Data is a Discussion!
June 28, 2018

Elisha Dunn-Georgiou
VP of Policy and Advocacy

CHAMPIONS OF GLOBAL REPRODUCTIVE RIGHTS

PAI

pai.org

Data and Advocates

- Good data is objective. Good advocates are not.
- Advocates are usually seeking data that will help them make a change they think needs to happen.
- Advocates may also use data to help hone their advocacy strategy.
- Advocates are looking for data that will move the audience that can make the change happen.
- Advocates are not always interested in the methodology behind the data as long as it is from a reputable, recognized source.

Using data for supply chain advocacy

- Data is an effective tool for change when part of a comprehensive advocacy strategy
- Simple and context specific data are key
- Interpretation and synthesis of data is necessary
- Too much data can be more confusing than it is helpful
- Data + human story + right messenger is more effective than data alone

PMA2015/KILIFI, KENYA

PERFORMANCE MONITORING & ACCOUNTABILITY 2020

PMA2020 uses innovative mobile technology to support low-cost, rapid-turnaround surveys to monitor key indicators for family planning. The project is implemented by local university and research organizations in eleven countries, deploying a cadre of female resident enumerators trained in mobile-assisted data collection. PMA2020/Kenya is led by the Ministry of Health in collaboration with International Centre for Reproductive Health Kenya (ICRHK), National Council for Population and Development, and Kenya National Bureau of Statistics. Overall direction and support is provided by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health and funded by the Bill & Melinda Gates Foundation. This brief summarizes key family planning indicators from the combined results of the first and second, and the third and fourth rounds of the survey, respectively, in Kilifi county.

KEY FAMILY PLANNING INDICATORS

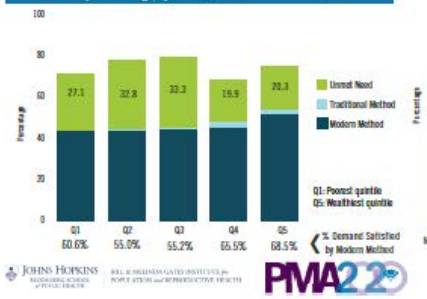
Select Family Planning Indicators Across Recent Surveys in Kilifi County (Married and All Women, Age 15-49)

	PMA2014 R1-R2		PMA2015 R3-R4	
	All Women	Married Women	All Women	Married Women
Contraceptive Prevalence Rate (CPR)				
All Methods CPR	26.4	32.3	32.9	45.3
Modern Method Use mCPR	26.0	31.9	31.8	43.8
Long Acting Method Use	9.0	11.5	15.6	22.1
Total Unmet Need	26.1	36.7	20.6	26.2
For Limiting	8.4	11.4	4.2	6.1
For Spacing	17.8	25.3	16.4	20.1
Total Demand	52.6	69.0	53.5	71.4
Demand Satisfied by Modern Method	49.5	46.2	59.4	61.3

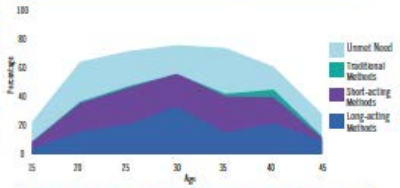
Fertility Indicators in Kilifi County (All Women)

	PMA2014 R1-R2	PMA2015 R3-R4
Recent Births Unintended (%)	39.1	43.2
Wanted Later	34.9	37.2
Wanted No More	4.2	6.0

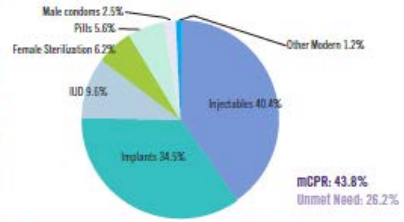
Current Use and Unmet Need Among Married Women of Reproductive Age, by Wealth Quintile (PMA2015 R3-R4)



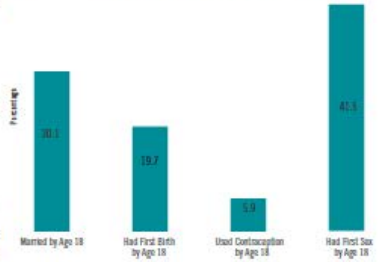
Unmet Need and Contraceptive Use, by Age (all Women)



Current Modern Method Mix Among Married Contraceptive Users, R3-R4



Percent of All Women Age 18-24, PMA2015 R3-R4:



JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

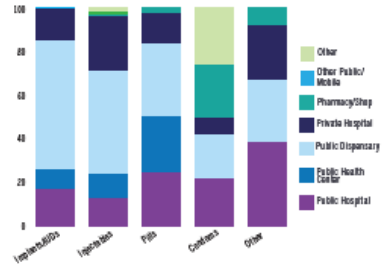
BILL & MELINDA GATES INSTITUTE for POPULATION and REPRODUCTIVE HEALTH

PMA2020

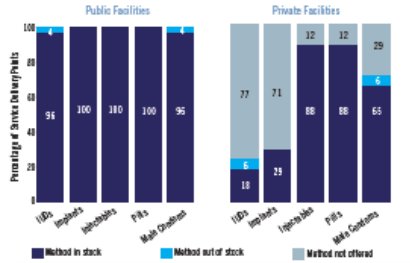
PMA2015/KILIFI/KENYA

INDICATORS FOR ACCESS, EQUITY, QUALITY AND CHOICE

Source of Method, by Provider (Married Women, ages 15-49), R3-R4



Percent of Facilities Offering & Currently In/Out of Stock, by Method, R3-R4



For Current Female Non-Users (n=571), R3-R4:

Reasons Mentioned For Non-Use Among All Women Wanting To Delay The Next Birth 2 Or More Years (%)

Not Married	39.8
Perceived Not-At-Risk/Lack of Need	38.7
Method or Health-related Concerns	23.8
Opposition to Use	16.4
Lack of Access/Knowledge	2.1
Other	10.2

Indicators for Access, Equity, Quality and Choice (All Women, ages 15-49, R3-R4)

	Total
Method Chosen By Self Or Jointly (%)	96.0
Obtained Method Of Choice (%)	93.1
Told of Other Methods (%)	68.6
Counseled On Side Effects (%)	69.0
Paid For FP Services (%)	29.8
Would Return To Provider & Refer a Friend Or Family Member (%)	89.8
Received Method From Public SDP (%)	76.1
Received FP Info. From Provider In Last 12 Months (%)	31.2
Exposed to FP Media in Last Few Months (%)	65.8

Percent of Public Facilities Offering at Least 3 or 5 Modern Contraceptive Methods

Facility Type	3 or more methods	5 or more methods
Hospital	100.0	100.0
Health Center	100.0	100.0
Dispensary	100.0	100.0
Total	100.0	100.0

The 28 public health facilities in the KHH study sample all reported offering 3 and 5 or more methods at their level of care

Service Delivery Points (n= 47; 28 public, 19 private), R3-R4

	Public	Private	Total
Among All Service Delivery Points:			
Percent Offering Family Planning	100.0	89.5	95.7
With Mobile Teams Visiting Facility In Last 12 Months (%)	85.7	10.5	55.3
Supporting CHWs From This Service Delivery Point (%)	60.7	10.5	40.4
Among Service Delivery Points Offering Family Planning Services:			
Average Number Of Days Per Week Family Planning Is Offered	5.1	6.5	5.6
Offering Female Sterilization (%)	21.4	0.0	13.3
Offering Family Planning Counseling/Services To Adolescents (%)	100.0	47.1	80.0
Charging Fees For Family Planning Services (%)	21.4	82.4	44.4
Percent Integrating Family Planning Into Their:			
Maternal Health Services *(among all offering maternal health services)*	96.4	85.7	94.3
HIV Services *(among all offering HIV services)*	100.0	100.0	100.0
Post-Abortion Services *(among all offering post-abortion services)*	100.0	71.4	92.3

SAMPLE DESIGN

This brief is based on data from two sets of pooled PMA2020 survey rounds. The final sample included 1,067 households, 1,209 de facto residential females, and 47 health facilities in Kilifi county, Kenya. Rounds 1 and 2 conducted in May/July 2014 and November/December 2014, respectively, are pooled and compared with Rounds 3 and 4 conducted in June/July 2015 and November/December 2015. The county subsample is powered to estimate mCPR with a 5% margin of error. This margin of error is reduced with the pooled sample. Kenya National Bureau of Statistics selected 13 enumeration areas in Kilifi from its master sampling frame. In each EA households and private health facilities were listed and mapped and 42 households randomly selected. Households were surveyed and occupants enumerated. All eligible females age 15 to 49 were contacted and consented for interviews

REPUBLIC OF KENYA MINISTRY OF HEALTH · NCPD · KNBS · ICRHK · PMA2020

– June 17, 2016 –

WHY FAMILY PLANNING?

Family planning is the most cost-effective way to prevent maternal, infant, and child mortality. It can reduce maternal mortality by reducing the number of unintended pregnancies, the number of unsafe abortions, and the proportion of high-risk births. In Zambia, an increased use of modern methods of contraception averted over 312,000 unintended pregnancies, 60,000 unsafe abortions and over 1000 maternal deaths in 2015.[1] Family planning also is linked to additional long-term health, social, and economic benefits: reduces infant mortality, slows the spread of HIV/AIDS, promotes gender equality, reduces poverty, accelerates socioeconomic development, and protects the environment.

These long-term benefits have the potential to radically change the development trajectory of a country like Zambia where more than 60% of the population lives below the poverty line.[2] Increased economic opportunities and growth can only happen if families have the number of children they can care for and educate to create a highly-skilled workforce.

Zambia's current fertility rate is 5.3 births per woman.[2] If this rate remains unchanged, Zambia's population would reach over 33 million people by 2037. However, if the Government of Zambia makes investments in family planning now, by 2037, total fertility would be reduced from 5.3 to 2.2 births and projected population would be 23 million.[4] These two fertility scenarios have fundamental implications for the education, health, and development sectors.

Box 1: Government of Zambia's FP2020 Commitments

OBJECTIVE: TO INCREASE THE CONTRACEPTIVE PREVALENCE RATE FROM 33 PERCENT TO 58 PERCENT

- Double the budgeted amount allocated for family planning commodities and to secure increased funding for family planning through existing donors and new partnerships.
- Strengthen the supply chain for family planning commodities through expansion of the Essential Medicines Logistics Improvement Program and other channels.
- Expand method mix and increase access, particularly for the underserved population. Zambia will allow task shifting to community health assistants and trained community based distributors to increase access for the underserved communities, and initiate new dialogue with religious and traditional leaders and NGOs at local level to generate demand, dispel the myths and 'open up the dialogue' on family planning. Finally, Zambia will utilize sub-district structures to generate demand for family planning.

Source: www.familyplanning2020.org/commitments[3]

Population Projection—Implications for Education[4]

Figure 1: **Number of Primary Schools Required (thousands)**

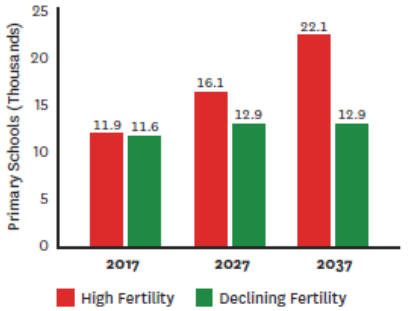
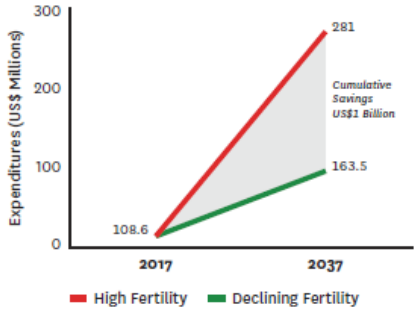


Figure 2: **Expenditure on Primary Schools Required (US $ millions)**



Under the two fertility scenarios **(Figures 1 and 2)**, continued high fertility would require more than 11,900 schools by 2017; more than 16,000 by 2027, and more than 22,000 by 2037. On the other hand, successful family planning interventions would culminate in the need for about 11,600 schools by 2017 and 12,900 schools by both 2027 and 2037. In a lower fertility scenario, about 9,000 fewer schools would be needed by 2037, thus saving the Zambian government significant resources.[4]

Population Projection—Implications for Health[4]

Figure 3: **Number of Nurses Required (thousands)**

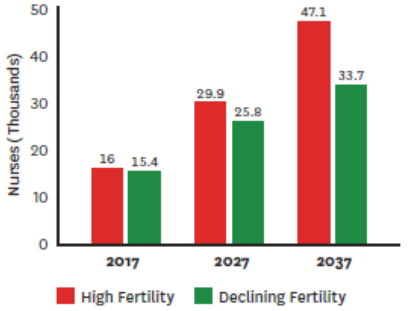
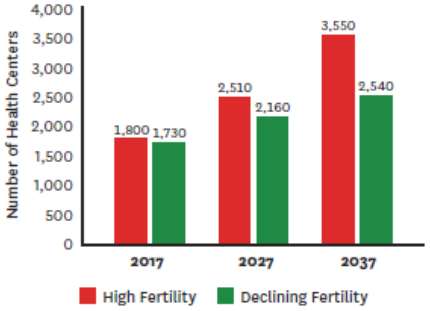


Figure 4: **Number of Health Centres Required**



High fertility is also projected to result in increased demand for human resources for health **(Figure 3)**. The number of nurses needed would be more than 29,900 in 2027 and 47,100 in 2037.[4] By contrast, declining fertility is projected to result in reduced need for nurses—25,800 by 2027 and 33,700 by 2037. In a lower fertility scenario, family planning would result in saving resources equivalent to employing 13,400 nurses by 2037. The savings in resources is even greater when one considers that nurses are not the only cadre of professionals required to deliver healthcare services.

MOVING FORWARD

The graduation of Zambia from a low income to lower middle income status means that the country is expected to graduate from donor dependency. Local resources from government allocations for family planning as a proportion of health support—even in the face of currency fluctuations will need to increase. Zambia should strive to improve its commodity security by deliberately setting aside and ensuring prudent use of resources for family planning commodities. Greater investments in adolescent sexual and reproductive health will be critical to addressing the national teenage pregnancy crisis. The increased coordination among relevant ministries and the development of a costed inter-ministerial work plan are important first steps. However, these efforts must be built upon to ensure that Zambian youth have the skills, education and opportunities to embark on the path to a more prosperous economic future for themselves and their country.

Next Steps

- **Make family planning a critical and central issue in the seventh National Development Plan:** Family planning touches all aspects of development. The principle policy direction for the country is derived from five-year development plans. It will be important for Zambia to set clear guidance on what must be achieved in family planning over the course of the next five years.
- **Include explicit family planning indicators in the next NHSP:** Sector development plans detail steps needed to achieve national development plan ambitions. The inclusion of family planning indicators in the 2017 to 2021 plan will ensure that family planning is prioritized. This inclusion will also embed family planning programming failures or successes in specific institutions as opposed to generalised assessments of performance.
- **Rebrand Family Planning:** The traditional concept of family planning represents a service for married women only. As a result, men, young people and single adults often do not see themselves as family planning users. Additionally, many women's first encounter with family planning services happens after they have their first pregnancy.

  This interpretation of family planning suggests the need for a new paradigm that will apply to all Zambians of reproductive age. The engagement of youth and adolescents will be a strong pillar in ensuring that appropriate information is made available to prepare young people for their sexual and reproductive lives. A family planning communications strategy is necessary to achieve this outcome.
- **Improve Demand Creation:** The inclusion of family planning in the education curricula is an important step towards demand creation. Communication about family planning is however conspicuously absent at health facilities and in the community. Health promoters know that information alone does not result in behaviour adoption or change. The high rate of teenage pregnancy in an education system that has a family planning module is testimony to the need to increase investments in innovative and engaging sexual and reproductive health education.

References

1. *UNFPA Zambia Annual Report*. United Nations Population Fund; 2015. Available at: http://zambia.unfpa.org/sites/esaro/files/pub-pdf/UNFPA%20Zambia%20Annual%20Report%20-%202015.pdf.
2. Central Statistical Office, Ministry of Health, University of Zambia, Lusaka, Zambia, Tropical Diseases Research Centre, Ndola, Zambia and Macro International Inc. *Zambia, DHS 2007 Final Report*. Calverton, Maryland: Macro International, Inc; 2009. Available at: http://dhsprogram.com/pubs/pdf/FR211/FR211%5Brevised-05-12-2009%5D.pdf.
3. Family Planning 2020 – Zambia Commitment. *Familyplanning2020org*. 2016. Available at: http://www.familyplanning2020.org/commitments?entity_id[]=150.
4. *Population And National Development*. Lukasa: Ministry of Finance and National Planning; 2010.
5. United Nations Development Programme. *Human Development Report 2014*; 2014. Available at: http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf.
6. Oanda Currency Calculator: Historical Exchange Rates 2013 - 2015. Available at: Oanda.com.
7. *2014 Educational Statistical Bulletin Tables*. Republic of Zambia's Ministry of Education, Science, Vocational Training and Early Education. Prepared by Directorate of Planning and Information. 2014.
8. Zambia Ministry of Finance and National Planning. National Population Policy. Lusaka, Zambia. 2007. Available at: https://books.google.com/books?id=12xQAQAAIAAJ&source=gbs_ViewAPI.
9. *National Health Strategic Plan 2011-2015*. Republic of Zambia's Ministry of Health; 2011. Available at: http://www.moh.gov.zm/docs/nhsp.pdf.
10. *Family Planning Services: Integrated Family Planning Scale-up Plan 2013-2020*. The Ministry of Community Development, Mother and Child Health (MCDMCH) Republic of Zambia; 2013. Available at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/07/CIP_Zambia.pdf.
11. *National Strategy On Ending Child Marriage In Zambia 2016-2021*. Ministry of Gender, Republic of Zambia; 2015. Available at: http://zambia.unfpa.org/sites/esaro/files/pub-pdf/CHILD%20MARRIAGE%20STRATEGIC%20PLAN%20FINAL.pdf.
12. *Vision 2030 For Zambia*. Republic of Zambia; 2006. Available at: http://faolex.fao.org/docs/pdf/zam149709.pdf.
13. Sustainable Development Goals: 17 Goals to Transform Our World. *United Nations Sustainable Development*. 2015. Available at: http://www.un.org/sustainabledevelopment/.
14. Central Statistical Office, Ministry of Health, University of Zambia Teaching Hospital, Lusaka, Zambia, Tropical Diseases Research Centre, Ndola, Zambia and ICF International. *Zambia, DHS 2013-2014 Final Report*. Rockville, Maryland: ICF International; 2015. Available at: https://www.dhsprogram.com/pubs/pdf/FR304/FR304.pdf.

Acknowledgements:

This brief is the results of the contributions of the Center for Reproductive Health and Education (CRHE), Marie Stopes Zambia and the members of the Family Planning Technical Working Group.

PAI
pai.org

Lessons Learned

- Advocates need to be sensitized to new and innovative sources of data
- Many advocates don’t know where to find data- making it accessible and transparent is key to increasing usage
- For data to be used by advocates, it needs to be disseminated to advocates and packaged for them when possible
- More conversations are needed between advocates and researchers about data collection and use.

Thank You!

edunn-Georgiou@pai.org