



Interpreting and Understanding Additional Users as Reported by Family Planning Programs

Purpose:

This document is meant to serve as a guide for those who are receiving reports on programmatic contributions to the FP2020 goals and pledges. It offers several points of consideration that the reader will wish to examine, when interpreting the number of additional family planning users reported by a program or organization, as well as the implications for the data when best practices were not followed, for any reason.

Data source:

This document assumes that the calculation of additional users of family planning comes from [MSI's Impact 2 calculator](#). MSI's Impact 2 calculator is a model, and provides a modeled aggregate estimate of additional users of family planning, above a user defined baseline year. The model makes the crucial assumption that all other providers in the country maintain their baseline contributions.

Example results:

MSI Ethiopia estimates that its programs contributed 25,000 additional users of family planning between 2013-2016, on top of sustaining its baseline contribution of 325,000 users.

Additional users were calculated using the Impact 2 model, including full historic data for MSI Ethiopia's services and socially marketed commodities, and data from yearly client exit interviews, representative of all MSI clinics.

Results notes and points of further inquiry:

1. Results above make it clear that this estimate is for a 4-year time frame (2013-2016). It implies that the baseline is 2012, but does not make it explicit.

When viewing or comparing estimates, the reader can ask:

- What is the baseline year?
 - What is the time period for the additional user estimate?
2. Example results above note that full historic data was used to calculate additionality results. This is the ideal approach, but may not always be feasible. Historical data refers to service provision data prior to the baseline year. When prior years' service provision data is included in the Impact 2 model, the number of users that have to be sustained, before additional users can be counted, goes up. The more years of



historical data that are entered, the larger the contribution of sustaining users to maintain.

When viewing or comparing estimates, the reader can ask:

- Is historical service provision data included in the model?
 - How many years of historical service provision data is included?
 - If no or limited historical service provision data is included, is an explanation provided?
3. Results note that service provision data included both services (presumably provided in a clinic) and socially marketed commodities. No detail on how the statistics from these two different points of sale is collected is provided.

Often, clinic based service statistics record each client and the service or commodity they received, providing a full count over the time period in question. By contrast, socially marketed commodities may be counted at the point of distribution, or through inventory adjustments, rather than at the point of sale. These figures would likely be higher than the number of commodities which were actually used, due to wastage at various points along the supply chain. Given that socially marketed FP commodities are primarily short term methods, the effect of reporting more commodities than were actually used will not affect the number of users an organization has to sustain over time, but could inflate the number of additional users reported.

When viewing or comparing estimates, the reader can ask:

- How are the service statistics data collected?
 - Are all data collected in a comparable way?
 - Does the organization account for supply chain wastage in its estimates?
4. Results indicate that the second source of data, to understand the client use profile, comes from yearly exit interviews, representative of all MSI Ethiopia clinics. The second source of data is crucial for the additional user calculation, and can come from routine or survey data. It identifies whether FP users are continuing use with the same provider, changing providers, or are adopting FP. Data on the client use profile must be entered for each year, but organizations may not be able to conduct a survey yearly to collect this data, or they may be reporting projections, for which it is not possible to know the use profile of clients. Second, in this example, client use profile data is representative of MSI clinics, but the service statistics data includes clinics and socially marketed commodities. While it may not be feasible to assess the use profile of those who purchase the socially marketed FP commodities, it is worthwhile to understand if they are similar to or different than clients of clinics.



When viewing or comparing estimates, the reader can ask:

- How were the client use profile data collected?
- Were they collected for each year of the reporting period? If not, what method was used to enter data for years in which data was not collected?
- Is it appropriate for the organization to provide a range for the additional users served, based upon different potential client use profiles?
- Is the population from which client use profile data was collected the same as the population from which service statistics were provided? If not, is an explanation provided for how this may impact the additional user estimate?