Urbanization, the Urban Poor, Family Planning and Reproductive Health: Implications for Development

Prepared by the Futures Institute for the Bill & Melinda Gates Foundation
Global Population Growth

World Population

Sources: US Census Bureau 2010 for different historical estimates and UN World Population Prospects, The 2010 Revision.
Global Urban-Rural Population Growth

Urban Populations Living in Mega-cities
Criteria for Defining an Area as a Slum

- Inadequate access to safe water
- Inadequate access to sanitation and other infrastructure
- Poor structural quality of housing
- Overcrowding
- Insecure residential status

Source: UN Habitat
Urban Population Living in Slums
Health Status
Family Planning
Urban Reproductive Health Initiative

Strategies

- Postpartum and postabortion integration
- Expanded, high quality services
- Public-private partnership
- Social marketing
- Voucher scheme
- Outreach, information, counseling
- Mass media and mid-media
- Policy and advocacy

Contribution to Increases in National CPR

Five Year Goal: Increase CPR by 20 percentage points in focus cities

By end of year 5, an estimated 37% of the ten-year goal will have been achieved

Ten Year Goal: Increase CPR by 20 percentage points in focus countries
Addressing Operational Barriers to Improve Reproductive Health in Uttar Pradesh, India

Subrato Kumar Mondal, Varsha Sharma, and Ratna Khare

November 30, 2011
Dakar, Senegal
Fostering Local Leadership for Urban Reproductive Health in Uttar Pradesh

‘Building Leadership Support for Urban Reproductive Health in Uttar Pradesh’
- a grant from Future Institute
Current Population (in million)

<table>
<thead>
<tr>
<th></th>
<th>India</th>
<th>Uttar Pradesh</th>
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<tbody>
<tr>
<td>Total</td>
<td>1,028.7</td>
<td>166.2</td>
</tr>
<tr>
<td>Rural</td>
<td>742.5</td>
<td>131.7</td>
</tr>
<tr>
<td>Urban</td>
<td>286.1</td>
<td>34.5</td>
</tr>
</tbody>
</table>

Population Foundation of India

Uttar Pradesh

Current Population (in million)

1,028.7

166.2

742.5

131.7

286.1

34.5
Total Fertility Rate

Source: NFHS 2005-06
Use of modern Family Planning Method

Source: NFHS 2005-06
Family Planning Scenario in Uttar Pradesh

• UP is the most populous state in India with an urban population of 34 million.
• UP has the second highest TFR (total fertility rate) in India after Bihar (NFHS-3).
• UP’s TFR is 3.8 compared to India’s 2.7.
• TFR among the urban poor in UP is 4.2.
• The use of modern FP methods is low (31% of women in lowest quintiles use modern contraceptives).
• Unmet family planning need is 22% (9% spacing & 13% limiting).
Objective

To raise awareness among national, Uttar Pradesh state and city municipal leaders for improved FP services for the urban poor in order to achieve national, state and city development goals.
Strategies

Strategy-1: Analysis of existing national, state and city FP/RH policies

Strategy-2: Assess gaps in urban FP/RH services and needs of the urban poor

Strategy-3: Use policy and gaps analyses to develop advocacy plan

Strategy-4: Implement and monitor advocacy plan
Strategy-1: Analysis of national, state and city FP/RH policies

• Ongoing analysis
  • Assess implementation status of policies e.g. National Rural Health Mission and Janani Suraksha Yojana provide monetary incentive to rural and urban poor women to give birth in facilities
  • Identify gaps and barriers in existing policies

• Prospective analysis: Financing structures and resources for urban FP/RH
Strategy-2: Assess gaps in urban FP/RH services and needs

• Meet with UP state and cities’ FP decision makers and experts to assess Family Planning program effort scores (FPE)

• Conduct key informant (KI) interviews in UP state and cities on FP and development concerns and priorities
Items Rates Highest and Lowest
Strategy 3: Use policy and gap analysis and develop advocacy plan

• Use results of policy analysis, FPE and KI to draft the plan
• Select 3 key FP issues for advocacy for 2011-2012
• Identify FP champions for each issue
• Identify and map key stakeholders per issue (leaders/groups opposing or supporting FP)
• Meet with FP champions to validate plan, issues, and stakeholder maps
Family planning use by women with child <12 months (Allahabad)

- Non-use: 48%
- Condom: 20%
- Traditional: 20%
- Female sterilization: 4%
- Pill: 3%
- Other modern: 5%

Are FP Services Routinely Offered Post-Partum and Post-Abortion?

- Facilities: 100%
- Providers: 80%
- Clients: 0%
Doctors who restrict clients' eligibility to use a method for reasons of **parity**

<table>
<thead>
<tr>
<th>Method</th>
<th>Allahabad</th>
<th></th>
<th>Gorakhpur</th>
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<tbody>
<tr>
<td></td>
<td>Number that provide method</td>
<td>Percent that restrict</td>
<td>Number that provide method</td>
<td>Percent that restrict</td>
</tr>
<tr>
<td>Pill</td>
<td>86</td>
<td>22.1</td>
<td>49</td>
<td>30.6</td>
</tr>
<tr>
<td>Condom</td>
<td>91</td>
<td>11.0</td>
<td>33</td>
<td>3.0</td>
</tr>
<tr>
<td>Sterilization</td>
<td>51</td>
<td>100.0</td>
<td>45</td>
<td>88.9</td>
</tr>
<tr>
<td>IUD</td>
<td>67</td>
<td>89.6</td>
<td>49</td>
<td>77.6</td>
</tr>
<tr>
<td>Injection</td>
<td>55</td>
<td>32.7</td>
<td>30</td>
<td>46.7</td>
</tr>
</tbody>
</table>
Significant Need for Methods Other than Sterilization for Limiting

Fertility Desires Among Women 35-39
- Want no more: 55%
- Not exposed: 4%
- Sterilized: 36%
- Want more: 5%

Family Planning Use Among Women 35-39
- Sterilized: 35%
- Traditional: 20%
- Condom: 16%
- Non-use: 22%
- Injectable: 2%
- Pill: 4%
- IUD: 1%
Strategy 4: Implement and monitor advocacy plan

• Develop advocacy tools-policy briefs, presentations, booklets
• Orient FP champions on using advocacy tools
• Support dialogues between FP champions and government-private sector leaders
  • Tap existing events, forums, decision makers’ meetings
  • Organize new events
• Monitor advocacy events and decision makers’ policy/program/funding actions
• Update adjust the plan as needed
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Ingredient for success: Collaboration

- Joint analysis of survey data to identify issues for advocacy
- Dialogues with state and city officials and health/FP managers on key issues
Ingredient for success: Data-based advocacy tools

Population Foundation of India

THE FAMILY PLANNING INDEX: UTTAR PRADHESH AND FOUR CITIES, 2011 BASELINE

This policy brief presents an application to India of the family planning index (FPI) for the first time. The index is calculated using data on fertility, sexual and reproductive health, and family planning. The FPI is calculated using a set of indicators that measure the level of family planning services and the extent to which women are able to access them.

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**Background and purpose**

The FPI is calculated using a set of indicators that measure the level of family planning services and the extent to which women are able to access them.

**Methodology and data**

The Family Planning Index (FPI) is calculated using data on fertility, sexual and reproductive health, and family planning. The FPI is calculated using a set of indicators that measure the level of family planning services and the extent to which women are able to access them.

**Results**

The FPI score for UP and four cities were averaged around 50-60 out of 100 percent, similar to the scores for all of India in 2009.

The FPI scores for UP and four cities were averaged around 50-60 out of 100 percent, similar to the scores for all of India in 2009.

**References**

1. R. J. Smith, R. J. Smith, R. J. Smith.

Perceptions of Uttar Pradesh State and City Leaders Regarding Urban Population and Family Planning Issues

BACKGROUND AND PURPOSE

The Population Foundation of India (PFI) is implementing an advocacy project from the Futures Institute (FI), a member of the Bill & Melinda Gates Foundation's Urban Reproductive Health Initiative (URHI), which aims to expand access to family planning services among the urban poor. URHI is being implemented in major cities in India (Uttar Pradesh), Kenya, Nigeria, and Senegal by a consortium of local and international organizations.

Developing family planning advocacy strategies requires insights into leaders' perceptions about urban population growth, development, and family planning. This policy brief attempts to answer these questions:

- Do majority leaders consider urban population growth a serious issue? Is the urban class population too large?
- What do majority leaders think about the situation?
- How do city leaders perceive family planning services among urban poor?
- Is family planning important in achieving development goals?

DATA AND METHODOLOGY

The data for this brief came from interviews with leaders that took place in April-May 2011 with key informants of Uttar Pradesh (UP) state of India and the UP cities of Agra, Aligarh, Allahabad and Gorakhpur.
Goal of HUP:

To improve the health status of the urban poor by adopting effective, efficient and sustainable strategic intervention approaches, adopting the principle of convergence of the various development programs

Objectives of HUP:

Provide Quality Technical Assistance to the Government of India, states and cities for effective implementation of the proposed National Urban Health Mission (NUHM) or on going Urban Health component of the National Rural Health Mission (NRHM)
Thanks for the Attention
Engaging City leaders on Resource Allocation for Family Planning

Authors and affiliations:
Nelson Keyonzo: Jhpiego, Kenya
George Kichamu: National Coordinating Agency for Population and Development
Irene Muhunzu: Family Health Options of Kenya

November 30, 2011
Outline

- Overview of KURHI (TUPANGE project)
- Advocacy Interventions
- Achievements
- Challenges & solutions
- Lessons learnt
Project Overview

- Tupange is part of a broader Gates-funded “Urban Reproductive Health Initiative”
  - 5 Year Program
- Strong focus on family planning among the urban poor
- Project is being implemented in 5 cities
  - Project covers 42% of the urban population
  - Represents 14% of the Kenya population
- Project implemented by a consortium of partners led by Jhpiego
**Tupange Project Sites**

### Urban Site (Municipality) vs Population

<table>
<thead>
<tr>
<th>Urban Site (Municipality)</th>
<th>Population</th>
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<tbody>
<tr>
<td>Nairobi</td>
<td>3,133,518</td>
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<tr>
<td>Mombasa</td>
<td>938,131</td>
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<tr>
<td>Kisumu</td>
<td>409,928</td>
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</table>

### Expansion Sites

<table>
<thead>
<tr>
<th>Site</th>
<th>Population</th>
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<tbody>
<tr>
<td>Machakos</td>
<td>150,041</td>
</tr>
<tr>
<td>Kakamega</td>
<td>91,768</td>
</tr>
</tbody>
</table>

Source: 2009 Kenya population and Housing Census

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**Legend**

- **Scale Up Urban Centers**
- **Initial Urban Centers**
- **Provincial Boundary**
# Kenya Population and CPR

<table>
<thead>
<tr>
<th>Demographic Statistics</th>
<th>Kenya</th>
<th>Nairobi</th>
<th>Mombasa</th>
<th>Kisumu</th>
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<tr>
<td>Pop (M)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>38</td>
<td>3.1</td>
<td>0.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Core Urban Pop (M)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>12</td>
<td>3.1</td>
<td>0.9</td>
<td>0.2</td>
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<tr>
<td>Tupange coverage (M)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>5</td>
<td>3.1</td>
<td>0.9</td>
<td>0.2</td>
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**CPR (39 %*)**

<table>
<thead>
<tr>
<th>CPR MM Urban (%)</th>
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<tbody>
<tr>
<td>41</td>
<td>43.7</td>
<td>29.4</td>
<td>44.4</td>
<td></td>
</tr>
<tr>
<td>CPR MM Urban Poor (%)</td>
<td>38.8</td>
<td>41.2</td>
<td>26.4</td>
<td>46</td>
</tr>
</tbody>
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**Unmet need (25.6 %*)**

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<thead>
<tr>
<th>Unmet need Urban (%)</th>
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<th></th>
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<tbody>
<tr>
<td>23</td>
<td>22</td>
<td>26.9</td>
<td>24.3</td>
<td></td>
</tr>
<tr>
<td>Unmet Need Urban Poor (%)</td>
<td>27.3</td>
<td>26</td>
<td>33.1</td>
<td>29.2</td>
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<th>Private sector share of contraceptive market (%)</th>
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<tbody>
<tr>
<td>42.7*</td>
<td>64.3</td>
<td>66.4</td>
<td>46</td>
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Data source: Tupange Baseline HH survey, (*) KDHS, (') 2009 Kenya Census
Project Goal

To achieve a 20 percentage point increase in contraceptive prevalence rates in each of the selected urban centers, specifically among the urban poor.
Project Objectives

1. Improving quality and availability of FP services (including integrating FP into other services)
2. Generating demand for FP services
3. Ensuring contraceptive security
4. Engaging private sector to inform best practices and lessons learned
5. Advocating for improved policy environment
Advocacy Gaps

1. Lack of pro poor issues in RH/FP policies
2. Low national budget line support for FP
3. Unclear operationalization of RH/FP rights within the devolved system
4. Limited FP support/leadership from political and religious leaders
Advocacy Interventions

1. Policy revision at national and city/municipal level to include urban poor and FP issues
2. Resource mobilization for FP at national and city level
3. Position FP as a major contributor of poverty reduction
4. Advocacy for local leaders at city/municipal levels to support FP initiatives for the urban poor
5. Using champions to promote FP
Advocacy Achievements

1. Improved policy environment
   I. National policies reviewed and gaps in the provision of FP services to the poor documented
   II. Existing Population Policy for National Development revised awaiting debate and adoption by parliament
   III. Increased budgetary allocation for RH/FP commodities
   IV. Sensitization of policy makers on the link between FP & MDGs (consequences of rapid pop growth & FP as the missing link to realization of MDGs)
Advocacy Achievements

2. Development and dissemination of the Tupange Advocacy Strategy and tools
3. Trained FP champions
4. Trained Tupange consortium members & LIPs on how to use data for decision making
5. Strengthened involvement of LIPs in promoting FP among urban poor
6. Sensitized journalists on FP issues
7. Advocated for political and financial support for repositioning of FP at national & county levels
### Challenges & Solutions

<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>SOLUTIONS</th>
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<tbody>
<tr>
<td>Opposition to FP issues based on culture, religion and perceptions</td>
<td>Continuous Advocacy at all levels</td>
</tr>
<tr>
<td>Limited resources for advocacy</td>
<td>Leveraging/Mobilization of resources</td>
</tr>
<tr>
<td>Inadequate advocacy networks to speak with one voice on issues of FP</td>
<td>Creation of more networks</td>
</tr>
<tr>
<td>Difficulties in sustaining FP advocates or champions in the general population and within the media fraternity</td>
<td>Continuous training and support</td>
</tr>
<tr>
<td>Conflicting statements by national leaders and media on issues of population growth and family planning</td>
<td>Continuous sensitization/dialogue of/with leaders at all levels on the benefit of a well managed population</td>
</tr>
</tbody>
</table>
Lessons Learnt

- Use of interactive state of art advocacy tools (multi media presentation & RAPID Model) to reach decision makers results in positive action
- Leveraging on available resources is key to sustainability of advocacy efforts
- Involvement of LIPs in the planning and implementation of project ensures community participation and ownership
Lessons Learnt

- Use of FP champions to lobby for political and financial support at national and city level for increased resource allocation for RH/FP programs
- Complimentary roles of consortium partners was important in the realization of the project objective
- Operationalization of RH/FP rights within the devolved system is important for sustainability of FP
Ensuring FP access and reducing inequalities to the urban poor
Acknowledgements

- Bill and Melinda Gates Foundation
- Government of Kenya
  - Ministry of State for Planning National Development and Vision 2030 (NCAPD)
  - Ministry of Health
  - Ministry of Local Government
  - Kenya National Bureau of Statistics
- USAID, World Bank, UNFPA
- Futures Institute/FHOK
- Stakeholders/Communities
COMPREHENSIVE AND TARGETED APPROACH TO BUILDING AN ENABLING ENVIRONMENT FOR FAMILY PLANNING AT THE DECENTRALIZED LEVEL IN FOUR CITIES IN NIGERIA

Anne Taiwo and Emily Sonneveldt
Introduction- Nigeria Context

- Government’s commitment to family planning in Nigeria has been sporadic and under-funded with a narrow supportive message focused solely on its role within maternal/child health efforts.

- The majority of advocacy efforts to change this paradigm have been focused on the national and state levels and have been fragmented between organizations and messages.
Family planning activities being implemented in four cities in Nigeria (soon to be six).

Provides an opportunity to collect city level quantitative and qualitative data to identify the interests, priorities, and beliefs of city level decision-makers in order to develop and implement city specific advocacy initiatives.

Utilization of data to directly target local decision makers with messages that address their interests, priorities, and personal beliefs (data driven).
Objective

- To develop evidence based, city specific advocacy initiatives aimed at creating an enabling environment for family planning by engaging previously unsupportive stakeholders.
Methods: Data Collection

Data from four main sources:

**Internal:**
- **Family Planning Effort Index (FPE):** Quantitative data based on expert opinions evaluating the government effort in key family planning areas (policy, supply, demand, commodities, quality, services, record keeping, and evaluation, and current government influences, justifications, and priorities).
- **Key Informant Interviews:** Qualitative data based on opinions and beliefs of local stakeholders.

**External:**
- Nigerian DHS
- Baseline data collected in the 4 cities for NURHI (MLE - Measurement Learning and Evaluation)
Important Findings

- Current language is not effective:
  - Respondents did not believe meeting unmet need was an important justification for family planning.
  - Respondents believe enabling couples to avoid unintended pregnancies is a very important justification.

- Some cities are ready to broaden their message from the current focus on avoiding maternal deaths.
  - One city (Ibadan)- participants showed acceptance of progressive messages, including reproductive rights and meeting fertility intentions.
Important Findings

- Complete confusion about the current allocation of resources towards family planning
  - Responses range from 1% to 45%
  - Important because one of the main objectives of our program is to increase government allocation of resources to FP. Hard to convince a person who thinks 45% of the budget is going towards FP that more resources are needed.

- Urban areas are seen as having a programmatic emphasis because there is geographical access to health facilities
  - Ignoring other access issues specific to urban areas

- City level decision-makers respond better to individual level issues, not nationally developed related issues
  - Some importance placed on MDGs
Methods: Data Use, City Level

- Both the qualitative and quantitative data was used to:
  - Identify content to be used in city level advocacy, including:
    - Theme of messages
    - Data included in messages
    - Terminology for messages
  - Identify who each of the messages would target
    - Religious and community leaders
    - Political leaders
    - City level decision makers

- Individual campaigns were designed for each city that used city level data to target messages aimed at building an enabling environment for implementation of family planning activities.
Seed grants given to CSOs to help build a critical mass of FP champions. Data supported the training by:

- Supplying site specific data on current family planning indicators and initiatives
- Identifying relevant stakeholders to target with messages
- Creating messages that are site specific
- Supplying site specific information to local advocates that is relevant to them and energized local officials
Next Steps

- Collection of midline data to adjust messages and monitor progress.
- Repeat of data collection and use process in two additional cities.
- Use data to create second phase of advocacy messages.
  - The 4 cities have different levels of CPR and their decision-makers are at different stages of support for FP.
  - Messages developed for each of the cities can potentially be reused in other cities when stakeholders advance in their knowledge and support of FP.
    - Example: Messages related to reproductive rights
Don’t assume that decentralized decision-makers have the same opinions and motivations as higher level decision-makers.

- Advocacy that works at the national level might not work at the city level

Comprehensive data can be used to both verify, validate, or nullify what we think we know

- Reproductive rights

Collecting data directly from stakeholders before preparing advocacy campaigns helps focus messages and can increase the possibility of building necessary support among key decision makers.

- Using local data can make them feel more involved