Using the National Composite Index for Family Planning (NCIFP) to Assess Quality, Equitable, Accountable, and Rights-Based Programming

Policy and Program Implications on FP2020 Commitments

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Abstract

The National Composite Index for Family Planning (NCIFP) was developed by the Global FP2020 Partnership (FP2020) to assess the policy and program environment for high-quality, accessible, and rights-based FP services. First used in 2014, the index is based on five dimensions: strategy, data, quality of care, accountability, and equity. This study assesses 2014 and 2017 NCIFP scores of three developing countries (Nigeria, Haiti and India) in the context of their commitments to FP2020. The three were selected to represent three stages of the S-curve concept that FP2020 uses to guide countries in the transition from low to high modern FP prevalence: Nigeria (low FP use), Haiti (mid-level prevalence with potential for rapid growth), and India (high prevalence). The analysis identifies activities that are progressing well or remain challenging with regards to country commitments. The NCIFP also specifies non-commitment issues that can affect the achievement of country commitments and broader objectives.

Key words: Family planning (FP), NCIFP, reproductive health (RH), FP2020, commitments, London summit, Nigeria, Haiti, India, FP strategy, action plan, quality (QOC), accountability, equity, monitoring tool, evaluation, rights-based

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

Background and Objective

In July 2012, a coalition of governments, civil society groups, international development assistance organizations, private sector entities, and academic and research institutions met in London to launch the Global FP2020 Partnership (commonly known as FP2020) to work together to address the most challenging barriers to expanding access to family planning (FP) services. FP2020 is a critical component of global efforts to achieve universal access to sexual and reproductive health (RH) services and rights by 2030, as specified in the United Nations (UN) sustainable development goal (SDG) of improving the health of women, children, and adolescents.

FP2020 emphasizes an enabling environment for FP through program development and implementation that aims to enable all individuals to choose whether, when, and how many children to have, and to act on their choices through improved access to high-quality reproductive health (RH) information, education and services free from discrimination, coercion, and violence (http://www.familyplanning2020.org/rightsinfp). Developed to support FP2020, the National Composite Index for Family Planning (NCIFP) measures the existence of FP policies, plans, and structures that affect quality of care, choice, accountability, and equity. In addition, the NCIFP includes questions on data collection and utilization for monitoring/evaluation and regarding rights-based concerns. Information on these program dimensions is not readily available from service statistics regularly collected by health ministries or periodic population-based demographic and health surveys (DHSs). FP2020 Working Groups, composed of representatives of national and international FP/RH organizations, guided Avenir Health's Track20 Project in tool development and analysis.

This study examines the 2014 and 2017 NCIFP scores of three countries -Nigeria, Haiti, and India - to point out progress, downturns, and gaps in national efforts to ensure high-quality services, reach vulnerable sectors of the population, and make rights-based FP programming a standard practice. The NCIFP results are analyzed in reference to each country's FP2020 commitments. The study illustrates a way of using NCIFP results and encourages national FP stakeholders to adapt the approach in their efforts to improve the program environment for FP services in their own countries.

Defining NCIFP Dimensions and Individual Components

The NCIFP is based on 35 items that fall under five key dimensions of an enabling FP program environment and a rights-based approach: strategy, data, quality, accountability, and equity.

Strategy - whether the FP plan includes quantified objectives, targets to reach the poorest and most vulnerable with high-quality services, projections of resource requirements, and support for diverse stakeholder participation. Strategy also includes two items that affect plan implementation: high-level program leadership and regulations that facilitate the importation or production of contraceptive supplies.

Data - whether the government collects information on private sector commodities and special sub-groups (e.g. the poor) and uses data to ensure that the most vulnerable have access. It also includes quality control of service statistics, data-based monitoring and evaluation, and management use of research findings to improve the program.

Quality of care (QOC) - whether facilities and providers have guidelines and capabilities to provide high-quality, scientifically based and medically appropriate information and services to enable individuals to

decide on options that best meet their needs. QOC items also involve the use of WHO standards of practice (SOP), task-sharing guidelines, and QOC indicators in public and private facilities. It also considers the existence of community structures to address QOC and the adequacy of structures for training, logistics, supervision, IUD and implant removal, and informed choice by monitoring provider bias and informing clients about the permanence of sterilization.

Accountability – whether the health system takes responsibility in safeguarding reproductive rights through mechanisms that exist to enable clients to make choices voluntarily and structures that are in place to review violations, report denial of services due to non-medical grounds, solicit and use feedback from clients at the facility-level, and encourage client-provider forums.

Equity - whether anti-discrimination policies exist, providers discriminate against certain population sub-groups, services are provided to underserved areas and populations through community-based distribution (CBD), and all sectors of the population have easy access to modern contraceptive methods (which includes short term methods (STMs), meaning short-term methods, and long-acting permanent methods (LAPMs) comprised of LARCs, meaning long-acting reversible contraceptives, and PM referring to permanent methods).

The NCIFP builds on the Family Planning Effort Score (FPES) that has been regularly applied to developing countries starting in 1972 to measure the extent of implementation of specific program activities, to diagnose program weaknesses and advocate for program strengthening, and to show gains that could result from improvements (Lapham and Mauldin, 1972 and 1985; Ross and Smith, 2011). Ross (2002) used the FPES of four widely available modern methods as a measure of FP access. Other studies analyzed the FPES in relation to increasing contraceptive use and declining fertility rates and to distinguish the effects of FP programs independent of the social settings of which they are a part (Freedman and Berelson, 1976; Bongaarts, Mauldin, and Phillips, 1990; Ross and Stover, 2001).

FPES and NCIFP questionnaires were fielded jointly in 90 countries in 2014 by Avenir Health and Palladium Group (See Kuang and Brodsky, 2015 for the 2014 FPES report; and Weinberger and Ross, 2015 for a report on NCIFP development and 2014 results). In 2017, Track20 conducted the second round of NCIFP data collection based on lessons learned from 2014 to simplify the 2017 questionnaire. Data collection in each participating country was managed by a local/regional consultant who provided questionnaires to 10-15 respondents identified by local contacts as FP policymakers, managers, leaders, and professionals. FP experts included the following:

a) government officials, managers, and decisionmakers - current heads or senior members of the national FP programs, the RH division of the health ministry/department, population or family health councils/commissions/directorates, and parliamentary/legislative committees involved in FP/RH, rights, youths, gender and related social issues;

b) private sector leaders and officers of local medical/health societies, NGOs, and women's groups that provide FP and/or reproductive health information, advocacy, and/or services;

c) resident staff of international development organizations especially the UNFPA, USAID, WHO, DFID, EU, World Bank, and regional population/development bodies;

d) faculty and researchers of universities and population survey or statistics institutions who have been involved in studies and evaluations of their national FP programs; and

e) former population/health policymakers and government officials, along with retired researchers and private sector leaders who remain knowledgeable about the FP program.

The 2017 NCIFP research team reached out to contacts in the 69 FP2020 priority countries (the world's poorest in 2012) and 30 other countries that participated in the 2014 FPE/NCIFP effort and earlier FPE studies. A total of 86 and 84 countries took part in the 2014 and 2017 rounds, respectively. In both cycles, most respondents opted to self-administer the questionnaire to allow themselves more time in responding.

The 2017 NCIFP questionnaire used yes-no questions followed by a 1-10 rating scale. Future data collection and analysis will use the 2017 format, but to enable assessment of 2014-17 trends, the present study uses scores based on the 2014 yes-no approach, hence a maximum score of 100. The scores for each country, converted into total and dimension scores, reflect the averages of responses given by FP experts.

This paper focuses on three priority FP2020 countries - Nigeria, Haiti, and India- that also made specific commitments to the Global FP2020 Partnership. They were purposely selected for this analysis to represent countries along an S-shaped gradient that proceeds from low-to-high levels of modern FP use. The three countries' differing socio-demographic attributes also help demonstrate the applicability of the NCIFP to countries of varied population-development characteristics.

Framework: Incorporating NCIFP Concerns into the S-concept in Contraceptive Transition

Global historical data indicate that modern contraceptive prevalence (mCPR) grows in an S-shaped pattern (upper box of Figure 1). Stage 1 is characterized by low mCPR, slow growth and little annual change. Stage 2, the middle phase, provides an opportunity for rapid growth during the transition from low to high mCPR. Stage 3 is typified by high mCPR level and slow growth. While all countries go through this general pattern, the duration and speed of growth in each stage vary[1].

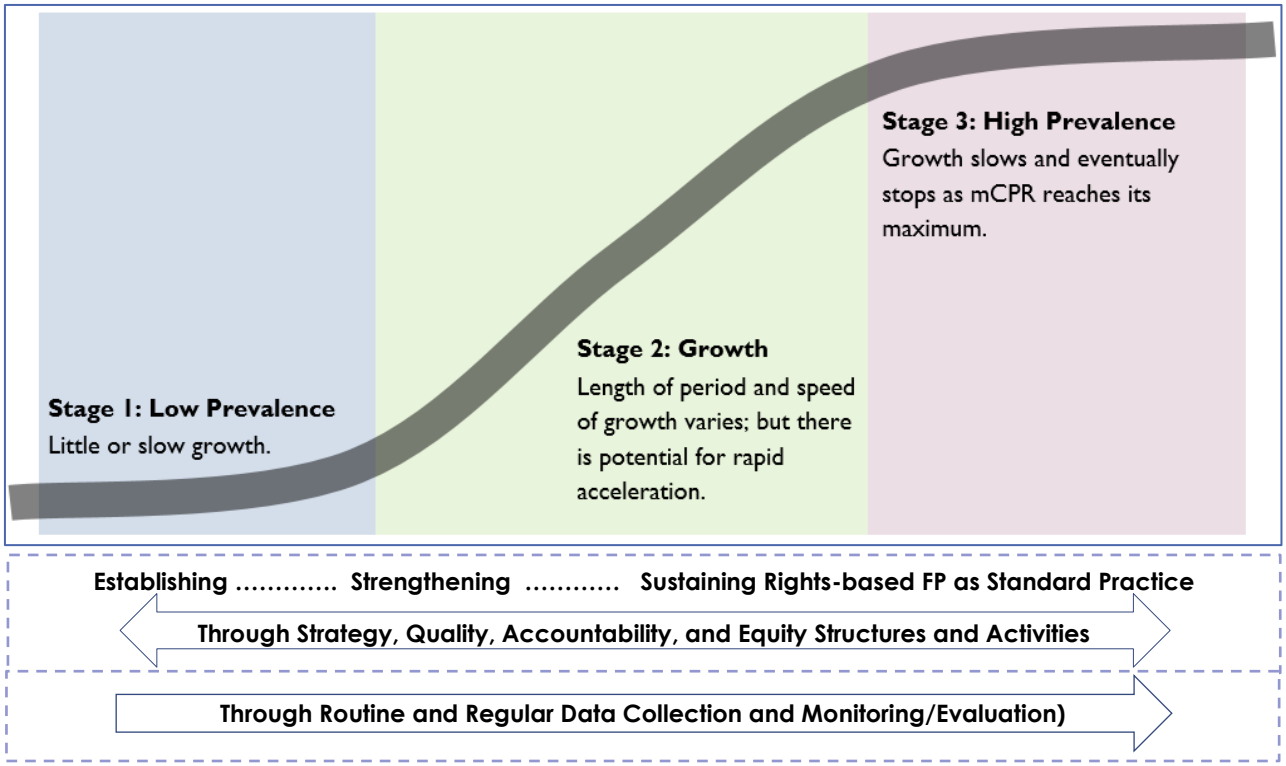
FP2020 uses the S-curve concept to guide countries in assessing and developing program priorities in the transition from low to high mCPR. Countries at Stage 1 (lower end of the curve) should focus on information provision, demand-generation, and changing social norms as well as establish and improve provider and physical infrastructure for FP services. Expectation of rapid mCPR growth at Stage 2 entails that barriers to access, choice, and high-quality services be identified and addressed even as efforts to generate demand and respond to unmet needs continue. As countries achieve higher mCPR and growth slows down (Stage 3), priorities should ensure that no groups are left behind and program sustainability is warranted through various public and private financial mechanisms.

This paper emphasizes the NCIFP's five dimensions within the S-concept. Four dimensions - strategy development, quality of care, equity, and accountability (middle box of Figure 1) – should be established and strengthened while emphasizing the most vulnerable and a rights-based approach at all stages and toward program sustainability. Moreover, program activities should be supported by regular data

[1] http://www.track20.org/pages/data_analysis/in_depth/mCPR_growth/s_curve.php

collection and assessment of past and current efforts (Figure 1 lowest box) to assess progress, learn lessons from the past, develop appropriate strategies, and guide implementation.

Figure 1. The S-Curve Concept and the Cross-cutting Emphasis on Rights-based FP



Efforts focusing on informed choice, quality of care, and access to safe, effective contraception are not new. FP policies and plans of developing countries all over had been citing these concerns for decades. FP2020 aims to build on country initiatives as well as revitalize the 1994 International Conference on Population and Development (ICPD) agenda which emphasizes human rights principles as the foundation of all FP activities and critical to making FP programs more people-driven, effective, accessible, and sustainable.

Background Characteristics of Three Countries

Table 1 displays population, economic, and FP characteristics of the three countries based on the latest available data. India with 1.4 billion total population and Nigeria with 206 million in 2020; both rank as the world's second and seventh most populated countries (UN, 2019). Haiti's total population is estimated to be about 11 million in 2020.

Economic statistics (World Bank, 2020) show that Haiti's GDP contracted in 2019 after posting positive growth in recent years that in turn reversed negative trends in past decades. Nigeria's GDP grew moderately compared to India's rapid expansion. Haiti's GDP per capita was much lower than those in the two other countries. Extreme poverty ratios (% of the population living on just $1.90 a day), however, indicate that the problem affects all three countries, although in varying degrees, with 22% for India, Haiti at 24%, and a very high 39% for Nigeria (the estimated global average was 3%).

Regarding the total fertility rate (TFR), India is approaching the replacement level of 2.1 lifetime births per woman. The latest global estimates for the 2015-2020 period (UN, 2019) averaged 2.6 TFRs for less developed regions and 4 for the least developed. Historical trends show that as

Table 1. Selected Demographic and Economic Indicators of Three Study Countries

Indicators *	Nigeria	Haiti	India
Demographic and Socio-economic Characteristics			
2020 total population, in millions (UN 2019)	206.1	11.4	1,380.0
• % Population age 0-14	44	33	26
• % Population age 15-24	19	19	18
Annual GDP growth in % (World Bank 2019 estimate)	2.2	-0.9	5.0
GDP per capita, current PPP (World Bank 2019)	5,348	1,850	7,034
Poverty headcount at $1.90 a day, % of pop. (World Bank)	39 (2018	24 (2012)	22 (2011)
Nurses/midwives per 10,000 population (WHO)	14.5 (2013)	6.8 (2018)	21.1 (2017)
% Women 15-49 who cited big problems in accessing treatment (DHS)	52	78	58
Maternal mortality ratio (or pregnancy-related deaths per 100,000 live births,WHO 2017)	917	480	145
Infant mortality rate (IMR or infant deaths per 1000 live births, UNICEF et al, 2018)	76	50	30
• IMR among babies born to mothers <20 years old	85	72	36
• IMR among babies born <2 years after a previous birth	95	90	44
Fertility and Family Planning Characteristics			
Total fertility rate (lifetime births per woman by age 50)	5.3	3.0	2.2
Modern contraceptive prevalence rate (MCPR), all women ages 15-49	11	22	38
MCPR among married women (MW) ages 15-49	12	32	48
• Rural/urban	8/18	31/33	46/51
• Lowest/highest wealth quintiles	4/22	28/28	36/53
Unmet need for modern FP (%) among MW ages 15-49	23	40	19
• Rural/urban	20/27	42/37	19/18
• Lowest/highest wealth quintiles	18/28	46/34	22/18
Young women ages 15-19			
• % who have begun childbearing	19	10	8
• % MCPR	2	25	10
• % with unmet need for modern FP	13	56	27

*Fertility and FP data are from DHSs for India (2015-16), Haiti (2016-17) and Nigeria (2018) at www.dhsprogram.com; economic statistics are from www.data.worldbank.org; health data are from https://www.who.int/topics/statistics/en/; all accessed in 2020.

fertility rates decline from very high to much lower levels, the percentage of the population in the youngest ages falls. At present, only a quarter of India's total population belong to the young dependent ages (below 15 years) compared to much larger proportions in the other two countries.

Although the proportion belonging to the youngest ages in India is lower than in the other two countries, the sheer number of individuals represented is daunting. Over 350 million children below age 15 currently require health care, nutrition, and education. A significant segment of this group will enter the childbearing ages in a few years. At present, 18% of India's population belong to the 15-24 age group, or almost 250 million young adults, of which about half are women in the youngest childbearing ages.

Haiti's TFR fell from over 5 in the 1990s to around 3 at present, a level midway between those of India and Nigeria. By contrast, Nigeria persists with its TFR of 6 in 1990 and 5.3 in 2018, one of the world's highest. Persistent high fertility levels mainly account for Nigeria's very young age structure, with almost 45% of the population below 15 years of age compared to a lower 33% for Haiti.

Despite some favorable demographic trends, Haiti faces numerous population-development challenges. Just like Nigeria, Haiti, must ensure access to basic nutrition, health, and education services among the youngest segments of the population. Both countries also must invest in training and employment for their work force, including young adults (ages 15-24) that comprise nearly one-fifth of their total populations. Like India, the two countries must consider that approximately half of young adults are women who will require maternal health services once they start childbearing.

Access to health services, however, is often limited in most developing countries. WHO estimates the nurses/midwife ratio per 10,000 population at 21 in India, 14 in Nigeria, and only 7 in Haiti. DHS household surveys reported that nearly 60% of women in India, 52% in Nigeria, and almost 80% in Haiti cited limited access to medical treatment for family members. The most common reasons given were lack of funds and distance to the facility. The data further showed access was even more pronounced among rural residents and the poorest in the three countries.

Table 1 also shows maternal mortality ratios (MMRs) and infant mortality rates (IMRs). High pregnancy-related deaths reflect inequalities in access to quality health services including between rich and poor women. The MMR in low-income countries in 2017 was 462 per 100,000 live births versus 11 per 100,000 in wealthy countries (WHO et al. 2019). Averaging many more pregnancies than women in the developed world, women in less developed countries have higher lifetime risk of dying due to pregnancy, with complications in pregnancy and childbirth even more elevated among girls age 10-19. Early childbearing also puts infants at great risk. Globally, the 2018 IMR was 29 deaths per 1000 live births. India approximates the global average but much higher IMRs in Haiti and Nigeria. Babies born less than 2 years after a previous birth face even greater mortality risks; this was more pronounced in Haiti and Nigeria where IMRs were more than double that of India.

The factors that affect a woman's exposure to the risk of childbearing include age at marriage (referring to both legal as well as consensual unions) and contraceptive practice. International studies give evidence that modern contraceptive use is most effective in preventing pregnancy. Table 1 shows modern contraceptive prevalence rates (mCPRs) among all women and those currently married ages 15-49 in the three countries, with levels in India consistently the highest and Nigeria the lowest. Nigeria's mCPR among married women in 2018 (12%) was not much higher than its mCPRs of around 10% from 2008 to 2013. Although levels vary, recent trends also indicate slowdowns in the two other countries. Haiti's mCPR of 32% in 2016-17 among currently married women hardly varied from the 2012 rate, a reversal

of significant gains during the 2000s. India's mCPR among married women remained below 50% between 2005-06 and 2015-16.

Detailed mCPR results reveal pronounced disparities between population sectors in India and Nigeria where rural residents and the poorest have much lower mCPRs compared to their urban and wealthiest counterparts. The MCPRs among the youngest married women were also lower in Nigeria (2%) and India (10%) compared to that of Haiti (25%)

Contraceptive use is influenced by the availability and quality of services, socio-economic environments and norms, family situations, and individual needs and constraints. Some women who are at risk of becoming pregnant want to space or limit childbearing but are not using modern contraceptives; in FP lexicon, they have unmet needs for modern FP. Unmet need was 19% among currently married women of India, the lowest of the three countries. Unmet need rates among married women ages 15-49 in India's rural and urban areas approximated the national level 19%), slightly higher among the poorest (22%), but much more elevated (27%) among teenagers age 15-19.

Unmet need among married women was 40% in Haiti in 2016-17. The need was even more pronounced among women in the youngest ages of 15-19, the lowest wealth quintiles, or rural areas. Nevertheless, Haiti has significant potential for rapid acceleration in MCPR *if* services are more accessible and responsive to unmet FP needs, including those of the most vulnerable populations.

Unmet need in Nigeria was 23% among married women, 28% in the highest wealth quintile vis-a-vis 20% in the lowest, and nearly similar levels, respectively, between urban and rural residents. The relative higher demand for FP services among richer or urban women in Nigeria suggests loosening traditional values in more modern settings. As late as 2018, large family size remains highly valued; mean ideal family size was still about 6 or higher among women across socio-economic groups and ages, including adolescents. Unmet need was only 13% among Nigerian females age 15-19. The 2018 DHS also showed nearly 20% of teenage girls were already mothers or pregnant with their first child. This included 44% of teenagers with no education who had begun childbearing. Teen-age pregnancy is associated with high maternal and child morbidity and mortality along with poor social outcomes such as dropping out of school and limited productivity that help fuel a continuing cycle of poverty (https://www.who.int/maternal_child_adolescent/adolescence/en/).

The countries on which this paper focuses - Nigeria, Haiti, and India - are priority countries for FP2020 assistance and are among the world's poorest. The three countries have also made specific commitments to the Global FP2020 Partnership. In terms of the S-curve concept, Nigeria is typical of countries in Stage 1, Haiti belongs to Stage 2 countries, and India is now in Stage 3. Overall, the three countries have marked economic-demographic differences but also share similar challenges, including still low modern contraceptive use among the most vulnerable sectors of their populations.

NCIFP Results for 2014 and 2017

Global NCIFP results (Table 2) provide reference for the ratings of the three countries. The total score (unweighted) for over 80 countries that participated in the 2014 round was 52.7 or about half of the maximum possible (Weinberger and Ross, 2015). The global total rose to 65.0 in 2017 (See Sonneveldt 2018 and Williamson 2018 for preliminary reports; Rosenberg, 2020 for the global study).

As Table 2 also shows, the Strategy dimension, averaging 61.2 in 2014 and 74.3 in 2017, improved the most and was the highest ranked during the two years. This is expected as countries all over, especially

priority FP2020 countries, have developed or updated their national FP strategies and plans. Much improved global averages for Data and Quality made the two dimensions rank next to Strategy in 2017. These two dimensions outscored Equity as its global average minimally increased from 57 in 2014 to 61 in 2017. On the other hand, Accountability persisted as the lowest rated in both years even though its score rose from 39 to 60 during the three-year span.

Table 3 shows total and dimension NCIFP results of the three countries. The total scores for India and Nigeria rose from the 50s in 2014 to over 60 in 2017, with both counties averaging higher in all five dimensions. Haiti had the opposite trend; its total score fell from 62 to 57. Dimension rankings of the three countries mirrored global results to some extent, with Strategy the highest rated and Accountability the lowest. Just like the global trend, the Equity dimension's averages for Nigeria and India registered the smallest increments compared to those of the other dimensions. Haiti differed: stagnant dimension averages for Strategy and Data, but falling for Quality, Accountability, and Equity. Haiti's most sizable decline involved Equity.

Table 2. Global Total and Dimension NCIFP Scores, 2014 and 2017 (Unweighted)[2]

	Strategy	Data	Quality	Accountability	Equity	TOTAL
2014	61	52	53	39	57	53
2017	74	64	64	60	61	65
+ or - Change	13	12	11	21	4	12

Table 3. Total and Dimension NCIFP Scores, Three Country Results, 2014 and 2017

Country and year		Strategy	Data	Quality	Accountability	Equity	TOTAL
Nigeria	**2014**	70	46	49	30	50	50
	2017	83	66	62	39	58	62
	+ or - Change	13	20	13	9	8	12
Haiti	**2014**	67	62	66	40	65	62
	2017	67	62	59	37	53	57
	+ or - Change	0	0	-7	-3	-12	-5
India	**2014**	69	53	46	47	61	54
	2017	81	60	64	54	62	64
	+ or - Change	12	7	18	7	1	10

[2] The 2014 and 2017 global data in Table 2 are based on information from over 80 countries that participated in each data collection effort. Rosenberg's global report (2020) focuses on 72 countries that participated in the 2014 and 2017 studies. While the number of countries varied, only one point separated the totals and averages for each dimension between the two studies.

Country Commitments as Background for Specific NCIFP Ratings

This paper refers to each country's FP2020 pledges in assessing specific NCIFP rating levels and trends. FP2020 member countries formally made financial, policy, and programmatic commitments to achieve their respective FP2020 objectives and contribute to the international goal of expanding access to contraception. Pledging countries also regularly review and update their respective FP2020 commitments and plans. India and Nigeria were among the first pledging countries as FP2020 was launched in 2012; both have since updated their country commitments. It was only in 2017 that Haiti specified its commitments. Documents related to country pledges are available in the FP2020 website (https://www.familyplanning2020.org/countries).

The first two NCIFP questions ascertain whether the national action plan has objectives that (1) are defined, time-bound, and quantified, and (2) aim to reach the poorest and most vulnerable groups with quality services. Relevant objectives of the three study countries are presented in the header rows of Tables 4, 5, and 6. The first entry in each header row specifies the country's contribution to the global FP2020 goal of increasing FP use. The second entry shows that each country aims to reach youths, the poorest, disadvantaged, and hard-to-reach groups. Haiti and Nigeria additionally focus on humanitarian crisis populations. India prioritized two other groups: populations in high-fertility areas that account for large shares of national maternal and infant mortality statistics, and newly married couples considering the large magnitude of young adults in the country.

The analysis regarding each country – starting with Nigeria (at S-curve Stage 1), followed by Haiti (Stage 2), then India (Stage 3) - consists of two parts. The first goes over commitments that are categorized according to relevant NCIFP dimension and component activities. Country pledges are given in detail rather than consolidated into one common thrust, for example, specific funding initiatives are cited instead of lumped into one category "increase funding".

The categorizations should be qualified as primarily the author's interpretations. Broadly stated commitments, especially in the case of Data, that could not be categorized according to NCIFP items are italicized pending more information. Certain commitments could also fall into more than one NCIFP issue, for example, efforts supporting informed choice can fall under Quality or Accountability, but a commitment statement emphasizing voluntariness is placed under Accountability. While a pledge to expand LARC or LAPM services falls under Equity, IUD and implant removal services (under Quality) are also highlighted as commitments, even if not explicitly mentioned in commitment documents, because these method-reversibility procedures are important components of high-quality services.

Overall, the results of the categorization (Tables 4, 5, and 6) show each country with several Strategy, Quality and Equity pledges but only a few Data commitments. Accountability commitments were rarer.

The second part of the country analysis deals with 2014 and 2017 NCIFP results which are shown in Figures 2, 3 and 5. Each graph highlights NCIFP items that are country-specified commitments or that are relevant to specific pledges. The analysis compares NCIFP score levels and trends vis-à-vis commitments. Salient rights-related issues are pointed out, as well as NCIFP results that have bearing on efforts to reach vulnerable populations.

Nigeria

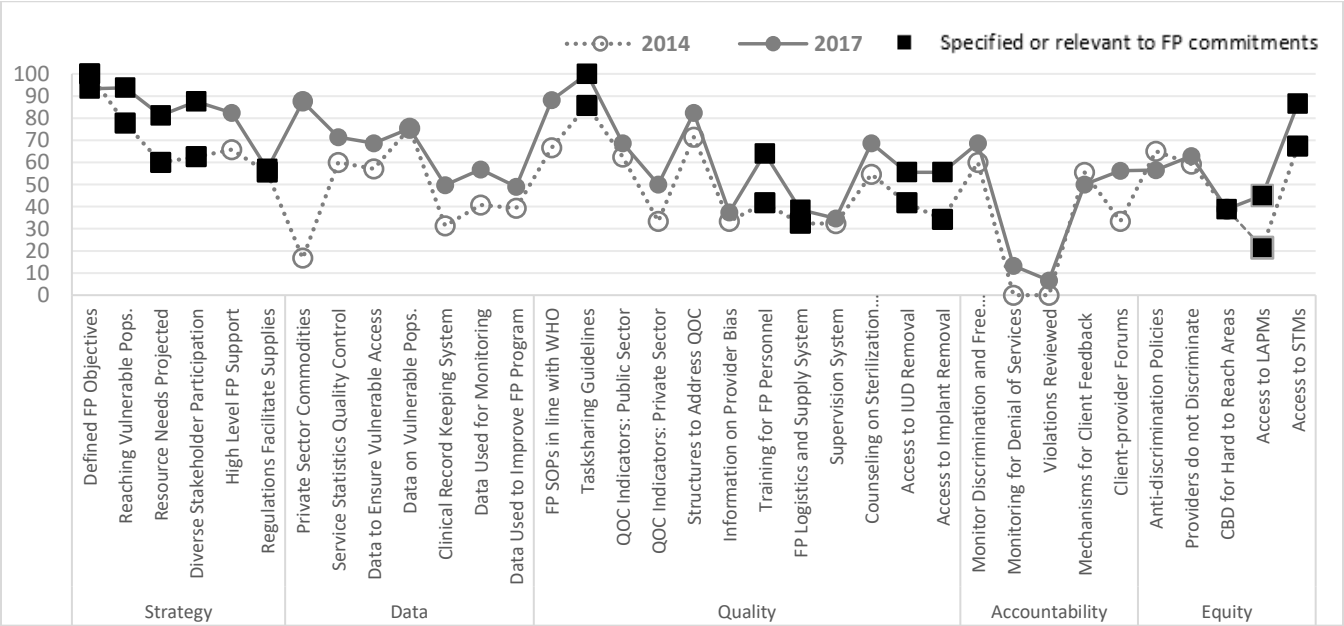
Commitments: Strategy-related pledges (Table 4) that are finance-related involve contraceptive procurement for the public sector, increased federal and state government funding through mechanisms

such as health insurance to make household expenses for FP reimbursable in the public and private sectors, and reducing contraceptive costs by removing regulatory barriers. Strategy commitments also aim to reform the national and state costed implementation plans (CIPs) by incorporating emerging issues such as a rights-based approach and FP provision in humanitarian situations. Efforts also include broadening stakeholder participation by working with government agencies and nongovernment entities to improve the youth's access and to change norms such as the preference for large families and women's lack of decision-making power (https://www.familyplanning2020.org/sites/default/files/CIP_Nigeria.pdf).

Table 4. Summary of Nigeria's FP2020 Commitments

Objective: Increase all women mCPR to 27% **Target Groups: Youths, populations who are disadvantaged, the poorest, hard-to-reach, and in humanitarian crisis**				
Strategy	**Data**	**Quality**	**Accountability**	**Equity**
• Increase govt. allocation for contraceptive procurement • Work with donors, state govts. and health insurance to reimburse households for FP expenses in the public and private sectors • Revise national and state blueprints and CIPs to include rights-based approach and FP in humanitarian situations • Remove import duties to reduce FP costs • Work with NGOs, the private sector, civil society orgs., traditional leaders and religious groups, community structures and ward committees • Work with Ministries (esp. Education and Youth) to update Strategic Plan and improve the youth's access • Remove import duties and other regulatory barriers	• *Track domestic resources and expenditures (More information needed on specifics esp. priority groups and rights-based issues)*	• Expand task-shifting to improve access of hard-to-reach and disadvantaged populations • Strengthen the logistics system • Train community health workers to provide various methods, especially LARCs		• Remove regulatory barriers to access • Increase the number of health facilities • Scale up FP provision in the public and private sectors • Support social marketing and CBD • Expand access in remote areas

Figure 2. Scores of Specific NCIFP Items, Nigeria, 2014 and 2017



Nigeria's sole Data-related commitment aims to track and document domestic resources and expenditures. Quality pledges include reforming task-shifting policy implementation, training health providers (especially community workers), and improving the logistics system. To date, Nigeria did not make a pledge along Accountability items specified in the NCIFP. This could change as proposed CIP revisions are envisioned to incorporate rights-based data to identify areas for acceleration. To improve Equity, Nigeria pledged to expand contraceptive access and choice by removing regulatory barriers to new methods, scaling up the provision of new methods including LARCs in the public and private sectors, strengthening CBD in hard-to-reach areas, and supporting social marketing.

NCIFP Results. Figure 2 shows that Nigeria's scores for most items either improved or remained high[3]. This is especially so under Strategy where nearly all items scored at least 80 in 2017, including perfect ratings for quantified national objectives. This is welcome news since nearly all NCIFP Strategy items are relevant to the country's FP2020 commitments. It should be noted, however, that the mark for regulations facilitating contraceptive importation remained in the mid-50s, raising concerns about negative effects on supply and in turn the population's choice and access.

Nigeria did not make any Data commitment specific to what the NCIFP measures, but Figure 2 shows increasing scores for most Data items. The biggest increment in NCIFP rating involved government collection of data on private sector supplies (rated 88 in 2017). Although scores improved for clinic recordkeeping/results-reporting back to clients and management use of research findings to improve the program, 2017 levels were still around 50.

The country's sole Data pledge focuses on tracking domestic resources and expenditures which closely aligns with several Strategy commitments involving funding. More information is needed on what the tracking activity covers, particularly what are actually funded, inputs used and activities undertaken to reach underserved areas, and who benefits.

All individual Quality ratings improved but resulting 2017 marks varied. Scores were about 90 or higher for the use of WHO standard operating procedures (SOPs) and tasksharing (the latter is a commitment item to enable community health workers to serve those in hard-to-reach areas.). Ratings in the low 80s followed for clinic/community structures to address QOC, an item that refers to local clinic initiatives as well as the key role Nigerian women's groups play in RH campaigns. Scores ranged in the 60s for the training system (a commitment item), and two non-commitment items: sterilization counseling and the use of QOC indicators in the public sector. By contrast, the score regarding the use of QOC indicators in the private sector was 50. Ratings were in the upper 50s for access to IUD and implant removal, both of which are important components of Nigeria's pledge to improve providers' LARC capabilities.

Some of the lowest Quality ratings, in the 30s, went to logistics (a commitment item cited in several sections of the country's FP2020 document). Low scores also went to two non-pledge items: the supervision system and government collection of information to monitor informed choice and provider bias. The low rating for this last item seems to differ from 2018 Nigeria DHS results showing that about 70% of current modern users stated they were informed about possible problems with the contraceptives they were using or what to do if experiencing side effects. Over 80% also responded that they were told

[3] The global 2014 and 2017 reports show most African countries with higher NCIFP scores than those in the other regions. The Africa pattern may reflect experts seeing notable actual progress in national program efforts, in part due to international initiatives such as the Ouagadogou Partnership and multi-lateral FP2020 partners working to revitalize FP programs in the continent with the highest fertility rates, the most rapid natural increase, and the poorest economic indicators in the entire world.

about other methods. Of the three countries, Nigeria had the largest percentages of current users who responded positively to questions about information on modern methods.

Although Nigeria did not make any Accountability pledge, its 2017 marks for individual items were relatively high, including 60s to the 70s for structures in place to ensure that FP choices are voluntary, to enable client-provider dialogues, and to solicit facility-level feedback. On the other hand, scores were only 15 or below regarding the existence of mechanisms to review violations and report denial of services based on non-medical grounds. These two items were the lowest rated across all NCIFP items and point to the need for the health system to build ownership and trust in FP services given very low FP acceptance among adolescents and disadvantaged groups in the country.

Nigeria made several Equity commitments; its NCIFP scores relevant to these commitments varied widely. The rating for access to short-term methods (STMs) rose to 86 in 2017 (likely taking into account government efforts to improve choice for young people and couples still in the family formation process considering that desired family sizes remain high). By contrast, the score improved only to the 40s for LAPM access (although the country's commitment focuses only on LARCs) but remained below 40 for CBD coverage, a pledge item that involves tapping community resource persons to provide services in hard-to-reach areas and among disadvantaged groups. These two low-scored items reflect concerns about barriers such as distance to facilities, time, and convenience that affect access to information and services, acceptance, and choice. On the other hand, the 2017 scores for two non-commitment items involving anti-discrimination efforts were about 60 (despite a slight decline for discrimination policies that are in place).

Overall, Nigeria's many high and rising NCIFP scores allude to positive steps the country has taken to achieve its FP2020 objectives. The results also indicate several areas that need more work, such as regulations affecting contraceptive importation, the logistics and supervision systems, mechanisms to monitor provider bias along with various accountability mechanisms, access to LAPM services, and CBD coverage. Improving key program dimensions is critical in building demand considering that mCPRs remain low in the country, most epecially among the most vulnerable.

Haiti

Commitments. Among the world's poorest and considered a priority FP2020 country since the Partnership started, Haiti specified its commitments to FP2020 in 2017, the same year that the 2017 NCIFP was conducted. As such, the country's commitments refer to important challenges the country faces, including some of the problems that NCIFP results point out.

Haiti's Strategy pledges (Table 5) focus on resource mobilization through the creation of a national budget line item for FP and contraceptive procurement, along with forming a high-level inter-ministerial committee to support resource-generation and monitor FP allocations. The government also plans to strengthen implementation of the Strategic Plan for Youths and Adolescents and create an adolescent RH intersectoral platform.

The country's sole Data commitment involves designating Ministry of Public Health (MPH) staff that will manage raw FP data at the system level. This is one key step of the government's efforts to rebuild Haiti's health information system that has been decimated in recent years by natural disasters and political turmoil. Relevant issues that should be considered include what FP data will be managed and types of staff to be involved along with tasks to be undertaken, including steps intended to foster data utilization in program monitoring and development.

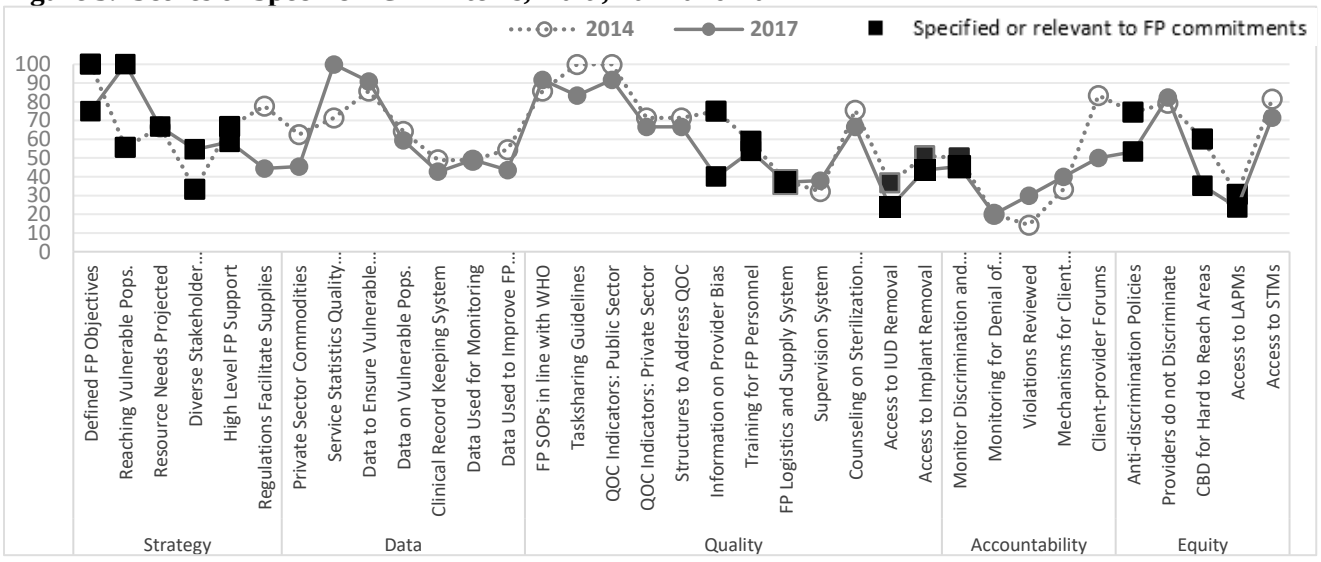
Haiti's Quality commitments include revising national FP standards by incorporating a module on rights/respect and supporting a free and informed approach by providing partners with information on contraceptive counseling, services, and products. These pledges appear to consider the results of Haiti's 2012 and 2016-17 DHS that showed declining proportions of current modern users reporting that they were informed about their methods' possible problems, what to do if experiencing side effects, and other contraceptive methods to consider. Haiti also pledged to make FP inputs available at all levels.

To improve Equity, Haiti pledged to offer a whole range of FP methods, especially LAPMs, at the community level. The government also aims to prioritize hard-to-reach areas for mobile unit services, integrate FP into various RH services, and ensure that continuity in maternal care includes FP services. There is also a plan to establish a legal framework for adolescent RH.

Table 5. Summary of Haiti's FP2020 Commitments

Objective: Increase all-women mCPR by 10% (from 2017 level of 23%) **Target Groups: Adolescents/youths and hard-to-reach or humanitarian crisis populations**				
Strategy	**Data**	**Quality**	**Accountability**	**Equity**
• Mobilize financial resources from various sources • Create government FP budget • Progressively increase funding for contraceptive procurement/importation • Establish FP/RH inter-ministerial committee led by Ministry of Public Health (MPH) to support funding efforts and monitor allocations • Strengthen implementation of MPH's Strategic Plan for Adolescent RH • Create an adolescent RH intersectoral platform	• Identify MPH staff and resources to manage raw FP data at the system level (*for review on whether data to be managed includes rights-based issues)*	• Revise FP standards to include module on rights/respect • Share with partners information on contraceptive counseling, services, and products • Ensure that FP inputs are available at all levels	• Develop a checklist to ensure free and informed choice	• Establish adolescent RH legal framework • Offer complete modern methods, especially LAPMs, at the community level • Prioritize mobile units to serve hard-to-reach populations • Integrate FP into various RH services and ensure continuity in maternal care especially in hard-to-reach areas

Figure 3. Scores of Specific NCIFP Items, Haiti, 2014 and 2017



NCIFP Results. As Figure 3 above shows, Haiti's averages for the Strategy and Data dimensions stagnated while those for Quality, Accountability and Data declined. Figure 3 gives Haiti's scores for individual NCIFP items in 2014 and 2017. A pattern of scores falling or persisting at low levels prevails across most items, with few exceptions.

Haiti's rating for its FP Strategy prioritizing specific vulnerable groups rose dramatically from the 50s in 2014 to perfect by 2017. However, the mark for whether the FP action plan has well-defined, quantified objectives fell from 100 in 2014 to below 80 in 2017. The score could reflect experts' concern about the country's capability to achieve the stated objective. The rating for regulations facilitating contraceptive importation declined even more sizably (from almost 80 to about 40). The mark for high-level support decreased slightly (from 67 to 59). Program leaders have to take this into account given the country's commitments to establish (1) an FP/RH inter-ministerial committee led by the MPH to generate resources and monitor allocations, (2) an intersectoral adolescent RH platform, and (3) a legal framework for adolescent RH services.

Haiti made one Data-related pledge - designating MPH staff that will manage raw FP at the system-level – which is rather broad and needs more information to assess its relevance to NCIFP conerns. As for currently categorized non-commitment items, Haiti scored 100 for quality control of service statistics and 92 for data utilization to ensure vulnerable groups have access, even though the mark for data collection on population subgroups fell to 60. The scores of all remaining items (government collection of data on private sector supplies, clinic record-keeping/results-reporting to clients, data-based monitoring/evaluation, and management use of research findings to improve the program) fell to the 40s or remained within that score range.

In terms of Quality, Haiti's 2017 ratings were above 90 for the use of WHO standards and QOC indicators in public facilities, and 83 for tasksharing guidelines (the scores of the last two mentioned items were slightly lower than 2014 levels). These three items were not among Haiti's pledges possibly because standards and indicators have been in use in the country for some time. Ratings remained in the high 60s to the 70s for three other non-commitment items: the use of QOC indicators in private facilities, clinic/community structures to monitor QOC, and counseling acceptors about sterilization being a permanent method.

Haiti made three specific QOC commitments, two of which are clearly rights-oriented. The first involves revision of FP standards to include a module on rights and respect. The second pledge fosters free and informed choice through government sharing of data on FP counseling, services, and products with other partners. Efforts to fulfill the two pledges, however, should be accompanied by improved collection of data to monitor informed choice and provider bias; the rating for this NCIFP item fell from 75 in 2014 to 40 in 2017.

Haiti's third Quality pledge aims to make inputs available at all levels, although it is not clear whether "inputs" refer to personnel, training, information materials, contraceptive supplies, and/or other physical resources. Since Haiti's documents in the FP2020 website suggest logistics and training as key inputs, both are highlighted in Figure 3 as relevant to commitments. The score for training stayed below 60 while ratings for logistics and supervision (the latter does not appear to be a commitment item) remained less than 40. The low scores point to the urgency of rebuilding support systems to prevent further deterioration that compromise the quality of FP services.

The last set of QOC items involve access to IUD and implant removal. Although these procedures were not explicit commitment items, both are highlighted in Figure 3 because method-reversibility is a necessary component of LARC services given their implications on reproductive choice, the unifying element of Haiti's QOC as well as Equity commitments. The scores for IUD and implant removal, already low in 2014, were only 24 and 44 respectively in 2017, raising more concerns about current capabilities of the health systems to ensure QOC.

Haiti's commitments emphasize choice, hence the importance of Accountability initiatives. The rating for mechanisms to monitor discrimination and free choice – the NCIFP item most relevant to Haiti's sole Accountability pledge – stayed in the mid-40s from 2014 to 2017. The country's results for all Accountability items are concerning. The score for structures to support client-provider forums fell from 83 to 50. Scores improved only slightly for structures to solicit client feedback at the facility level (40 in 2017) and to review violations regularly (30 in 2017). The rating for mechanisms to report the denial of services on non-medical grounds stagnated at 20, the lowest among all 35 NCIFP items.

Most Equity items are relevant to Haiti's commitments. The country aims to improve access among adolescents and hard-to-reach populations, but its NCIFP results show sharp contrasts. The 2017 score for providers not discriminating against certain population groups (the only non-pledge item) stayed around 80, the mark for whether anti-discrimination policies are in place dropped from 74 to 53. The 2017 rating for STM access was 72 (a slight decline from 81 in 2014) compared to the score for LAPM access stagnating at around 30. Moreover, the score for CBD coverage of underserved populations declined precipitously from 60 in 2014 to 35 in 2017.

To summarize, the high demand for modern FP services in Haiti especially among vulnerable segments of the population contrasts sharply with the country's mostly low and declining ratings across all five NCIFP dimensions, particularly activities intended to improve access and choice and to monitor rights-based efforts to address these concerns.

India

Commitments. Overall, India's commitments focus on reducing inequities in access, expanding contraceptive choice and reach, and improving the quality of services (Table 6). Aside from pledging to broaden civil society participation, the government's Strategy commitments aim for financial sustainability through increased national and local funding, CIP implementation, and continued production of contraceptive products for domestic use and the international market.

Data-related pledges are broad and system-oriented rather than focused on the collection or use of specific FP information. These pledges involve providing information on private sector services in the national data portal, establishing a web-enabled tracking system to improve mother-child care, and ensuring access to FP data through the FP Division's website.

Commitments to improve the Quality of FP services focus on strengthening the logistics system, training health workers especially on IUD procedures, developing dedicated counselors that include youths, and establishing QOC monitoring indicators and reporting systems. To improve Accountability, India pledged to establish a system for obtaining after-visit facility level feedback from FP clients.

India's Equity pledges include shifting the country's long focus on sterilization to more efforts to promote spacing methods such as injectables and new LARCs. Considering the public sector's long domination of FP service delivery, the government also pledged to expand private sector participation in sterilization and

IUD services and to provide free FP services in accredited private facilities. India will also deploy trained clinical staff in mobile vans to underserved areas with high fertility rates, mobilize community health workers to deliver pills and condoms to local users previously screened by providers, and encourage male involvement by promoting condom use.

NCIFP Results. India's scores improved for most items although levels varied widely within most dimensions except under Strategy, where all items rated over 70 in 2017(Figure 4). The mark for the national FP action plan's defined and quantified objectives minimally changed but remained the highest rated. The ratings for diverse stakeholder participation and regulations facilitating contraceptive production and importation rose more than 20 points to over 80 in 2017. Scores stayed in the mid-70s for the action plan's objectives to reach the most vulnerable and estimates of projected resource requirements.

In terms of Data, the mark for quality control of service statistics soared and nearly doubled to near perfect in 2017. Scores of 60 in 2017 followed for data-based monitoring/evaluation and the use of data to ensure the most vulnerable have access. All remaining items were rated in the low 50s in 2017, including the collection of information on special population sub-groups (its score fell from 66 to 52). One item- data on private sector supplies - is relevant to the county's pledge to make information on private sector services accessible in the national data portal. Available information on India's two other Data commitments - tracking mother-child care and providing access to FP data in the FP Division's website - are not specific enough for this study to ascertain NCIFP relevance but these data systems appear to have the potential to provide important information such as the needs of priority groups like young mothers and other health system concerns (e.g. where specific LARC services are available) that can be used to monitor, evaluate, and strengthen key program initiatives.

India's ratings also improved for most items under Quality, although resulting 2017 levels ranged between 100 to 10. Scores rose to 90 or higher regarding the use of WHO-based SOPs, QOC indicators in public facilities, and community/facility structures to address QOC. Other high marks included around 80 for the use of task-sharing guidelines and counseling clients about sterilization being permanent. Access to IUD removal, a key component of LARC services, scored 67 in 2017. By contrast, access to implant removal was rated 4 in 2014 and 10 in 2017, which were India's lowest across all 35 NCIFP items for both years. As stressed earlier, implant removal procedures should be part of LARC services since method choice implies reversibility. The scores for two other commitment items that involve operations support systems-logistics and training- increased to around 60 while that of the supervision system, a non-commitment item, remained at 50.

Other Quality items with low scores in 2017 include government collection of data on informed choice and provider bias (45). This rating appears consistent with DHS 2015-16 results: 47% of current modern users stated that they were informed about potential problems with the contraceptives they were using; 39% said they were told what to do if experiencing side effects. However, the DHS also reported that over half of modern users saying they were informed about other modern methods and 80% of acceptors were told about the permanence of sterilization.

Other low marks for Quality items in 2017 included 36 for the use of QOC indicators in private facilities (from 25 in 2014); this slow improvement is concerning given the government's efforts to expand private sector participation in FP service delivery. This also means that India's fourth Quality pledge, to establish QOC monitoring indicators and reporting systems, should involve the government working with the private sector to adopt QOC indicators, using lessons learned from their use in public facilities.

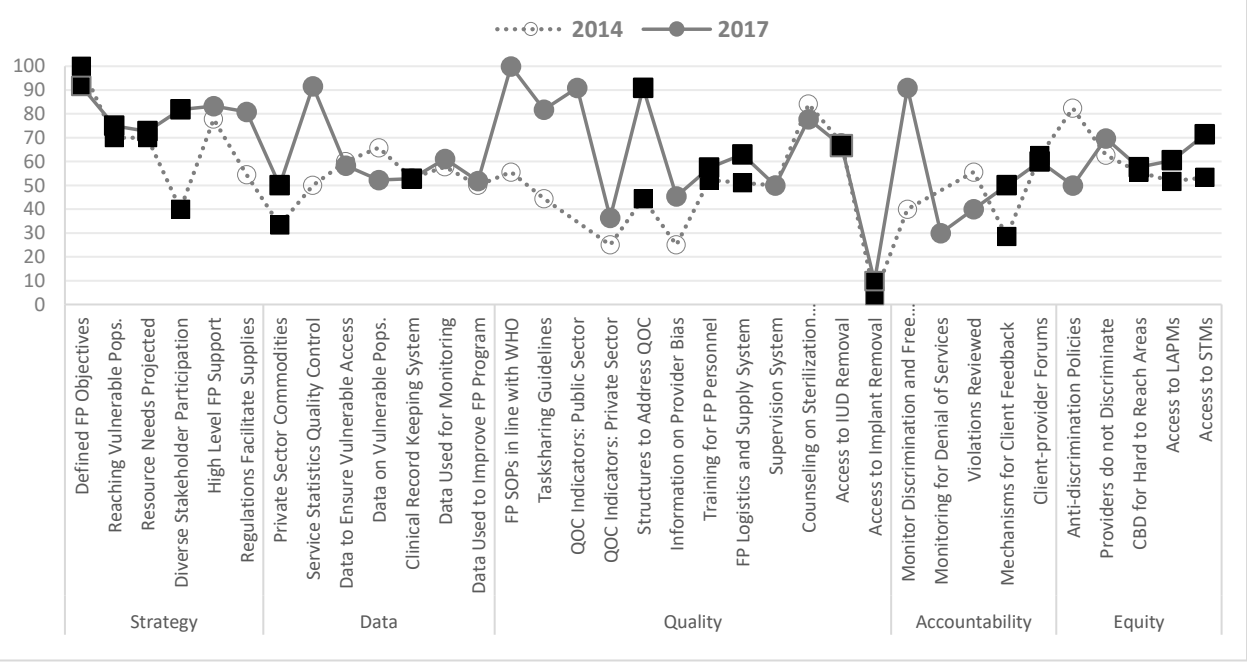
Individual Accountability ratings also varied widely. Two items with significantly improved scores involved mechanisms to monitor access to voluntary, non-discriminatory services (from only 40 in 2014

to near perfect in 2017) and to solicit facility-level feedback (improving from 29 to 50). The latter is India's sole Accountability pledge; the improved score may reflect progress in putting feedback mechanisms in place. Two other items, however, scored no higher than 40 in 2017: structures to report the denial of services on non-medical grounds and to review violations regularly (the latter scored a higher 56 in 2014). These low ratings raise imply concerns about discrimination and rights.

Table 6. Summary of India's FP2020 Commitments

Objective: Increase mCPR to 54% by improving access, choice, quality **Target Groups: Adolescents/youths, hard-to-reach populations, high-fertility districts with high infant and maternal mortality, newlyweds**				
Strategy	**Data**	**Quality**	**Accountability**	**Equity**
• Increase national and local funding • Implement CIP • Involve civil society and influencers • Continue domestic contraceptive production for international and local use	• Establish mother-child web tracking system • Provide access to data in FP Division website • Provide information on private sector services in the national data portal	• Strengthen logistics • Improve training (esp. on IUD) • Develop dedicated counselors (incl. youths) • Establish QOC monitoring indicators and reporting system	• Establish systems to obtain clients' after-visit feedback	• Shift focus from limiting to spacing methods by expanding choice, including new LARCs • Mobilize community health workers to deliver pills and condoms • Deploy trained clinical teams in mobile vans to underserved areas • Provide free FP services in public and accredited private facilities • Revitalize social marketing • Expand private sector role esp. in sterilization and IUD services • Rejuvenate condom uptake for male involvement

Figure 4. Scores of Specific NCIFP Items, India, 2014 and 2017



In terms of individual Equity items, India's score sharply fell from 82 to 50 regarding policies that are in place to prevent discrimination. The decline may partly reflect experts' concerns about accountability mechanisms as pointed out in the preceding paragraph. Nevertheless, the score for providers not discriminating against certain population sub-groups improved to 70, suggesting providers' readiness to serve various population sectors despite limited policy support. The results for the country's three Equity commitment items consist of STM access rising from 53 to 71 compared to a smaller increment for LAPM access (from 52 to 61). The score for CBD coverage stayed below 60.

In sum, India's scores for most NCIFP items improved, including several that comprise or are relevant to the country's FP2020 commitments. Nevertheless, India also has very low NCIFP scores for key program elements that involve the private sector, choice concerns involving implant reversibility, certain accountability mechanisms, and anti-discrimination policies.

Challenging NCIFP Items and Recommended Actions

The analysis of specific NCIFP items identifies several national program activities that are in place, including commitments and non-commitment items. However, the results also unveil NCIFP items with ratings that were either a) falling by more than 10 points to scores of around 50 or below in 2017, or b) remaining at 50 or lower in 2017. The cut-off of 50 is arbitrary, though well below global totals and dimension averages in 2017 shown in Table 2.

Table 7 provides an overview of what could be considered the most challenging NCIFP items of each country. Commitments are underscored to distinguish them from other items in the table. The results show that most NCIFP items with still low or significantly falling scores are those not explicitly cited by each country. But the NCIFP also showed that many non-commitment items are rights-based; they can affect or are related to most commitments, hence, should be considered. Possible actions that each country can take are given in the following paragraphs.

Nigeria pledged to update the national and state blueprints and CIPs to include a rights-based approach and revise the Strategic Plan to ensure delivery of youth-friendly services given the low FP use and demand among adolescents. NCIFP results specified various low-rated items that should also be considered in these updates: improving LARC access and CBDs as well as monitoring and addressing provider bias, violations, and denial of services on non-medical grounds, such as age and marital status. Since adolescents may prefer to go to private providers, there is also a need to ensure that QOC indicators are used in these facilities.

Haiti pledged to incorporate a rights-based module into FP standards and to develop a checklist to safeguard free and informed choice. These initiatives would especially benefit the large numbers of youths and populations in humanitarian crisis. These modules and checklists could include low-scoring NCIFP items, particularly whether anti-discrimination policies are in place, client feedback is solicited at the facility level, services are not denied due to non-medical reasons, violations are promptly reported and addressed, and CBD exists. Enhancing access and choice considering high unmet need will also require increased LAPM access along with LARC removal services.

India's NCIFP results show generally high scores for commitment items, but also indicate the need to enhance the availability of implant removal services to support choice and to ensure accountability. This could be accomplished by putting in place anti-discrimination policies and mechanisms to review violations and report unnecessary denial of FP services and establishing QOC monitoring and reporting

systems. Experts also cited the low use of QOC indicators in private facilities, a problem that needs to be addressed considering the key role of private sector involvement in program sustainability.

The illustrative examples above emphasize rights while referring to each country's mix of commitments and scores: Nigeria given low demand for FP; Haiti in its efforts to respond to very high unmet need, and India as it moves toward sustainability. In most instances, the configuration of FP policies, plans, systems, and structures that a country needs to work on vary depending on its socio-economic and political characteristics, commitments, and challenges including those identified by the NCIFP.

Table 7. Low-Scoring or Significantly Declining NCIFP Items

Country	Strategy	Data	Quality	Accountability	Equity
Nigeria	• Regulations facilitating importation	• Clinic record-keeping/results reporting back to clients • Management use of research findings to improve the program	• Use of QOC indicators in private facilities • Collection/monitoring information on informed choice and provider bias • Logistics • Supervision	• Mechanisms to report denial of services on non-medical grounds • Mechanisms to review violations	• CBD coverage • LAPM access
Haiti	• Regulations facilitating importation	• Government collection of data on private sector supplies • Clinic record-keeping/results reporting back to clients • Data-based M/E and reporting • Management use of research findings to improve the program	• Collection/monitoring information on informed choice and provider bias • Logistics • Supervision • Access to IUD removal • Access to implant removal	• Mechanisms to monitor discrimination and free choice • Mechanisms to review violations • Mechanisms to report denial of services on non-medical grounds • Structures for client facility-level feedback • Support for provider-client forums	• Policies in place to prevent discrimination • LAPM access • CBD coverage
India		• Government collection of data on private sector supplies • Data collection on vulnerable groups	• Use of QOC indicators in private facilities • Collection/monitoring information on informed choice and provider bias • Supervision • Access to implant removal	• Mechanisms to review violations • Mechanisms to report denial of services on non-medical grounds	• Policies in place to prevent discrimination

Conclusion

Commitments are important by themselves and in relation to each other. The NCIFP results reveal that countries must also consider other program concerns to ensure that pledges and objectives are achieved in the transition to modern contraceptive use. This is particularly relevant for countries pledging to prioritize the most vulnerable and disadvantaged as the commitment has bearing on other commitments. For one, this implies that countries should also consider assessing actual resource allocation and utilization as well as who actually benefits. Countries have progressed in the use of WHO-based standards and tasksharing guidelines, but to what extent are standards and guidelines being applied to disadvantaged groups or in remote areas where personnel and infrastructure are limited? The countries studied in this paper have some of their lowest scores for rights-oriented Quality, Equity, and Accountability items. How are the most vulnerable further disadvantaged by these low scores? When objectives aim to reach this most vulnerable population, are the necessary policies and structures for quality, accountability, and equity in place? Are the needed data being collected and do policymakers and program managers have the capabilities to use this information?

This paper provides only an initial elaboration of relevant NCIFP items. A more exhaustive analysis is best left for country stakeholders to undertake using the NCIFP given its great potential in monitoring the rights-related content of FP programs. The tool is intended for more regular use; at present, every three years to assist FP2020 priority and pledging countries. The tool can certainly be modified for use at the sub-national level, especially in decentralized governments, to develop their own strategies and commitments. The NCIFP can also be adapted to focus on specific target populations to ensure that appropriate information is collected.

Finally, the approach employed in this paper should be qualified. The categorization is the author's interpretation based mainly on country-specific documents in the FP2020 website. The analysis is illustrative; it is intended to encourage FP stakeholders across countries, including those in the three countries studied, to assess their own countries' NCIFP ratings vis-à-vis FP2020 commitments. Multi-sectoral review of NCIFP results vis-à-vis commitments, FP plans and policies is highly recommended, with the results of the review used in advocacy, policy dialogue, and decision-making about next steps toward rights-based policy and program reform.

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