Using Impact 2 to estimate your contribution to reaching FP Summit pledges

The Family Planned summit pledged to reach 120 million additional users by 2020. Impact 2 can be used to help you estimate how many additional users your programme could contribute towards reaching the pledge.

What this means:

The pledge to reach 120 million additional users can only be achieved if services are also provided to sustain the 258 million women already using modern contraception in the world's poorest countries. At a programme level, this means you have to first account for what services would be needed to *sustain* those women already using family planning from your programme; only then can you look at your additional reach. Impact 2 can be used to do both of these, and in doing so, takes account of:

- **Substitution**—some women may be new to your programme, but, not new to family planning. If clients were already using a contraceptive method from another provider, they were already a user, so they will not contribute toward reaching 'additional users'
- **Sustaining your baseline**—in order to sustain the same number of users your programme had in 2012 out to 2020, you will need to provide resupply of methods to short-term method users and replace IUDs and Implants that have been removed. In addition, some women may stop using family planning as they no longer have a need for contraception, or, they might stop visiting your programme for other reasons. When this happens, you must reach adopters to 'fill the gap' in order to keep up your baseline number of users.
- **Reaching additional women**— only after you have accounted for substitution and sustaining your baseline can you contribute towards reaching additional users. These additional users must be family planning adopters (i.e. not currently using a method before coming to your programme)

Impact 2 is designed to look at your contribution to increasing CPR, which is similar to estimating additional users, however, it has an added dynamic of accounting for population growth. Because the FP Summit pledge is focused on absolute numbers of users, rather than CPR, the assumptions that go into the model need to be modified slightly. The step-by-step instructions below will help you to do this. More details can be found in the technical note at the end of the document.

What you need:

- Service provision data by method and year (pre-2012 already loaded for MSI countries)
- Client profile data (% adopters, % continuers, % changing providers) – this comes from exit interviews or programme plans

General approach:

There are 2 different ways that you can get to results:

A. Set a goal for number of 'additional users' to reach to determine how many services will be required to serve them
B. Enter planned future service provision, and see how many 'additional users' would be reached

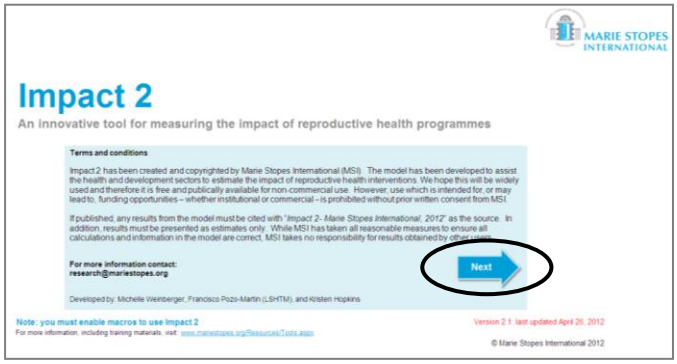
You will find step by step instructions below for each of these approaches. These steps will walk you through how to estimate all of the numbers needed to create a country-specific version of MSI's global pledge to the FP Summit. Depending on the audience (donor concept note, National Government, etc.), you may also wish to include your own information about how much money would be needed to achieve these results.

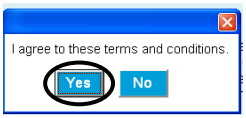
Step by step instructions:

A. Set a goal for number of 'additional users' to reach

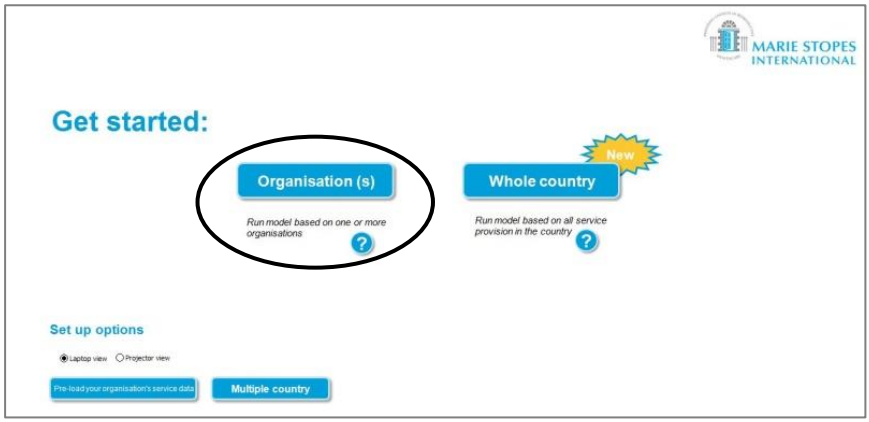
1. **Open Impact 2—make sure you have enabled macros or else the model will not work**

2. **Click next, and say "yes" to the terms and conditions**



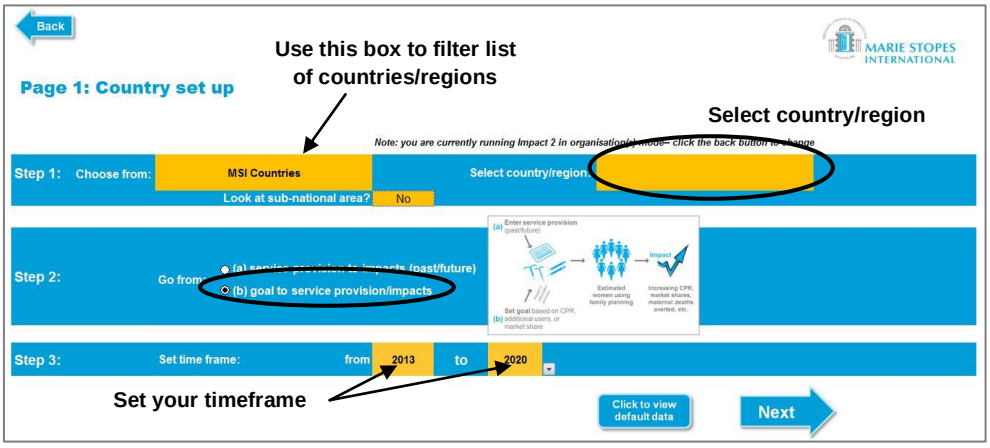


3. **Pick 'Organization(s)' mode**



4. **Select your country from the drop down list**

   Hint: use the list on the left to filter to the list of countries. You can also run Impact 2 on an entire region by selecting "Regions/sub-regions" from the filter list on the left.



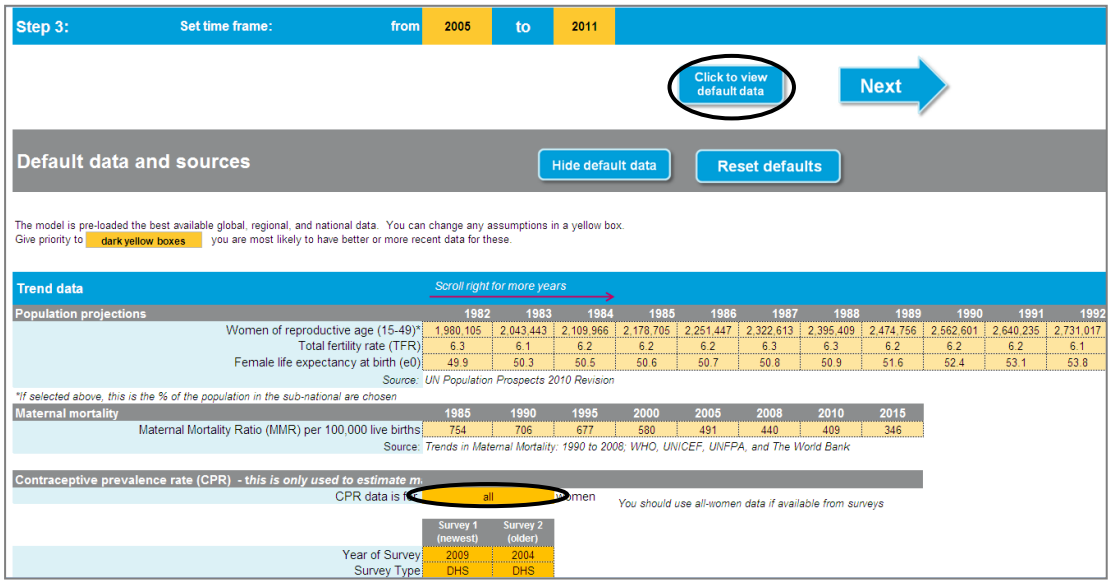
5. **Under 'Step 2' select (b) goal to service provision/impacts**

6. **Under 'Step 3' set your timeframe from 2013 to 2020**

   The FP Summit pledge uses 2012 as a baseline, and looks at increases that happen from 2013 to 2020. Therefore, you should set you start year at 2013 and your end year at 2020 (unless in your country they are looking at a shorter timeframe).

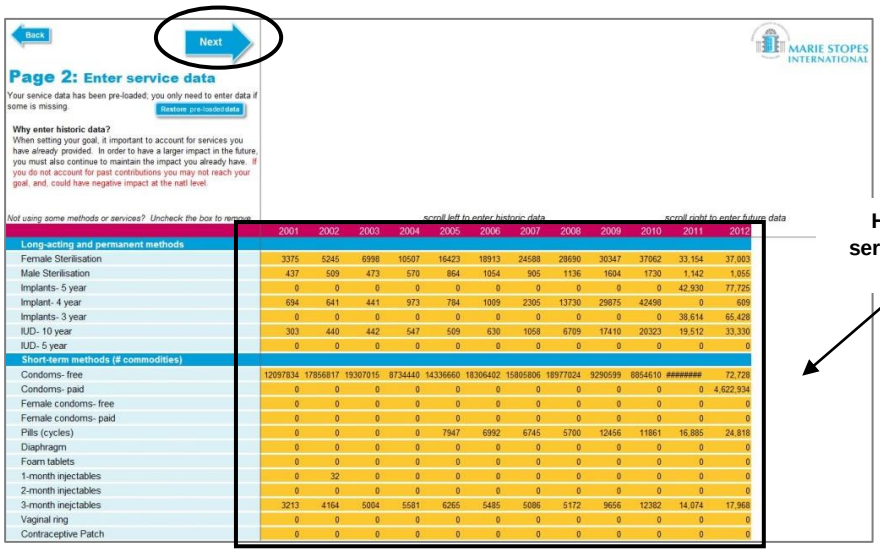
7. **Click the 'click to view default data".**

   Here you can review the data that is driving the model and update figures (CPR, MMR, etc) if you have more up-to-date figures than the most recent DHS.



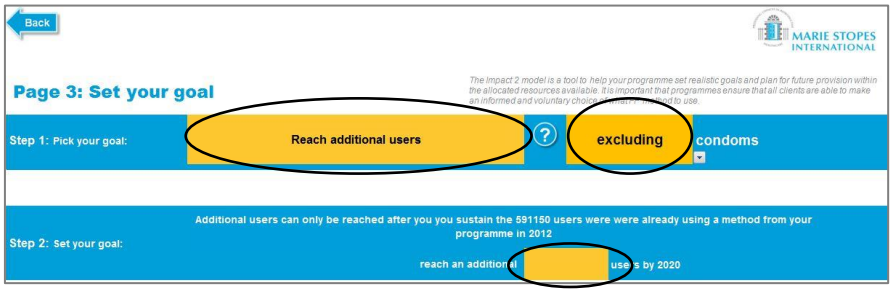
8. **Click next**

9. **Double check you service data for 2012 and hit next.**
   You county's historic services up to 2012 should already show up in the table (based on MSI's annual partnership statistics). However, this is a good opportunity to double check and make sure all the information is correct before moving forward.



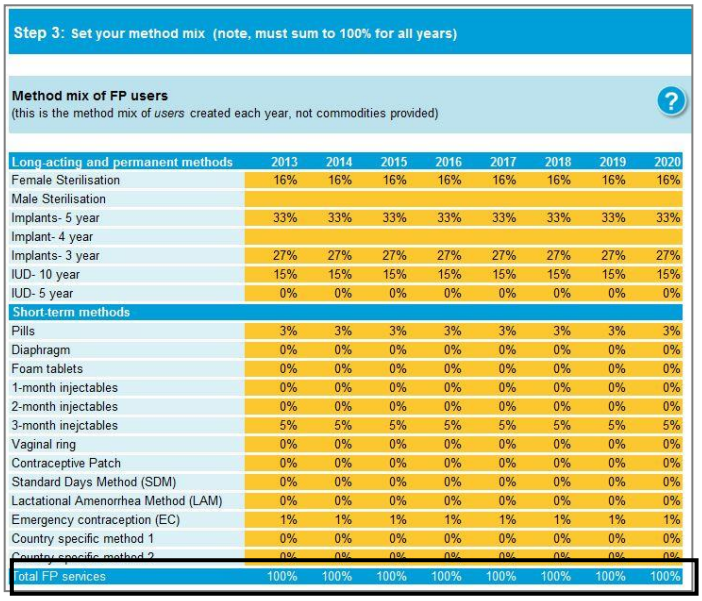
Historic service data

10. **Pick your goal in Step 1:**
    - **Pick "Reach additional users" from the drop down menu**
    - **Select "including" or "excluding" condoms.**
      We recommend excluding condoms so that condom use is not counted in your 'user numbers'. We don't know much about how many condoms that are sold/distributed are actually used, and, in some cases, condoms are being used for dual protection (i.e. at the same time as another FP method). For these reasons, the estimated of the number of 'condom users' is not very strong.



11. **Review the user number you will need to sustain in Step 2 and then enter the number of additional users your programme is aiming to reach by 2020 in the box.**

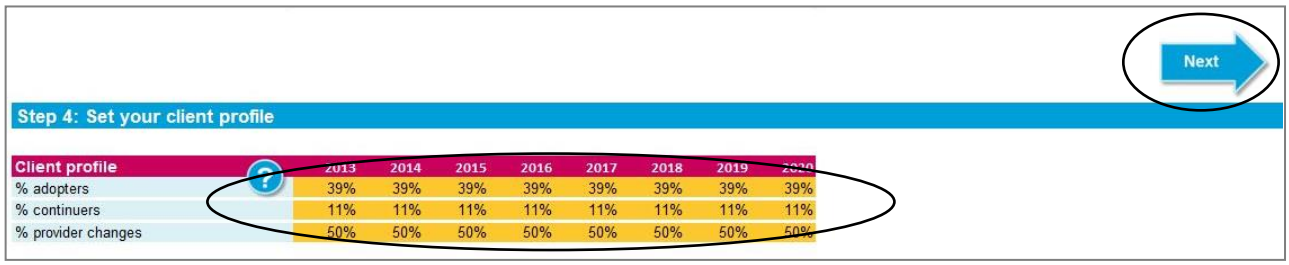
12. **Scroll down and set your method mix of FP Users for 2013-2020.**
    The method mix shown is the method mix of the 2012 services that you entered, applied over 2013-2020. If you think your programme will continue to provide a similar mix of services, you can leave this as it is. If not, you can update the method mix, just make sure that the total sums to 100%. *If you chose "excluding condoms" earlier, you will need to redistribute the % of condom users to other methods in order to reach 100%.*



13. Scroll down and enter your client profile, then click next

Client profile data can be taken from Exit Interviews, or, client-based information systems. If you country does not have this data, you will need to estimate what your client profile may be. A few important things to consider:

- You may wish to vary the client profile over time; for example, if your are expanding to a new area with low CPR you may reach a higher proportion of adopters in the first few years of your programme, but it will likely decline overtime as your begin to saturate the area.
- Think about the design of your programme- outreach to rural areas with low CPR will likely reach a higher % adopters than providing clinic-based services in urban areas.
- Make sure you document what client profile data you have used, so you can refer back to this later (copy and paste into a new Excel worksheet).

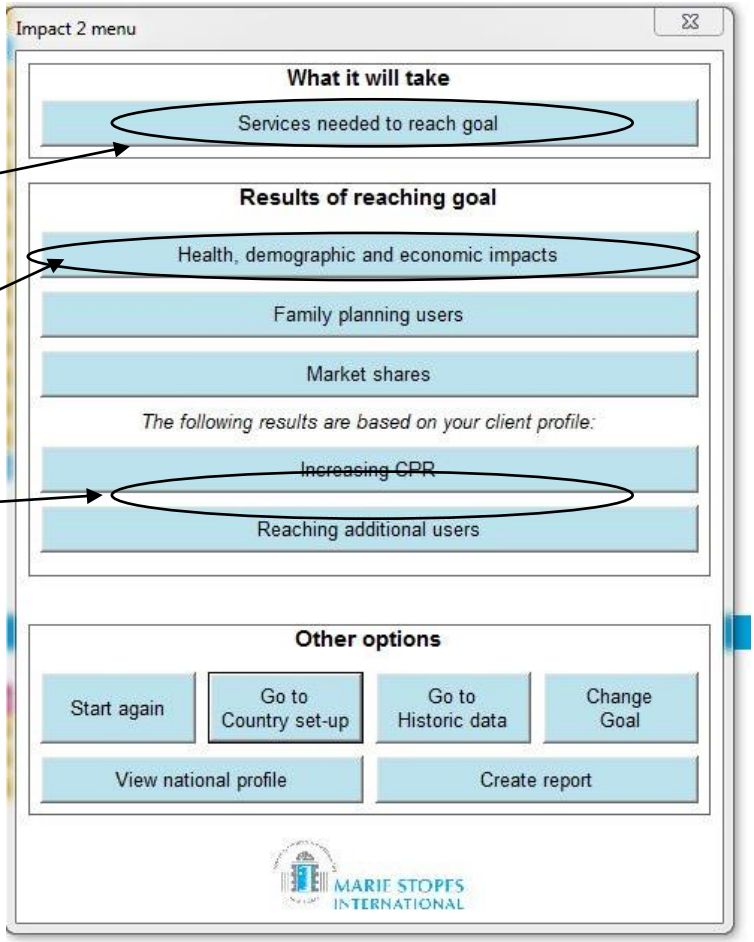


14. Select the results you would like to see from the Impact 2 Menu

When you click next, the following menu will pop-up. From this menu you can choose to view:

- The services needed each year to reach your 2020 Additional Users Goal
- The various impacts your programme is estimated to achieve by reaching that goal
- The number of additional users it is estimated your programme will reach between 2013 and 2020, given the inputs you provided.

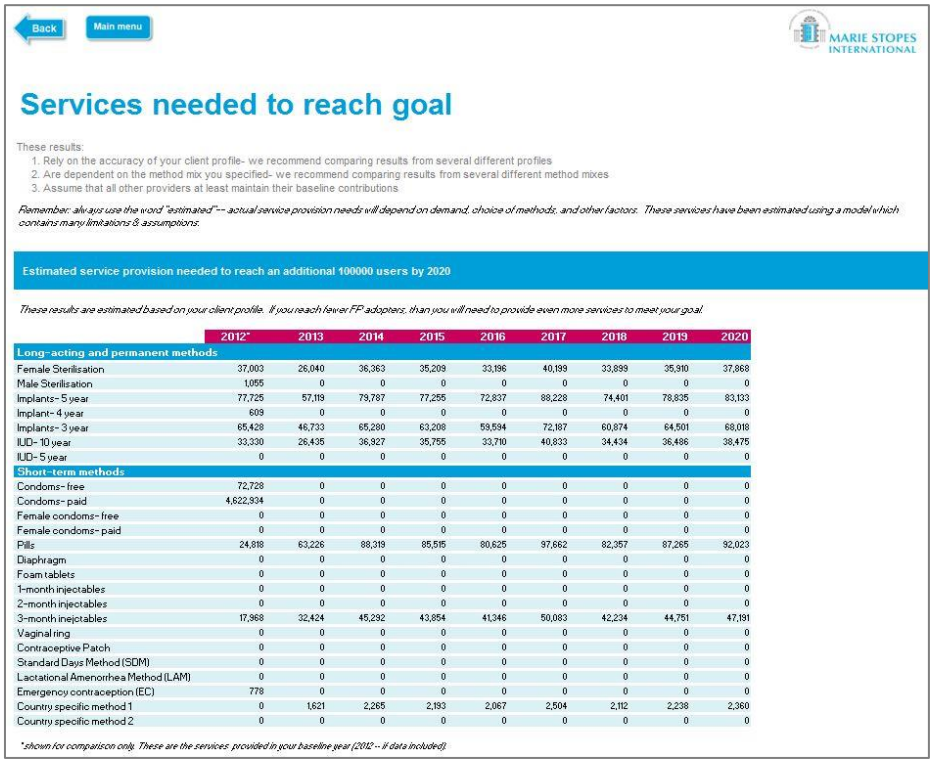
From each of these pages you can select the "Main menu" button to return to this menu, or hit the "Back" button to revise your target.



The following steps will walk you through the Impact 2 results produced.

Services needed to reach goal

This page describes the services that your organization will need to provide in order to meet the additional users goal set in the previous steps.



Back | Main menu

MARIE STOPES INTERNATIONAL

Services needed to reach goal

These results:
1. Rely on the accuracy of your client profile- we recommend comparing results from several different profiles
2. Are dependent on the method mix you specified- we recommend comparing results from several different method mixes
3. Assume that all other providers at least maintain their baseline contributions

Remember: always use the word "estimated" -- actual service provision needs will depend on demand, choice of methods, and other factors. These services have been estimated using a model which contains many limitations & assumptions.

Estimated service provision needed to reach an additional 100000 users by 2020

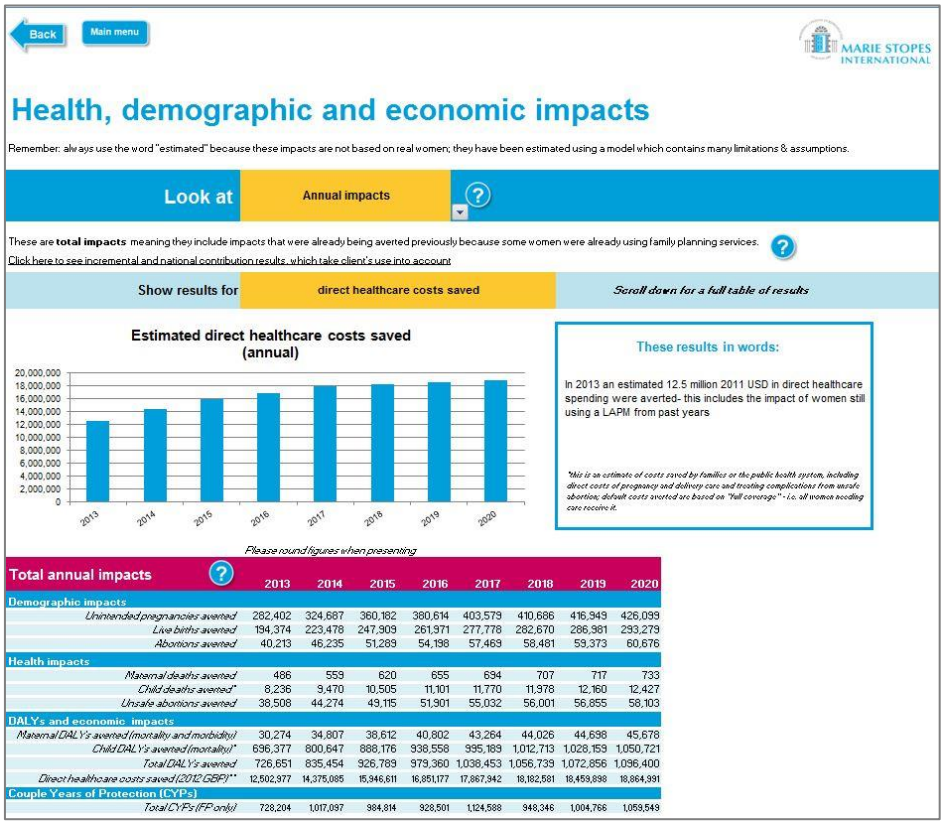
These results are estimated based on your client profile. If you reach fewer FP adopters, than you will need to provide even more services to meet your goal.

	2012*	2013	2014	2015	2016	2017	2018	2019	2020
Long-acting and permanent methods									
Female Sterilisation	37,003	26,040	36,363	35,209	33,196	40,199	33,899	35,910	37,868
Male Sterilisation	1,055	0	0	0	0	0	0	0	0
Implants- 5 year	77,725	57,119	79,787	77,255	72,837	88,228	74,401	78,835	83,133
Implant- 4 year	609	0	0	0	0	0	0	0	0
Implants- 3 year	65,428	46,733	65,280	63,208	59,594	72,187	60,874	64,501	68,018
IUD- 10 year	33,330	26,435	36,927	35,755	33,710	40,833	34,434	36,486	38,475
IUD- 5 year	0	0	0	0	0	0	0	0	0
Short-term methods									
Condoms- free	72,728	0	0	0	0	0	0	0	0
Condoms- paid	4,622,934	0	0	0	0	0	0	0	0
Female condoms- free	0	0	0	0	0	0	0	0	0
Female condoms- paid	0	0	0	0	0	0	0	0	0
Pills	24,818	63,226	88,319	85,515	80,625	97,662	82,357	87,265	92,023
Diaphragm	0	0	0	0	0	0	0	0	0
Foam tablets	0	0	0	0	0	0	0	0	0
1-month injectables	0	0	0	0	0	0	0	0	0
2-month injectables	0	0	0	0	0	0	0	0	0
3-month inejctables	17,968	32,424	45,292	43,854	41,346	50,083	42,234	44,751	47,191
Vaginal ring	0	0	0	0	0	0	0	0	0
Contraceptive Patch	0	0	0	0	0	0	0	0	0
Standard Days Method (SDM)	0	0	0	0	0	0	0	0	0
Lactational Amenorrhea Method (LAM)	0	0	0	0	0	0	0	0	0
Emergency contraception (EC)	778	0	0	0	0	0	0	0	0
Country specific method 1	0	1,621	2,265	2,193	2,067	2,504	2,112	2,238	2,360
Country specific method 2	0	0	0	0	0	0	0	0	0

**shown for comparison only. These are the services provided in your baseline year (2012 -- if data included).*

Health, Demographic, and Economic Impacts

This page describes the impacts of the services your organization will need to provide in order to meet the additional users goal set in the previous steps. These impacts include unintended pregnancies averted, maternal deaths averted, unsafe abortions averted, and direct healthcare costs saved, among others.



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MARIE STOPES INTERNATIONAL

Health, demographic and economic impacts

Remember: always use the word "estimated" because these impacts are not based on real women; they have been estimated using a model which contains many limitations & assumptions.

Look at: Annual impacts

These are **total impacts** meaning they include impacts that were already being averted previously because some women were already using family planning services.

Click here to see incremental and national contribution results, which take client's use into account

Show results for: direct healthcare costs saved — *Scroll down for a full table of results*

Estimated direct healthcare costs saved (annual)

These results in words:

In 2013 an estimated 12.5 million 2011 USD in direct healthcare spending were averted- this includes the impact of women still using a LAPM from past years

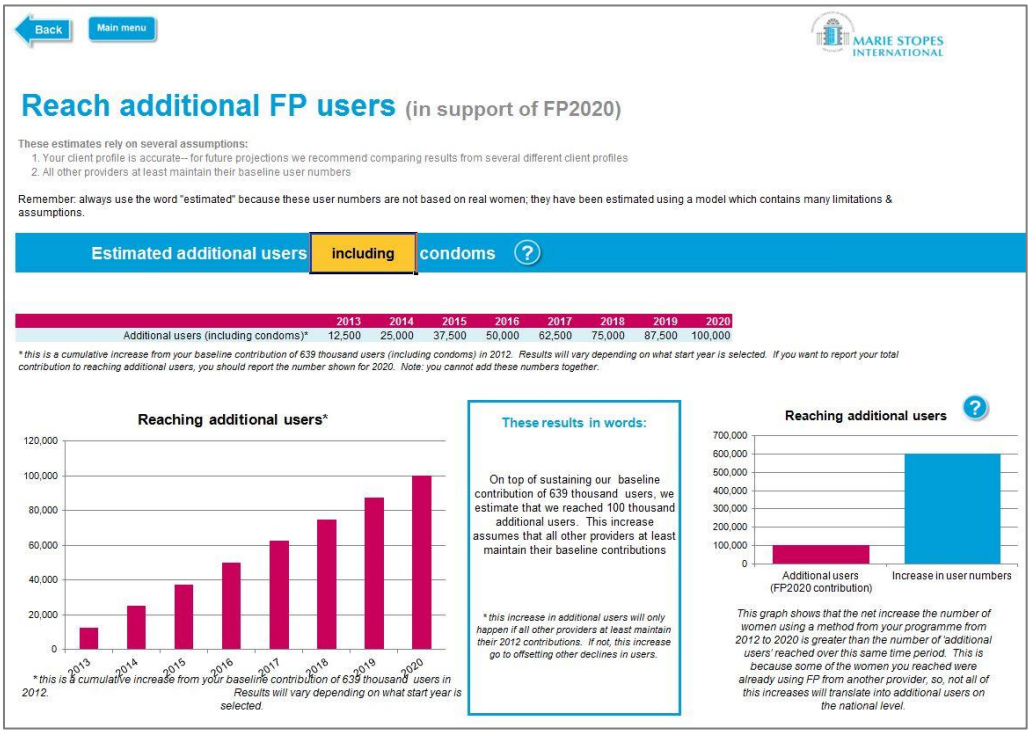
**this is an estimate of costs saved by families or the public health system, including direct costs of pregnancy and delivery care and treating complications from unsafe abortion; default costs averted are based on "full coverage" - i.e. all women needing care receive it.*

Please round figures when presenting

Total annual impacts	2013	2014	2015	2016	2017	2018	2019	2020
Demographic impacts								
Unintended pregnancies averted	282,402	324,687	360,182	380,614	403,579	410,686	416,949	426,099
Live births averted	194,374	223,478	247,909	261,971	277,778	282,670	286,981	293,279
Abortions averted	40,213	46,235	51,289	54,198	57,469	58,481	59,373	60,676
Health impacts								
Maternal deaths averted	486	559	620	655	694	707	717	733
*Child deaths averted**	8,236	9,470	10,505	11,101	11,770	11,978	12,160	12,427
Unsafe abortions averted	38,508	44,274	49,115	51,901	55,032	56,001	56,855	58,103
DALYs and economic impacts								
Maternal DALYs averted (mortality and morbidity)	30,274	34,807	38,612	40,802	43,264	44,026	44,698	45,678
*Child DALYs averted (mortality)**	696,377	800,647	888,176	938,558	995,189	1,012,713	1,028,159	1,050,721
Total DALYs averted	726,651	835,454	926,789	979,360	1,038,453	1,056,739	1,072,856	1,096,400
*Direct healthcare costs saved (2012 GBP)***	12,502,977	14,375,085	15,946,611	16,851,177	17,867,942	18,182,581	18,459,898	18,864,991
Couple Years of Protection (CYPs)								
Total CYPs (FP only)	728,204	1,017,097	984,814	928,501	1,124,588	948,346	1,004,766	1,059,549

Reach additional FP Users

This page describes the estimated cumulative additional users your programme will reach over the period of 2013-2020, in order to reach the target you set in the previous step by 2020.



15. Document and present your results

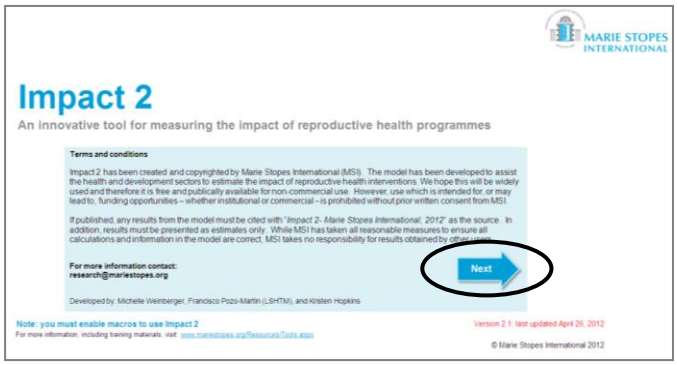
Present these in a short summary paper. Key points to include:

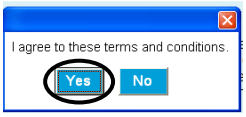
- This reflects the cost to both maintain your baseline user number and reach an additional xxx users by 2020
- This accounts for the fact that once you reach an additional user, you need to keep that user supplied with contraceptives until 2020 (e.g. you reach 100 additional women in 2013 with pills- you would need to keep providing them pills (or another method) until 2020 so that they are still 'users' in 2020)
- This accounts for substitution- so that you are not getting 'credit' for taking clients from other providers (but—you should stress that for these women, you are providing access to improved choice and quality)
- Remember—the client profile plays an important role in determining how many services you need to provide to reach your goal (i.e. higher % adopters = fewer services provided to reach goal). We don't want to over commit, so make sure you keep your projections realistic (e.g. you are unlikely to reach 90% adopters each year)

B. Enter planned future service provision, and see how many 'additional users' would be reached

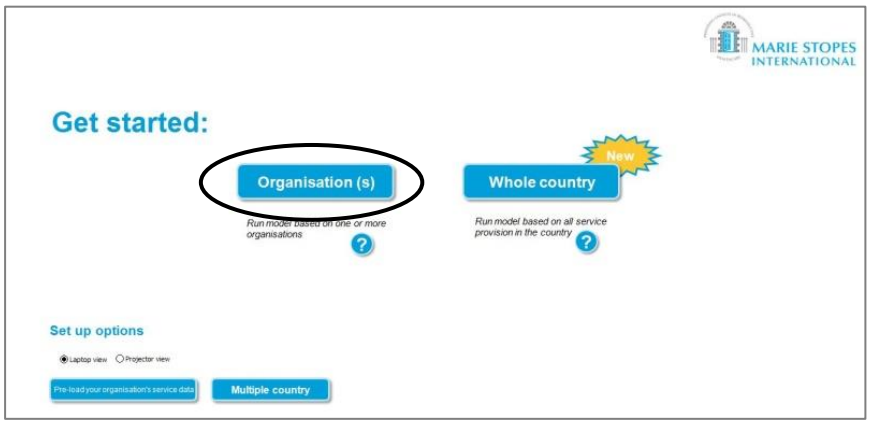
1. **Open Impact 2—make sure you have enabled macros or else the model will not work**

2. **Click next, and say "yes" to the terms and conditions**



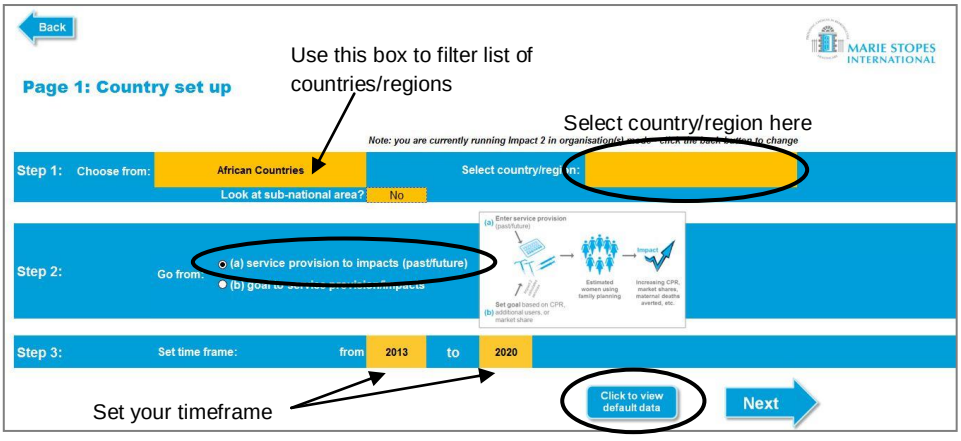


3. **Pick 'Organization (s)' mode**



4. **Select your country from the drop down list**

   Hint: use the list on the left to filter to the list of countries you are looking for. You can also run Impact 2 on an entire region by selecting "Regions/sub-regions" from the filter list on the left.



5. **Under 'Step 2' make sure "(a) service provision to impacts (past/future)" is selected**

6. **Under 'Step 3' set your timeframe from 2013 to 2020**

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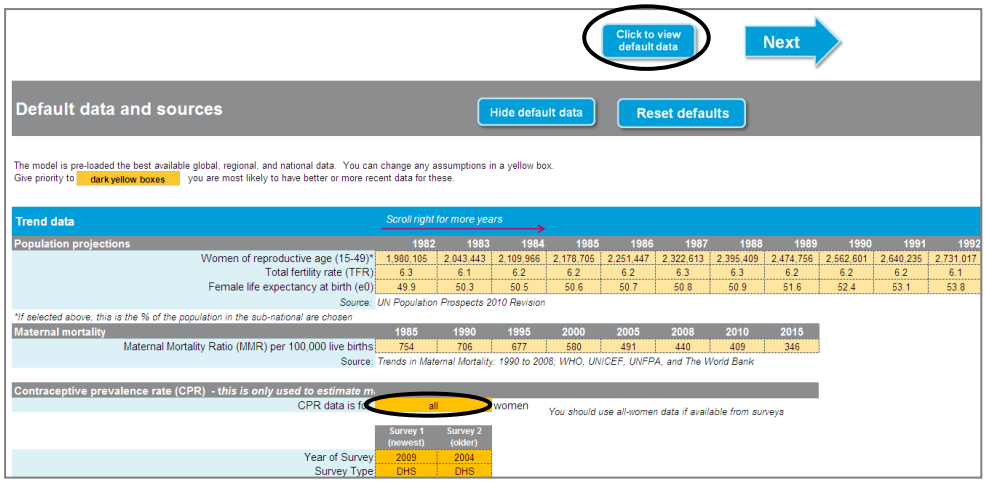
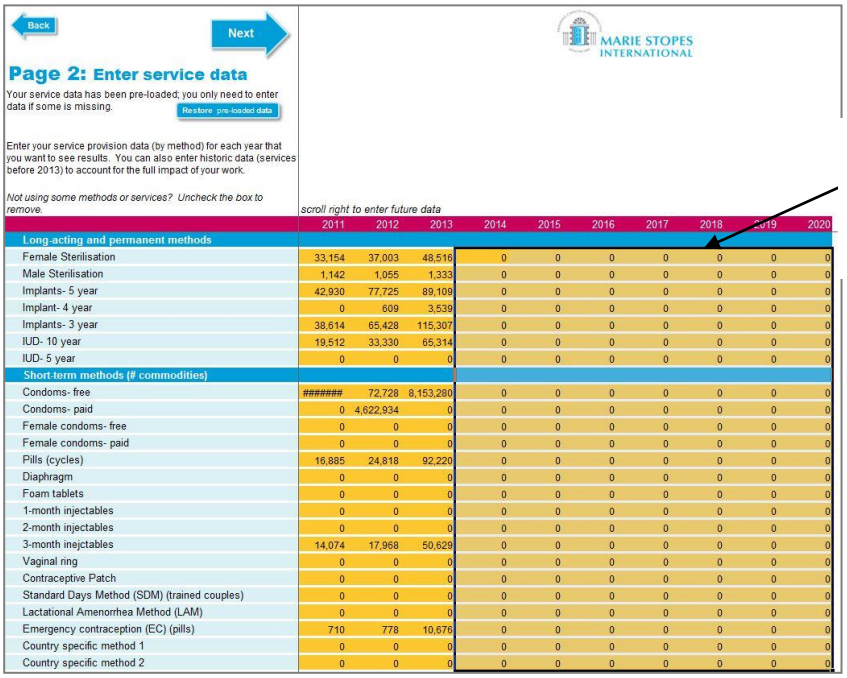


8. **Click next**

9. **Enter service data for 2014 to 2020, and click next**
   You county's historic services up to 2013 should already show up in the table (based on MSI's annual partnership statistics). The FP summit uses 2012 as a baseline.

   You will need to enter the services you plan to provide from 2014 to 2020—your contribution to reaching additional users will be estimated from these service numbers. You can estimate these in a few ways:

   - If you have a specific 'ask' for money— you can work backwards to services that could be provided with this money
   - You can assume a set growth rate in your service numbers continues out to 2020



Fill in service provision numbers by method for 2014 to 2020.

10. Enter a client profile for 2013 to 2020, then click next

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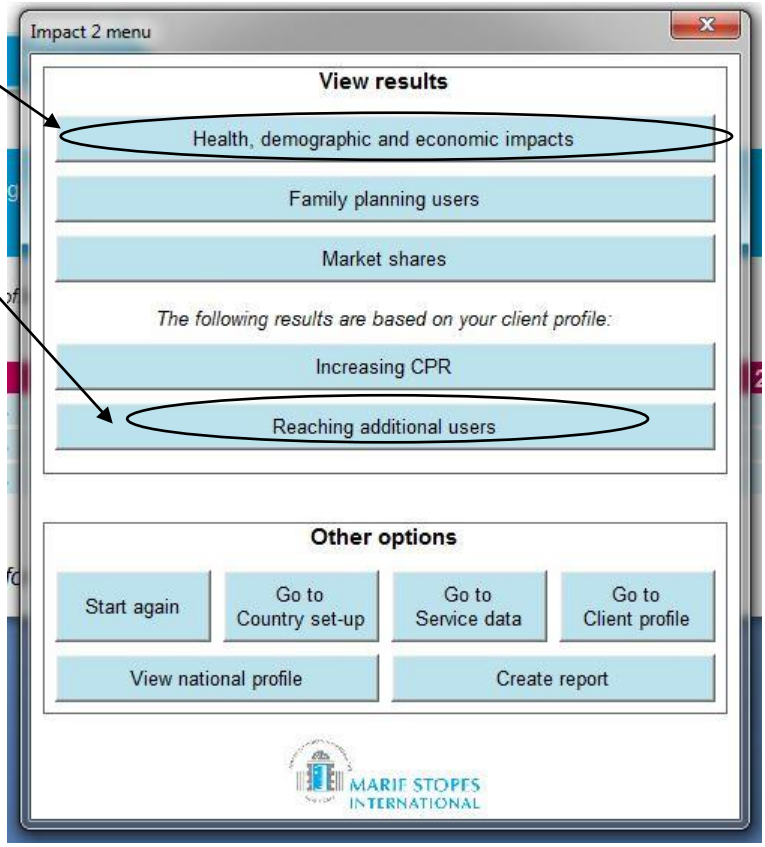

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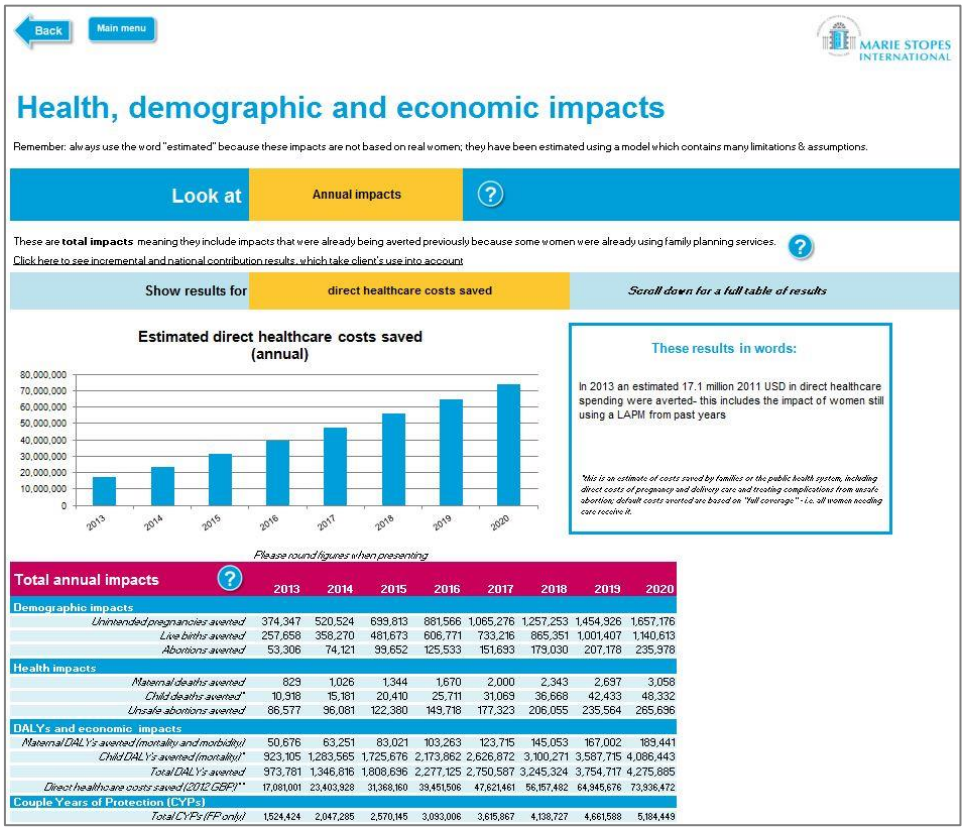
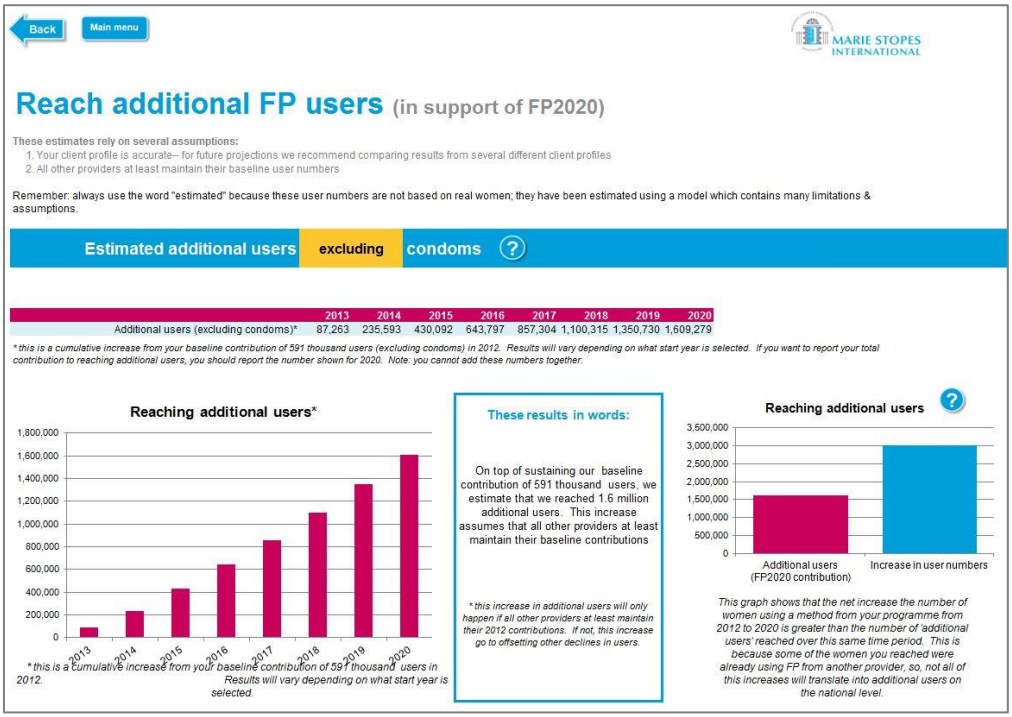


Reach additional FP Users

This page describes the estimated cumulative additional users your programme will reach over the period of 2013-2020, based on the services you plan to provide and your client profile.



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- Remember—the % adopters in your client profile plays a big role in determining how many additional users your will reach. We don't want to over commit, so make sure you keep your projections realistic (e.g. you are unlikely to reach 90% adopters each year)

Interpreting results

It is important to correctly interpret and write about results generated using Impact 2:

- **% point contribution to increasing CPR:** The results calculated by Impact 2 are a programme's estimated percentage point contribution to *increasing* CPR above their baseline contribution. This result is *cumulative*, meaning that the CPR increase show in the final year of the trend represents the full increase from the baseline. In addition, this means that a programme's *total contribution* to CPR will be the increase + the baseline contribution.
  - ➔ *"on top on maintaining a baseline contribution of 3% points, our programme will further increase the national CPR by 2% points"*

- **Other providers at least maintain their baseline contributions**: The model isolates the contribution on an individual service provider. In doing some, there is an underlying assumption that all other providers *at least* maintain their baseline contributions. If not, the increase contributed by the programme will offset these other declines, meaning, a national-level increase may not be realised.
  - ➔ *"Note: in order for CPR to increase, all other providers must at least maintain their 2010 contributions."*

- **Retrospective analysis:** A programmes estimated contribution to increasing the national CPR can be compared to a measured change in CPR (based on DHS or other surveys). For example, a programmes contribution to increasing CPR from 2005 to 2010 was estimated to be 2% points. And, based on DHS survey done in 2004 and 2010; the national CPR increased by 10% points (from 20% to 30%) between these two surveys.
  - ➔ *"Our programme contributed 2 of the 10% points increase in national CPR from 2004 to 2010, or in other words, our programme was responsible for 1/5th of the increase in CPR."*

- **Negative results:** When including historic services, it is possible to see negative contributions to increasing CPR. This is negative because a programme did not provide enough services to maintain their baseline contribution. This means that the national CPR could decrease, unless other providers increased their service levels.
  - ➔ *"Our programme did not provide enough services to maintain our 2010 CPR contribution. Therefore, unless other providers increase their contributions, national CPR may decline"*

Key assumptions and limitations

- **Results are very dependent on the client profile** (e.g. % adopters, % continuing, and % changing from another provider): It is recommended that programme's conduct regular exit interviews so that they can have an accurate picture of whom they are reaching. However, when making future projections, programmes must rely on a 'best guess' for who they are going to reach in the future. Therefore, it is recommended that CPR increases are re-run with several different client profiles to show a range of potential impact depending on how well a programme does at reaching adopters.
- **Assume all other providers at least maintain their baseline contribution:** If a provider shuts down, the assumption that other providers at least maintain their baseline contributions will not hold. In this case, an organisation may wish to count clients who change from the shut provider towards CPR contribution, rather than excluding them altogether. This is because these women might stop using contraceptives (thus drop out of the CPR) if they do not get access elsewhere. proportion of continuers.
- **Reliance on demographic projections from the United Nations:** Impact 2 uses data on fertility rates (e.g., Total Fertility Rate (TFR)) and demographics (e.g., WRA), meaning, the model is unable to account for a dynamic relationship between increased contraceptive use, fertility rates and population growth and age structure. However, because Impact 2 works on a relatively short time frame, the projected WRA population used to estimate CPR contributions will not be affected by short-term changes in the CPR and TFR, due to a lag between the emergence of smaller birth cohorts and when these cohorts reach reproductive age. Therefore the micro level results from this model are still useful and relevant.
- **Accounting for impacts beyond the CPR:** Focusing on increasing CPR does not capture many of the benefits of family planning programmes. For example, women who were already using FP from another provider do not count towards a programmes contribution to increasing CPR (because these women were already in the CPR). However, if the programme offered them greater choice of methods (and access to more effective methods), or greater quality services, an additional benefit was provided. Therefore, other metrics should also be captured to show these benefits.

For more information on how impacts are calculated, full details can be found in the methodology paper, available online here: http://www.mariestopes.org/impact-2