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OPTIONS

Strategic Planning for the Expansion of Family Planning

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STRATEGIC PLANNING FOR THE EXPANSION OF FAMILY PLANNING

BY THOMAS W. MERRICK

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PREFACE

OPTIONS for Population Policy II is a five-year project funded by the Office of Population of the U.S. Agency for International Development. The goal of the project is to help A.I.D.-assisted countries formulate and implement policies that address the need to mobilize and effectively allocate resources for expanding family planning services. The project provides technical assistance to:

- improve the analytic capacity of developing country institutions to design, manage, and monitor family planning programs;
- assess legal and regulatory policies affecting the delivery of family planning services;
- promote efficient use of public sector resources in family planning programs; and
- increase private sector participation in service delivery.

The OPTIONS II Project has developed special policy approaches to promote expanded support for family planning. Technical experts have prepared working papers aimed at codifying project experience and analytic approaches. The papers are intended to provide uniform guidance to OPTIONS current and future staff, furnish A.I.D./W and Mission staff with analytic tools to improve program and strategic planning, and help developing country policy makers and analysts to conceptualize and critically analyze policy aspects of the population sector.

The papers are being published as part of an ongoing Policy Paper Series focusing on various aspects of operational policy in family planning. Titles in the Policy Paper Series include:

(1) Assessing Legal and Regulatory Reform in Family Planning

(2) Strategic Planning for the Expansion of Family Planning

(3) Policy Issues in Expanding Private Sector Family Planning

(4) Communicating Population & Family Planning Information: Targeting Policy Makers

(5) Cost Recovery and User Fees in Family Planning

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INTRODUCTION

A revolution is under way in reproductive behavior in developing countries. Between 1960 and 1990, contraceptive use in less developed countries (LDCs) expanded by 325 million women. Back in 1960, only nine percent of an estimated 415 million married women in reproductive ages were using some form of fertility control, including traditional methods. By 1990, the proportion of users had increased to an estimated 51 percent. Contraceptive use has expanded most in East and Southeast Asia and in Latin America. There are also signs of progress in South Asia, the Middle East and North Africa. Even in sub-Saharan Africa, where average prevalence remains low, there are positive signs in countries such as Zimbabwe and Kenya.

Over the same 30 years, the number of married, reproductive-age women in LDCs increased from 416 to 716 million. Because of this very large increase in the number of women, the increase in prevalence reduced the number of women not using contraceptives by only 30 million, from an estimated 380 million to 350 million. Further, China accounts for over 40 percent of current users in the developing world. Excluding China, the proportion of users drops to 41 percent for all methods and 34 percent for modern methods.

Demographic momentum will add another 170 million to the potential user population during the 1990s. Women who were born when fertility rates were higher are now entering their reproductive ages. Just to maintain current levels of prevalence, services will have to be expanded to an additional 87 million women during this decade. To maintain the pace of fertility declines assumed in the United Nations medium range projections, contraceptive use will have to be expanded by at least 62 million more women who currently are not users. This means that during the 1990s services need to be expanded by half again as much as they were during the previous three decades.

Organized family planning programs have played an important role in the expansion of contraceptive use. Yet, to deal with current challenges, program planners and managers have to mobilize more financial and human resources to meet rapidly growing demand, extend access to underserved groups, improve deficiencies in service quality, and maintain current standards of quality lest they erode under pressure from the increased numbers of clients. These challenges differ from earlier ones, which were to get programs started and respond to unmet but latent demand for services that existed at early stages of program development.

Meeting these new challenges requires a strategic approach to planning and management at all levels of service delivery, from individual providers to the donors and national coordinating agencies that mobilize and allocate program resources. To deal at the same time with limitations on national budgets and the scarcity of foreign assistance funds, attention needs to be given to the efficiency of resource use, to opportunities for cost recovery and to ways of broadening the base of financial support for programs. Strategic planning is an important tool for accomplishing this.

Business, government, and non-profit organizations have used strategic planning to provide direction and set priorities for resource allocation, and in the process to

cope with uncertainty and change in their operating environment and to provide an objective basis for control and evaluation.[1] This paper outlines an approach to strategic planning at the sector level. Because it applies to a multi-institutional setting with diverse sources of support, sector-level strategic planning differs from that which has been well elaborated for businesses and other single institutions.

Like strategic planning at the organizational level, sector-level strategic planning is a participatory process. Participants should include leaders in LDC family planning programs at the national and regional levels in the country as well as donors and representatives of individual groups that provide services, including non-governmental organizations and private commercial providers. To the extent that family planning is linked to or integrated in health services, representatives of the health sector should also be involved.

While strategic planning begins with certain analytical and decision-making steps, it does not end with them. The analytical and decision-making efforts should provide a framework for implementation, monitoring and periodic evaluation of the program strategies they produce. Nor do they substitute for the strategic planning that individual agencies should also do. They also provide a backdrop for agency-level planning efforts by providing a sector-level overview of these agencies' future roles in the expansion of family planning services in their country.

OVERVIEW

Sector-level strategic planning is a five-step process:

(1) **Assessment** of the current situation in the population/family planning sector and examination of future prospects in the sector, leading to the setting of goals and objectives and the specification of the criteria that should be used in selecting among alternative programmatic approaches;

(2) **Identification** of the alternative program approaches that could be employed to achieve stated goals and objectives, spelling out the financial and human resources needed for each alternative and the ways in which those resources could be mobilized;

(3) **Review** and ranking of these program approaches in preparation for the selection of the one which best suits the needs and conditions of the country during the time period covered by the strategic plan;

(4) **Commitment** by the decision makers and other key players to an action plan to implement the chosen program expansion strategy; and

(5) **Agreement** on arrangements for monitoring and periodic evaluations of programs to ensure that the plan is on track and that the original assumptions and conditions are still valid.

The first two stages are primarily analytical and provide the basic information and analytical frameworks needed for the planning process. The last three are primarily procedural, leading to decisions and actions to expand family planning services. Each of the stages is described. There are also a number of analytical tools that could be used to mobilize the needed data and assess alternative program paths. One feature of these tools is that they allow users to work through the key analytical steps in the planning process once basic data have been assembled and essential parameters have been identified. A useful reference in preparing for the exercise could be the check list of questions and topics developed by the OPTIONS II Project to assist A.I.D. in planning population assistance (see Appendix I).

While there are some commonalities in strategic planning at the agency and sector levels, many issues and concerns vary between the two levels. Even in low prevalence countries where the still incipient "sector" is served by only a single organized family planning provider, it is still important to view questions of strategy on two levels. Decisions about expanding family planning in the sector and on mobilizing resources to achieve sector-level goals should consider alternative paths that might or might not involve expanding the activities of the organization that dominates the sector at the time the plan is articulated.

Success in sector-level planning requires the engagement and commitment of the key players who manage the sector and who control the allocation and utilization of resources for family planning in the country. The players will have different roles at each stage of the planning process.

- Decision makers in ministries (for example, health, finance, planning) and donor agencies should be involved in determining the overall scope of work for the process and in identifying key issues and questions to be addressed. They

should be sensitive to and seek input from individuals who work at the level of service delivery to ensure that the scope of work is responsive to realities at that level.

- Analysts from the lead national family planning agency, or from the national population council or coordinating unit, will carry out the analytical work in the assessment phase. They may require assistance by outside consultants.
- Program managers should be brought into the process of mapping alternative family planning expansion paths, determining their resource requirements and institutional/organizational feasibility. They will also play a consultative role in articulating plans for implementing and evaluating the strategy.
- The national coordinating unit or lead agency should also organize and provide the venue for selecting among the alternative approaches to expansion of family planning. Top-level decision makers from all relevant constituencies (government, non-governmental organizations and private commercial providers, and donors) should be brought into the review process, informed about the alternatives, and involved in the decision-making process.
- Managers and analysts in the coordinating unit should also be responsible for articulation of an implementation plan for the strategy and for designing and carrying out evaluation of progress toward achievement of its goals and objectives.

The remaining sections of this document provide more detailed discussion of each of the stages in the sector-level strategic planning process.

STAGE 1—ASSESSMENT OF THE CURRENT SITUATION

The first step in strategic planning is to set the stage for discussion of alternative approaches to the expansion of family planning services. This involves four sets of questions about the sector:

- **Where is it now?** What is the nature of demand and need for family planning? What is the capacity of the existing family planning delivery system to meet that need?
- **How are conditions likely to change over the next 5-10 years?** How will changing demographic and socio-economic conditions affect demand and unmet need for family planning? What are the obstacles to expansion of family planning?
- **Where should it be in 5-10 years?** How do these changes translate into goals for program expansion? What configuration of services will be required in order to meet growing demand, expand access to underserved groups, and improve the quality of services? How can obstacles to the expansion of family planning be overcome?
- **What criteria should guide consideration of alternative paths for program expansion?** What weight should be given to such considerations as financial sustainability, equity, the demographic impact of the program, its contribution to the health and welfare of families?

An adequate mapping of where the sector is and where it is headed requires more detailed information about several important aspects of fertility and family planning in the country:

- Current levels of fertility and contraceptive prevalence for the country as a whole and for relevant population groups; the range of family planning services available and who uses them.
- The nature of the political, legal and regulatory environment for family planning; the strength of leadership support; the policy obstacles to expansion of services.
- The organization of services, including the role of government, non-governmental organizations, private and commercial distribution channels; whether services are free-standing or integrated with the delivery of general health services.
- The financing of family planning, including which services are subsidized, how costs are recovered, the role of donors, and issues that affect cost-effectiveness in the sector.

Obviously, full analysis of each of these points would require an investment of time and resources well in excess of the budgets of most planning units. Still, this kind of information is essential for planning. Depending on the stage of program development in the country and the way in which services are organized, some questions may be more significant than others. To assist in the identification of issues that should be addressed, the Strategic Planning Checklist in Appendix 1 should be consulted. More attention should be given to those questions which knowledgeable observers judge to be most pertinent in a given situation.

This stage of the planning process is similar in scope to what development assistance agencies do as part of the "sector analyses" they carry out prior to initiating projects. In many cases, analysts starting work on this stage of a plan may be able to incorporate information derived from such

earlier sector work for their own assessment. Examples of this kind of work include sector reviews and project assessment documents prepared by The World Bank and country sector reviews (PRSD — Program Review and Strategy Development) conducted by the United Nations Population Fund (UNFPA).

Many of the tasks at this stage are analytical and can be based on information sources such as the Demographic and Health Surveys (DHS), other fertility and family planning surveys, and administrative data. A number of analytical tools such as the TARGET-COST package developed under the OPTIONS Project could be used to compile and present the information needed for the assessment stage and to lay the base for further stages in the planning process.[2]

Once basic information about the sector has been assembled, analysts need to do the groundwork that will enable decision makers to look ahead from the current situation in the population/family planning sector to where it will be at the end of a given planning horizon. Changes could result from shifts in demand and from efforts to meet that demand through alternative service expansion strategies. A variety of political, demographic, and socio-economic forces beyond the control of planners will also shape demand in the sector. Planners need to consider how these forces might shape demand for family planning to make the appropriate decisions about the level and direction of resource allocations.

The choice of a planning horizon is important. Most high-level decision makers are politicians. Their real world planning horizons are typically very short, measured in months rather than the five- to ten-year periods that demographers consider "short run." At the same time, the duration of most projects is five to ten years. Thus, horizons of that length are probably optimal for these projection exercises, provided that special efforts are built in to help the ultimate decision-making audience focus on them. Projections should also be prepared for periods extending beyond the immediate planning horizon in order to bring home to decision-maker audiences the long-term impact of demographic momentum: decisions that affect the pace of current fertility declines in a seemingly small way now could have a large future impact on the numbers to be served by family planning and other age-related services and could mortgage huge amounts of public sector resources as demand for services expands.

A useful starting point would be to project the potential client population for family planning services over the next five to ten years: how many clients will there be in total and in different population groups, where will they be, and how will they differ by age, parity, and other socio-economic characteristics relating to their family planning needs? Standard U.N. population projections, projections prepared by local statistical offices, or projections prepared especially for this exercise could be used to determine the amount by which the number of women of reproductive age could increase. Data on marriage and fertility patterns can be used to estimate the number of women in union at various age and parity levels.

Shifts in rural-urban residence and patterns of educational attainment also affect future demand for services. In countries where a much larger proportion of children are currently enrolled in school than in the past, the demand for family planning (which generally increases with the level of education) could increase even more rapidly than the number of women in reproductive ages, so that both the proportion of users in the population and the absolute size of the population to be served will grow. Attention should also be given to the average age at marriage, which generally rises as educational attainment increases.

Another guidepost for determining future demand for family planning relates to increases in the number of contraceptive users required to maintain a given pace of decline in the total fertility rate. Here the data and assumptions already incorporated in the TARGET-COST model could be used to demonstrate the level and method mix of contraceptive use needed to maintain the fertility decline assumptions in standard projections or to achieve alternative fertility decline targets over the course of the planning period and beyond. One of the advantages of the TARGET-COST exercise is that it allows users to experiment with a variety of paths toward these fertility decline objectives.

In addition to country-level needs, family planning decision makers may be interested in extending services to specific population groups which are currently underserved. Indeed, the achievement of program goals generally requires both the maintenance of services for groups that are currently well served and the incorporation of groups currently lacking access to information and services. Equity and other welfare considerations provide additional reasons for targeting underserved groups. The information on unmet need compiled in the assessment stage can be combined with projections to "segment" the expanding market for family planning into various target groups.

Target groups may be differentiated by such characteristics as their place of residence and socio-economic status as well as the method mix and service delivery channels they rely on for family planning services. If available, data should be incorporated on what each group pays for services and the extent to which services are being subsidized. This point is particularly important for decisions about future subsidies to expand services and for measures to increase cost recovery or increase private sector participation in service delivery. When public sector and donor resources are limited, appropriately scaled fees may be instituted for groups whose services are currently subsidized but for whom subsidies can no longer be justified because their capacity to pay for services has increased.

In addition to the analytical work on the family planning sector's current status and future prospects, Stage I includes the translation of its findings about prospective changes in the sector into a set of program goals which address the identified needs. Goal setting is both a technical and a political process. On the technical side, the need is to get the facts straight so that goals address real needs in the sector such as the number of women who need to be served and changes in the method mix that respond more adequately to women's reproductive health needs.

At the same time there are policy considerations that go beyond the numbers. Attention needs to be directed to other considerations which have an important bearing on the performance of the sector such as the priority that should be given to equity concerns, quality of services, financial and organizational sustainability of programs, as well as political risks and cultural acceptability. Recognition should be given to the possibility of conflicts among objectives; for example, a method mix that would be the most effective in reducing fertility rates, but which would not work in the given cultural context. In presenting findings to their decision-maker counterparts, those who carry out the analytical work of Stage I need to make these trade-offs clear. There is little point to presenting a strategy for program expansion that leadership groups who set policy and control resources will not accept.

STAGE II—ALTERNATIVE EXPANSION PATHS AND RESOURCE REQUIREMENTS

The second stage in the analytical process focuses on how we would get from (a) where we are to (b) where we want to be — that is, from the current situation as assessed at the beginning of Stage I to the goals stated at the end of that stage. The main task in Stage II is to identify and present alternative programmatic paths from (a) to (b) in terms that will make clear to those who will be making programmatic decisions what the key issues are with respect to the mobilization and effective utilization of resources.

It is important for decision makers to recognize that alternative expansion paths are possible at every stage of family planning program development and that different paths have different resource requirements as well as different chances of success within the political and cultural context, legal and regulatory environments, and other constraints under which programs have to operate. The point of the exercise is not to identify every possible expansion path but rather to focus attention on the two or three realistic alternatives that could be followed but which may result in different levels of success in attaining program goals. In a given country, these paths might be those followed by other countries in the region or by other countries at similar phases in their program development process.

Expansion paths can be defined in a three-step process:

1. The first step consists of listing the feasible family planning delivery modes which could be used to expand services. This list would include the modes currently available in-country as well as those that experience in the same or other regions suggests as a possibility. Each delivery mode should be described in terms of the following characteristics:

- The type of service delivery mode: government hospitals, primary health care clinics and dispensaries; free-standing privately operated clinics; private physicians, nurses, and midwives; employer-based systems; community-based delivery systems; pharmacies and other commercial outlets;
- How services are paid for: government subsidies, donor assistance, social insurance reimbursements, fee-for-service, social marketing schemes, etc.;
- The method mix provided through each delivery mode;
- The client populations that are likely to be served through each mode and how they would be served: mothers served through post-partum services, integrated maternal and child health services, community-based or home-visit programs; adolescents and young couples who have not yet borne children; male factory workers, etc.;
- Resources required to provide coverage to a given number of couples each year under alternative approaches: personnel, equipment, facilities, information, education and communication (IEC) programs, training and commodities.

Inclusion of one or another service delivery mode on this list will depend on the existing and potential institutional capacities in the country, on the cultural and political environment of the country, and on its legal/regulatory climate. For example, a clinic-based strategy that promotes sterilization might have the largest potential impact on fertility decline, but would not be cultur-

ally or politically viable in a country with strong religious opposition to the practice.

2. The second step is to describe feasible country-level alternative expansion paths or scenarios for the family planning sector. These scenarios consist of combinations of the feasible delivery modes (which vary in terms of the resources allocated to them, the timing of investments, changes in the legal/regulatory environment needed to make them work, and other considerations). Some of these scenarios may seem attractive to decision makers because they yield immediate gains in prevalence. However, they may fail to achieve other program objectives. For example:

- In African country "A," prevalence is low and limited to women in the capital city, who are served by private physicians and a few non-governmental organization (NGO) family planning clinics. Two alternatives might be considered.

  (a1) The first scenario builds on latent demand among women in urban areas through government subsidies for expansion of services in existing hospitals and channeling donor aid to private clinics. Many Latin American countries have followed this path and have achieved relatively high prevalence levels because the expansion coincided with rapid urbanization. In Africa, this approach would yield an initial surge in prevalence, but one which would probably level off fairly soon as the limited latent demand is exhausted.

  (a2) The second and more advisable scenario encourages expansion of existing services by easing regulatory constraints on the private sector (possibly including selective investments to encourage expansion of commercial distribution of contraceptives) but focuses public sector subsidies and donor aid on public facilities targeted to underserved rural and small-town populations. This model is more typical of Asian countries. The approach has a lower initial impact on prevalence because it requires investments in infrastructure, but the overall increase in family planning users is likely to be greater.

- In another example, Latin American country "B," services have expanded along the lines of the first scenario outlined for country "A." Now donors and government officials are faced with the challenge of reaching underserved groups in rural areas and poorer sections of large cities while holding on to existing users as they shift subsidies toward underserved users.

  (b1) The first scenario expands services through existing channels by helping NGO providers expand their programs to currently underserved groups. This approach would continue government subsidies to existing users and would require additional donor support for expansion of services through private clinics.

  (b2) An alternative path for "B" is a primary health system targeted to low income groups in rural and urban areas, with a gradual shift of services for other groups from a subsidized to a fee-for-service basis. This path requires building a primary health care infrastructure, a pricing scheme that will not discourage existing

users, and careful donor coordination (since many donors still favor private sector channels).

Each of these expansion paths has its own cost implications and thus a different service expansion potential. To explore these differences, the TARGET-COST model is a powerful analytical tool. TARGET-COST provides a vehicle for bringing the demographic and family planning information assembled in the first two stages of the planning process together with cost data associated with the various delivery mode combinations to portray the costs, resource requirements and service delivery outcomes associated with each.

3. The third step in selecting scenarios is to consider other significant but non-quantifiable factors that could affect the expansion of services. While the goal of TARGET-COST is to specify the costs, operational requirements, and program impacts of each alternative in quantitative terms, care must be taken in presenting these outcomes so as not to reduce the process to mechanical comparisons of the alternative paths. Rather, these quantifiable dimensions of potential expansion paths should be assessed in concert with a number of other considerations which are not quantified in the model, including:

- The program organization and management structures required by each approach.

  The choice of a service delivery strategy also involves decisions about organizational and management structure; while a given structure may have worked elsewhere for services, that structure may not work as well under the existing political and institutional constraints of the country in question. This is difficult to quantify, but could be a reason for rejecting a scenario which under other circumstances would be preferable according to TARGET-COST criteria.

- The training and staff development requirements implied by each scenario.

  Quantitative models may be able to specify the numbers of doctors, nurses, and midwives needed to implement a particular type of service model, but usually do not indicate whether the country's service delivery personnel are adequately trained for that approach. An approach could be very appealing on paper but fail because of personnel deficiencies.

- The IEC requirements implied in each strategy.

  The TARGET-COST model is supply-oriented in the sense that it spells out requirements associated with achievement of fertility reduction goals, prevalence levels, method mix, etc., to accommodate increases in the number of women in reproductive ages. It does not guarantee that women will actually utilize each of the alternatives specified. Particularly under circumstances in which a new approach to service delivery appears to be more cost-effective, IEC work may be required to inform, reassure, and motivate the potential user-population.

- The underlying assumptions about commodity supplies, logistics arrangements, and equipment requirements for each alternative.

  If strategic choices imply shifts in the contraceptive method mix, consideration should also be given to the country's

capacity to produce or import the needed supplies as well as store and ship them to service outlets. Other assumptions about logistics such as transportation, and the capacity to acquire equipment and build and maintain facilities, also need to be questioned.

These are questions that will have to be addressed later and in more detail at the implementation stage of the planning process. However, it would be helpful at this stage to have the comments of experts with knowledge about training, management, IEC, and logistics issues. They could function as "devil's advocates" on these dimensions of each scenario to make sure that TARGET-COST's very powerful analytical capacity to portray alternative service expansion strategies is balanced by a recognition of the real world constraints and requirements that the model does not capture.

To conclude, the end product of Stage II is a set of family planning service expansion scenarios described in terms of target population served, financing and cost-recovery mechanisms, method mix and service delivery channels. The description of each scenario should include program inputs, costs and resource requirements.

STAGE III—SELECTING ONE OF THE ALTERNATIVE EXPANSION PATHS

In the remaining stages of the strategic planning process, the focus shifts from analysis of alternative family planning expansion paths to the selection of one of those scenarios and the establishment of an implementation plan. While good strategic planning requires careful analytical work, it is important to remember that such work will accomplish nothing if the findings are not put to use by those who make key program decisions. This requires developing a communications strategy that involves all key players in the family planning sector: the technical staff of institutions working on the analyses and modeling outlined in the earlier two stages; the decision makers to whom the analytical findings need to be addressed; and the program managers whose work will be affected by the outcome.

The decision-making process is more complicated in sector-level strategic planning than for an individual organization. In the latter case, the organization's management will generally be involved from the very beginning and will, at a minimum, be monitoring progress on the analytical stages of the process. At the sector level, chances are that the technical work will be done by a unit in one of the ministries or in the national population council, but that the decision-maker audience will be spread across several ministries and other groups with only remote connections to the technical unit.

For this reason, sector-level planners need to devote special attention to the communication of analytical findings to participants in the decision-making process. A key requirement is a plan for disseminating the analytical findings to those audiences. The dissemination plan will:

- Identify key decision-maker audiences who should participate in reviewing the alternative scenarios and in selecting the scenario that will actually be pursued. These audiences may consist of ministers, public officials, and members of the national population council, if one exists, or other leaders whose views and influence on policy, resource allocation, and the regulatory environment are likely to affect the expansion of family planning.
- Develop mechanisms to inform audiences about progress on the analytical stages of the plan so that they will have a sense of "ownership" about it when the analytical findings are presented to them; for example, the national population council could have an oversight role over the analytical work and be given ongoing progress reports.
- Specify the various formats and communication channels through which the alternative scenarios developed in the analytical stages will be presented to these audiences; for example, alternatives could be presented using microcomputer-based storyboard presentations, with flip-charts or chartbooks outlining each scenario, or some combination of both.
- Design an event or series of events and accompanying materials, in which the pros and cons of each scenario will be discussed, leading to a consensus to pursue one of the strategies.

For decision makers to evaluate alternative family planning expansion scenarios, they need information not only about the delivery modes already operating in their country, but also real life examples of the alternative modes that are being considered. One mechanism for informing them about these alternative modes is observational travel to countries where those modes have already been implemented. Another is to

provide them with materials describing successful implementation of an approach in another country.

The end product of Stage III is a decision by participants in the planning process to pursue one of the family planning expansion scenarios articulated in Stage II. Their decision will be based on the technical information provided about demographic trends and program expansion options as well as resource requirements, institutional changes, and other steps that have to be taken to implement that strategy. Issues of cultural acceptability and political risk will also have to be taken into account.

STAGE IV—DEVELOPING AN ACTION PLAN

It is essential that a sector-level strategic planning exercise be capped by an action plan which clearly states key program objectives and spells out the specific steps that will be taken to achieve those objectives. If the analytical work of Stages I and II has been done adequately, most of the information needed for an action plan will already have been compiled and will only need to be restated in reference to the expansion path chosen in Stage III. For this to happen, analytical work done at earlier stages needs to be very specific about what has to be done to implement each of the family planning modes being considered: what resources and other program inputs are required, when they are required, who will pay for them, who has to make decisions regarding allocations, and what benchmarks will be used to measure progress toward program objectives.

These objectives and the actions required to achieve them should be formally recognized by the participants in the planning process, and a declaration of commitment to them should be issued. A highly publicized event should be organized to present the declaration and action plan to the country's leaders and the community at large. Materials to explain the plan and develop support for it should be prepared and distributed to the media and key public and private organizations in the sector.

The action plan should also address in detail the qualitative issues raised in Stage II about the alternative scenarios: organization and management structure, training requirements, IEC plans, and the full range of logistics questions from supplying and transporting commodities to facilities and equipment.

STAGE V—FOLLOW-UP: MONITORING AND EVALUATION

Follow-up on the action plan is also essential, particularly if a large number of agencies are involved in implementing it. High-level oversight and commitment to implementing the plan are required to avoid having the interest and enthusiasm generated by the planning process evaporate as concerns about other problems and priorities crowd the agendas of leaders who are responsible for it.

Specific arrangements should be made for monitoring implementation of the plan and for periodic evaluations to measure its progress toward achievement of program goals. This could be accomplished using a matrix similar to the one shown in Appendix 2, in which program goals are keyed to program inputs, management decisions, and evaluation benchmarks. The example in Appendix 2 illustrates a strategy to extend family planning to rural women by including it in a primary health care project targeted to rural areas. The matrix could be incorporated in the declaration or issued separately in chartbook form.

Implementation is more likely to succeed if it is managed by an ongoing coordinating council involving the key players, supported by a small technical staff to monitor and report on progress. Provision should be made for periodic meetings of the coordinating council, keyed to the timing of resource allocation and management decisions as well as the review of progress toward evaluation benchmarks. The technical staff would have responsibility for organizing meetings.

The style and structure of follow-up activities will depend on the nature of the plan (and where the country is in terms of family planning development) as well as political and cultural sensitivities. Obviously the concerns and orientation of the plan and of implementation activities would be different in a country with high contraceptive prevalence than in a country where family planning is just beginning and where major efforts are required to meet rising demand.

CONCLUSION

Not everyone may want to invest in as comprehensive an elaboration of the strategic planning process as the one outlined in this document. For example, a particular donor may want some elements of what has been described above for a project paper or as background for a specific activity. While planners should make every effort to help potential collaborators understand what the ideal strategic planning process involves, they should also be prepared to pursue "second best" alternatives, particularly when time and resource constraints are limiting factors. Another alternative is to approach strategic planning in phases, with a first phase that focuses on short-run decisions that can be implemented without delay and a second phase that takes a more comprehensive look at what might be accomplished over a longer planning horizon.

Above all, everyone involved in the process should be in agreement about what is to be done and what the expectations are before moving ahead with the proce

- With whom will planners collaborate in the analytical Stages (I-II) of strategic planning, and who are the likely audiences/participants in decisions about expanding family planning and implementing an action plan in Stages III and IV?

  If the decision-making audience consists mainly of members of a national population council, then the technical unit which supports that council is the logical choice for the analytical work, provided that it has the analytical skills. If not, consideration should be given to building its staff capacity, training staff members, obtaining donor support for a resident advisor to assist the staff, or to subcontracting some of the work to a university or consultants. These choices should be approved by the decision-making audience, because it will do no good to have the analytical work done by individuals whose competence or objectivity they question.

- What needs to be done, who will do it, and when will tasks be completed?

  A work plan needs to be prepared that outlines all of the analytical tasks outlined in the first two stages of the process as well as those activities that center on the selection process and the elaboration of an action plan. This work plan will specify responsibilities for tasks, the analytical tools required, the materials to be produced, the events to be organized, and a timetable for carrying them out. It should also include a budget for staffing, travel, and other inputs required to do the work.

- What role will outside experts play in this work?

  As noted, outside experts could play an advisory role in the strategic planning process. During the analytical stages, these experts could assist counterparts in the design of a work plan, provide training in policy tools such as the TARGET-COST model, assist in the compilation of data for analyses, and provide help in the mapping of alternative service expansion scenarios. During the decision and action plan stages, the experts could assist in the dissemination plan and preparation of materials. The work plan described in the previous paragraph should make specific reference to the role that such experts will play.

- What are the expected outcomes and performance indicators?

  The scope of work for strategic planning activities should include its own performance and outcome indicators against which progress on these activities can be measured. The five-stage planning process outlined above delineates specific analytical, dissemination and action planning tasks as well as outcomes for each stage. It would be useful to list performance and outcome indicators, as well as how and when they will be measured, for each of the planning stages and present this list in matrix form as part of the work plan for strategic planning.

1 See, for example, J.M. Bryson and R.C. Einsweiler (eds.), *Strategic Planning*, American Planning Association, 1987; and J. Koteen, *Strategic Planning in Public and Non-Profit Organizations*, Praeger, 1989.

2 See John Stover et al., *Target Cost: A Model for Projecting the Family Planning Service Requirements and Costs to Achieve Demographic Goals*, The Futures Group, Glastonbury, CT, 1991. For DHS data, see Karen Forcit, "Strategic Planning to Meet Unmet Need for Appropriate Contraception," The Futures Group OPTIONS II, Washington, DC, 1992; Katrina Galway, "Strategic Use of DHS Data in Family Planning Program Development," The DHS World Conference Proceedings, Vol. 2, p. 889-896, 1991.

3 See K. Kanagaratnam, "Review of Organizational Options," The Futures Group, n.d.

APPENDIX 1—STRATEGIC PLANNING CHECKLIST

The purpose of this checklist is to assist staff of A.I.D. and its cooperating agencies in thinking comprehensively and systematically about national population and family planning programs and to help all of us bear in mind the multiple considerations that should enter into ensuring more efficient and effective resource allocation. The questions are by no means exhaustive, and the answers to each are likely to suggest the need for further probing, either into documentary sources of information, or in consultations with knowledgeable individuals and organizations.

POLICY

- What are the main policy and program objectives of the government in the population sector? Has a policy been officially adopted, or are further steps needed to develop a formal policy?
- How much support exists for the policy and for family planning activities among top political leaders? Ministers? High-level executive and legislative officials? Other elites? Various ethnic and regional groups? Key private sector groups (women's groups, religious groups, corporations, etc.)? The general public? Are there major sources of opposition?
- How much money is allocated to family planning in the government budget, and what is the trend? How does it compare to the overall health budget?
- What legal and regulatory barriers impede delivery of contraceptive methods and related services, including both private and public sectors? Barriers to specific methods? Barriers to IEC activities? (See special section on "Medical Barriers to Family Planning".)
- To what extent do policies and programs in related sectors (education, health, etc.) take account of population and affect family planning supply/demand?

DATA AND EVALUATION

- When was the last DHS or Contraceptive Prevalence Survey (CPS)? Is another one planned?
- When was the last census? Does the government produce reliable basic population data? What capacity exists for analysis and dissemination?
- What is the content and coverage of the service statistics system? How accurate are the data?
- How will the impact of the program be measured and evaluated?
- What data will be necessary to evaluate impact? What baseline data are available?
- What capacity exists for collecting the data necessary to evaluate program impact?
- To what extent are recent service statistics and survey data being utilized effectively for program planning and evaluation?

SERVICES

- What is the level of unmet need? Which population groups have the greatest unmet need (e.g., as defined by gender, class, ethnicity, geographical region, urban/rural residence, age, parity, and marital status)?
- How widely available are contraceptive methods and services?
- Which population groups have least access to services?

- What are the roles of different service delivery organizations and method sources in the public and non-profit sectors? Potential for expansion? For cost recovery?
- What is the role of the private commercial sector? Potential for expansion? Do public sector services or subsidies undercut the private sector?
- How well utilized are existing services? If not, why are they not utilized?
- Is the current method mix appropriate to the needs of the client populations the program seeks to serve? Are there methods not in use for which a potential demand exists, e.g., Norplant, injectables?
- Are there deficiencies in the quality of care from major service providers that impede contraceptive use and continuation? How can these be remedied?
- Is the prevalence of AIDS and other STDs a factor in planning service delivery?

MEDICAL BARRIERS TO FAMILY PLANNING

- Are there unnecessary regulations, restrictions, and/or protocols which both impede the delivery of family planning services and which are inappropriate given the resources available and the relative risks to clients, e.g., unnecessary limitations on methods provided by age, parity, or other criteria; excessive tests, exams, screening protocols, and follow-up schedules; limitations on what categories of personnel can perform procedures?
- Which constraints are most critical? Are these constraints known, or is further assessment needed?
- What are the sources of these constraints, e.g., lack of knowledge of contemporary standards of practice in the provision of family planning services; differences in assessments of risks and their consequences; physicians' efforts to maintain monopoly; other provider attitudes, misinformation, or method-specific biases?
- Who has the power to change or remove the constraints, and what short-term and long-term interventions might be necessary, e.g., educational efforts aimed at medical groups; regulatory changes adopted at various levels of government; unilateral decisions by clinics, hospitals, or other family planning service provider organizations; inclusion of new material in training programs and other curricula; operations research or demonstration projects?

TRAINING AND HUMAN RESOURCES

- What kinds of service providers (physicians, nurses, paramedical personnel, etc.) will be needed under different assumptions about the method mix? How many providers are needed in these categories to meet service delivery targets?
- What training programs exist for service providers and other program personnel (managers, researchers, demographers, etc.) and which ones need to be expanded or added?
- Is family planning included in the curricula of schools of medicine, nursing, and public health?
- Do training plans exist at national and local levels?

IEC

- What is the current emphasis of IEC activities? Are they linked to specific service delivery objectives? To increased capacity at existing service sites?
- What is the infrastructure for undertaking IEC activities?
- Is accurate, method-specific information available? Is it culturally appropriate and suited to the educational level of the target audience?
- Are there prevailing rumors, myths, misinformation, or provider attitudes that impede service delivery?
- Who are the target audiences for information and what are the best ways to reach them (e.g., policy makers, physicians, existing and potential users, and partners of users)?
- How broad is the reach of the mass media (radios, TV, print media), and how are they being used?

MANAGEMENT

- Does the government have a national strategic plan for expanding family planning activities?
- What are the main agencies involved in carrying out the family planning program? How committed are leaders of these agencies to family planning as a central mission, and how is their capacity to manage and coordinate the different facets of the program? What are the management constraints to program implementation?
- How centralized/decentralized is program management?
- Is there an Management Information System (MIS)? Is it comprehensive and reliable? Are other financial accountability and personnel management systems adequate?
- Do effective coordination mechanisms exist between the MOH, the family planning program (if autonomous), and other ministries? Between the government and NGOs? Among NGOs? Among donors?

COMMODITIES LOGISTICS MANAGEMENT

- Which contraceptives does the program currently use and in what quantities? Has the program experienced excess supplies or stockouts, and what has been done to correct it?
- Is there a MIS to monitor contraceptive supplies and trigger key actions — ordering, tracking distribution to users, and making periodic inventories? How well does it function?
- What provision is there for quality control of contraceptive stocks, including periodic testing, removal, or destruction of products when needed? Are there provisions to ensure that product specifications are respected and that FIFO ("first in/first out") procedures are used at all stages of the distribution/storage chain?
- Do recipient organizations have trained personnel to estimate requirements and related funding needs and to manage supplies?
- What are the arrangements for information sharing and coordination among donors in estimating new contraceptive requirements, financing supplies, and scheduling shipments?

- Have there been long-term forecasts of contraceptive needs that take into account desired changes in method mix and in the roles of different public and private sector providers? Have these forecasts been reconciled with decisions about near-term requirements and donor assistance?

OPERATIONS RESEARCH (OR)

- What are the lessons learned about successful service delivery in this country?
- Has an assessment been undertaken of the quality and availability of family planning services (situation analysis)?
- What unanswered service delivery, IEC, management, and training questions should be researched?
- What capacity exists for operations research? Is training needed?
- Have previous OR findings been utilized? Do implementing agencies appreciate the potential value of OR to their programs and support OR activities?

THE ROLE OF A.I.D.

To apply the strategic assessment in A.I.D.'s programming process for a priority country, the next steps will be to determine:

- A.I.D.'s own objectives and areas of comparative advantage in assisting the country, taking into account experience with previous assistance;
- the long-term goals and objectives towards which specific A.I.D. activities will be directed;
- which activities will be supported by A.I.D. and their expected outputs over the life of the projects (and under which A.I.D. accounts), which by the government (or local private sector entities), and which by other donors;
- the roles of the cooperating agencies; and
- how new program inputs will be managed and coordinated.

APPENDIX 2—ILLUSTRATIVE PLANNING MATRIX

PROGRAM GOAL & TIMETABLE	PROGRAM INPUTS & RESOURCE REQUIREMENTS	MANAGEMENT & DECISION RESPONSIBILITIES	OUTCOME MEASURES
Incorporate family planning in rural health service project			
YEAR 1—Groundwork for initiation of program	Conduct baseline rural health/FP survey	MOH/Human Resources Division	50 primary health workers 20 managers trained
	FP training for rural health workers	National population council technical staff	Survey conducted, reports generated, specific objectives of effort defined
	IEC plan to alert rural couples about FP	MOH subcontracts to local NGO	IEC strategy and implementation plan drawn
	Build/remodel facilities for FP services	MOH ties into World Bank rural health loan	10 facilities prepared within 100 km of capital
	Establish supply procurement and distribution system	MOH procurement division works with USAID health office	Contract issued to local pharmaceutical supplier
	Establish client record and referral system	A.I.D. CA subproject set up	Management information system in place
YEAR 2—Initiate program on a pilot basis	Initiate services in facilities located within 100 km of capital	MOH/local suboffices	Full operation in all 10 facilities by mid-year
	Train home visit workers	MOH/Human Resources Division	50 community field workers trained
	Implement IEC program	MOH/Communications Division	Radio spots; market-day exhibits, etc.
YEAR 3—Expand program to remaining coverage areas	Start services in remaining rural areas	Same MOH divisions	Operations extended to remaining 20 facilities and incorporated in home visitor program
	Continue IEC and training initiatives		Increased awareness and service use reported to decision makers
	Conduct follow-up survey	Population council staff	

Note: A.I.D. USAID = Agency for International Development; CA = Cooperating Agency; FP = Family Planning; MOH = Ministry of Health