THE respond PROJECT

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Reality Check Experiences: Use of a Program Planning and Advocacy Tool for Family Planning Initiatives

INTRODUCTION

The contraceptive prevalence rate (CPR) is a key benchmark in most family planning (FP) programs (MEASURE Evaluation PRH, [no date]). However, FP program designers, managers, and implementers often lack the data or tools needed to set realistic CPR goals and to develop plans to meet those goals.

Reality Check is an easy-to-use tool that FP programs can use to set realistic FP goals and plan for service expansion to meet them. It can also provide data for advocacy, by estimating program requirements for implementation along with the health impact of achieving contraception goals. The tool enables users (a) to quickly test future goal scenarios, including changes in the method mix, and (b) to compare those future scenarios with past performance, to determine whether current goals are feasible. Reality Check complements several existing FP tools[1]; Reality Check's uniqueness is that it allows for macro-level exploration of future goal scenarios at the subnational level and combines planning and advocacy outputs for all service providers (public and private).[2]

Between 2010 and 2014, under the RESPOND Project, EngenderHealth led Reality Check activities in eight countries: Bangladesh, Burkina Faso, Ghana, Kenya, Malawi, Senegal, Tajikistan, and Togo. Based on stakeholder interest, the nature of the activities ranged from a one-time training to an introduction and goal-setting exercise with high-level stakeholders, followed by a full training and training of trainers. While some Reality Check activities focused solely on national-level planning and forecasting, others built capacity for subnational planning and advocacy.

[1] In particular, Reality Check's goal-based commodity outputs can be used with John Snow Inc.'s PipeLine (USAID|DELIVER Project, [no date]), which helps users plan for contraceptive procurement and delivery and monitor stock levels. Further, the tool aligns with Impact 2 from Marie Stopes International (2014), which works at the micro level to estimate a single FP service organization's contribution to the national CPR and the health and economic impacts of FP services.

[2] More information on complementary tools for FP programming and advocacy can be found in the *Crosswalk of Family Planning Tools* (Godbole & Smith, 2012).

METHODS

Research Approach

To review the process and document the results of using Reality Check, RESPOND staff completed a desk review of key documents, including trip reports, activity reports, and workshop evaluations and reports. Further field research was conducted in Ghana, Kenya, Malawi, and Togo, where researchers held key informant interviews with 25 individuals, representing ministries of health and partner nongovernmental organizations: six in Ghana, seven in Kenya, six in Malawi, and six in Togo.

All interviewees had received training to use Reality Check or supervised staff who had been trained. The interviews explored ways in which Reality Check had been used, future plans to use it, challenges and successes, perceptions of and reactions to it, and ways in which the tool and the training and implementation process could be improved. Interviews were audio-recorded and partially transcribed, with relevant quotes transcribed verbatim. All interviewees provided oral informed consent to being interviewed and audio-recorded. ATLAS.ti was used to code and analyze interview notes and transcripts.

In addition to the structured efforts described above, observations on experiences in Senegal were gathered, and three individuals in Tajikistan were contacted via e-mail for their impressions.

"At the end of the year, we got together and we did planning for the coming year. Before Reality Check, we just did it in the dark. We did it without a scientific method. We said that this year we dispensed at this level, so next year let's add a little bit, without a scientific base."

—former District Medical Chief, Togo

Limitations

Not all Reality Check trainees were interviewed, and the opinions expressed by the interviewees may not be representative of all who were trained. Also, experiences in each country were different, and while Reality Check was introduced in eight countries, individuals from only four of the eight were interviewed. There is a possibility of courtesy bias in the responses; interviewees may have given responses that they expected the interviewer wanted to hear. Each country experience presented here represents a unique set of circumstances, and results in other settings may differ.

"The way we were doing our forecast was to check the actual consumptions from the facilities and add 10%... but always that has not worked for us, because oftentimes we would have stock-outs."

—Official in the Ministry of Health, Malawi

RESULTS

Past Approaches to Goal Setting and Quantification

Most respondents indicated that before Reality Check, they lacked a dedicated tool for goal setting and quantification for contraceptives; planners often used Excel worksheets or a calculator. PipeLine was the most frequently mentioned tool for developing supply-chain management plans, but it did not help respondents to use population-level data, set goals, or develop alternative method-mix scenarios. One Malawian respondent noted that planners had previously tried to model future changes in method mix but had not found a tool that could simulate different scenarios.

In the past, planners had generally used service statistics and contraceptive commodity reporting to calculate consumption for a given period of time. They then applied a percentage, often determined arbitrarily, to estimate the increase in ordering for the next year. One respondent in Togo said that stock-outs were a common problem with this method, particularly when forecasting exercises based on past consumption patterns did not take outreach activities into account.

In Ghana and Togo, lower-level officials were unclear on how national FP goals were determined, as they reported playing no part in these decisions. Rather, such officials were expected to meet goals established for their area at the national level, even if they considered them to be overambitious.

Use of Reality Check by Country

Kenya

In October 2011, RESPOND conducted a national stakeholders' meeting to introduce the tool to Kenyan government officials, donors, and development partners. Subsequently, representatives of the Division of Reproductive Health (DRH) and partners were trained in the use of Reality Check both for advocacy and for the planning of contraceptive procurement. The DRH then used Reality Check in quantification exercises in 2012 and again in 2013. In addition, independently of EngenderHealth, the DRH conducted a joint training with Management Sciences for Health (MSH), which trained DRH staff in PipeLine, while the DRH trained MSH staff in Reality Check, so the two tools could be used complementarily for forecasting and quantification.

"[Reality Check] has … in-built functionalities which help sell your case, in case you needed resources for family planning. There are graphs you can project…, and it is easy for policymakers to then make decisions based on what you're projecting through the various practical presentations. So it's a very good advocacy tool."

—Senior Technical Advisor, Management Sciences for Health, Kenya

In January 2012, at the request of the DRH, RESPOND conducted a training of trainers with representatives of six pilot districts in Rift Valley and Nakuru provinces. In August 2013, RESPOND met with trainees from the six districts to share their experiences and to discuss the extent to which Reality Check had been used, complementing the findings from the interviews.

DRH respondents reported that Reality Check has made forecasting and quantification easier and more focused on national goals. Reality Check also has helped the DRH leverage more funding for FP from the Kenyan government. According to one DRH respondent, FP funding from the Ministry of Health increased after the Reality Check training by 20% (from US $5.9 million in 2012 to US $6.9 million in 2013); this increase was due at least in part to advocacy conducted by the DRH using Reality Check data. Further, at the time of the interview, the DRH anticipated an additional increase in funding, to approximately US $7.9 million, for the next funding cycle.

"Reality Check came just at the right time.… The Directorate of Reproductive Health was thinking about applying to Parliament to set aside money to procure FP commodities, and people were talking about strengthening the FP pipeline.… Reality Check came basically when the house was on fire, and you guys were running to us with a bucket of water."

— Officer, Health Technical Support Services, Ministry of Health, Malawi

Trainees from two districts reported using impact projections from the tool in community advocacy work. In three districts, planners were using the tool to set district goals for the annual workplan and to forecast contraceptive needs. A DRH representative indicated that Kenya will continue to use Reality Check as its primary tool for national FP quantification; the DRH hopes to expand use of the tool into counties.[3]

Malawi

RESPOND introduced Reality Check to stakeholders in Malawi to help them assess the feasibility of the ambitious CPR goal established during the 2012 London Summit on Family Planning. RESPOND then built capacity to use the tool for short- and long-term planning at the national and district levels. In January 2013, at a national meeting to discuss the CPR goal, RESPOND and the Directorate of Reproductive Health introduced stakeholders to Reality Check and its outputs and implications. RESPOND subsequently held six regional stakeholders' meetings (from January to May 2013) to use Reality Check to develop CPR and method-mix goals, in preparation for the development of implementation plans for all 28 districts. The district health management teams were then able to use Reality Check data to inform their implementation plans. While not all FP activities in supported

[3] In 2013, Kenya changed its health system to encompass 47 counties, rather than eight provinces comprised of 70 districts.

districts were ultimately funded at the levels they requested, overall funding for FP activities in the 13 districts for which documents were available more than doubled, from US $144,00 in fiscal year 2012–2013 to US $324,000 in fiscal year 2013–2014 (Jarvis, Walton, & Kachingwe, 2014).

The regional meetings were originally planned only for 15 USAID-supported districts, but Malawi's enthusiasm about the goal-setting process in the initial districts led to a decision to set CPR goals in the remaining 13, with support from Population Services International (PSI) and the United Nations Population Fund (UNFPA). In June 2013, RESPOND trained 13 trainers, who subsequently trained 44 FP program managers in the use of Reality Check. RESPOND also provided the JSI-led USAID|DELIVER Project with district-specific estimates of the contraceptives and supplies needed to reach the 2020 goal, for use in an annual national quantification exercise. DELIVER used these data to order FP commodities for 2014 and confirmed in March 2014 that it plans to continue using Reality Check data for future quantification exercises.

A national-level official of the Directorate noted that in the past, when districts needed to trim budgets, they would often cut FP first; however, after being oriented to Reality Check and to the efforts needed to reach the national commitments, they took more ownership of FP activities, as evidenced by the dramatic increase in funding for FP activities. Further, 2013 was the first year in which the national budget included a specific line for FP commodities, indicating the increasing emphasis placed on FP in Malawi. According to a national official of the Malawian DRH, Malawi now has "better informed district health management teams, especially for planning." An assistant zonal supervisor stated that she would like to use Reality Check again during the next year "because it gives meaning to the planning."

Ghana

In Ghana, RESPOND built the capacity of district-level staff to use Reality Check, rather than begin by first engaging national-level stakeholders. In collaboration with EngenderHealth's Reducing Maternal Morbidity and Mortality (R3M) Project, in 2010

"Since the training, it was something like an eye-opener for me to know that these are the projections I have to make, this is the forecasting I have to do.... It tends to give you an idea that you don't just order in a vacuum. You should order based on some formula that is guiding you."

—Public Health Nurse, Ghana

RESPOND trained a representative of the Ghana Health Service (GHS) as a Reality Check trainer. Co-training of district-level GHS staff in two regions in the use of Reality Check for district planning and quantification followed in November 2010.

In Ghana, the tool has increased understanding and awareness of the national goals and what is needed at the district level to reach them. One public health nurse noted that knowledge of the gap has helped her put an FP strategy in place for her region and that she has used Reality Check to advocate with her superiors for additional resources for FP. While Ghana has not yet used the tool for planning, it has received funding from the European Union to work toward the Millennium Accelerated Framework for Millennium Development Goals 4 and 5; a portion of these funds has been set aside for improving quantification and forecasting systems for FP programs. To this end, the Ghana Ministry of Health has specifically budgeted for additional national- and district-level training on Reality Check in fiscal year 2013–2014.

Togo

In June 2011, RESPOND trained 15 staff from the Department of Family Health and partner organizations in the use of Reality Check for national goal-setting and planning. Since the training, however, the tool has been used only minimally, for three reasons:

- High-level stakeholders were not engaged from the beginning of the activity, and as a result, did not buy into its use.
- RESPOND was unable to support cascade trainings, and without the buy-in of stakeholders, cascade trainings were not implemented.
- RESPOND was unable to support integration of the tool into national forecasting exercises.

Respondents commented that they appreciated the tool, but thought it would have been more successful had there been additional follow-up after the initial training. Some commented that they would like to use the tool in the future, particularly because of how it can be used to advocate for programs.

Other Country Experiences

Senegal

Although interviews were not completed with stakeholders in Senegal, Reality Check activities in that country led to noteworthy outcomes. RESPOND facilitated the use of Reality Check for goal-setting and planning through a process of stakeholder involvement. In collaboration with IntraHealth International, which provides ongoing technical assistance to strengthen FP in Senegal, RESPOND introduced Reality Check to the national Contraceptive Procurement Team (CPT) in September 2011, providing demographic projections to complement the usual consumption-based forecast. A major challenge was that as part of the Millennium Development Goals process, Senegal had committed to meeting a national goal of raising CPR from 10% in 2010 to 45% by 2015.

In January 2012, RESPOND and IntraHealth led a meeting of national stakeholders, who used Reality Check to estimate the resources that would be required to achieve the 45% CPR goal. Agreeing that the country was not prepared to meet the 45% target, stakeholders used Reality Check data to establish a more realistic CPR goal of 27% for 2015. Senegal announced the revised goal at the London Summit on Family Planning in July 2012 and later used Reality Check to inform its national FP action plan.

Tajikistan

Tajikistan conducted its first ever DHS in 2012, revealing that the CPR among married women aged 15–49 had declined from 37.9% in 2005 (SCS, 2007) to 27.9% in 2012 (SA, MOH, & ICF International, 2012). In June 2014, RESPOND, in collaboration with Mercy Corps and the Quality Health Care Project (managed by Abt Associates), conducted a meeting of national FP stakeholders, including donors, partners, and government entities. In that meeting, RESPOND used Reality Check data to show the inputs required to increase CPR in Tajikistan and the effect that such an increase would have on maternal health. RESPOND also led a one-day hands-on Reality Check orientation for MOH, partner, and U.S. Agency for International Development (USAID) staff.

The exercise was timely, as Tajikistan is developing its next Reproductive Health Strategic Plan. As a result of the national stakeholders meeting and the in-depth Reality Check orientation, the MOH, USAID, and partners are equipped to set—and plan to meet—national and regional CPR goals that are both realistic and ambitious.

Immediately following the event, stakeholders had positive reactions to the tool and ideas for its use. One USAID staff member commented: "Reality Check is a very helpful tool. One of the main advantages is that it is easy to understand and easy to use... to set up country-specific and realistic goals for FP and how to achieve these goals through strategic planning, better planned services, and advocacy. It is also advantageous that the tool can be used starting from the national level by the government policymakers and down to the district level by health personnel, where population and CPR data are available."

KEYS TO SUCCESS

Stakeholder Involvement for Translating Data into Action

One key to Reality Check's success was involving individuals who have national decision-making power, including the director of the Division of Reproductive Health (or equivalent), donors, and representatives of the private sector and development partners, from the beginning of the project. In the most successful applications of Reality Check, groundwork was carefully laid by introducing the tool to decision makers before any training: In Kenya, Malawi, and Senegal, RESPOND began by introducing Reality Check to high-level officials in the Ministry of Health, who were enthusiastic about its potential and requested technical assistance. In contrast, in Togo, Reality Check was introduced directly to trainers and users rather than to decision makers. District-level medical officers then faced

"Initially I know people felt that the figures were huge; they had never seen those huge figures. But then when we came to explain that we are planning for scale-up and reaching the targets and so forth, people are comfortable with the figures now; even when they look quite huge, they are seen as realistic… But it looks like now it's being accepted and now they understand from where we are coming. We are not just planning for what is there; we are actually looking at a target."

—Official, Division of Reproductive Health, Kenya

the conflict between the Reality Check data and a plan that had been predetermined without their involvement. In places where planning for FP is top-down, regional or district-level officials may find themselves unable to influence goal setting or quantification exercises. Instead, they act only as policy implementers and must work with what the central level gives them. While high-level stakeholders do not necessarily need to be trained in the use of Reality Check, their understanding of its purpose and function and the data that it generates increases buy-in. Commitment from decision makers is critical to ensuring that Reality Check outputs are translated into advocacy messages, budgets, work plans, and other action steps; training individuals to use Reality Check without first laying this groundwork with stakeholders is not recommended.

Strategic Timing of Training

Respondents often stated that the timing of training is important. For Reality Check to be most successful, the country should initiate the process of establishing a new FP goal and plan to meet that goal, as in Malawi; should be open to the possibility of revising an existing goal, as in Senegal; or should be poised to budget and plan for an existing goal, as in Kenya. Several participants said it was, or would have been, helpful to receive training right before the national quantification exercise; the Reality Check trainer could then provide technical assistance so that the tool could be used as part of the exercise. A pharmacist in Malawi noted the importance of introducing Reality Check data to policymakers just before budget exercises. In Malawi, this timing helped the District Family Planning Coordinators and District Health Management Teams leverage more funding for FP in their annual district budgets. In Kenya, the head of the DRH used Reality Check data to advocate for more funding in the months following the Reality Check training.

"If you want [Reality Check] to succeed, you must follow it up. You must do supervision. That is one of our weaknesses I can see… just training people and just leaving them like that without any support, it's not possible. So if they send support, we can follow up these facilities and we can also expand."

—Official, Division of Reproductive Health, Kenya

Training an Adequate Number of People

Several respondents indicated that increased funds and increased numbers of individuals trained would have helped the process and that Reality Check was more successful when a greater investment was made in training. Some participants in the training of trainers said they had planned to roll the training out but had received no funding or support, either from RESPOND or from the government, and as a result the activity stagnated. In contrast, in Malawi, where cascade trainings were conducted, Reality Check was used nationwide for district-level planning, and in Kenya Reality Check has been used for quantification and advocacy at both national and regional levels. Training multiple people on a team or across teams also ensures that the knowledge will not be lost when one individual moves to another job.

Respondents noted the importance of cascade trainings. Many mentioned that they needed additional funding to train more people at the regional and district levels. A few indicated that they were not sure what was expected of them after the first supported cascade training: Who would lead additional trainings? Who would fund them? When should they occur? In Togo, where training was not cascaded beyond the national level, respondents indicated that Reality Check would be much more useful if they had received support to use the tool at the regional and district levels.

"When you follow up, people tend to think 'This is important, I need to do this, this is part of my job.'"

—Officer in the Ministry of Health, Malawi

Posttraining Follow-Up

Nearly every respondent from all four countries emphasized the importance of timely follow-up in order to institutionalize Reality Check. Some said that trainees needed to be reminded to use the tool, to be supported in overcoming challenges, and to monitor progress toward established goals. Most respondents agreed that regular, in-person follow-up is the most effective way to determine if and how the tool is being implemented and to ensure continued engagement of trainees. One respondent commented that follow-up must be timely; if trainers return for follow-up months later, they may find that trainees have done nothing. Several respondents also noted that they would forget how to use Reality Check without follow-up.[4]

Contraceptive Security

While accurate projections can estimate quantities of contraceptives needed, they do not guarantee that those contraceptives will be obtained. Funding for contraceptives and for FP activities continues to be a challenge across countries, as do poor supply chain management, transportation problems, and other elements of supply. Respondents noted that correctly projecting contraceptive needs was only half of the battle; obtaining the needed commodities was a different story. Further, projected contraceptive inputs must align with planned demand creation activities to ensure that FP uptake will meet the goal and to avoid waste. Reality Check will have a stronger impact if paired with contraceptive security activities and as part of a holistic FP program.

"We are not in charge of commodities. The commodities we request from national to the region, so if you request and there's none, there's nothing you can do. You really have to wait until there is stock, even at the regional level."

—Public Health Nurse, Ghana

Several participants in Ghana, Kenya, and Togo noted that they had used or could envision using PipeLine and Reality Check in complementary roles. They would employ Reality Check to set goals and determine the quantity of commodities needed and then would use PipeLine to organize the supply chain for contraceptives identified by Reality Check, helping to mitigate challenges of contraceptive stock-outs.

Accurate, Recent Population-Level Data

While district-level planning was encouraged, participants often did not have district-level data. Sometimes the only data available from the Demographic and Health Survey (DHS) were many years old, causing participants to question their accuracy and utility for planning. While service statistics or consumption statistics can be used at the district level in place of DHS data, this information often is not accurate; it is difficult to obtain comprehensive statistics from facilities across the public, private, nonprofit, and faith-based sectors. When forecasting is the goal and district-level data are not available, subnational-level consumption data can be cross-referenced with population data and used as a proxy measurement. However, if no reliable CPR estimates are available, stakeholders should not use Reality Check, as it is most effective when accurate data are available.

A simple, user-friendly tool

Responses regarding the difficulty of using the Reality Check tool varied widely. Several participants felt that Reality Check was relatively simple compared with other forecasting and planning tools. Reality Check does not require an Internet connection or special software; this fact makes it widely usable and accessible. In contrast, other participants reported that they found the tool difficult to use because it required extensive data entry as well as manipulation of cells within Excel. Many of those who faced challenges mastering the tool indicated that they did not use Excel routinely; such participants would need more practice time during training, or a longer training, to master the tool. To address this feedback, RESPOND has developed a streamlined, user-friendly version of the tool in a Windows format. The new tool, which requires minimal data entry,

[4] A new, simpler version of Reality Check approaching finalization at the time of this study may solve this problem.

walks users through multiple future "what if" CPR scenarios, instantly displaying graphs and tables that illustrate the inputs required to achieve the scenarios. The tool is equipped with national and subnational DHS data for dozens of countries.

CONCLUSIONS

As evidenced by successful applications in several countries, Reality Check can be useful in establishing realistic CPR goals, planning to meet those goals, and advocating for funding. Future research could explore the accuracy of Reality Check projections by comparing service statistics to use predicted by Reality Check. However, Reality Check is just one element of a comprehensive FP program; increasing CPR requires strengthening the supply of quality FP services, increasing demand for those services, and creating an enabling policy environment for FP. Timing of the intervention and stakeholder buy-in are critical to ensuring that goal-setting and planning translate into action. Posttraining follow-up is key to ensuring that Reality Check continues to be used for decision making and that trained users retain aptitude with the tool so that they can use it in future goal-setting and planning activities. The new streamlined, user-friendly version of Reality Check can be downloaded at http://www.respond-project.org/realitycheck/ or can be requested by e-mailing info@engenderhealth.org.

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