 round allow for finer nuances in responses. This section provides a brief analysis of the impact of using scaled responses versus yes/no responses.

Figure 14 shows the unweighted 2017 global scores by dimension based on yes/no responses and 1-10 scale responses. There were 20 items that included both a yes/no response option and a 1-10 scale response option. The remaining 15 items had only a 1-10 scale response option (see Table 4). In order to directly compare the overall scores when based off of yes/no responses and 1-10 scale responses, only the 20 items with both options were included in Figure 14.

We see that scores are lower when based on the 1-10 scale responses – the total score was lower by about 23 points. Strategy was the highest scoring dimension and accountability was the lowest scoring dimension according to both response types.

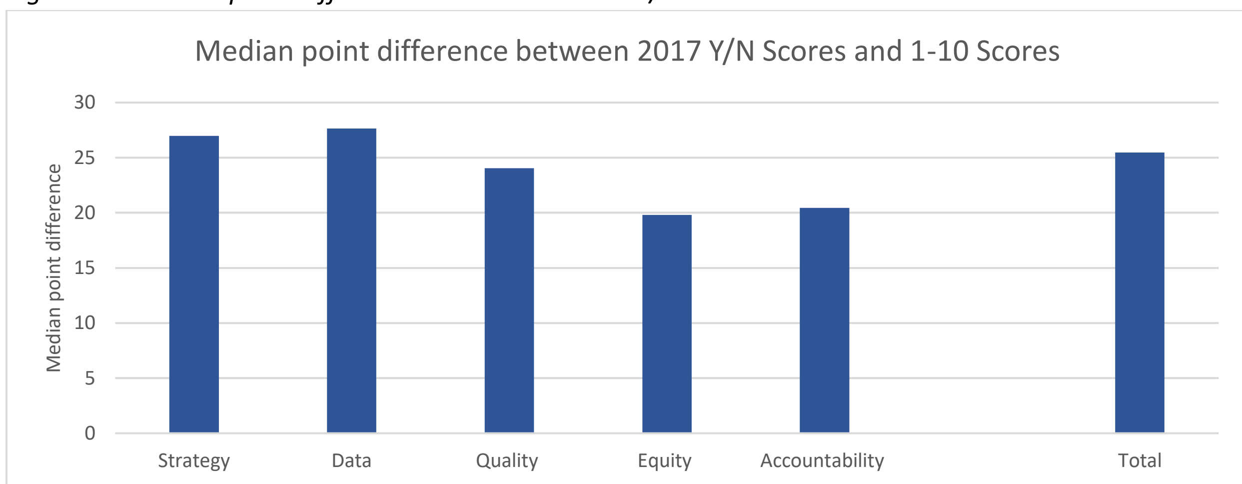
Figure 14: Comparison of Dimension Scores Based on Yes/No Responses and 1-10 Scale Responses



Median point differences between the yes/no scores and 1-10 scores for 2017 are shown in Figure 15. As in Figure 14, only items with both a yes/no response item and 1-10 response option were included in the figure. Median response differences were calculated by subtracting the median 1-10 score across all countries for each dimension from the median yes/no score across all countries for each dimension. Positive median point differences indicate the median yes/no score was higher than the median 1-10 score for that dimension.

Median dimension scores were lower when the 1-10 scale was used to generate scores. In terms of the total score, the median difference between yes/no responses and 1-10 responses was 25 points. Median point differences were largest for the data dimension (28 points), and smallest for the equity dimension (20). It should be noted that only one item with both a yes/no and 1-10 scale response option fell within the equity dimension, so these results should be interpreted with caution.

Figure 15: Median point differences between 2017 Yes/No Scores and 1-10 Scores



Figures 16 and 17 show the unweighted individual item scores, separated by response type. These figures show all 35 items, including those that only have a 1-10 scale response option. There are 20 yes/no response items and 35 1-10 scale response items.

Overall, scores based on the 1-10 scale responses tend to be more moderate in range, and more closely grouped across regions. Yes/No responses force respondents to choose extreme values, while the 1-10 scale response allows for more nuance. Table 8 provides an overview of the unweighted score ranges, by response type. The "minimum score" is the lowest score across all items and regions. It is represented in Figures 16 and 17 as the lowest data point. The "maximum score" is the highest score across all items and regions and is represented as the highest data point in Figures 16 and 17. The "largest item difference" is the largest score difference between regions for an individual item and corresponds to the item where the gap between lines (i.e. regions) is the widest in Figures 16 and 17. Finally, the "smallest item difference" is the smallest score difference between regions for an individual item and is where the lines are most tightly grouped together in Figures 16 and 17.

Table 8: Score Ranges for Individual Items, by Response Type

	Yes/No Items (unweighted)	1-10 Items (unweighted)
Minimum Score	31	29
Maximum Score	97	77
Range	66	48
Largest Item Difference	42	28
Smallest Item Difference	13	6

The minimum score for all yes/no items and all 1-10 items was for the "Does government collect information related to informed choice and provider bias?" (31 points and 29 points, respectively).

The maximum score for all yes/no items was for the item "Are FP operating procedures in line with WHO and used for determining areas of need for quality FP improvement?" (97). For 1-10 items, the highest scoring item was "Extent to which service providers discriminate against special subgroups" (77 points).

The item with the largest yes/no score difference across regions was "Are indicators for quality of care collected and used for private sector family planning services?" (a point difference between the highest scoring and lowest scoring region of 42 points). The item with the largest 1-10 score difference across regions was "Extent to which the entire population has ready and easy access to IUD removal" (a difference of 28 points).

The item with the smallest yes/no score difference across regions was "Are FP operating procedures in line with WHO and used for determining areas of need for quality FP improvement?" (a difference of 13 points). The item with the smallest 1-10 score difference across regions was "Extent to which training programs are adequate to provide personnel with information and skills necessary to carry out their jobs effectively" (a difference of 6 points).

Figure 16: 2017 NCIFP Individual Scores for Yes/No Response Items (unweighted)

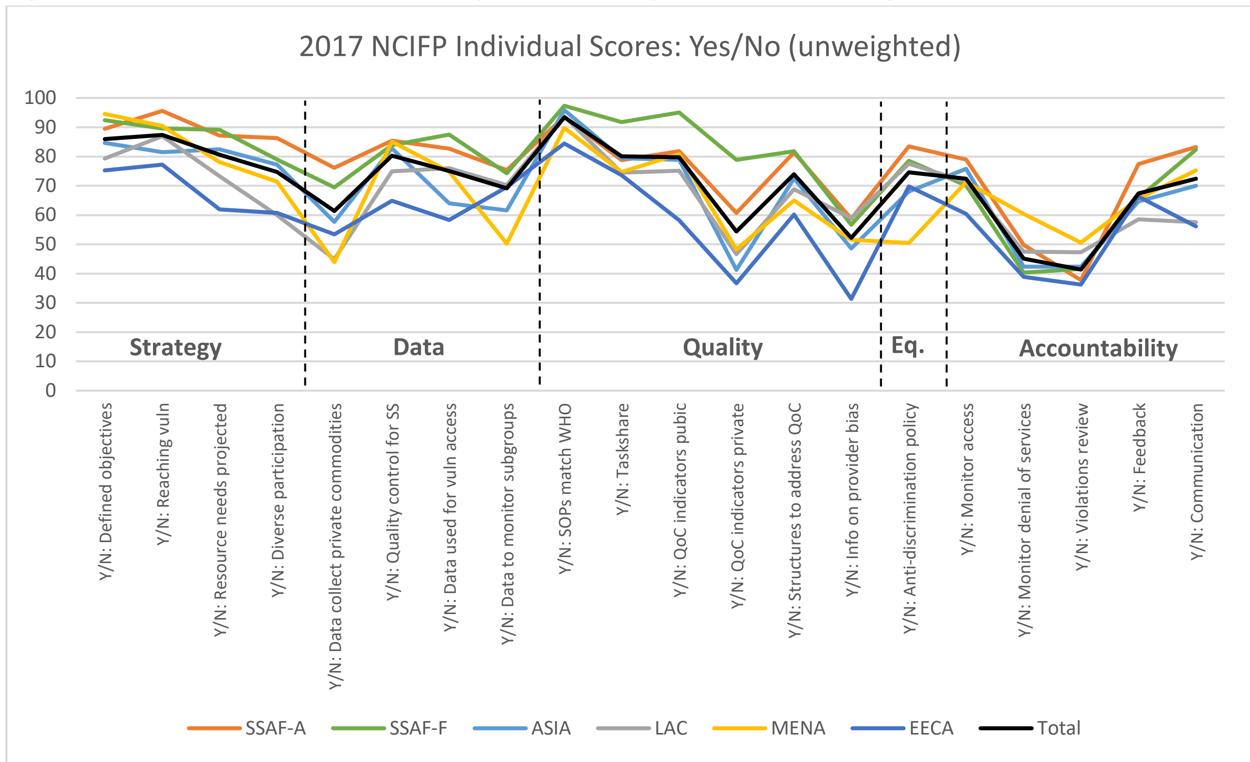
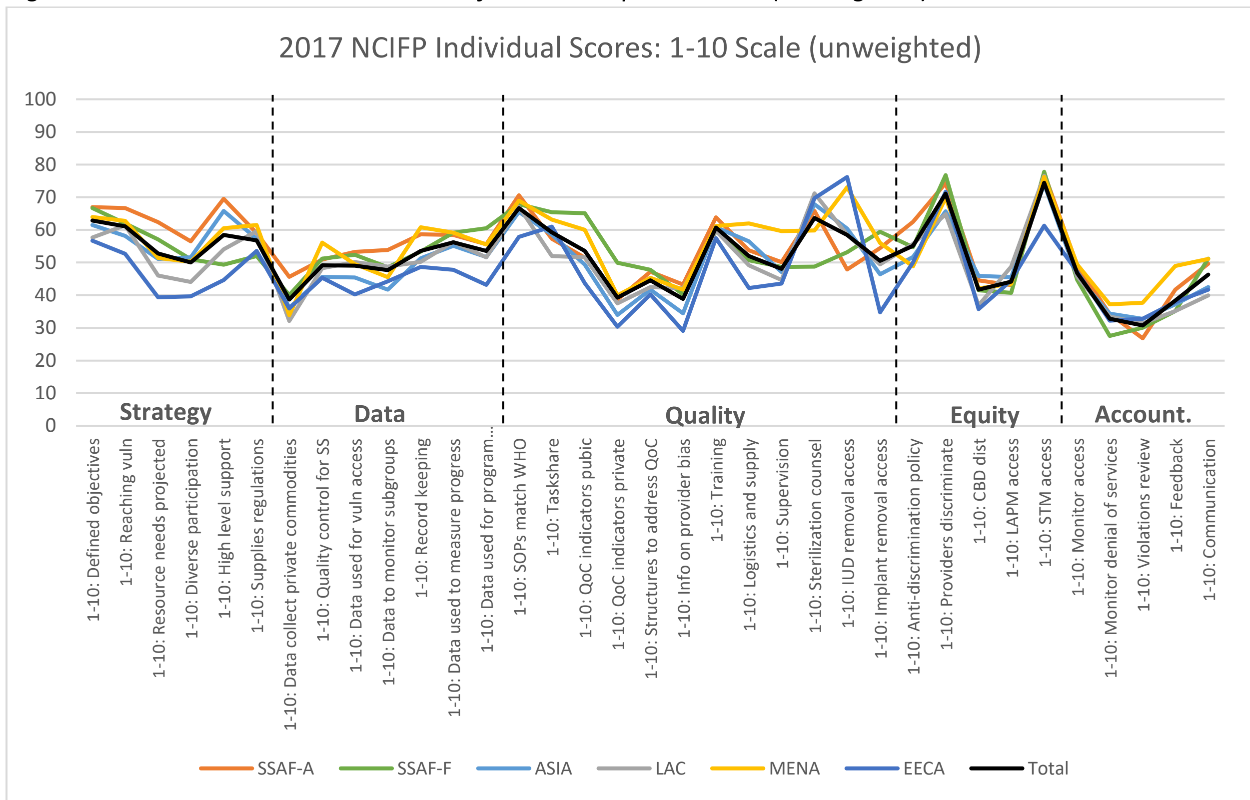


Figure 17: 2017 NCIFP Individual Scores for 1-10 Response Items (unweighted)

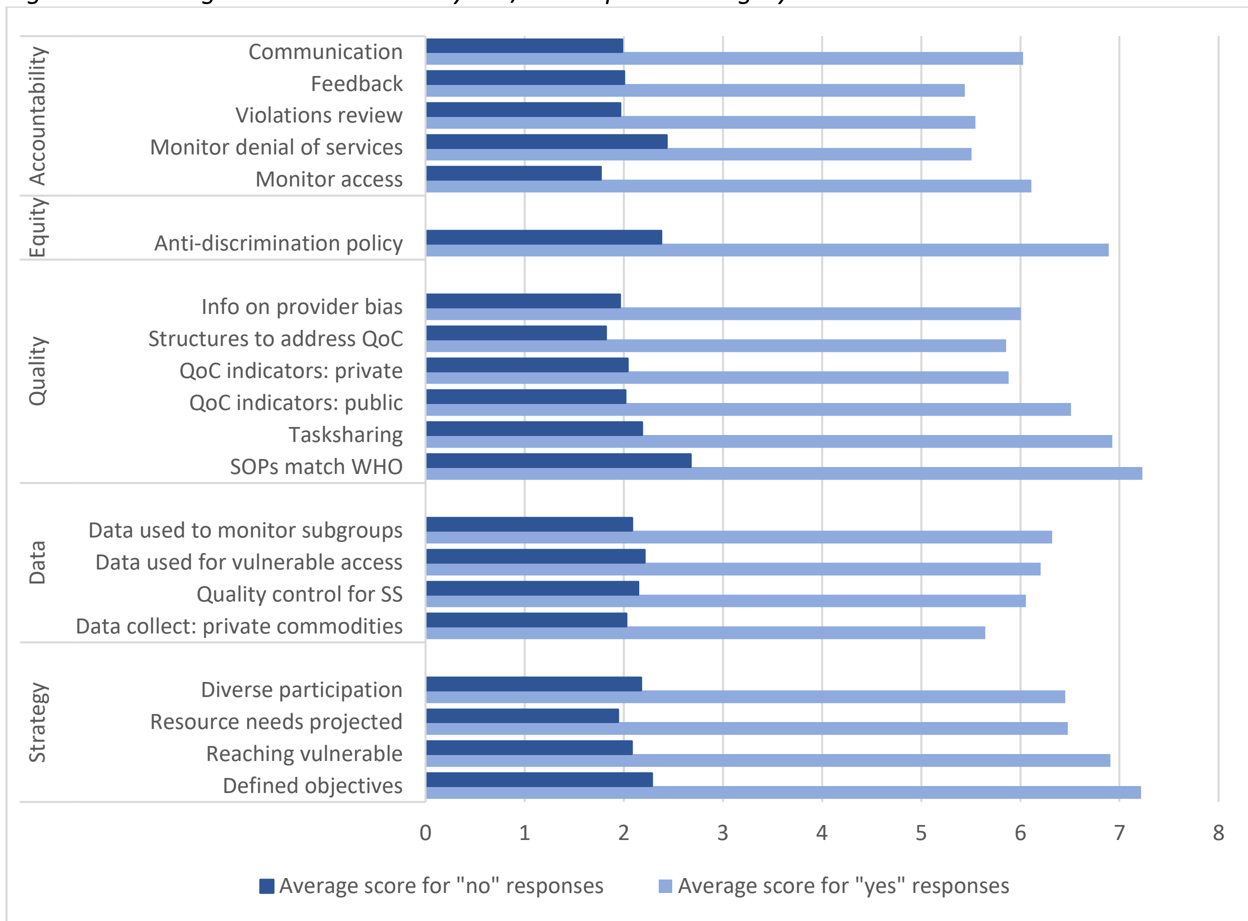


The analysis of yes/no responses versus 1-10 scale responses revealed a degree of variability between what is considered a "yes" response and what is considered a "no" response. Figure 18 shows the average item scores based on the 1-10 scale calculation, separated by yes/no response category. 1-10 response scores connected to a "yes" response ranged from 7.2 (the average score across all countries for the items "Are FP Standard Operating Procedures in line with WHO and used for determining areas of need for quality FP improvement?" and "Does the national FP action plan include defined objectives over a 5 to 10 year period, including quantitative targets?") to 5.4 (the average score across all countries for the item "Are there mechanisms in place at the facility level to solicit and use feedback from clients?"). Higher 1-10 scale scores for "yes" responses tended to be concentrated in the strategy dimension, but variability can be seen across all dimensions. The overall average score for all "yes" responses was 6.3.

1-10 response scores connected to "no" responses ranged from 1.8 (the average score across all countries for the item "Are there mechanisms in place at the national, sub-national, and facility level to monitor whether or not access to voluntary, non-discriminatory FP information and services is being achieved?") to 2.7 (the average score across all countries for the item "Are FP Standard Operating Procedures in line with WHO and used for determining areas of need for quality FP improvement?"). The overall average score for all "no" responses was 2.1.

Scores suggest that including the 1-10 responses adds additional information about the continuum of effort that countries follow. Instead of only allowing a score of "no", indicating that a country is not showing any effort in that area or "yes", indicating that a country is showing maximum effort, participants are able to show the varied level of effort, enabling a better perspective of where improvements are needed.

Figure 18: Average 1-10 item scores by Yes/No Response Category



Analysis of Response Rates

Analysis of Yes/No Responses vs. 1-10 Scale Responses

The response rate for the 35 items varied, both by question and by country. To ensure all responses were informed opinions rather than guesses, key informants were told to leave a question blank if they do not know the answer. Therefore, non-response is an indicator of which components of family planning programs are less understand by key informants.

The average response rate was 89.0%. Looking at the average response rate across all questions for each individual country (82 means to consider), values ranged from to 61.1% to 99.9%. Looking at the average across all countries for each individual item (35 means to consider), values ranged from to 63.6% to 97.9%.

The 10 items with the lowest response rates are shown in Table 9. Four of the five accountability items appeared in this list, indicating the accountability dimension may be the most difficult for key informants to understand or that they know the least about this component of the FP program. Another important, though not surprising finding is that all 10 items with the lowest response rates are 1-10 scale items following a yes/no item. The yes/no portion of each of these items have higher response rates. This is due in part to the fact that many respondents did not provide a 1-10 scale score for items to which they responded “no.” The fifth column in Table 9 shows the percent of non-responses or

"blanks" for each question that occurred after a "no" response to the yes/no item. Non-response following a "no" accounts for most of the non-response in the 10 items with the lowest response rates. However, this behavior was not consistent – some respondents provided a scale score for "no" responses when others did not. This issue might be resolved by removing the yes/no responses all together or by allowing respondents to provide a score of "0" when they feel there is no evidence of that particular item. Instructions should explicitly state that respondents are expected to complete the 1-10 scale for every item. This will allow us to distinguish between non-response, which might be an indicator of lack of knowledge on the item and/or difficulty in answering the question, and low scores (i.e. "0").

Table 9: Items with the lowest response rates

Question type	Dimension	Question	Mean Response Rate	% Non-responses occurring after "No" on the Yes/No item
1-10 scale following Yes/No	Account.	Are violations reviewed on a regular basis?	63.6%	62.0%
1-10 scale following Yes/No	Account.	Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds or coercion?	68.6%	67.6%
1-10 scale following Yes/No	Quality	Does government collect information related to informed choice and provider bias?	69.7%	67.3%
1-10 scale following Yes/No	Quality	Are indicators for quality of care collected and used for private sector family planning services?	73.2%	68.2%
1-10 scale following Yes/No	Account.	Are there mechanisms in place at the facility level to solicit and use feedback from clients?	81.1%	71.4%
1-10 scale following Yes/No	Data	Does the government collect data to monitor special subgroups?	81.6%	69.3%
1-10 scale following Yes/No	Data	Does the government collect data from the private sector on commodities?	81.9%	72.0%
1-10 scale following Yes/No	Account.	Are there mechanisms in place at the national, sub-national, and facility level to monitor whether or not access to voluntary, non-discriminatory FP information and services is being achieved?	82.2%	66.0%
1-10 scale following Yes/No	Equity	Are there policies in place to prevent discrimination towards special subgroups?	82.5%	57.7%
1-10 scale following Yes/No	Quality	Are there guidelines on task sharing of family planning services?	82.7%	42.0%

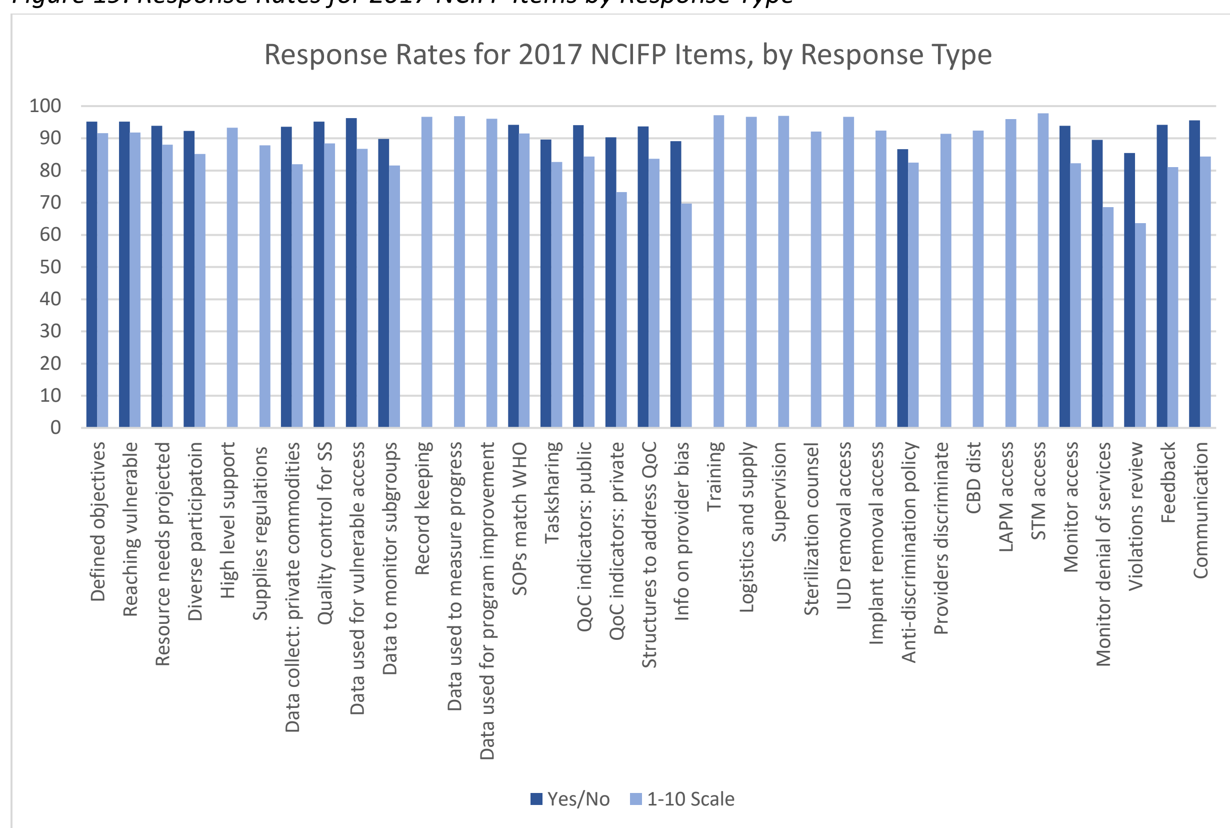
We also looked at which items had the highest response rates. 1-10 scale items also dominated this list. Most of the items fell within the data and quality dimensions. Four of the items with the highest response rates were related to access or data to monitor access.

Table 10: Items with the highest response rates

Question type	Dimension	Question	Mean Response Rate
Standalone 1-10 scale	Equity	Extent to which entire population has ready and easy access to STMs	97.8%
Standalone 1-10 scale	Quality	Extent to which training programs, for each category of staff in the family planning program, are adequate to provide personnel with information and skills necessary to carry out their jobs effectively	97.2%
Standalone 1-10 scale	Quality	Extent to which the system of supervision at all levels is adequate (regular monitoring visits with corrective or supportive action)	96.9%
Standalone 1-10 scale	Data	Extent to which program statistics, national surveys, and small studies are used by specialized staff to report on program operations and measure progress	96.9%
Standalone 1-10 scale	Data	Extent to which systems for client recordkeeping, clinic reporting, and feedback of results are adequate	96.7%
Standalone 1-10 scale	Quality	Extent to which the logistics and transport systems are sufficient to keep stocks of contraceptive supplies and related equipment available at all service points, at all times and at all levels (central, provincial, local)	96.7%
Standalone 1-10 scale	Quality	Extent to which the entire population has ready and easy access to IUD removal	96.7%
Yes/No	Data	Are data used to ensure that the poorest and most vulnerable women and girls have access to quality FP services?	96.3%
Standalone 1-10 Scale	Data	Extent to which program managers use research and evaluation findings to improve the program in ways suggested by findings	96.1%
Standalone 1-10 scale	Equity	Extent to which entire population has ready and easy access to LAPMs	95.9%

The average response rate was 91.2% across all yes/no items and 87.8% across all 1-10 scale response items. Figure 19 shows response rates for each of the 35 NCIFP items, by response type. Interestingly, when 1-10 scale responses were accompanied by a yes/no response the response rates were much lower, but when the 1-10 scales stood alone, response rates were the highest among all 35 items. As mentioned previously, this pattern is largely due in part to respondents not completing the 1-10 scale when the yes/no response was "no."

Figure 19: Response Rates for 2017 NCIFP Items by Response Type



Analysis of 2017 Response Rates, by Country

For each country, the average response rate across all 35 questions was calculated. The ten countries with the highest response rates are presented in Table 11. Four are in EECA and the others are in Asia, SSAF-F and LAC (two in each region). None of them are in SSAF-A or MENA. Response rates by country may not be very telling of each country's programmatic effort but is likely a reflection of the selection of respondents and follow-up work of the country manager.

Table 11: Countries with the highest response rates

Region	Country	Mean Response Rate
ASIA	Solomon Islands	99.9
EECA	Turkmenistan	99.8
EECA	Armenia	99.6
ASIA	Viet Nam	99.4
SSA-F	Chad	98.8
EECA	Uzbekistan	98.5
LAC	Bolivia	98.3
SSAF-F	DR Congo	98.0
EECA	Tajikistan	97.8
LAC	Guatemala	96.9

On the other end of the spectrum are the countries with the lowest response rates, presented in Table 12. Six of the 10 countries with the lowest response rates are located in EECA and MENA (three each).

The remaining countries are located in SSAF-F, LAC and Asia. None are in SSAF-A. However, little can be concluded about country determinants of the response rate.

Table 12: Countries with the lowest response rates

Region	Country	Mean Response Rate
EECA	Romania	69.1
ASIA	Malaysia	73.5
SSAF-F	Cote d'Ivoire	73.8
EECA	Russia	74.4
EECA	Moldova	75.3
LAC	Jamaica	76.5
MENA	Iraq	76.9
MENA	Palestine	78.5
MENA	Morocco	80.7
SSAF-F	Central African Republic	81.3

Next, we looked at response rates by regional averages (Table 13). Again, the mean response rate across all countries and items was 89.0. As a whole, SSAF-A had the highest mean response rate, closely followed by LAC and SSAF-F. MENA had the lowest mean response rate, with Asia and EECA in the middle. Interestingly, the mean response rates by region are not unlike the ranking for total NCIFP score: SSAF-A, SSAF-F, Asia, LAC, MENA, EECA. Though the reasons for differences across regions in mean response rate are speculative, the level of effort in FP programs may be reflected by the dedication of FP experts in completing this and other FP-related surveys.

Table 13: Average Response Rates by Region

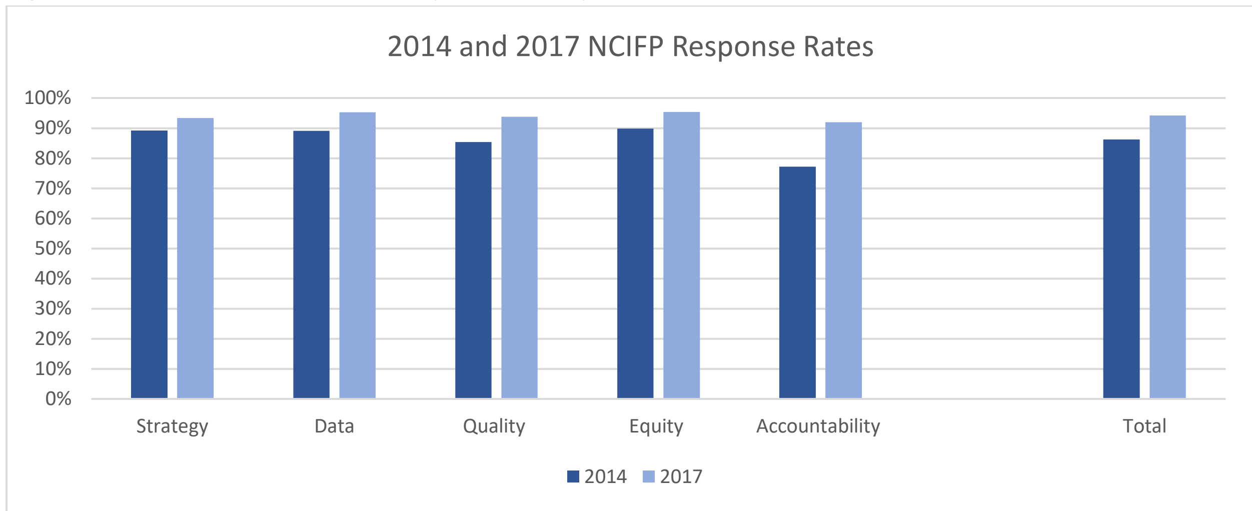
Region	Mean Response Rate
SSAF-A	90.9
LAC	90.3
SSAF-F	90.2
ASIA	89.5
EECA	88.5
MENA	84.3
Total	**89.0**

Analysis of 2017 Response Rates Compared to 2014 Response Rates

It is important to note that overall, the response rates have improved since the 2014 round of the NCIFP. In 2014, the overall response rate was 86%, compared to 94% in 2017 (for countries with data in both rounds). This difference in response rates between rounds may be indicative of recruitment of more knowledgeable key informants and/or improved understanding of the different components of the NCIFP.

Figure 20 shows the 2014 and 2017 NCIFP response rates for each dimension. Response rates improved from 2014 to 2017 for every dimension, with the accountability dimension showing the greatest increase. In both 2014 and 2017, response rates were highest in the equity dimension and lowest in the accountability dimension.

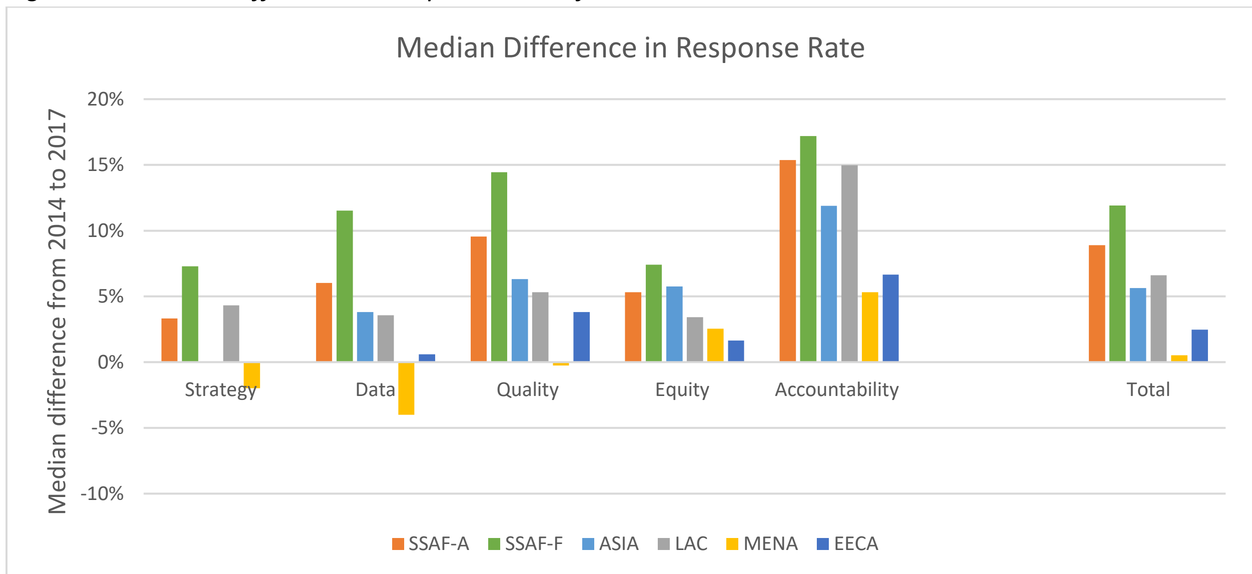
Figure 20: 2014 and 2017 NCIFP Response Rates for each Dimension



Next, we looked at the median difference in response rates from 2014 to 2017 by domain and region. The accountability dimension shows the largest median increases for all regions. The strategy dimension had the smallest median increases for SSAF-A, SSAF-F, Asia and EECA. The equity dimension had the lowest median increase in response rates for LAC and the data dimension had the smallest for MENA (a decline 4%).

Looking at regions, SSAF-F had the largest median increase across all dimensions. With declines for the strategy, data and quality dimensions, MENA had the smallest increase in response rates for all but one dimension. EECA had the smallest increase in response rates for the equity domain.

Figure 21: Median Difference in Response Rates from 2014 to 2017



Increase in Accountability Dimension: Result of improved scores or improved response rates?

One final area we felt warranted further analysis was the large improvement in the accountability dimension from 2014 to 2017. We hypothesized this outcome could be due to two different causes: 1) improved reporting rates over time; or 2) higher raw scores over time. Improved reporting rates would

indicate that key informants have a better understanding of the five items that make up the accountability dimension – either a better understanding of the NCIFP questions themselves or more familiarity with how the FP program performs on these indicators. Higher scores would indicate that the FP program has actually improved on these indicators. To discover the cause for the large increase in accountability score over time, we looked at the raw scores (yes, no, or no response) across all key informants for each of the five accountability dimension items. We calculated the percent of responses that were "yes," the percent that were "no" and the percent that were "no response" to see how these categories changed over time. For comparability, we only included data from countries that completed the NCIFP in both 2014 and 2017. We only looked at yes/no responses, because the 1-10 scale response was not an option for any of the accountability items in 2014. The number of key informants for some countries changed slightly between 2014 and 2017 rounds, so the total "N" for key informants is different for each year.

Table 14: Yes/No Scores and Non-Response (NR) for Accountability Items in 2014 and 2017

	2014 NCIFP (N=955)			2017 NCIFP (N=1,006)		
Accountability item	**% Yes**	**% No**	**% NR**	**% Yes**	**% No**	**% NR**
Are there mechanisms in place at the national, subnational, and facility level to monitor whether or not access to voluntary, non-discriminatory FP information and services is being achieved?	39	43	18	68	26	6
Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds (age, marital status, ability to pay), or coercion (including inappropriate use of incentives to clients or providers)?	20	55	25	40	50	10
Are violations reviewed on a regular basis?	19	55	26	35	51	14
Are there mechanisms in place at the facility level to solicit and use feedback from clients?	32	45	23	62	32	6
Is there a system in place that encourages dialogue and communication between users and service providers/health officials about service availability, accessibility, acceptability and quality? (The system for dialogue and communication can include interviews after clinic visits, regular community forums, joint quality improvement systems, or other interactive sessions.)	39	39	22	68	27	4
Dimension Total	**30**	**47**	**23**	**55**	**37**	**8**

Table 14 shows the percent of all key informant responses that were "yes," "no" and "no response" for each accountability item. We can see that the percent of key informants responding "yes" increased for each item, and the percent who did not respond to the question decreased for each item from 2014 to 2017. Although the percent change in proportion of "yes" responses was larger than the percent change in the proportion of "no response," the large increase in accountability scores (from 39 to 59) is likely the result of both improvements in response rate and increases in raw scores.

Conclusion

The National Composite Index for Family Planning (NCIFP) is a measurement tool to help capture the enabling environment in which family planning (FP) programs are implemented. The first round of the NCIFP was conducted in 2014, and this report presents the finding of the second round, which was conducted in 2017. Results of the two rounds are comparable, allowing us to see trends in the different indicators over time. Results of the 2017 round of the NCIFP have revealed improvements in the existence of policies and program implementation across all five dimensions: strategy, data, quality,

equity, and accountability. In both 2014 and 2017, strategy was the highest scoring dimension and accountability the lowest.

Results are presented globally, by region and by country which can be useful for informing policy judgements and resource allocations. At the country level, decision-makers can review the scores for specific items to identify areas for potential improvements. Patterns in scores across regions reveal areas that may be more difficult to address globally. For example, most regions scored well on items related to defined objectives, standard operating procedures, and quality control, but lower on items related to access to LAPMs, monitoring denial of services and violations review.

Areas where scores improved over time is also telling. Equity was one of the lower-scoring dimensions in both rounds, but it is also showed the smallest improvement in scores from 2014 to 2017. These results indicate that efforts may be stagnating despite room for improvement. Though accountability was the lowest scoring dimension in both rounds, it also saw the largest increase over time. This increase is likely due to both improved reporting rates (a measure of improved understanding and/or knowledge of accountability items) and increases in raw scores.

Correlation coefficients between scores and fertility indicators were also presented in this report. Analyses found higher modern contraceptive use when total NCIFP score and dimension scores were higher. Relationships between contraceptive use and NCIFP were stronger among sub-Saharan African countries. Correlation results also showed that efforts to ensure policies and providers do not discriminate against youth may have a large impact on youth mCPR in countries where sexual activity among youth is relatively high ($\geq$ 29% of 15-24-year-olds are sexually active). A 10-point increase the average score of NCIFP items related to youth was accompanied by a 12-point increase in youth mCPR in high youth sexual activity countries (r=0.46). We also found a moderate correlation between the NCIFP item measuring access to LAPMs and the percent of modern users using a LAPM (r=0.58), indicating efforts related to improving access may impact use. When more rounds of the NCIFP have been completed, it will be interesting to see how change in the NCIFP relates to change in different FP indicators.

The NCIFP is the first comprehensive measure to cover important topics related to equity and accountability. While it is a useful tool, it provides only one perspective. Additional research is needed to develop complementary measures to gain a better understanding of the five dimensions of strategy, data, quality, equity, and accountability.

References

Agence Nationale de la Statistique et de la Démographie - ANSD/Sénégal and ICF. 2018. Senegal: Enquête Démoggraphique et de Santé Continue (EDS-Continue) 2017 [Dataset], SNIR7ZFL. Dakar, Sénégal: ANSD and ICF [Producers]. ICF [Distributor], 2018.

Central Statistical Agency - CSA/Ethiopia and ICF. 2017. Ethiopia Demographic and Health Survey 2016 [Dataset], ETIR71FL. Addis Ababa, Ethiopia: CSA and ICF [Producers]. IFC [Distributor], 2017.

Institut Haïtien de l'Enfance - IHE/Haiti and ICF. 2018. Haiti Enquête Mortalité, Morbidité et Utilisation des Services 2016-2017 - EMMUS-VI [Dataset], HTIR70FL. Pétion-Ville/Haïti: IHE/Haiti, ICF [Producers]. ICF [Distributor], 2018.

Institut National de la Statistique des Études Économiques et Démographiques - INSEED/Tchad, Ministère de la Santé Publique - MSP/Tchad, and ICF International [Producers]. 2016. Enquête Démographique et de Santé et à Indicateurs Multiples au Tchad (EDS-MICS) 2014-2015 [Dataset], TDIR71FL. IFC [Distributor], 2016.

Ministère à la Présidence chargé de la Bonne Gouvernance et du Plan - MPBGP, Ministère de la Santé Publique et de la Lutte contre le Sida - MSPLS, Institut de Statistiques et d'Études Économiques du Burundi - ISTEEBU, and ICF. 2017. Burundi Troisième Enquête Démographique et de Santé 2016-2017 [Dataset], BUIR70FL. Bujumbura, Burundi: MPBGP, MSPLS, ISTEEBU, and ICF [Producers]. IFC [Distributor], 2017.

Ministerio de Salud Pública y Asistencia Social - MSPAS/Guatemala, Instituto Nacional de Estadística – INE/Guatemala, Secretaría de Planificación y Programación del la Presidencia – Segeplán/Guatemala, and ICF International. 2017. Encuesta nacional de salud materno infantil 2014-2015: informe final [Dataset], GUIR71FL. Rockville, Maryland, USA: MSPAS, INE, Segeplán and ICF International [Producers]. ICF [Distributor], 2017.

Ministerio de Salud y Protección Social y Profamilia. 2017. Colombia Encuesta Nacional de Demografía y Salud 2015 [Dataset], COIR72FL. Bogotá,Colombia: Profamilia/Colombia [Producers]. IFC [Distributor], 2017.

Ministry of Health and Sports - MoHS/Myanmar and ICF. 2017. Myanmar Demographic and Health Survey 2015-16 [Dataset], MMIR71FL. Nay Pyi Taw, Myanmar: MoHS and ICF [Producers]. ICF [Distributor], 2017.

National Institute of Statistics of Rwanda, Ministry of Finance and Economic Planning/Rwanda, Ministry of Health/Rwanda, and ICF International. 2016. Rwanda Demographic and Health Survey 2014-15 [Dataset], RWIR70FL. Kigali, Rwanda: National Institute of Statistics of Rwanda, Ministry of Finance and Economic Planning/Rwanda, Ministry of Health/Rwanda, and ICF International [Producers]. ICF [Distributor], 2016.

National Population Commission - NPC and ICF. 2019. Nigeria Demographic and Health Survey 2018 – Final Report [Dataset], NGIR7AFL. Abuja, Nigeria: NPC and ICF [Producers]. ICF [Distributor], 2019.

National Statistical Office - NSO and ICF. 2019. Papua New Guinea Demographic and Health Survey 2016-18 [Dataset], PFIR70FL. Port Moresby, Papua New Guinea: NSO and ICF [Producers]. ICF [Distributor], 2019.

National Statistical Office/Malawi and ICF. 2017. Malawi Demographic and Health Survey 2015-16 [Dataset], MWIR72FL. Zomba, Malawi: National Statistical Office and ICF [Producers]. ICF [Distributor], 2017.

National Statistical Service - NSS/Armenia, Ministry of Health - MOH/Armenia, and ICF. 2017. Armenia Demographic and Health Survey 2015-16 [Dataset], AMIR72FL. Yerevan, Armenia: NSS, MOH, and ICF [Producers]. IFC [Distributor], 2017.

Philippine Statistics Authority - PSA and ICF. 2018. Philippines National Demographic and Health Survey 2017 [Dataset], PHIR70FL. Quezon City, Philippines: PSA and ICF [Producers]. ICF [Distributor], 2018.

Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health - MOH/Tajikistan, and ICF. 2018. Tajikistan Demographic and Health Survey 2017 [Dataset], TJIR71FL. Dushanbe, Tajikistan: SA/Tajikistan, MOH/Tajikistan, and ICF [Producers]. ICF [Distributor], 2018.

Uganda Bureau of Statistics - UBOS and ICF. 2018. Uganda Demographic and Health Survey 2016 [Dataset], UGIR7BFL. Kampala, Uganda: UBOS and ICF [Producers]. ICF [Distributor], 2018.

United Nations, Department of Economic and Social Affairs, Population Division (2019). Interpolated female population by broad age group, region, subregion and country, annually for 1950-2100 (thousands). *World Population Prospects 2019*, Online Edition. Rev. 1.

United Nations, Department of Economic and Social Affairs, Population Division (2020). Estimates and Projections of Family Planning Indicators 2020. New York: United Nations.

United Nations, Department of Economic and Social Affairs, Population Division (2019). Total fertility by region, subregion and country, 1950-2100 (live births per woman). *World Population Prospects 2019*, Online Edition. Rev. 1.

Weinberger, M & Ross, J. (2016). The National Composite Index for Family Planning (NCIFP). Retrieved from http://www.track20.org/download/pdf/NCIFP%20Report%20(2016.8.11).pdf.

Zimbabwe National Statistics Agency and ICF International. 2016. Zimbabwe Demographic and Health Survey 2015: Final Report [Dataset], ZWIR72FL. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International [Producers]. ICF [Distributor], 2016.

Annex: 2017 NCIFP Questionnaire

IINTERNATIONAL FAMILY PLANNING

PROGRAM STUDY

NATIONAL COMPOSITE INDEX FOR FAMILY PLANNING

--2017 CYCLE—

____

Country

Conducted By

Avenir Health

QUESTIONNAIRE

NATIONAL COMPOSITE INDEX FOR FAMILY PLANNING

CHARACTERISTICS AND STRENGTH OF EFFORT

- This questionnaire is intended to provide internationally comparable information for nearly 85 countries. It concerns large-scale family planning programs, and it will update previous investigations of the characteristics and strengths of these programs.

- Throughout this questionnaire we refer to "the family planning program." In most countries there is only one large-scale program, and usually it operates under government auspices. The focus is on the national picture of family planning activities. If these are merged with maternal and child health activities please focus on the family planning aspects.

- The contents of the 2017 questionnaire has sections on the contents of the country's family planning plan or strategy, government collection of data to monitor the program's progress and accomplishments, data use for decision-making, quality of care guidelines, choice, equity, and accountability.

- Do not respond for pilot projects or small service networks. The focus is at the national level.

- Please do not complete questions for which you lack information – other respondents in your country may handle those. Please confer with other individuals as you wish, and answer the items simply in your personal capacity, giving your own best judgment. All responses are entirely confidential.

- Thank you for your assistance with this study.

FOR THE SURVEY ADMINISTRATOR (Skip if self-administering survey)

Hello, and welcome to the 2017 National Family Planning Composite Index (NCIFP) questionnaire. Please read the above guidelines and sign below indicating that you have read and understand the directions and explained them to the respondent.

Does the respondent agree to participate? Y N

Signature of survey administrator:___________________________________
Date:_____________________

INFORMED CONSENT

Hello, and welcome to the 2017 National Family Planning Composite Index (NCIFP) questionnaire. The 2017 NCIFP study is being conducted by Avenir Health/Track20 Project. The NCIFP estimates the strength of different components of the national family planning program, and is measured in over 80 countries around the world. The NCIFP provides a unique look at components of the family planning program that focus on a governments commitment to integrating a family planning program that prioritizes equity and the rights. The first NCIFP was done in 2014, the 2017 round is second time the data has been collected. It measures five different dimensions of an FP program: strategy, data use, quality of services, equity, and accountability. The scores are used by researchers around the world as a way of estimating programmatic strength.

The questionnaire is confidential and you will not be identified by name, position or institution in any reports or analyses of the results. No identifying information will be shared beyond the research team. Completion of this questionnaire is voluntary and you can choose not to answer any individual question or all of the questions. You can stop at any time. However, we hope that you will participate in this questionnaire since your views are important.

Will you participate in this study? Y N

At this time, do you have any questions about the questionnaire? Y N

This study is funded by the Bill and Melinda Gates Foundation

To give a summary picture of program effort, please answer the following questions. For some questions, you will be asked to respond with a yes/no, and if you respond yes, to provide a score for the same question. The score provides additional detail that allows you to rate the strength of the item.

For the score: 1 represents non-existent, which is equivalent to having responded "no". 2 represents very weak effort and 10 represents extremely strong effort.

Within each section there are some questions that only require a yes/no response and some that are only a scale. These questions are noted, but please read carefully.

Try to answer each item; omit it only if you lack information.

Description	1= Non existent to 10= Extremely strong									
	1	2	3	4	5	6	7	8	9	10
STRATEGY										
Does the National Family Planning Action Plan include defined objectives over a 5 to 10 year period, including quantitative targets?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Does the National Family Planning Action Plan include objectives to reach the poorest and most vulnerable groups with quality FP information and services?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Does the National Family Planning Action Plan include projection of the resources (material, human, and financial) required to implement the strategy, as well as sets forth a plan to secure the resources?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Does the National Family Planning Action Plan include a mechanism and funding to support meaningful participation of diverse stakeholders?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
For the following questions there is no yes/no response, please respond only using the scale.										
High level of seniority of the director of the national family planning program and whether director reports to a high level of government	1	2	3	4	5	6	7	8	9	10
Extent to which import laws and legal regulations facilitate the importation of contraceptive supplies or	1	2	3	4	5	6	7	8	9	10

extent to which contraceptives are manufactured locally	

Description	1= Non existent to 10= Extremely strong									
	1	2	3	4	5	6	7	8	9	10
DATA										
Does the government collect data from the private sector on commodities?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Is there a system of quality control for service statistics?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Are data used to ensure that the poorest and most vulnerable women and girls have access to quality FP services?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
For the following questions there is no yes/no response, please respond only using the scale.										
Extent to which systems for client recordkeeping, clinic reporting, and feedback of results are adequate	1	2	3	4	5	6	7	8	9	10
Extent to which program statistics, national surveys, and small studies are used by specialized staff to report on program operations and measure progress	1	2	3	4	5	6	7	8	9	10
Extent to which program managers use research and evaluation findings to improve the program in ways suggested by findings	1	2	3	4	5	6	7	8	9	10
Does the government collect data to monitor special sub-groups?	**This question only requires a scale response for each sub-group.**									
Youth	1	2	3	4	5	6	7	8	9	10
Unmarried Women	1	2	3	4	5	6	7	8	9	10
Unmarried youth	1	2	3	4	5	6	7	8	9	10
Postpartum women	1	2	3	4	5	6	7	8	9	10
Wealth Status	1	2	3	4	5	6	7	8	9	10

Post-abortion Clients	1	2	3	4	5	6	7	8	9	10
HIV Status	1	2	3	4	5	6	7	8	9	10

Description	1= Non existent to 10= Extremely strong									
	1	2	3	4	5	6	7	8	9	10
QUALITY OF SERVICES										
Are FP Standard Operating Procedures in line with WHO and used for determining areas of need for quality FP improvement?				Yes				No		
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Are there guidelines on task sharing of family planning services?				Yes				No		
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Are indicators for quality of care collected and used for public sector family planning services?				Yes				No		
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Are indicators for quality of care collected and used for private sector family planning services?				Yes				No		
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Are there structures in place to address quality, including participatory monitoring or community/facility quality improvement activities?				Yes				No		
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Does government collect information related to informed choice and provider bias?				Yes				No		
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
For the following questions there is no yes/no response, please respond only using the scale.										

Extent to which training programs, for each category of staff in the family planning program, are adequate to provide personnel with information and skills necessary to carry out their jobs effectively	1	2	3	4	5	6	7	8	9	10
Extent to which the logistics and transport systems are sufficient to keep stocks of contraceptive supplies and related equipment available at all service points, at all times and at all levels (central, provincial, local)	1	2	3	4	5	6	7	8	9	10
Extent to which the system of supervision at all levels is adequate (regular monitoring visits with corrective or supportive action)	1	2	3	4	5	6	7	8	9	10
Extent to which clients adopting sterilization are routinely informed that it is permanent?	1	2	3	4	5	6	7	8	9	10
Extent to which the entire population has ready and easy access to IUD removal	1	2	3	4	5	6	7	8	9	10
Extent to which the entire population has ready and easy access to Implant removal	1	2	3	4	5	6	7	8	9	10

Description	1= Non existent to 10= Extremely strong									
	1	2	3	4	5	6	7	8	9	10
Accountability										
Are there mechanisms in place at the national, sub-national, and facility level to monitor whether or not access to voluntary, non-discriminatory FP information and services is being achieved?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds (age, marital status, ability to pay), or coercion (including inappropriate use of incentives to clients or providers)?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Are violations reviewed on a regular basis?	Yes					No				
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Are there mechanisms in place at the facility level to solicit and use feedback from clients?	Yes					No				

If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10
Is there a system in place that encourages dialogue and communication between users and service providers/health officials about service availability, accessibility, acceptability and quality?				Yes			No			
If you responded yes, please rate:	1	2	3	4	5	6	7	8	9	10

Description	1= Non existent to 10= Extremely strong									
	1	2	3	4	5	6	7	8	9	10
Equity										
For the following questions there is no yes/no response, please respond only using the scale.										
Are there policies in place to prevent discrimination towards the following special sub-groups?	**Please respond for each sub-group**									
Youth	1	2	3	4	5	6	7	8	9	10
Unmarried Women	1	2	3	4	5	6	7	8	9	10
Wealth Status	1	2	3	4	5	6	7	8	9	10
Post-Abortion Clients	1	2	3	4	5	6	7	8	9	10
HIV Status	1	2	3	4	5	6	7	8	9	10
Extent to which service providers discriminate against special sub-groups?	**Please respond for each sub-group**									
Youth	1	2	3	4	5	6	7	8	9	10
Unmarried Women	1	2	3	4	5	6	7	8	9	10
Wealth Status	1	2	3	4	5	6	7	8	9	10
Post-Abortion Clients	1	2	3	4	5	6	7	8	9	10
HIV Status	1	2	3	4	5	6	7	8	9	10
Extent to which areas of the country not easily serviced by clinics or other service points are covered by CBD programs for distribution of contraceptives (especially rural areas)	1	2	3	4	5	6	7	8	9	10
Extent to which entire population has ready access to voluntary sterilization services for women	1	2	3	4	5	6	7	8	9	10

Extent to which entire population has ready access to voluntary sterilization services for men	1	2	3	4	5	6	7	8	9	10
Extent to which entire population has ready and easy access to IUDs	1	2	3	4	5	6	7	8	9	10
Extent to which entire population has ready and easy access to implants	1	2	3	4	5	6	7	8	9	10
Extent to which entire population has ready and easy access to condoms	1	2	3	4	5	6	7	8	9	10
Extent to which entire population has ready and easy access to pills	1	2	3	4	5	6	7	8	9	10
Extent to which entire population has ready and easy access to injectables	1	2	3	4	5	6	7	8	9	10

Final Questions:

Name ___________________________________

Job Title _________________________________

Sector (for example, private, public, international, NGO, donor, academic, etc): ______________

Gender   M   F   Other

Have you filled out the NCIFP Survey before? __ Yes   __ No

We would like to disseminate the results to you when they are finalized. Please list an email address where we can reach you:____

Please note here any contraceptive methods not listed in this questionnaire that are growing in importance in your country or national family planning program.
____

____

You were invited to work with other individuals if you wished.

How long have you been closely acquainted with the national family planning program? _________ years

During most of this time, what has your relationship been to the program?

Any final comments or suggestions?

____