Global Trends in Family Planning Programs, 1999–2014

CONTEXT: *Since 1972, the Family Planning Effort Index has measured national family planning program activities in developing countries and provided a longitudinal perspective on a standardized set of program characteristics.*

METHODS: *In 2014, experts in 90 developing countries assessed national family planning program effort in four main component areas—policies, services, monitoring and evaluation mechanisms, and access to methods—using a standardized questionnaire. Results were compared with previous years' data.*

RESULTS: *Globally, family planning program effort has progressed in all four main component areas. The service component, historically the weakest, was rated lowest of all components in 2014, at 47% of the maximum effort, despite a marked improvement of 7.6 percentage points since 1999. Policies, generally the strongest component, remained the strongest in 2014, with 55% of the maximum score and a 6.7 percentage-point improvement since 1999. Monitoring and evaluation improved the most, by 7.8 percentage points, from 45% to 53%, while access improved more modestly, by 2.7 points, from 49% to 52%. Family planning efforts were generally strongest in Asia and Oceania and generally weakest in Central Asia and Eastern Europe.*

CONCLUSIONS: *Global family planning programs have improved consistently over the last few decades, although there is room for further development in all regions.*

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National family planning programs emerged in the 1960s and are now active in many developing countries throughout the world. These programs vary greatly in effectiveness and coverage. Strong national family planning programs have certain key features, such as provision of a variety of high-quality family planning, counseling and contraceptive options, as well as broad multisectoral governmental and private sector support. Clear national policies help provide structure to family planning programs, which should be sustained by regular monitoring and evaluation, training, supervision, and logistic support. Because services and methods should be accessible to the entire population, effective programs have extensive outreach strategies to serve the general population and targeted approaches to reach underserved populations through mass media programs, social marketing or community-based distribution. Also, successful programs have rights-based quality assurance measures in place to ensure voluntary and well-informed uptake of family planning.[1]

National family planning programs benefit from regular monitoring to identify both successes and areas in need of development. Since 1972, the Family Planning Effort Index has provided standardized periodic measurements of the strength of national-level family planning programs worldwide. Its measures, categorized into four main component areas—policy context, service provision, monitoring and evaluation, and access to methods—are based on important features of successful programs.[2,3] This longitudinal data set spans five decades and serves as the only publicly available international source for analyzing changes in national family planning programs over time. Because the Family Planning Effort Index measures inputs, rather than outcomes, programs are able to use it to determine where greater effort should be expended; also, Family Planning Effort Index scores have often been used by major donors and development partners both to identify program weaknesses and to measure progress over time. Family Planning Effort Index scores have also figured in numerous analyses over the years to investigate program impact separately from socioeconomic changes on contraceptive use and fertility levels and changes.[4–6]

While the prominence of family planning on the development agenda has risen and fallen over the years, the Family Planning Effort Index has historically been used as a reliable and consistent data source for countries and development agencies. For example, Family Planning Effort Index studies conducted in 1999, 2004 and 2009 were used to monitor national efforts expended to achieve Millennium Development Goals (MDGs) 4 and 5, which focused on reducing maternal and child mortality and improving access to reproductive health care.[7]

The Sustainable Development Goals[8] (SDGs), adopted in 2015 as a follow-up to the MDGs, outline similar maternal and child health priorities for 2030 in SDG 3, which calls for ensuring health and well-being at all ages. Additionally, SDG 3.7 sets the goal of "universal access to

sexual and reproductive health care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs."[8(p.18)] Furthermore, SDG 5 promotes gender equality and empowerment of women and girls; SDG 5.6 reiterates the goal of universal access to sexual and reproductive health and emphasizes the goal of universal access to reproductive rights.

Family Planning 2020 (FP2020) is a global partnership of governments, donors, private organizations, civil society and the research community in support of "the rights of women and girls to decide freely, and for themselves, whether, when and how many children they want to have."[9] With its focus on 69 priority countries, FP2020 has also raised the profile of family planning on the development agenda and further highlighted the importance of political engagement, financial support, high-quality rights-based services, and consistent monitoring and evaluation. Thus, the Family Planning Effort Index will be useful as a monitoring tool over the course of FP2020 and toward achievement of the SDGs.

In this article, we summarize the results of the 2014 Family Planning Effort Index, which uses 36 ratings in the four component areas to describe the current landscape of national family planning program efforts in the developing world. Using the longitudinal data set from 1999 onward, we assess the extent of improvement in family planning program effort from national, regional and global perspectives. Our article presents the first full analysis of the 2014 cycle and uses those data, as well as data from the 1999, 2004 and 2009 cycles, to examine trends over the last 15 years.

DATA AND METHODS

The 2014 round of the study used methods very similar to those used in all rounds since 1999. One exception was the use of two implementing agencies, each with separate funding. The United States Agency for International Development–funded Health Policy Project provided support to the Futures Group to conduct the project in anglophone Sub-Saharan Africa; Asia and Oceania; the Middle East and North Africa; and Central Asia and Eastern Europe, excluding the FP2020 priority countries. The Bill and Melinda Gates Foundation supported Track20, implemented by Avenir Health, to conduct the project in the FP2020 priority countries, as well as in francophone and lusophone Sub-Saharan Africa and in Latin America and the Caribbean. All procedures used by the two organizations were identical.

First, we identified a study manager for each country who possessed close familiarity with the national family planning program and who could select respondents knowledgeable about the program. Study managers drew respondents from a variety of backgrounds, including the government, the private sector, academia, nongovernmental organizations and international agencies.

We sought to collect data in developing countries with populations of more than one million that satisfied at least one of the following criteria: an active national family planning program, inclusion in at least one previous study wave or inclusion in the FP2020 priority country list. We defined an active national program as any public-sector activity devoted to the provision of family planning. We attempted to contact experts in 100 countries; ultimately, we collected and analyzed data from 90 countries comprising more than 90% of the population in the developing world. We omitted 10 countries because study managers failed to respond or to identify country experts after repeated attempts. The number of countries represented in 2014 was greater than the number represented in the other cycles examined here (81 in 2009, 82 in 2004 and 87 in 1999).

The study managers each identified 10–15 expert respondents in their country, yielding a total of 1,177 respondents in the 90 countries. Respondents completed a standard questionnaire rating the level of effort expended on 36 features of their country's family planning program. Each feature was rated on a scale of 1 (minimal to no effort) to 10 (highest level of effort). Additional items were included, as had been done in 2009, covering topics not used to calculate the overall Family Planning Effort scores. They focused on family planning program justifications, the emphasis placed on reaching special populations (such as unmarried youth or rural populations) and the perceived quality of the family planning program.

To minimize bias introduced by variability in respondents' areas of knowledge, study managers instructed respondents to skip questions if they were unsure of the answer or did not have the relevant knowledge. Study managers entered data from the questionnaires into a country-level database, and teams from both the Health Policy Project and Track 20 manually reconciled databases against a selection of original questionnaires to verify the accuracy of the data entry; extreme values were checked with study managers.

For a given country, the ratings on each question were averaged across respondents. These ratings were then averaged by component to produce the four component scores; policy context was measured by eight ratings, monitoring and evaluation by three, access by 12 and service provision by 13. The policy context measures the enabling environment, such as support from in-country leaders, the regulatory guidelines for importation or manufacturing of supplies, and budget allocation for family planning activities. The monitoring and evaluation component assesses the extent of data collection and evaluation and the extent to which data are used to improve operations. The access questions focus on the extent to which various methods, method-specific services and safe abortion (regardless of legality) are available to the whole population, while the service questions measure features such as the availability of community-based distribution, the extent to

which facilities are adequately staffed, and the extent to which personnel are trained and supervised. The total Family Planning Effort Index score was the average of all 36 ratings. The responses to the additional questions on program justifications and subgroup emphases were not used to calculate component scores or the overall total Family Planning Effort Index (but are available for use by researchers and stakeholders).

Across all countries, the response rate was 96% for the questionnaire items used to calculate the Family Planning Effort Index and the four component scores; the response rate for the additional questions regarding program justifications and emphases on population subgroups was 98%. Finally, all ratings were calculated as percentages of the maximum score, allowing for easy comparisons between the components and with previous study cycles. Although past experience shows that the scores of the best-performing countries have been only about 80% of this maximum, we have retained the 100% figure for the full perspective and for consistency with past reports.

We calculated both unweighted and weighted scores for each region by averaging the component scores and total Family Planning Effort Index scores for all included countries in the region. The unweighted global average, covering all regions, is the average of all countries' component scores and total Family Planning Effort Index scores. Each country's scores were weighted by its total population size, taken from the United Nations' World Population Prospects 2013 Revision.[10] Except for Figure 1, in which both weighted and unweighted scores are presented, analyses of 2014 results present weighted scores, while historical analyses are unweighted because of changing population distributions over time.

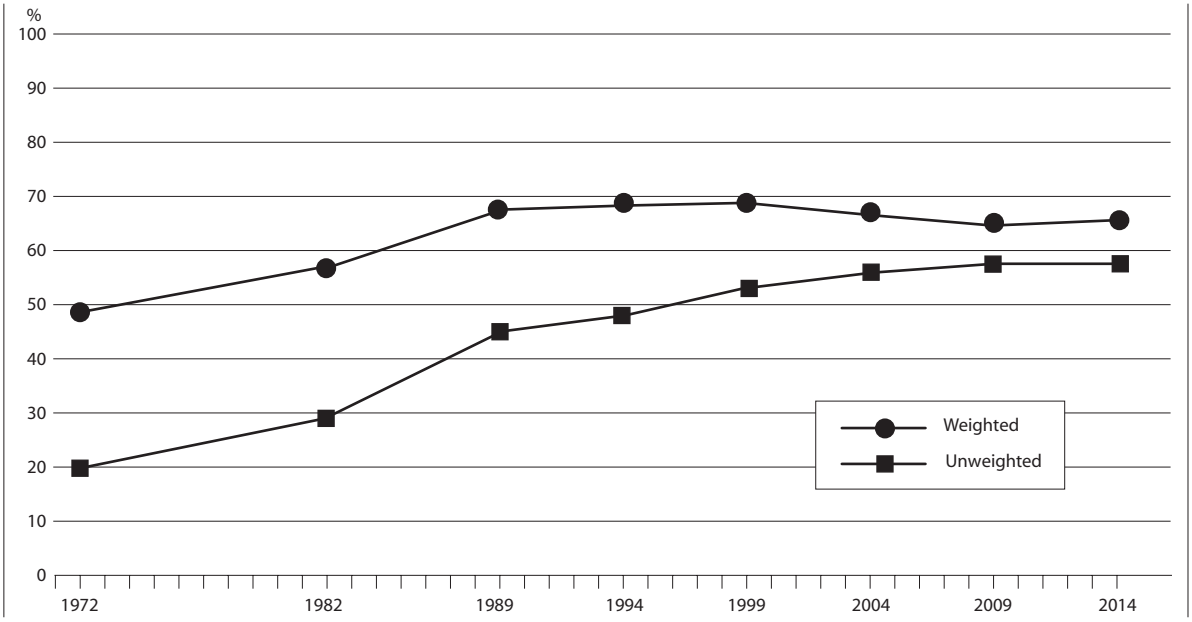
This article analyzes trends from study cycles for 1999, 2004, 2009 and 2014. We also use data from 1972–1994 to show trends from the first to the last cycle of the study.

Methodology Changes in 2014

The 2014 iteration of the Family Planning Effort Index differed from previous cycles in two ways. First, in all countries, the Family Planning Effort questionnaire items were followed by the items for the National Composite Index for Family Planning (NCIFP), a collection of FP2020 indicators designed by Track20 to measure specific progress indicators of the FP2020 initiative. The NCIFP measures the enabling environment for family planning, particularly among the 69 FP2020 priority countries; we thus searched for study managers in all 69 FP2020 countries, regardless of whether these countries met the population criteria.

Second, the 2014 cycle of the Family Planning Effort Index included five new items in the access component in addition to the original seven. These were added to reflect the growing importance of newer contraceptive methods and services—specifically IUD removal services, implants, implant removal services, emergency contraceptives and counseling on permanent methods. We included removal and counseling services to measure informed consent and voluntary uptake of family planning. To maintain comparability between survey waves, only the seven original access ratings were used to calculate the access component score and the total Family Planning Effort Index when we

FIGURE 1. Weighted and unweighted global total Family Planning Effort Index scores as a percentage of the maximum possible score, 1972–2014



Notes: The global score for each survey year includes all countries assessed in that year. Both weighted and unweighted scores were adjusted for comparability between the long-form and the short-form survey. The original seven-item access measure was used to calculate the 2014 total Family Planning Effort Index score.

compared 2014 with past surveys. In contrast, in cross-sectional analyses of the 2014 survey only, all 12 access ratings were used to calculate both the overall access component score and the total Family Planning Effort Index score.

Adjustments to Maintain Comparability

We adjusted several calculations to improve comparability between survey cycles. First, with the exception of Figure 1, wherever 2014 scores were compared with historical scores, we included only the 54 countries that were included in all four study rounds from 1999 through 2014. (See Appendix 1 for a list of the 54 countries.) In contrast, when 2014 scores were analyzed alone, all 90 countries were included in the calculations.

For Figure 1 only, all countries surveyed in each year were included and, consequently, the count of how many countries figured into the calculations and which countries were assessed differs from cycle to cycle. Also, prior to 1999, a longer form of the questionnaire was used. A simpler form was adopted in 1999 and implemented alongside the longer form to allow for calibration. The average difference between the long and short forms in 1999 lets us adjust subsequent results to produce the full series in Figure 1. This adjustment was applied only in Figure 1 because it encompasses both long-form and short-form results; all other graphs and charts tracking historical patterns focus only on short-form surveys and thus needed no further adjustments.

Limitations

There are two types of limitations for this research: those common to the methodology, and those particular to this cycle. For the first, the data come from subjective ratings by observers of the national family planning program. The advantage of observer ratings, however, is that estimates emerge for variables for which no objective measures exist, such as the quality of training and supervision or the proportion of the whole population having "ready and easy" access to each contraceptive method.

An additional limitation is that because the cycles are about five years apart, the respondents differ to some degree from one cycle to the next. Also, some countries included in one cycle are omitted in the next cycle, for a variety of reasons. The latter is addressed in the results with time trends only for countries included in all cycles of interest. Balanced against these limitations are the advantages of a standard set of effort measures for most developing countries, obtained at approximately the same point in time, at reasonable cost, with trends for each of the ratings.

The second set of limitations for this particular cycle includes changes in the questionnaire—specifically, adding items for the access component. On average, however, comparisons of the two versions showed little difference in the results. Perhaps a more important change was that the Family Planning Effort Index questions were followed by the NCIFP questions. This was not done in previous years and may have increased respondent fatigue (although there was no evidence of elevated nonresponse rates).

RESULTS

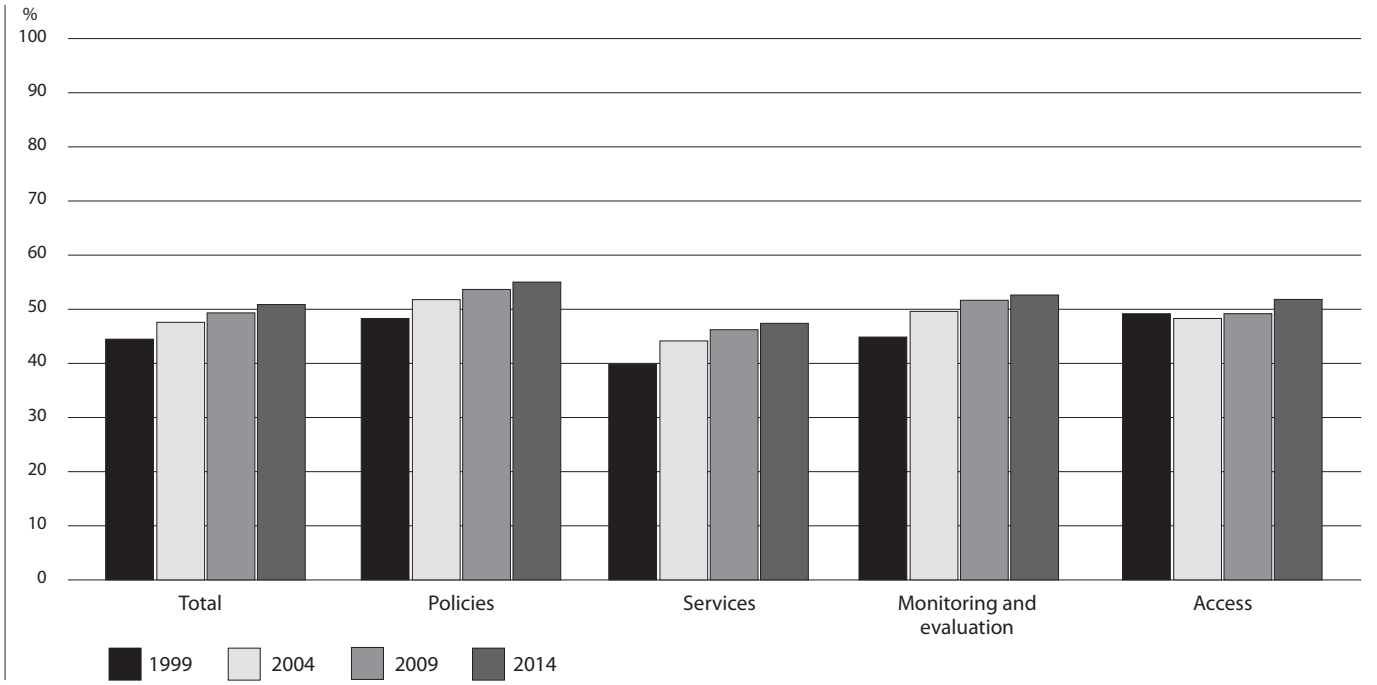
Trends in Global Scores

The weighted and unweighted global Family Planning Effort Index score (the mean Family Planning Effort Index score across all countries, weighted by country population) rose dramatically between 1972 and 1990 (Figure 1). The weighted scores stabilized during the 1990s, while the unweighted scores continued to rise. In the 2000s, the weighted scores declined slightly and then stabilized after 2010, while the unweighted scores continued to edge upward between 2000 and 2014. Both weighted and unweighted Family Planning Effort Index scores increased slightly in the last five years. The difference in trajectory between the unweighted and weighted averages suggests that family planning programs are increasing their strength of effort at the country level and that countries adopting new programs have started off strong, but that improvements in smaller countries may be offset by stagnancy or limited improvements in larger countries.* For example, while scores for smaller countries such as Nicaragua and Benin improved by more than 15 percentage points between 2009 and 2014, scores for more populous countries like China and Indonesia have decreased steadily over time, with a 5–6 percentage-point decline in the last five years (not shown). Furthermore, although there has been both long- and short-term improvement, the highest global scores are still less than 70% of the maximum possible score, indicating space for further growth.

We also looked separately at the global mean Family Planning Effort Index total and component scores for all study cycles conducted since the short-form questionnaire was adopted in 1999 (Figure 2). For this analysis, we included only the 54 countries that were included in all four survey cycles. We also calculated the 2014 access score with the original set of contraceptive methods and service items only. Most program components improved consistently between 1999 and 2014. The total Family Planning Effort Index score improved by more than six percentage points, from 45% to 51%, demonstrating steady improvement in programs established 15 or more years ago. The monitoring and evaluation component scores saw the largest growth, with a 7.8 percentage-point improvement, followed by services and policies at 7.6 and 6.7, respectively. Finally, access also improved, but by only 2.7 percentage points. This pattern persisted when the 12-item access measure was used in the 2014 total Family Planning Effort Index score and in the access component score, although the degree of improvement was attenuated for both scores (not shown).

*Unweighted scores reflect family planning program status from a country-by-country perspective, while weighted scores speak to family planning program strength from a per-capita perspective.

FIGURE 2. Unweighted global mean total and component Family Planning Effort Index scores as a percentage of the maximum possible score, by survey year



Notes: Based on data from the 54 countries included in all four study cycles. The original seven-item access measure was used to calculate the 2014 total and access scores. Scores were unadjusted because all data were collected with short-form surveys.

Trends in Regional Scores

• *Total scores.* We looked at historical trends by region, again among only the 54 countries that were included in the last four survey cycles. We found that although the global average had improved steadily for family planning programs, differences between regions persisted both in overall program strength and in level of change over time (Table 1). For example, while the Middle East and North Africa and Asia and Oceania had the highest total Family Planning Effort Index scores in 2014 (55% and 58%, respectively), the absolute increase in their scores (five and four percentage points, respectively) between 1999 and 2014 was much lower than in other regions. During that period, total scores in Latin America and the Caribbean and in Central Asia and Eastern Europe improved by more than 10 percentage points each and in francophone and lusophone Sub-Saharan Africa by approximately nine points. Anglophone Sub-Saharan Africa has had a U-shaped pattern of progress and its score in 2014 was lower than its score in 1999.

• *Policy scores.* In 2014, Asia and Oceania had the highest policy score (64%), while francophone and lusophone Sub-Saharan Africa had the lowest score (48%). In the last five years, policy effort increased notably in Asia and Oceania (five percentage points), with dramatic strides made in the Philippines, Myanmar and Bangladesh (not shown). Over the same period, the policy score in anglophone Sub-Saharan Africa improved by nearly four percentage points, while that score declined in francophone and lusophone Sub-Saharan Africa by approximately the same amount. Although the policy score for the Middle East and North Africa had risen by six points between 1999 and 2004 (to 64%), it dropped back to 59% by 2014. The score for Central Asia and Eastern Europe improved by less than one percentage point over the period between the last two surveys.

• *Service scores.* Nearly all regions increased their service scores between 1999 and 2014. Asia and Oceania had the highest service score in 2014 (55%), while Central Asia and Eastern Europe had the lowest score (43%), down almost three percentage points in the last five years. In the last five years, the region with the greatest improvement was anglophone Sub-Saharan Africa, whose score increased by nearly four percentage points (to 46%); however, the region's service score has not yet returned to its 1999 level (47%), following a marked decrease between 1999 and 2004. In contrast, francophone and lusophone Sub-Saharan Africa improved by only 0.5 percentage points in the last five years but by nearly 10 percentage points since 1999.

• *Monitoring and evaluation scores.* Monitoring and evaluation saw substantial improvements in most regions between 1999 and 2009, and either stability or modest improvements in the five years between 2009 and 2014. Although anglophone Sub-Saharan Africa has not improved consistently, it did experience the strongest five-year improvement (three percentage points), recovering to almost 50% in 2014 after a decline of nearly six

TABLE 1. Unweighted mean total and component Family Planning Effort Index scores as a percentage of the maximum possible score, by region, according to survey year

Program effort	1999	2004	2009	2014
Total				
Asia/Oceania	53.7	55.8	53.8	57.9
Central Asia/Eastern Europe	35.0	47.3	51.0	51.9
Middle East/North Africa	49.6	50.2	54.4	54.7
Latin America/Caribbean	39.1	46.4	48.5	49.2
Sub-Saharan Africa				
Anglophone	51.3	45.1	45.9	49.4
Francophone/lusophone	36.5	41.9	45.5	45.2
Policies				
Asia/Oceania	59.0	61.3	58.8	63.8
Central Asia/Eastern Europe	36.1	55.0	53.5	54.0
Middle East/North Africa	57.8	63.7	62.3	58.8
Latin America/Caribbean	42.1	47.2	49.7	52.7
Sub-Saharan Africa				
Anglophone	55.4	49.2	51.6	55.5
Francophone/lusophone	40.4	45.5	51.6	47.9
Services				
Asia/Oceania	48.1	53.5	52.1	54.5
Central Asia/Eastern Europe	28.8	39.4	45.5	42.6
Middle East/North Africa	44.6	44.0	50.4	52.2
Latin America	34.2	43.1	45.5	44.7
Sub-Saharan Africa				
Anglophone	47.3	42.9	42.6	46.2
Francophone/lusophone	33.7	39.6	43.0	43.5
Monitoring and evaluation				
Asia/Oceania	55.4	54.6	54.4	55.4
Central Asia/Eastern Europe	27.9	44.4	57.7	55.8
Middle East/North Africa	51.8	54.6	60.4	60.4
Latin America/Caribbean	37.1	48.3	50.1	51.4
Sub-Saharan Africa				
Anglophone	51.6	46.0	46.1	49.5
Francophone/lusophone	41.0	46.4	49.2	49.7
Access				
Asia/Oceania	57.9	54.2	51.1	58.5
Central Asia/Eastern Europe	50.5	54.4	55.6	58.3
Middle East/North Africa	48.3	44.6	50.3	52.3
Latin America/Caribbean	46.6	50.9	52.2	52.8
Sub-Saharan Africa				
Anglophone	54.1	44.0	45.6	48.5
Francophone/lusophone	35.3	40.0	41.4	43.5

Notes: Scores are based on data from the 54 countries included in all four study cycles. The original seven-item access measure was used to calculate the 2014 total and access scores.

percentage points between 1999 and 2004. The Middle East and North Africa region had the highest monitoring and evaluation score in 2014 (60%), similar to its score in the previous survey and largely attributable to a very high score in Morocco (not shown).

• *Access scores.* Scores measuring access to contraceptive methods increased, albeit slowly, between 1999 and 2014. Asia and Oceania scored the highest in this area in 2014, with 59%, while francophone and lusophone Sub-Saharan Africa scored lowest at 44%. Progress in Asia and Oceania in the last five years was particularly strong, with every single country except Nepal reporting greater access (not shown); however, the 2014 regional access score for Asia and Oceania was not much higher than its 1999 score (58%). Other regions also reported fairly steady improvements in access over the last five years, with most experiencing a 2–3 percentage-point increase in their score.

Current Landscape

The 2014 global picture of family planning program efforts, including all 90 countries surveyed in 2014, weighted by country population and with new contraceptive methods included in the access component, shows that the policy component was rated the highest (62%), followed by access (57%), monitoring and evaluation (54%), and services (53%—Table 2). However, when we look at component areas by region, the pattern of which program components ranked highest varied somewhat. For all regions except Central Asia and Eastern Europe, the policy component was rated as either the strongest or second-strongest component. In most regions, access was also the strongest or second-strongest, with the exceptions of the Middle East and North Africa and francophone and lusophone Sub-Saharan Africa, where monitoring and evaluation emerged as the strongest component (57% and 53%, respectively).

Asia and Oceania was the highest rated region in total program effort (60%) and also in the policies (67%), services (57%) and access components (60%). Programs that received lower scores were generally in less-populous countries, such as Afghanistan, Papua New Guinea and Timor-Leste (see Appendix 1 for country-level results). Although China and India could potentially have dominated regional trends because of their large populations,

TABLE 2. Weighted mean total and component Family Planning Effort Index scores as a percentage of the maximum possible score, by region and globally, 2014

Program effort	Global	Asia/ Oceania	Central Asia/ Eastern Europe	Middle East/ North Africa	Latin America/ Caribbean	Sub-Saharan Africa	
						Anglophone	Francophone/ lusophone
Total	**56.1**	**60.3**	**42.0**	**47.3**	**52.3**	**49.0**	**46.2**
Policies	61.7	66.7	42.4	47.5	55.4	57.1	51.8
Services	52.6	57.4	31.9	47.2	44.4	45.5	43.5
Monitoring and evaluation	53.9	55.5	46.7	56.9	54.8	46.8	53.3
Access	56.7	60.3	51.5	44.9	58.1	47.9	43.7

Notes: Based on data from the 90 countries surveyed in 2014. The new 12-item access component was used to calculate the total and access scores. The regional average is the average score of the countries in the region, with the score for each country weighted by the country's population; the global average is also weighted by countries' populations.

they were often rated on opposite sides of the regional average and tended to offset each other (not shown). The total Family Planning Effort Index score and the component scores were weakest, with the exception of access, in Central Asia and Eastern Europe (32–47%). Russia, the most populous and thus most influential country in Central Asia and Eastern Europe, performed particularly poorly in the policies, services, and monitoring and evaluation areas, which depressed the regional average for these components (not shown).

The monitoring and evaluation component was ranked highest in the Middle East and North Africa (57%) and was rated fairly evenly across countries, with the exception of very high scores in Morocco and Tunisia and a very poor score in Libya, which had little effect on the average because of its small population (not shown). The access component was weakest in francophone and lusophone Sub-Saharan Africa (44%); this was heavily influenced by a low access score in the Democratic Republic of the Congo, the most populous country in the region.

Effect of Adding Items to the Access Component

In the decades during which the Family Planning Effort Index has been studied, the range of available family planning methods has expanded to include new choices, and interest in the quality of method-specific services has increased. We added five items to the original seven items in the access component to reflect these shifts. However, to maintain longitudinal consistency, we calculated the access component with all 12 items ("New measure") and also with the original seven items only ("Original measure"). We looked at the impact of the additional five items both globally and by region and found that the additions did not make a substantial difference in the access component score (Table 3).

A closer look at regional differences shows that Asia and Oceania's access average was the only one that declined notably when the new items were included (64% with original items vs. 60% with the additional items), which is in line with the observation of limited family planning effort progress in recent years in that region. Although the family planning programs in Asia and Oceania have historically been strong, improvements in recent years have been modest, possibly because of the higher baseline. Sri Lanka and Papua New Guinea were two clear exceptions to the Asia and Oceania pattern and were markedly stronger at providing the full range of new access features than the original group of items (not shown).

In contrast, nearly all other regions were slightly stronger in access efforts when assessed using the new access component than when using the original one. However, analysis at the country level revealed interesting patterns. First, the Middle East and North Africa region showed an increase of 1.1 percentage points in access when the new items were included. However, this was affected by the dramatic increase reported in Iran—the second most populous country in the region—of nearly eight percentage points; almost every other Middle Eastern and North African country reported a decline (not shown).

The access score for the francophone and lusophone region of Sub-Saharan Africa was one percentage point higher when the expanded access component was used; however, this was largely because of a 4.9 percentage-point increase in access in the Democratic Republic of the Congo, the most populous country in the region. In contrast, in anglophone Sub-Saharan Africa, approximately two-thirds of countries in the region scored higher under the new access measure than under the original access measure. Namibia and Eritrea were two clear exceptions, showing a decline of about six percentage points each; however, this had little impact on the regional averages because both countries have small populations. South Africa was a similar exception, with a decline of three percentage points (not shown).

The results for Eastern Europe and Central Asia and for Latin America and the Caribbean were more evenly distributed across countries. Approximately half of countries' scores decreased when all 12 items were included, while scores for the other half increased.

TABLE 3. Access component score as a percentage of the maximum possible score, by region and globally, according to access measure used, 2014

Region	Original measure	New measure
Global	58.9	56.7
Asia/Oceania	63.8	60.3
Central Asia/Eastern Europe	51.7	51.5
Middle East/North Africa	43.8	44.9
Latin America/Caribbean	57.7	58.1
Sub-Saharan Africa		
Anglophone	47.4	47.9
Francophone/lusophone	42.7	43.7

Notes: The original access measure was based on seven items; the new measure was based on 12 items. The regional average access score is the average access score of the countries in the region, with the score for each country weighted by the country's population.

Regional Scores for Additional Questions

Despite not being used to calculate the overall Family Planning Effort Index scores, the questions on program justifications, the emphasis programs put on special populations and the perceived quality of the country's family planning program add context to the Index scores and how they might be improved. They also shed light on how programs differ, country to country and region to region.

Globally, the most frequently cited justifications for national family planning programs were to improve women's health and avoid unwanted births, both scoring 76% of the maximum scores (Table 4). This finding was similar to past results.[11] Reducing unmarried adolescent childbearing was the lowest global priority at 52%, although this was heavily influenced by especially low ratings in Asia and Oceania (49%) and the Middle East and North Africa (25%), where nonmarital childbearing remains highly taboo. Reducing population growth was strikingly

TABLE 4. Weighted mean scores for additional program considerations as a percentage of the maximum possible score, globally and by region, 2014

Program consideration	Global	Asia/Oceania	Central Asia/ Eastern Europe	Middle East/ North Africa	Latin America/ Caribbean	Sub-Saharan Africa	
						Anglophone	Francophone/ lusophone
Justification							
Reduce population growth	68.5	78.1	11.3	53.8	57.8	66.0	50.4
Enhance economic development	65.3	67.1	49.1	59.2	61.2	70.3	64.3
Avoid unwanted births	76.1	75.0	74.6	71.5	77.4	82.1	85.1
Improve women's health	76.3	73.7	78.1	78.2	82.5	85.0	86.0
Improve child health	72.7	71.0	71.1	72.6	72.9	80.1	83.7
Reduce unmarried adolescent childbearing	51.7	49.1	62.9	25.3	64.2	63.8	68.4
Reduce unmet need	71.3	72.7	58.4	64.1	72.1	74.5	70.8
Emphasized populations							
Unmarried youth	40.2	39.3	41.8	20.4	60.7	43.3	47.8
Poor	62.2	66.5	35.3	61.2	64.4	56.7	49.8
Rural	68.9	75.3	38.0	65.4	62.3	57.7	56.9
Postpartum women	59.3	60.2	54.7	59.8	64.1	54.3	57.7
Postabortion women	55.1	56.3	56.4	47.7	49.7	53.1	55.0
Family planning service quality	**55.4**	**57.1**	**56.3**	**54.8**	**57.3**	**51.9**	**53.9**

Notes: The regional average is the average score of the countries in the region, with the score for each country weighted by the country's population.

unimportant in Central Asia and Eastern Europe, where it scored at just 11%—nearly 40 percentage points lower than the next lowest region, francophone and lusophone Sub-Saharan Africa. The two regions least concerned with reducing population growth also occupy opposite ends of the fertility spectrum (not shown). At the global level, reducing population growth was rated at 69%, in large part because of high scores in the populous Asia and Oceania region.

The population subgroup receiving the strongest emphasis was rural residents, with a global score of 69%. Asia and Oceania scored rural residents as the subgroup receiving the strongest emphasis (75%), while Central Asia and Eastern Europe identified this group as receiving the least emphasis (38%), prioritizing unmarried youth, postpartum and postabortion women higher (42–56%). Globally, at 40%, unmarried youth were seen as the least emphasized subgroup, attributable in part to low scores in Asia and Oceania (39%) and the Middle East and North Africa (20%). In contrast, the score for unmarried youth in Latin America and the Caribbean was 61%. This may reflect the relative social acceptability of sexual activity among Latin American youth, in contrast to, say, abortion; for instance, with a score of approximately 50%, postabortion women were seen as the least emphasized special population in Latin America and the Caribbean, ranking more than 10 percentage points lower than every other special population (61–64%).

The final item on the questionnaire asked respondents to rank overall family planning service quality in their country. Globally, the average score was 55%, and regional scores were distributed fairly closely around this number, with Latin America and the Caribbean and Asia and Oceania scoring the highest (57% each). (These two regions also had the highest total Family Planning Effort scores.) Anglophone Sub-Saharan Africa scored the lowest in family planning service quality (52%).

DISCUSSION

Family planning programs exist around the world; some have been in place for decades and have been strengthened over time, while others still receive low ratings. However, in the last five years, family planning program efforts have increased, from both a country-by-country perspective and a per-capita perspective, as evidenced by unweighted and weighted scores, respectively. Globally, each program component also gained in strength in the last five years, with the largest strides being made in access, followed by improved efforts in the policy area. Adequate access is necessary for the adoption of family planning; thus, the increase in access strength favors family planning uptake. Further development in monitoring and evaluation and in services, such as absence of financial incentives, provision of method removal services and regular supervision and training, will ensure that uptake is voluntary and occurs within the context of a rights-based approach. Justifications for family planning programs as assessed here have varied over the years, but most programs today focus on improving health among women and children, and enabling women to avoid unwanted births.

Although the 2014 Family Planning Effort Index demonstrates consistent global progress in family planning program effort in all four main component areas, the highest scores are still far from the maximum, and indicate areas for further improvement at both the country and regional levels. Furthermore, the quality of family planning programs was consistently rated at around 50% of the maximum by all regions, demonstrating that the in-country experts feel there is room for further growth.

Although improvements in family planning program effort have been steady, unmet need is still high in many developing countries,[12,13] which is indicative of gaps in access, services or policies that neither the public nor the private sector has addressed. Survey data continue to show that substantial proportions of births are still too closely spaced, are of birth orders greater than three or are occurring among adolescents—all of which are linked to adverse maternal and child outcomes.[14–16] As a result of insufficient family planning access, poor family planning services or negative sociopolitical environments, mistimed and unwanted births continue to occur, exacerbating unmet need. Greatly improved family planning access, services and policies may lower unmet need by decreasing barriers to family planning uptake, and may also increase the demand for contraception.[9,17] In any case, addressing unmet need and preventing unwanted pregnancies and births will relieve pressure on the health, economic and social sectors, leading to positive ramifications at the household, community and national levels.

There are many pathways through which national and subnational governments can improve their family planning programs and address the policy, service, monitoring and evaluation, access and uptake gaps. Governments can continue to improve the policy and access environment for family planning by removing bottlenecks in the supply chain, such as facilitating importation or local manufacture of contraceptives, and also by improving the enabling environment for private-sector provision of services and supplies. Additionally, governments can issue statements in support of family planning from prominent leaders, and can allow unrestricted family planning advertisements in the media. Programs can better reach those most vulnerable and in need by making a comprehensive range of methods and services easily accessible to all women—unmarried women, adolescents, migrant women, mobile populations, and poor and rural women. These efforts can use such traditional channels as public clinics or outreach via fieldworkers, as well as more innovative outreach methods, such as mobile health (e.g., mobile clinics or health services supported by mobile phones) or social franchising. In an increasingly urban world, channels for reaching mobile or hard-to-reach populations, urban youth or the urban poor will need to adapt to serve the women who have the least access and independent agency, but may be the most in need. And finally, as more and more births are attended by professional birth attendants, postpartum opportunities should be leveraged as a crucial point of contact for counseling women on their family planning needs, in both public and private facilities.

With the 2014 wave of the Family Planning Effort Index, up-to-date national and regional data are now available in the public domain, enabling policymakers, program planners and family planning researchers to further investigate program strengths and weaknesses, renew commitments from stakeholders and set priorities for future improvements. Lessons can also be drawn for policy and program improvements and for adjustments to the changing contexts in which the programs work, including decentralization, integration, funding reversals and attention to special populations. Finally, with longitudinal monitoring mechanisms such as the Family Planning Effort Index, governments, nongovernmental organizations and international agencies are equipped to more effectively allocate resources, identify shortfalls and devise country-customized approaches to improving family planning programs.

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RESUMEN

Contexto: *Desde 1972, el Índice de Esfuerzo de Planificación Familiar ha medido las actividades de los programas nacionales de planificación familiar en países en desarrollo y ha proporcionado una perspectiva longitudinal de un conjunto estandarizado de características de los programas.*

Métodos: *En 2014, usando un cuestionario estandarizado, expertos en 90 países en desarrollo evaluaron los esfuerzos realizados por los programas nacionales de planificación familiar en cuatro principales áreas componentes: políticas, servicios, mecanismos de monitoreo y evaluación, así como acceso a métodos. Los resultados se compararon con datos de años anteriores.*

Resultados: *A nivel mundial, los esfuerzos realizados por los programas nacionales de planificación familiar han progresado en las cuatro principales áreas componentes. El componente de servicios, que históricamente ha sido el más débil, obtuvo el puntaje más bajo de todos los componentes en 2014, a 47% del esfuerzo máximo, a pesar de una marcada mejora de 7.6 puntos porcentuales con respecto a 1999. Las políticas, generalmente el componente más fuerte, se mantuvo como el más sólido en 2014, con 55% del puntaje máximo y una mejora de 6.7 puntos porcentuales con respecto a 1999. El componente conformado por el monitoreo y la evaluación evidenció la mejora más pronunciada, de 7.8 puntos porcentuales, de 45% a 53%, mientras que el acceso tuvo una mejora modesta de 2.7 puntos porcentuales, de 49% a 52%. En general, los esfuerzos de planificación familiar fueron más fuertes en Asia y Oceanía, y más débiles en Asia Central y Europa Oriental.*

Conclusiones: *Los programas de planificación familiar han mejorado consistentemente a nivel global en las últimas décadas, aunque todavía hay espacio para un mayor desarrollo en todas las regiones.*

RÉSUMÉ

Contexte: *Depuis 1972, l'indice d'effort de planification familiale mesure les activités du programme national de planification familiale des pays en développement et apporte une perspective longitudinale sur un ensemble standardisé de caractéristiques programmatiques.*

Méthodes: *En 2014, les experts de 90 pays en développement ont évalué, sur la base d'un questionnaire standardisé, l'effort des programmes nationaux de planification familiale sur quatre plans majeurs: politiques, services, mécanismes de surveillance et d'évaluation et accès aux méthodes. Les résultats ont été comparés aux données des années précédentes.*

Résultats: *Globalement, l'effort des programmes de planification familiale a progressé sur les quatre plans. Celui des services, historiquement le plus faible, a reçu la cote la plus faible en 2014, à 47% de l'effort maximum, malgré une amélioration distincte de 7,6 points de pourcentage depuis 1999. Les politiques, qui représentent généralement le composant le plus fort, conservent cette position en 2014, avec 55% de la cote maximale et une amélioration de 6,7 points de pourcentage depuis 1999. La surveillance et l'évaluation présentent la plus forte amélioration, de 7,8 points de pourcentage, les portant de 45% à 53%, tandis que l'accès s'améliore plus modérément, de 2,7 points, de 49% à 52%. Les efforts de planification familiale se révèlent généralement les plus forts en Asie et en Océanie, et les plus faibles en Asie centrale et en Europe de l'Est.*

Conclusions: *Globalement, les programmes de planification familiale présentent une amélioration constante depuis quelques décennies, bien qu'il reste du chemin à parcourir dans toutes les régions.*

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APPENDIX 1. Weighted total and component Family Planning Effort Index scores as a percentage of the maximum possible score, by country, 2014

Country	Total	Policies	Services	Monitoring and evaluation	New Access (12 items)	Original Access (7 items)
Asia/Oceania						
Afghanistan	31.1	32.3	32.4	37.0	27.4	33.3
Bangladesh*	65.9	72.7	60.9	66.7	66.7	71.9
China*	67.9	73.9	63.1	57.4	71.6	72.5
Cambodia*	55.4	60.7	53.8	53.3	54.0	56.7
India*	55.2	61.9	54.3	53.6	52.2	59.8
Indonesia*	53.1	60.8	50.3	50.2	51.9	54.4
Malaysia*	63.2	59.5	60.3	73.3	66.2	65.6
Myanmar*	40.9	46.5	39.0	39.3	39.7	39.2
Nepal*	56.6	65.4	55.2	51.5	53.6	57.5
Pakistan*	47.7	54.2	46.4	41.9	46.1	46.3
Papua New Guinea	34.3	30.8	30.3	39.5	39.8	36.9
Philippines*	54.8	71.4	54.2	60.2	43.1	45.8
Sri Lanka	62.4	57.7	63.3	69.8	62.6	55.8
Thailand	71.5	68.3	69.7	74.7	74.7	73.7
Timor-Leste	32.8	33.1	29.4	35.9	35.7	35.2
Viet Nam*	66.9	75.0	62.4	62.0	67.8	73.2
Central Asia/Eastern Europe						
Armenia	32.1	31.9	25.5	32.2	39.2	37.7
Azerbaijan	35.1	41.8	23.7	28.5	44.8	44.9
Georgia	48.3	48.6	35.7	46.5	62.3	58.9
Kazakhstan*	40.5	47.4	29.3	31.9	50.2	49.8
Kyrgyz Republic*	51.4	44.2	51.2	74.3	50.6	55.6
Moldova	48.4	54.0	41.0	55.1	51.0	57.2
Mongolia	57.1	50.5	60.1	65.5	56.1	59.5
Romania	34.2	40.0	27.6	28.3	39.0	40.8
Russia	38.2	34.7	22.9	44.1	55.8	55.0
Tajikistan*	63.4	63.3	54.4	61.1	73.9	75.4
Turkey*	38.5	38.6	30.3	53.0	43.8	39.6
Turkmenistan	67.4	49.9	66.8	68.3	79.4	76.2
Ukraine	42.0	45.6	34.1	46.3	47.2	48.5
Uzbekistan*	64.7	76.4	65.8	58.7	57.0	71.0
Middle East/North Africa						
Algeria	48.3	64.3	52.6	59.9	30.2	30.4
Egypt*	50.1	53.5	49.8	53.7	47.2	48.5
Iran	39.2	27.9	42.7	56.2	38.6	30.8
Iraq	39.4	30.1	35.8	55.6	45.5	47.9
Jordan*	60.0	62.2	58.1	63.3	59.7	57.5
Lebanon	44.9	37.7	39.1	37.0	53.3	58.0
Libya	16.7	11.3	2.5	0.2	39.9	49.0
Morocco*	61.5	70.1	59.6	77.5	53.7	53.7
Oman	59.3	50.2	58.3	65.7	64.8	69.4
Tunisia	71.8	76.7	67.8	73.3	72.5	70.1
Yemen*	45.8	49.4	41.2	47.1	48.2	49.3
Latin America/Caribbean						
Bolivia*	47.0	43.9	43.0	63.4	49.2	52.0
Costa Rica*	47.6	58.1	43.3	45.8	45.8	55.0
Dominican Republic*	49.1	58.3	43.2	40.7	51.4	51.3
Ecuador*	45.8	46.8	37.5	29.9	58.1	53.2
El Salvador*	50.0	45.9	48.8	55.6	52.7	60.0
Guatemala*	34.5	33.6	30.7	29.0	40.7	40.1
Haiti*	50.3	63.9	42.8	50.7	49.3	47.9
Honduras*	54.0	55.1	51.9	65.0	52.7	56.3
Jamaica*	65.2	76.6	60.3	74.2	60.6	59.4
Mexico*	59.1	62.0	48.2	62.7	68.3	67.1
Nicaragua*	63.4	61.8	67.6	68.7	58.6	68.8
Panama*	37.4	40.5	32.2	36.1	41.3	41.8
Paraguay*	43.4	44.9	42.1	47.7	42.6	45.8
Peru*	41.3	46.3	33.6	49.6	44.2	41.2
Trinidad and Tobago	52.1	61.3	51.7	45.7	47.9	53.3
Anglophone Sub-Saharan Africa						
Eritrea	43.6	48.3	38.9	44.4	45.5	51.4
Ethiopia*	59.0	72.2	56.4	50.9	54.9	53.2
Gambia	46.5	39.1	44.6	46.9	53.5	52.1
Ghana*	53.8	56.5	50.2	67.6	52.6	49.9
Kenya	49.4	61.6	42.3	44.4	50.2	46.6
Lesotho*	42.2	48.8	39.1	39.1	41.9	40.9
Liberia	45.7	58.4	40.3	47.8	42.5	40.6

(*Continued*)

Country	Total	Policies	Services	Monitoring and evaluation	New Access (12 items)	Original Access (7 items)
Malawi*	47.6	45.8	46.1	53.7	48.9	46.6
Mauritius	64.7	52.8	63.2	79.3	70.6	68.7
Namibia	51.2	66.1	46.3	54.5	45.7	51.9
Nigeria*	40.7	50.1	37.7	37.1	38.6	38.5
South Africa*	60.8	66.0	53.7	60.4	65.3	68.3
South Sudan	22.5	33.1	22.0	18.1	17.0	19.3
Swaziland	52.3	50.3	49.4	66.4	53.3	51.5
Tanzania*	46.7	47.5	42.6	49.3	49.9	50.2
Uganda*	51.0	62.4	48.4	45.9	47.4	45.8
Zambia*	43.9	50.0	41.8	41.8	42.8	43.1
Zimbabwe	58.7	60.4	63.1	60.8	52.3	51.9
Francophone/lusophone Sub-Saharan Africa						
Benin*	57.3	59.0	58.1	68.7	52.3	50.6
Burundi	55.7	61.6	53.5	58.5	53.4	52.1
Cameroon*	38.6	42.4	36.0	33.1	40.3	42.3
Chad*	45.6	53.9	43.1	49.5	41.7	42.1
Congo*	38.1	41.9	36.9	34.1	37.7	37.2
Democratic Republic of the Congo	40.2	51.3	34.5	51.5	36.3	31.4
Côte d'Ivoire*	43.5	55.1	41.4	51.9	36.0	37.1
Guinea Bissau	43.3	34.7	43.9	44.5	48.1	49.2
Madagascar*	47.3	46.8	48.2	48.7	46.4	45.1
Mali*	50.9	54.6	51.9	54.0	46.7	46.3
Mauritania*	24.1	25.3	21.3	23.6	26.5	31.6
Mozambique*	43.1	42.9	38.1	64.1	43.4	46.3
Niger*	49.9	54.9	50.6	56.6	44.0	43.0
Rwanda	73.5	85.9	70.0	71.4	69.5	67.6
Senegal*	55.3	50.3	53.1	62.5	59.2	56.9
Togo	50.3	53.8	46.1	65.6	48.9	52.4

*One of the 54 countries followed since 1999.