

**Zambia Case Study:
Ready for Change**

**A Repositioning Family
Planning Case Study**

September 2005



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

ACQUIRE Report

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By Julie Solo, Monde Luhanga, and Damien Wohlfahrt



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Contents

Acknowledgments.....	v
Executive Summary	vii
Introduction.....	1
Methodology.....	3
Findings.....	5
Timeline	5
What has been achieved?	6
What was done?	8
Context.....	8
Policy and government and donor support	10
Program.....	11
Lessons Learned.....	21
Challenges.....	23
Recommendations.....	27
References.....	31
Appendix 1: List of Contacts	33
Appendix 2: Documents Reviewed for This Report.....	35
Table	
Table 1. TFR by residence, education, and province, 1992 to 2001–2002.....	7
Table 2. Current use of family planning methods by currently married women aged 15–49, 1992, 1996, and 2001–2002	12
Figures	
Figure 1. Contraceptive prevalence by province, 2001–2002	6
Figure 2. Prevalence of modern contraceptive use, by wealth quintile, 1996 and 2001–2002.....	8
Figure 3. Percentage of girls aged 6–10 currently attending school, by wealth quintile, 1996 and 2001–2002.....	9
Figure 4. USAID support for family planning in Zambia, in US\$ (millions), FY 1995–2004.....	11
Figure 5. Tracking stockouts at Chibolya Health Centre.....	14
Figure 6. Wall mural for SafePlan, Lusaka.....	15
Figure 7. Group discussion with community volunteers, Kishikishi Rural Health Centre.....	17

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Executive Summary

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well documented, the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. This is particularly true for Sub-Saharan Africa; for the region as a whole, only 14% of women are using modern methods of contraception (PRB, 2004). To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. Case studies were undertaken in three countries that have been successful in increasing contraceptive use and reducing fertility—Ghana, Malawi, and Zambia—so that lessons learned can be used to guide strategy development and identify key investments. A three-person team conducted interviews and site visits in Zambia from February 14 to February 25, 2005, interviewing 31 key informants and holding group discussions with community volunteers.

In the 1970s, family planning received minimal political support in Zambia: “Politicians didn’t see family planning as part of development but as part of the white man’s efforts to control the growth of the black population.” A number of factors in Zambia contributed to high fertility, such as low education levels, desire for large families, high levels of infant and child mortality, and low levels of family planning knowledge and use. A shift occurred in the early 1990s, however, as the reintroduction of multiparty democracy brought about a number of changes, including health-sector reform. The Population Policy of 1989 also signaled changing attitudes towards family planning, highlighting that overall economic development depended on lowering fertility, that family planning was good for the welfare of the mother and the child, and that information and access to family planning services was a fundamental human right. The 1990s saw a strong focus on family planning, with a number of champions ensuring that it received necessary emphasis. Now, with the prevalence of HIV/AIDS among adults at 16%, it is not surprising that many of these champions have moved away from family planning to focus on addressing HIV/AIDS.

The success of the family planning program in Zambia—increasing the prevalence of modern contraceptive use from 8.9% to 22.6% between 1992 and 2001–2002—shows the potential impact of research that is well-designed and implemented. The 1995 Contraceptive Needs Assessment and the 1996 Demographic and Health Survey (DHS) both emphasized similar needs:

- To enhance contraceptive choice
- To improve the clinical and counseling skills of providers
- To strengthen the contraceptive logistics system
- To address misperceptions and biases in the community and among providers.

These studies then led to appropriate interventions to address the identified needs. Key stakeholders were involved in the research process and funding was immediately made available to implement the recommendations.

Until the mid-1990s, most women who used modern family planning methods used either oral contraceptives or the condom. Interventions sought to expand contraceptive choice, in particular working to overcome long-standing biases against Depo Provera, which had essentially been banned in the country since 1982. Projects in Lusaka and Copperbelt Provinces trained providers, supplied equipment, and incorporated community involvement and outreach. This led to increased uptake of all methods and a scaling up of pilot projects: “The range of methods encouraged women to come forward because now they had a wide range to choose from.” Depo Provera was found to be particularly popular and was finally registered in the country in 2004.

Another key step in enhancing choice and improving services was the 1997 launch of *Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines*. The policy was published in the newspaper for public input, and it was disseminated at a meeting that included representatives from all districts in the country. An important aspect of the policy was that it addressed unjustified barriers to services, such as spousal consent, age, and parity restrictions. The need for this was shown, for example, in the 1997 Situation Analysis Study, which found that 42% of providers felt that a client must have a child or children before she could receive the injectable. Therefore, training not only gave providers skills so that they would feel more confident and comfortable in providing services, but it also addressed the biases that create such barriers. The logistics system was strengthened through the provision of commodities by donors and with a dedicated staff member at the Central Board of Health; this was a fundamental factor in the improvement of family planning services.

In addition to supply-side improvements, there was also a strong emphasis on demand creation through a wide range of communication activities, such as development of a family planning logo and radio and television programs. The number of women hearing a radio message about family planning or viewing a message on television increased, and this exposure was associated with increased contraceptive use. For example, according to the 2001–2002 DHS, 24.4% of listeners of any radio program were currently using family planning, compared with only 11.9% of nonlisteners.

Social marketing through the Society for Family Health (SFH) has also contributed significantly to family planning in Zambia, through *Maximum* condoms (which represents roughly one-third of the market share of condoms) and an oral contraceptive *SafePlan*, which is now used by almost one in five pill users. SFH has also played an important role in raising awareness about family planning.

Projects in Zambia have incorporated a number of innovative strategies, including involving the community (such as male motivators, peer counselors, and women’s support groups called “circles of friends”). This work always started with meetings with community leaders—for example, going to villages during the traditional chief’s tours. There have also been efforts to move services beyond the clinic walls through community-based distribution (CBD) agents, commercial sales agents, and employer-based agents. These activities have had some success, but they have tended to be on a

fairly small scale, and there is still a need to improve access to family planning in rural areas, both through CBD and through strengthened clinic services.

Some of the key lessons learned from Zambia's experience include:

- Research can effectively lead to change and scaled up programs if stakeholders are meaningfully involved and if action follows immediately.
- Expanding method choice beyond pills and condoms can significantly increase contraceptive prevalence, and methods can be effectively introduced (or reintroduced) if this is done in a holistic manner.
- Improving logistics is essential and requires dedicated staff.
- Exposure to information, education, and communication (IEC) messages is associated with increases in knowledge and changes in behavior.
- Social marketing is an effective complement to public health systems for method supply and promotional activities.
- CBD is an effective way to get services to rural populations, but it needs to be more widespread to have an impact.

Introduction

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well documented, in recent years the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though the need remains high. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003).

To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. In the face of scarce resources, weak infrastructure, and a growing focus on HIV/AIDS, it is extremely difficult for African country programs to make significant gains in strengthening their family planning programs and thereby raising contraceptive prevalence. USAID has committed itself to providing incremental assistance to a selected number of focus countries at the very early stages of program development. To help guide these investments, lessons learned by countries in the region that have made significant progress will be very useful.

Therefore, USAID has undertaken a project to document the success of the family planning programs in three countries in Sub-Saharan Africa over the past 10–20 years and to identify which program interventions led to that success. The three countries selected for analysis are Ghana, Malawi, and Zambia, all of which have shown considerable growth in contraceptive prevalence and significant fertility decline, despite a challenging environment and limited resources. Their success can provide guidance for other Sub-Saharan African countries. The case studies will be used by USAID to guide strategy development for Repositioning Family Planning and to inform efforts to identify key investments for the region. In addition, a synthesis paper will pull out key lessons from the three case studies.

Methodology

This report documents the achievements, the process, and the keys to success from the family planning program in Zambia. The sources of data for this case study included in-depth interviews with key informants (Appendix 1) and a document review (Appendix 2). A three-person team conducted interviews and site visits in Zambia from February 14 to February 25, 2005. In addition, the team contacted a number of individuals at USAID/Washington and other respondents who had worked in Zambia. In total, 31 individuals were interviewed. Quotations from these interviews appear throughout the report. The following were the main questions addressed in these interviews:

1. What are the main achievements and successes of the family planning program in Zambia in the past 10 years?
2. What were the main reasons for success (including program factors, policies, and societal/cultural factors)?
3. What were the main challenges or constraints encountered in implementing the family planning program?
4. How were these challenges addressed?
5. Have any regions of the country or segments of the population been more challenging to effectively provide services to? If so, what has been done to meet their needs?
6. What are the current priorities for the family planning program in Zambia?
7. What do you see as the main lessons learned from the work on family planning in Zambia?

The information presented in this report gives a picture of the family planning program in Zambia; based on the data and opinions of key informants, general lessons learned are identified. However, these findings have some limitations. First, since we are looking at the program over the past 20 years, getting accurate information about the past can be difficult. This is due both to staff turnover and to the fact that people are generally more conversant about their current programs. Often, inadequate documentation and evaluation of projects have made it difficult to determine exactly what was achieved. In addition, directly attributing particular outcomes—e.g., increases in CPR—to specific interventions is difficult. However, based on the wide range of information gathered, it is possible to make general conclusions about effective aspects of the program that contributed to the country's success.

Findings

Timeline

Year	Key Policy and Program Activities	Impact	Context
1964 ⇒			• Nation achieves independence.
1970– 1973 ⇒	<ul style="list-style-type: none"> • Churches Health Association of Zambia (CHAZ) is formed. • Planned Parenthood Association of Zambia (PPAZ) comes into being to advocate for child spacing. 		• New constitution ushers in one-party political system.
1978 ⇒	<ul style="list-style-type: none"> • Government recognizes family planning as an integral part of primary health care. 		
1979 ⇒	<ul style="list-style-type: none"> • Family Health Unit is established in the Ministry of Health (MOH). 		
1980 ⇒		TFR: 7.2	
1982 ⇒	<ul style="list-style-type: none"> • Training of family health nurses by MOH begins (and continues until 1993). 		• Depo Provera is banned in Zambia.
1983 ⇒			
1984 ⇒	<ul style="list-style-type: none"> • Norplant introductory trials are conducted at University Teaching Hospital (1984–1990) 		• First AIDS case is detected at University Teaching Hospital.
1985 ⇒			
1986 ⇒			
1987 ⇒	<ul style="list-style-type: none"> • Second UNFPA Country Program (CP), with family planning, is set up. 		
1988 ⇒	<ul style="list-style-type: none"> • Contraceptive Prevalence Survey (CPS) is conducted. 	CPR: 3.4%	
1989 ⇒	<ul style="list-style-type: none"> • National Population Policy is established. • Interagency Technical Committee on Population (ITCP) is formed. • PPAZ establishes clinic in Lusaka. 		
1990 ⇒		Population: 7.8 million	• Constitution is amended to reintroduce multiparty system.
1991 ⇒	<ul style="list-style-type: none"> • PPAZ establishes clinic in Kitwe. 		<ul style="list-style-type: none"> • Health-sector reform begins. • Multiparty elections are held.
1992 ⇒	<ul style="list-style-type: none"> • Demographic and Health Survey (DHS) is conducted. • Social marketing of Maximum condoms begins. • Training of trainers in family planning is conducted in Mauritius. • Third UNFPA CP is set up. 	TFR: 6.5 CPR: 8.9%	• Depo Provera is approved by U.S. Food and Drug Administration.
1993 ⇒	<ul style="list-style-type: none"> • USAID-funded Zambia Family Planning Services Project begins (1993–1998). 		
1994 ⇒	<ul style="list-style-type: none"> • CARE Community Family Planning Project begins (1994–2001). • ODA provides support primarily in contraceptive supplies and logistics (1994–1999). 		• International Conference on Population and Development is convened.
1995 ⇒	<ul style="list-style-type: none"> • Contraceptive Needs Assessment is conducted. 		• Beijing conference takes place.
1996 ⇒	<ul style="list-style-type: none"> • DHS is conducted. • Expanding Contraceptive Choice Pilot Study is conducted in three districts in Copperbelt Province (1996–2001). • Kafue Adolescent Reproductive Health Project begins (1996–2002). • Family planning logo is launched. • Social marketing of SafePlan oral contraceptives begins. • Fourth UNFPA CP is set up. 	TFR: 6.1 CPR: 14.4%	
1997 ⇒	<ul style="list-style-type: none"> • Zambia Situation Analysis Study is conducted. • <i>Family Planning in Reproductive Health Policy, Framework, Strategies and Guidelines</i> is launched. • Nurses and Midwifery Act is passed. • Phase I of emergency contraception study is conducted. 		
1998 ⇒	<ul style="list-style-type: none"> • USAID-funded Zambia Integrated Health Project (ZIHP) begins. • Phase 2 of emergency contraception study begins. 		

(cont.)

Timeline (cont.)

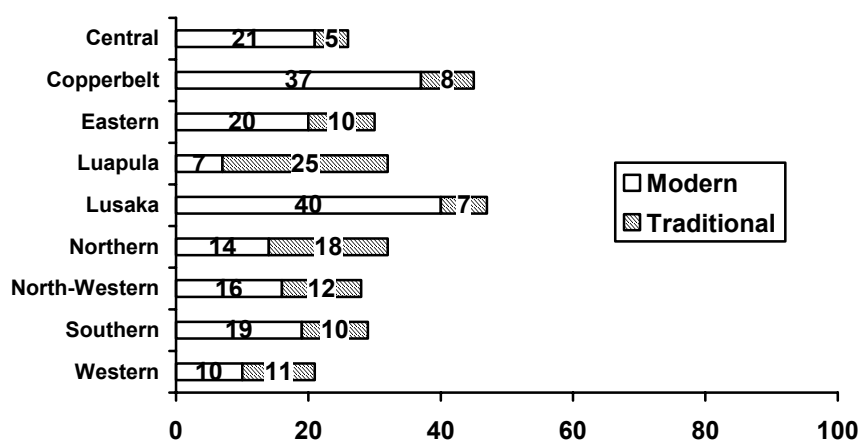
Year	Key Policy and Program Activities	Impact	Context
1999 ⇒	<ul style="list-style-type: none"> UK Department for International Development (DFID) support for contraceptive supplies and logistics is continued (1999–2003). 		
2000 ⇒		Population: 10.3million	
2001 ⇒	<ul style="list-style-type: none"> DHS is conducted. 	TFR: 5.9 CPR:22.6%	<ul style="list-style-type: none"> Adult HIV prevalence is 16%
2002 ⇒	<ul style="list-style-type: none"> PRP Initiative is launched in Copperbelt Province. Fifth UNFPA CP, providing contraceptives, is set up, focused on Northwestern Province. 		
2003 ⇒	<ul style="list-style-type: none"> DFID funds for contraceptive supplies are transferred to basket fund. 		
2004 ⇒	<ul style="list-style-type: none"> USAID-funded Health Services and Systems Program (HSSP) begins. 		

What Has Been Achieved?

Use of modern contraception in Zambia has increased from 8.9% in 1992 to 22.6% in 2001–2002. At the same time, the total fertility rate (TFR)¹ has decreased from 6.5 to 5.9 lifetime births per woman, thereby achieving the target set out in the 1989 Population Policy to reduce the TFR from 7.2 to 6.0 births per woman by 2000, with the future goal of reaching a TFR of 4.0 by 2015. In addition, the policy aimed to make family planning services available, accessible, and affordable to at least 30% of all adults in need of such services by the year 2000.

Women in urban areas were much more likely to be using modern contraception than were women in rural areas (39% vs. 14%). The contraceptive prevalence rate (CPR) for modern methods also varied greatly by province, ranging from a low of 7% in Luapula Province to highs of 37% and 40% in Copperbelt and Lusaka Provinces, respectively (Figure 1). Respondents explained that programs have typically focused on urban areas—

Figure 1. Contraceptive prevalence by province, 2001–2002



¹ Total fertility rates are calculated for women aged 15–49 and are based on births in the three-year period preceding the survey. Rates may differ slightly from those published in 1988, 1993, and 1998, as these were based on births in the five years preceding the survey.

particularly in Lusaka and Copperbelt Provinces—because they are densely populated and thus are where the projects can show the greatest impact.

Likewise, fertility has declined much more rapidly in urban areas than in rural areas over the past decade, with the urban TFR falling by 1.5 births per woman, compared to a decline of only 0.2 births per woman in rural areas (Table 1). Besides the urban-rural difference, there are notable differences in TFR trends and current rates by education level and region. Women with a secondary or higher education have a TFR almost half (3.9) that of women with no education (7.4). The TFR in Copperbelt and Lusaka provinces declined by more than 20% in the past decade, and women in both provinces have had one birth less than the national average. In Central, Luapula, Northern, and Southern provinces, the TFR has declined gradually; it has remained static in Eastern and Western provinces and actually increased in the North-Western province.²

Table 1. TFR by residence, education, and province, 1992 to 2001–2002

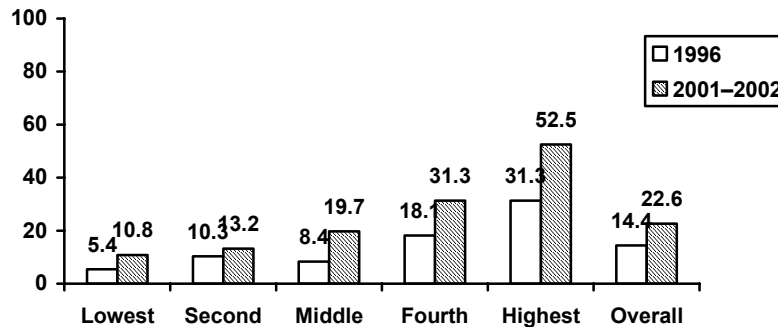
Background characteristics	1992	1996	2001–2002
Residence			
Urban	5.8	5.1	4.3
Rural	7.1	6.9	6.9
Education			
No education	7.1	6.8	7.4
Primary	6.8	6.7	6.5
Secondary/Higher	4.9	4.5	3.9
Province			
Central	6.8	6.3	6.2
Copperbelt	6.2	5.6	4.5
Eastern	6.8	7.1	6.8
Luapula	7.4	7.2	6.9
Lusaka	5.5	4.9	4.3
Northern	7.4	7.2	6.9
North-Western	6.0	5.5	6.4
Southern	7.1	5.2	6.1
Western	6.0	6.1	5.9
Total	6.5	6.1	5.9

The proportion of women with an unmet need for family planning decreased from 33% in 1992 (21% for spacing and 12% for limiting) to 28% in 2001–2002 (17% for spacing and 11% for limiting). While almost two out of three women in urban areas (64.2%) had met their need for family planning, only half (49.5%) of rural women had done so.

There were also significant differences in modern contraceptive use between the different wealth quintiles, with a 53% CPR among the wealthiest Zambians compared with only 11% among the poorest (Figure 2, page 8). Thus, while impressive gains have been made, the family planning success story in Zambia is still an unfinished one.

² Per the 2001–2002 Zambia Demographic and Health Survey final report, this increase may be the result of improved reporting of births rather than an actual increase in births.

Figure 2. Prevalence of modern contraceptive use, by wealth quintile, 1996 and 2001–2002



What Was Done?

Context

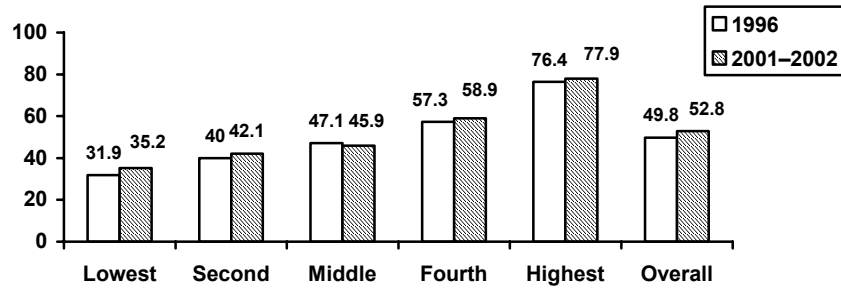
Zambia is a landlocked country in Southern Africa covering a total of 752,614 square kilometers. Both the vastness of the country and its geographical location in the subcontinent pose serious challenges for the country's national development efforts. The range of mountains in the east, alluvial plains and sands in the west, and extensive river basins in the north and the center of the country further add to the challenges of improving access to health care. Administratively, Zambia is divided into nine provinces and 72 districts.

A number of factors have contributed to Zambia's high fertility rate. As spelled out in the National Family Planning Programme (1992–2000), these include:

- Low age at first marriage
- Low education levels
- Low socioeconomic status among women
- Desire for large families
- Economic rationality of large family size
- High levels of infant and child mortality
- Low levels of family planning knowledge and use.

Several of these factors have changed over the past 10 years, contributing to a reduction in the fertility rate. Levels of family planning knowledge and use have increased significantly. (This will be discussed at length in the following section.) There have also been efforts to increase education levels, as it is widely recognized that improving access to education for girls has many positive benefits for development, including reducing fertility. An objective of Zambia's draft Reproductive Health Strategy was to achieve a lower level of population growth by ensuring improved access to 12 years of education for all, especially for girls and women. DHS data, however, indicate that education levels changed minimally between 1996 and 2001–2002 (Figure 3, page 9) and that the disparity between the wealthiest and the poorest remains great.

Figure 3. Percentage of girls aged 6–10 currently attending school, by wealth quintile, 1996 and 2001–2002



Perhaps most important in terms of its impact on fertility is the economic decline that has led to the desire for smaller families. Zambia’s economy has always depended on copper mining, which accounted for 95% of export earnings and contributed 45% of government revenue during the decade following independence (1965–1975). The mid-1970s saw a sharp decline in copper prices and a sharp increase in oil prices, resulting in the deterioration of the country’s economy: “We are the children of the copper spoon that broke,” one respondent explained. According to a 1998 survey, 73% of the population lives below the poverty line, with much higher levels of poverty in rural areas (83%) than in urban areas (56%) (World Bank, 2004).

On a more positive note, in 1990–1991, the government reintroduced multiparty democracy, which allowed people to have a say in the way they are governed and to take more control of their lives. Respondents described a change in the mentality in the country, a feeling that things had become so bad that something had to be done to improve the situation; it was “an environment that was ready for change.” As part of this desire for change, the health sector was reformed to improve the lives of all Zambians, with the basic principle of providing “cost-effective health care as close to the family as possible.” The health-sector reform of 1992 was characterized by a move from a strongly centralized system to a decentralized one. The focus of the reform was the district level: Districts were given the new responsibilities of making their own action plans and budgets, handling funds, implementing programs, and evaluating the results. To empower the districts, management training was emphasized. New systems were created, such as the financial and health management information systems (HMIS). With the focus on shifting responsibility to the district level, the provincial level was initially left out of health-sector reform. However, it became clear after a few years that involvement of the provincial level was essential if activities were to be monitored most effectively.

The factor that had the strongest effect in Zambia, however, was HIV/AIDS; prevalence in the adult population is estimated to be 16%. Most Zambians live in extreme poverty, making them more vulnerable to the epidemic and its effects. The loss of productive workers has adversely affected the country’s economy, and the high morbidity and mortality have overwhelmed health facilities. Efforts by government and donors have opened up a dialogue on sexuality, but safer sex is still not the norm. The demands of HIV are so tangible, real, and immediate that family planning has been overshadowed: “The system is overwhelmed by HIV demands, and so family planning is ignored.”

Policy and Government and Donor Support

Throughout the 1970s, family planning programs received minimal support in Zambia: “Politicians didn’t see family planning as part of development but as part of the white man’s efforts to control the growth of the black population.” Attitudes toward family planning began to change in the 1980s, as shown by the establishment of the Family Health Unit in the Ministry of Health (MOH), the introduction of family planning services in health institutions starting in 1981, and the development of the Population Policy in 1989. The Population Policy highlighted that overall economic development depended on reducing fertility and the growth rate, that family planning was good for the welfare of the mother and the child, and that information and access to family planning services was a fundamental human right.

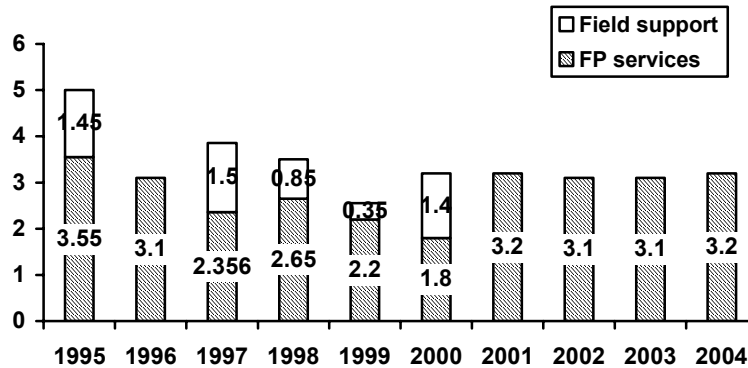
Following the development of this policy, the Interagency Technical Committee on Population (ITCP) was formed as “a body that aims to provide a conducive climate and basic institutional structure within which population issues, including those concerning reproductive health, can be addressed” (CBoH, 2002). The ITCP has subcommittees on reproductive health and information, education, and communication (IEC), both of which have been very active at various times since their creation.

A number of policies had a direct impact on improving service delivery. The most important was *Family Planning in Reproductive Health: Policy Framework, Strategies, and Guidelines*, which was launched in 1997. (This is discussed in greater detail in the following section.) In addition, the Nurses and Midwifery Act of 1997 broadened the scope of operation for midwives and nurses, which had important implications for increasing access to services.

Champions have helped ensure that there is a focus on family planning. A former MOH employee emphasized the general commitment to family planning in the mid-to-late 1990s: “There was focus and emphasis at our planning meetings. We would always be asked what we were doing with family planning.” Programs are, of course, greatly affected by the people running them. While previously there had been champions for family planning, many of these same people understandably have now switched to becoming advocates for HIV/AIDS, in part because of how the pandemic has touched them personally. For example, one respondent who had been a champion for family planning described how after losing two sisters to HIV/AIDS and taking over the care of four of her nieces and nephews, she dedicated herself to working on HIV/AIDS.

Respondents praised the support received from donors over the years: “We had a lot of good will from critical partners.” In particular, support from USAID, DFID, UNFPA, and SIDA was mentioned. As Figure 4 (page 11) shows, the USAID Mission in Zambia has provided roughly US\$3 million per year from 1996 to the present. Since 1994, UNFPA has provided approximately \$750,000 a year for reproductive health, including family planning.

Figure 4. USAID support for family planning in Zambia, in US\$ (millions), FY 1995–2004



It is important that government feels ownership of programs. Respondents discussed problems with projects that operated outside of the MOH, leading to complaints that this was creating parallel structures. As staff at the Central Board of Health explained regarding USAID-supported projects: “We worked together this time, which was not the case before. We corrected it this time around.”

Program

Using research for change

The success of the family planning program in Zambia shows the potential impact of research that is well-designed and implemented. The 1995 Contraceptive Needs Assessment and the 1996 DHS both emphasized similar needs (and the findings were strengthened because they came from multiple sources):

- To enhance contraceptive choice
- To improve the clinical and counseling skills of providers
- To strengthen the contraceptive logistics system
- To address misperceptions and biases in the community and among providers.

These studies then led to appropriate interventions to address the identified needs. The interventions were guided by a focus on scaling up successful pilot projects, and involved stakeholders and communities in a variety of innovative ways. This research was different, according to respondents, because resources were immediately made available to implement the recommendations.

The process of how research is conducted can be as important in bringing about change as the actual findings. The 1995 Contraceptive Needs Assessment used the World Health Organization (WHO) strategy for contraceptive introduction, which helps governments broaden available contraceptive options by examining user’s needs and the capability of the service-delivery system to provide those methods with appropriate quality of care. A key aspect of this methodology is the involvement of a range of stakeholders and decision makers in the assessment team, so they can see the issues around the country firsthand. A former member of the Central Board of Health who was part of the assessment team

commented that, like many, she had thought that she knew what was going on in the country, but she was very surprised at what she saw during the data collection in the field. This contributed to her commitment to ensure that the assessment would have an impact.

The key actions that followed are described in detail below.

Broadening the method mix

Until the mid-1990s, most women who had used modern family planning methods used either oral contraceptives or the condom; use of other methods was negligible (Table 2). The most striking changes between 1992 and 2001–2002 were the increases in injectable use (this includes both Noristerat and Depo Provera) from 0.1% to 4.5%, the tripling of pill use (from 4.3% to 11.9%), and the doubling of condom use (from 1.8% to 3.8%).

Table 2. Current use of family planning methods by currently married women aged 15–49, 1992, 1996, and 2001–2002

Method	1992	1996	2001–2002
Any method	15.2	25.9	34.2
Any modern method	8.9	14.4	22.6
Pill	4.3	7.2	11.9
IUD	0.5	0.4	0.1
Injectable	0.1	1.0	4.5
Diaphragm/foam/jelly	0.1	0.1	0.1
Condom	1.8	3.5	3.8
Female sterilization	2.1	2.0	2.0
Any traditional method	6.3	11.5	11.6
Natural family planning	0.9	1.9	1.1
Withdrawal	3.0	4.5	5.1
Other	2.2	5.2	2.7

Following up on the Contraceptive Needs Assessment and the 1996 DHS, projects in Lusaka and Copperbelt expanded contraceptive choice through training, provision of equipment and supplies, and community involvement and outreach. This resulted in increased uptake of all methods and scaling up of pilot projects: “The range of methods encouraged women to come forward because now they had a wide range to choose from.” A choice of methods is important the range of needs that different women have are to be met. As one community volunteer explained, “people are encouraged because of various family planning methods. So if a person can’t take Microgynon [a brand of oral contraceptive], there is natural family planning or injectables.”

One of the methods reintroduced through these projects was Depo Provera. This three-month injectable had been used in Zambia in the late 1970s but was withdrawn in 1982. The primary reasons for its withdrawal were that it was being used selectively and nonconsensually in what was then Southern Rhodesia (now Zimbabwe) and South Africa and that it was not registered in the United States, its country of origin (Hall, 2002). In the projects in Lusaka and Copperbelt, Depo Provera was found to be very popular among clients. After the interventions in the Copperbelt Province, injectables made up more than one-third (35%) of method use, compared with only 9% before the project.

(Ninety percent of injectable use was Depo Provera, with Noristerat making up the other 10%.) Depo Provera was finally registered in Zambia in 2004, after considerable lobbying.

Offering an expanded choice of family planning methods requires that health facilities have the proper infrastructure and supplies. The 1997 Situation Analysis found that only about one-half of facilities had the equipment to provide injectables, while only 15% could offer the IUD. As a result of these findings, many of the interventions developed included providing health facilities with supplies and equipment.

From the beginning, the project in Copperbelt Province focused on scaling up (see box below). As one respondent explained, “What is the point of doing a pilot program if you are not scaling up? It is only through a national program that you see impact on indicators.” The Central Board of Health is currently planning to expand the Copperbelt Province project nationally.

The Steps in Scale Up: Expanding Contraceptive Choice in Copperbelt Province (and Beyond...)

1. *Assessment.* 1995. Identified need to expand contraceptive choice
2. *Pilot.* 1996–2001. Introduced new methods, including Depo-Provera, provided supplies and equipment, developed new tools for training and supervision, and employed a variety of ways of communicating with and involving the community. Worked in three districts covering 240,000 people. Key findings included:
 - Injectable users had a clear preference for Depo Provera over Noristerat.
 - The number of new acceptors increased for each method.
 - Continuation rates were high.
3. *Pilots to Regional Programs.* 2002–2005. Expanded to eight districts with population of 1 million, with three broad sets of activities: expanding contraceptive choice, training health care workers, and bringing together communities and the health care system. Managed by Provincial Health Office.
4. *Adopted as national best practice.* 2005. This is currently being planned by the Central Board of Health.

Creating policies and guidelines

The *Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines* was launched in 1997. This comprehensive document described the program guidelines and provided substantial detail on eligibility criteria for the various methods. Interestingly, even though Depo Provera was still not approved in the country, it was included in the guidelines. The policy was also published in the newspaper for public input, leading to good public debate over the content of the policy. In addition, it was disseminated at a meeting that included representatives from all districts in the country.

An important aspect of the policy is that it addressed barriers to services, such as spousal consent, age, and parity restrictions. The 1997 Situation Analysis had found that 42% of

providers felt that a client must have a child or children before the injectable could be prescribed. Such barriers were addressed through training (described below).

Training

To have a real choice of methods and quality of care, training was essential to making providers more confident about and comfortable with providing the service. After training, providers felt that they knew how to handle the complications related to side effects: “Nurses who are equipped with the knowledge don’t shout at the clients.” One of the training approaches involved a very popular kit with an innovative system for profiling clients: “The kit became a hotcake—everyone wanted it.” The kit categorized clients and then identified the family planning methods that would most likely meet their specific needs. The Central Board of Health recently described this model of profiling clients as a best practice, calling attention to its benefit of grouping clients by needs, rather than just describing methods. A critical element of training was incorporating DHMT supervisors: “They are usually left out, so they feel inadequate when they go to supervise.”

Training is a continual need. For example, in the Expanding Contraceptive Choice project in Copperbelt Province, over the first two years of the project, three-quarters of the 22 original providers had left the project, either because they were no longer providing reproductive health services, they had been transferred to other health centers, they had moved away, or they had died. Programs have typically started with training of trainers, so that it is more feasible to train new providers to replace those who leave or die.

Logistics

One of the most fundamental needs to be addressed was strengthening the contraceptive logistics system. According to a 1991 survey, 52.3% of the country’s health facilities had run out of family planning commodities at some point in the six months prior to the study (UNFPA, 1996). Commodities were provided by donors, and a dedicated staff member at Central Board of Health handled contraceptive logistics. “When we bought commodities, everyone was smiling,” as one donor explained.

Figure 5. Tracking stockouts at Chibolya Health Centre

Method	Stock Level
MICROSYNON	2304
MICROLOT	300
M/NORISERAT	4.00 P/P
IAS DEPO-PROVERA	0
FEMALE CONDOMS	0
MALE CONDOMS	360 P
NORPLANT	0
S.D.M.	5
I.U.D.	0

FAMILY PLANNING MET IN STOCK

A comprehensive overview of Zambia’s contraceptive logistics supply system reports that in 2000, donors (DFID, USAID, and UNFPA) financed 100% of contraceptive purchases (Bates & Rao, 2000). In addition, DFID supported the full-time logistics specialist in the Contraceptive Commodities Logistics Unit. As a result of these inputs, the study concluded, “In 1998, . . . the MOH logistics system was reasonably effective at ensuring availability of some contraceptives at most service-delivery points. . . . There was a general rise in both total and per capita expenditures for contraceptives from 1995 through 1998, and then a decline in 1999. . . . The 1999 drop in expenditures is associated with project completion and disbursement of the last batch of funds.”

Recently, the problem of stockouts has returned in some places. As an indication of this, at a site visit in Copperbelt Province, the clinic had no Depo Provera, female condoms, Norplant, or IUDs (Figure 5).

Information, Education, and Communication

A wide range of communication activities was conducted in Zambia, including the creation of a national family planning logo, radio programs, and television programs. These efforts used well-known and respected opinion leaders to help promote family planning and to address opposition. For example, multiple respondents mentioned an advertisement that showed the Minister of Health holding a condom. As a result, almost all women and men (98%) know of at least one method of contraception. Pills and condoms were the most commonly known methods among both women and men. The IUD, on the other hand, was known by only two out of five women and one out of four men. The least-known method was emergency contraception. Knowledge of hormonal implants and injectables showed the most significant increases between 1996 and 2001–2002, rising from 10% to 31% and from 53% to 81%, respectively.

DHS data show that the percentage of women reporting that they had heard a radio message about family planning nearly doubled between 1996 and 2001–2002, rising from 24% to 46%. The number of women who had heard family planning messages on television increased from 2% to 26%. More importantly, exposure to either the radio program or the television program was associated with increased contraceptive use. For

Figure 6. Wall mural for SafePlan, Lusaka



example, 24% of listeners to any radio program were currently using modern contraceptives, compared with only 12% of nonlisteners. Viewers of television programs were almost three times as likely to be using modern contraception as were nonviewers (30% vs. 14%). Exposure to family planning messages increased significantly in urban areas, rising from 58% to 74%. In rural areas, this proportion rose slightly, from 27% to 33%. Exposure to family planning messages was higher in Copperbelt and Lusaka than in other provinces.

While these IEC activities have been effective in urban areas, respondents highlighted that less attention had been drawn to addressing the sociocultural aspects that affect fertility and contraceptive use in rural areas. UNFPA is currently trying to do this in Northwestern Province and plans to share their experiences through the Reproductive Health Subcommittee.

Social marketing

The Society for Family Health (SFH) began work on social marketing in Zambia in 1992, with the promotion of the Maximum condom. In 1996, SFH also began marketing an oral contraceptive called SafePlan. This work has helped to broaden access and increase awareness, supplementing and reinforcing government supplies and services: “We are a team.” Since 1997, the Maximum condoms have made up roughly one-third of all condoms distributed or sold in Zambia. While SafePlan started in 1997 at only 7% of all oral contraceptive use in the country, this share increased to a high of 22% in 2002 (Table 3). Data from the 2001–2002 DHS found that almost one in five pill users (19%) were using SafePlan, although this varied by urban-rural residence (22% vs. 12%). Besides being distributed through traditional outlets—pharmacies, drug stores, and kiosks—Maximum condoms and SafePlan pills are also available at rural health centers and from community based distributors, providing a valuable buffer stock when Central Board of Health’s usual supplies are exhausted.

Table 3. Numbers and share of oral contraceptives and condoms distributed through social marketing program, 1997–2003³

	1997	1998	1999	2000	2001	2002	2003
Oral contraceptives							
SafePlan	193,064	288,576	339,396	446,928	517,536	507,120	595,568
Public (millions)	2.3	1.7	2.1	2.2	2.4	1.4	3.4
PPAZ	185,769	574,320	423,227	345,170	163,139	386,000	175,047
Total (millions)	2.7	2.5	2.8	2.9	3.1	2.4	4.3
SafePlan share	7.01%	11.3%	12.05%	14.9%	16.8%	21.5%	16.1%
Condoms							
Maximum (millions)	6.6	5.2	6.6	8.5	10.1	10.1	13.1
Public (millions)	13.1	12.4	12.8	15.3	17.1	16.2	32.2
PPAZ	-	-	-	80,500	258,576	130,224	56,528
Private	100,000	471,000	1 mill.	N/A	N/A	N/A	N/A
Total (millions)	20	18.2	20.5	24	27.4	26.5	45.4
Maximum share	33%	29%	32%	36%	37%	38%	29%

³ Data are from the Society for Family Health.

In addition to increasing access to pills and condoms, SFH has played an important role in raising awareness about family planning in general. This has included community sensitization through drama, mobile video units, and work with community leaders.

Community involvement: Breaking down clinic walls

Projects in Zambia have incorporated a number of innovative strategies for involving the community and raising awareness, including the “circle of friends,” male motivators, and peer counselors. This work always started with meetings with community leaders—for example, going to villages during the traditional chief’s tours. The circle of friends concept encouraged women to bring friends and form support groups, in part to help address problems of low continuation rates due to side effects, so women could support each other. Respondents reported that these satisfied clients ended up increasing utilization of services: “A satisfied client is the best motivator.”

In addition to involving the community, efforts to increase access have involved a variety of means of providing methods at the community level, including through community-based distribution (CBD) agents, commercial sales agents, and employer-based agents. These activities have had some success but have tended to be on a fairly small scale. In the dissemination of the results of the Expanding Contraceptive Choice study in the Copperbelt Province, community members discussed the impact of the project, and one representative explained that “the one weakness in the District’s family planning program was the absence of individuals within the community who could provide contraceptive methods, particularly during the rainy season when the Kafulafuta River floods and cuts off access between her village and the district health centers” (CBoH, Population Council, & CARE, 2001). Similarly, the end-of-project evaluation for the Community Family Planning Project recommended the creation of more community-based activities (CARE International, 2001).

Figure 7. Group discussion with community volunteers, Kishikishi Rural Health Centre



Rather than imposing family planning or other programs, it is essential to respond to the community's expressed needs: "Projects fail when you dictate—it is better to ask the people." One respondent told a story that illustrates this point. When working with the Flying Doctors in the mid-1980s, they encountered a great deal of resistance from the community when family planning was brought up. The community said that they were concerned about malnutrition among their children, and so the program attempted to integrate family planning with something that addressed the community's needs. They began a deworming program, which showed immediate and tangible results: "This changed the face of the project. The community said, 'These people helped us. We saw the worms. We can listen to them.'" Similarly, on the chief's tours, they would not only talk about family planning, but also about water and other needs.

Adolescent reproductive health

Zambia has a young population, with almost half (46%) of its 10.9 million people younger than 15. As a result, improving the provision of reproductive health information and services to young people has been given increased attention. Similar to general family planning efforts, a review of youth programs found that although activities were ongoing in all seven provinces, the most concentrated efforts for young people took place in Lusaka Province (particularly Lusaka Urban District and Kafue District) and the Southern and Copperbelt Provinces (FOCUS on Young Adults, 1999).

Group discussions with community volunteers in Copperbelt Province: "We have the heart for the people"

What have been the benefits of family planning?

- Spacing children improves health of women and children; "Now we don't have children dying of malnutrition."
- "Most people have realized that family planning is important for their families."
- Previously, "children were being laid like eggs, with no planning for them. When family planning came to us, we found it very helpful. Now we can manage to take our kids to school."
- Women have time to do other things
- Improved relationships between husbands and wives; "marriages are more stable because couples have time for each other."
- "Family planning is bringing development not only with the family but at the national level. If they have three or four children rather than ten then they can educate them and bring development to the family and the nation."

What is their motivation?

- Helping people in the community
- They were given a lot of information which their friends don't know and so they need to share this information
- They would like to be given something in appreciation of their hard work, in particular bicycles because they are covering long distances on foot

Interventions have included setting up youth-friendly corners in health facilities, working with peer educators, and offering family life education in schools. While some respondents felt that the youth-friendly corners had led to increased utilization of

services, they felt that such use generally was still not very high. In addition, drop-out of peer educators is often high, as young people leave to seek income-generating activities.

As expected, there has been some opposition to these programs—e.g., “you are spoiling the morals of our communities”—but many people also expressed a pragmatic attitude that faced the reality of the situation: “We shouldn’t put our heads in the sand and pretend these girls aren’t having sex.” One way in which opposition has been addressed is by bringing key leaders into the program. For example, the Kafue Adolescent Reproductive Health Project began with sensitization meetings in all of the communities and obtained signed commitments from community leaders.

Some improvements in young people’s reproductive health have been seen. For example, more young women are postponing childbearing; among women aged 45–49, 48% had their first birth by age 18, compared to 35% of women aged 20–24. Education contributes to postponing childbearing. Women with a secondary or higher education had a median age at first birth of 20 years, compared to one of 18.4 for women with a primary education and 18.2 for women with no education.

Lessons Learned

Zambia's experience has demonstrated that:

1. Research can effectively lead to change and to scaled up programs if stakeholders are meaningfully involved and if the research is immediately followed by action in implementing recommendations.
2. Contraceptive choice is critical. Expanding method choice can significantly increase contraceptive prevalence.
3. Methods can be effectively reintroduced if this is done properly and with evidence.
4. Choice can only be expanded if providers are adequately trained to be confident to provide services and if they have necessary equipment to do so.
5. Improving the logistics system for contraceptives is key to strengthening family planning programs.
6. Decentralization to the district level can be successful with adequate capacity building, and it is important to not eliminate the provincial level, as it can play an essential role in scaling up and monitoring activities.
7. Exposure to IEC messages is associated with increases in knowledge and changes in behavior, such as increased use of modern contraception.
8. Social marketing is an effective complement to public health systems for method supply and promotion activities.
9. The community must be involved in programs from the beginning, and programs should use needs identified by the community as their entry point. It is important to sensitize opinion leaders at the beginning of programs to get their support rather than face their opposition later.
10. CBD is an effective way to get services to hard-to-reach, rural populations but needs to be more widespread to have an impact on increasing access in rural areas.

Challenges

Among the greatest of the challenges facing Zambia are the following:

- *HIV/AIDS has monopolized people’s attention.* Because of the severity and urgency of the HIV/AIDS epidemic, the Ministry of Health/Central Board of Health, donors, and international and local nongovernmental organizations are focusing their time, money, and staff on minimizing its impact. Instead of being understood as an intrinsic component of HIV/AIDS prevention and care, family planning may be perceived as being “yesterday’s priority,” one that is no longer relevant.
- *There is a serious human resource crisis.* In common with other African countries, Zambia’s public health services suffer severe and worsening shortages of skilled health workers, especially midwives, nurses, and doctors, particularly in rural areas. Reasons for these shortages include:
 - Retirement due to age
 - Resignation due to the voluntary retrenchment scheme and to ill health, low salaries, and poor working conditions
 - Death (especially due to HIV/AIDS)
 - Emigration
 - Moves to positions with United Nations agencies and international nongovernmental organizations, which often can offer better employment conditions
 - The training of inadequate numbers of new staff by training institutions

The UNFPA is attempting to alleviate acute shortages in North-Western Province by offering undergraduate training scholarships in return for recipients’ agreeing to work in the province for a minimum of two years following graduation. (It is too early to determine the effectiveness of this approach.)

- *The availability and use of long-term and permanent methods of contraception are limited.* A number of factors contribute to this problem. These include:
 - *Ambivalence concerning permanent contraception:* Both health workers and community members expressed considerable doubts about the wisdom and acceptability of irreversible, permanent contraceptive methods, even for older women. Interviewees raised many hypothetical “what if” scenarios: What if a child dies? The husband leaves and the woman remarries? The family’s financial situation changes? The husband or wife changes his or her mind? Reversible long-term methods appear to be more acceptable, because they allow couples to change their minds should their personal circumstances change.
 - *Health workers’ bias:* Health workers’ negative attitudes toward long-term and permanent methods hinder clients’ access to them. In recent pretesting for a situation analysis being conducted by HSSP, providers had consistently negative attitudes about the IUD, which will greatly hinder efforts to increase access.
 - *Lack of skilled staff and essential surgical equipment:* Although all obstetric and gynaecology interns at University Teaching Hospital are now trained to perform bilateral tubal ligation, the service is only available at University Teaching

- Hospital and the larger provincial hospitals. Rural people find it difficult to find the time or the funds to travel to distant hospitals for a bilateral tubal ligation, and long waiting lists are an additional deterrent.
- *Commodity insecurity.* Experience in Zambia and elsewhere demonstrates that reliable contraceptive supplies are critical for the success of family planning programs and for a sustained increase in the contraceptive prevalence rate. Health workers report that, since DFID’s Contraceptive Supply Project ended at the end of 2003, contraceptive supplies have again deteriorated and stockouts have increased, especially for newly approved methods such as Depo Provera and implants. Contributing factors include:
 - The Ministry of Health/Central Board of Health has allocated inadequate money from the “basket fund” for contraceptive purchases.
 - The current Health Management Information System (HMIS) provides inadequate information at the central level to allow for accurate forecasting of contraceptive needs.
 - Because some general pharmacy technicians do not fully understand contraceptive forecasting, they do not order sufficient stocks for the provinces or districts.
 - Busy health workers at health centers do not submit regular, accurate reports and do not order sufficient contraceptives.
 - Medical Stores Limited (MSL) delivers supplies only to the district level, and due to transportation difficulties, there are often delays in districts’ delivering supplies to health centers or in health workers’ coming in to collect their supplies.
 - *Many rural areas still have limited access to family planning services.* Reasons for this include:
 - *Distance.* Many rural residents live long distances from their nearest health facility, and many women lack transportation, time, and money to seek family planning services.
 - *Opposition to family planning by some religious groups.* In many rural areas, the only available health services are those operated by religious organizations that oppose all contraceptive methods apart from natural family planning.
 - *Staff, equipment, and commodity shortages.* These problems are particularly acute in rural health clinics; with 65% of the population living in rural areas, it is essential that access be improved.
 - *Some projects have successfully targeted youth, but no large-scale program addresses adolescent reproductive health.* The Ministry of Health/Central Board of Health recognizes the need for establishing youth-friendly reproductive health services, but activities have typically been small-scale and unsustainable. Experience also points to the need for establishing stand-alone youth services. Respondents commented that patronage of the youth corners in regular health centers is limited, largely because young people are concerned that they might be seen by their parents, relatives, teachers, or parents’ friends.
 - *Basic infrastructure needs remain.* Health workers report a lack of space to ensure privacy and a lack of equipment and sterile space to insert IUDs or implants or to

perform bilateral tubal ligations. Even with careful use, equipment wears out and needs regular, scheduled replacement.

- *Some project funding mechanisms restrict the broad promotion of condoms, including for dual protection.* Studies worldwide have demonstrated repeatedly that consistent, proper use of male condoms is the single most effective available technology to reduce the sexual transmission of HIV and other sexually transmitted infections (STIs) (WHO, UNAIDS, & UNFPA, 2004). In addition, when used consistently and properly, male condoms can be a highly effective family planning method (WHO, 2004). However, current guidelines of the U.S. President’s Emergency Program for AIDS Relief (PEPFAR) restrict the advertising of condoms to narrow “high-risk groups” and mandate that advertising emphasize condoms’ limitations rather than their effectiveness: “With PEPFAR, we can’t promote condoms for family planning, only for high-risk groups. This is a big problem.” Such restrictions not only stigmatize condom use by reinforcing the myth that condoms are only for “illicit” sex, but they limit access to a contraceptive method that can effectively protect against both unwanted pregnancy and infection with HIV or other STIs.
- Finally: “No one is putting forward a strong enough case to put effort into family planning.”

Recommendations

Overall, there is a need to make sure that the systems that support family planning are still working, that commodities are getting to health facilities, that providers are getting regular updates, and that “those systems don’t fall apart in the context of the overwhelming demands [for] antiretrovirals (ARVs).”

Some specific recommendations follow:

- *Make the case for family planning; explore ways to make family planning and its importance more visible.* Without downplaying the importance of HIV/AIDS prevention and care, family planning programs continue to play a vital role in improving peoples’ lives and welfare. Family planning needs international and local champions who can explain its continuing relevance and who can advocate successfully for appropriate funding to ensure that the momentum and achievements gained over the last decades are not lost. The Repositioning Family Planning initiatives currently being implemented by USAID, UNFPA, and WHO are promising first steps. At the national level in Zambia, it will be important to conduct advocacy with the Ministry of Finance and to encourage international and local NGOs to give greater priority to family planning in all programs, especially in reproductive health and HIV programs. For their own survival, NGOs tend to “follow the money” when deciding their own priorities. When donors increase funding for family planning, NGOs will be able to implement appropriate activities. Advocacy for family planning will be particularly important as more donors move towards sector-wide approaches (SWAp) and basket funding, so that adequate funds are still allocated to family planning.
- *Have a unit in the MOH that focuses on reproductive health, with a person dedicated specifically to family planning.* Decentralized, integrated health service delivery offers many advantages compared with health departments that have multiple vertical programs. However, there is always the risk that traditional vertical programs will lose focus. A balance between central policy setting and oversight and decentralized implementation is ideal. Interviewees commented that under the current MOH/CBOH structure, reproductive health comes under an all-embracing Public and Clinical Health Systems Directorate. Due to the ever-urgent demands of clinical health services, the priorities of preventive services, including family planning, tend to be lost. The current MOH/CBOH restructuring provides an ideal opportunity to create a specific Directorate for Reproductive Health and to designate a person with specific responsibility for family planning. Such a reorganization will help to reposition family planning and to accord family planning the priority it deserves.
- *Ensure that contraceptive logistics are strong, with a dedicated staff member, and improve the HMIS to capture use of family planning methods.* Bates and Rao (2000) argue that “vertical” contraceptive logistics systems are more effective at assuring reliable contraceptive supplies, that “push” delivery systems are better at preventing stockouts at service-delivery points, and that continued, long-term financial underwriting by donors is critical for guaranteeing that contraceptive supplies are sufficient to meet increasing demand. In an attempt to marry the advantages of

decentralized, integrated health services with the benefits of vertically managed specialist family planning programs, the MOH/CBOH and donors should consider the following strategies for improving the contraceptive logistics supply:

- Employ a full-time dedicated logistics specialist at the central level with specific responsibility for forecasting and ordering contraceptives. Depending on the workload, this person might also be responsible for forecasting and ordering other essential reproductive health supplies, such as antibiotics for treating STIs, HIV test kits, and ARVs.
- Modify the existing HMIS system, as required, to capture accurate information on the use of each contraceptive method to allow accurate forecasting of requirements at the central level.
- Conduct a trial of a partial “push” supply system at selected health facilities to test whether it is more effective at preventing stockouts, especially at more remote rural health centers.
- Encourage donors to commit to an agreed level of continued, long-term financial underwriting to ensure that contraceptive supplies are sufficient to meet increasing demand.
- *The CBOH should adopt the CBD program nationally and should explore different incentive schemes to improve continuity in CBD programs.* Despite the practical difficulties of establishing and sustaining CBD programs, in many parts of Zambia, CBD agents may be the only practical source of supply for many women. Some DHMTs have taken over CBD programs previously run by PPAZ, for example, and this should be encouraged in more districts. In implementing CBD programs, the CBOH should recognize the practical difficulties of retaining volunteer distributors indefinitely and should accept that inevitably turnover will be relatively high. Experience demonstrates that providing appropriate incentives can work wonders in motivating and retaining volunteers. In Zambia, bicycles appear to be the most valued and most motivating incentive. Donors should recognize that in the long run, funding such incentives can be a cost-effective strategy for ensuring program sustainability.
- *Socially marketed methods are an essential component of Zambia’s contraceptive mix, and support for social marketing should continue.* As noted earlier, socially marketed contraceptives (condoms and pills) are an important source of supply in Zambia. It is essential that donors continue to support social marketing programs adequately.
- *Develop and implement policies and strategies to curtail the exodus of skilled health workers from the public health sector.* With the active support of international donors, the Zambian MOH and CBOH should develop and implement a range of policies and strategies to reverse the loss of skilled health workers from the public health system. For example, strategies could include:
 - Increasing the number of undergraduate health workers trained each year. This will probably require the expansion of existing training institutions (or the establishment of new ones), the provision of sufficient training equipment and teaching materials, development of the training skills of existing staff, and the training of new teachers.

- Bonding all new graduates to work for the MOH/CBOH in priority areas of need for a minimal period following graduation.⁴
- Improving the salaries and working conditions of public-sector staff, especially those working in rural areas.
- Improving in-service training opportunities for staff working in “difficult” or remote areas.
- Ensuring a nondiscriminatory, supportive working environment for HIV-infected health workers and giving health workers access to ARV programs, so that HIV-infected employees remain healthy and productive.
- *Continue to promote longer-term methods such as IUDs and implants, as is currently being undertaken by the Health Services and Systems Program.* Discussions with both health providers and community members confirmed that there is a high unmet need for reliable, long-term contraception by women who want to limit their family size. Given the ambivalence concerning *irreversible* contraception that was discussed earlier, promotion of longer-term methods should emphasize their effectiveness, their safety, their ready removal, and the rapid restoration of normal fertility following their removal. This will require staff training (including training in addressing biases), improvement in infrastructure, supplies of essential equipment, and IEC activities with communities.
- *Explore the potential for the wider provision of the “standard-days method,” particularly in areas where there is strong religious opposition to family planning.* The limited experience gained from trials of the standard-days method in the Copperbelt suggests that the method is acceptable to many Zambian women who are reluctant to use other modern contraceptive methods, be it for religious reasons or the fear of or actual experience of unpleasant side effects. The standard-days method could be a useful addition to Zambia’s contraceptive method mix, especially in remote rural areas where religious opposition to other methods is strong. “Although it is doubtful that [the standard-days method] will ever become as popular as the pill or injectable, for those women who do not want hormonal contraception, the introduction of [the standard-days method] may make all the difference in the world. Over 70% of all new [standard-days method] clients under the PRP initiative are first-time users of any family planning method” (PRP, 2003).
- *Take advantage of opportunities to integrate family planning and HIV/AIDS, including having donors address funding practices that hinder such integration.* HIV/AIDS has not reduced the importance or priority for family planning. On the contrary, it has increased it. For example, during family planning counseling, uninfected women can appraise realistically their risks for infection with HIV and other STIs and can institute steps to remain uninfected. In particular, voluntary family planning is critical for the primary prevention of mother-to-child transmission of HIV (PMTCT). To date, family planning programs have been more successful in integrating HIV-related activities into their activities, while HIV/AIDS programs have paid less attention to integrating family planning into their activities. Donors

⁴ MOH/CBOH already have the power to bond staff following training; however, these powers are not implemented or enforced.

should take the lead by ensuring that an adequately resourced family planning component is included in all HIV programs that they support.

- *Reproductive health programs should refocus on primary prevention, in which family planning plays an important role.* It is far better to prevent unwanted pregnancy and infection with HIV and other STIs than it is to provide expensive care afterwards, such as postabortion care, repair of obstetric fistula, or provision of ARVs. One respondent observed, “We are now spending a lot of time and effort on PMTCT, on diagnosing, counseling, and providing ARVs to infected mothers and their children. However, we shouldn’t have missed all these steps before she was pregnant.”
- *Expand programs to meet the needs of in-school and out-of-school youth.* All community members and health workers interviewed were highly supportive of adolescent reproductive health programs that address the needs of in-school and out-of-school youth. Community members accept that many adolescents are already sexually active and that RH services should respond in a pragmatic, nonjudgmental way to this reality. To build trust and to ensure privacy, youth-friendly reproductive health clinics should where possible be “stand alone” services, separate from clinics where adults gather.
- *Ensure continuity of support: Don’t forget the sites you started with.* It is human nature to focus our attention on the newest program, on the latest intervention, and on the expansion of programs to new sites. We take earlier successes for granted and neglect to provide continuing support to established sites. As one respondent commented, “Once we are finished, we forget where we came from.” As a result, many successful programs falter when support is withdrawn. Providing some level of support to these sites could serve an important function in scaling up because these initial sites are potential centers for learning, which continues the process of using evidence for change.

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Appendix I: List of Contacts

Name	Title	Organization
Jeannie Friedmann DyNESS Kasungami	Deputy Director, Office of Population, Health and Nutrition Senior Health Advisor	USAID/Zambia
Patricia Stephenson		USAID/Washington
Dr. B.U. Chirwa	Director General	Central Board of Health
Dr. Miriam Chipimo	Adolescent and Reproductive Health Specialist	Central Board of Health
Grace Sinyangwe	Health BCC Specialist	Health Communication Partnership Zambia
Russel Mushanga	Senior Programme Officer	Department for International Development (DFID)
Rebecca Kalwani	Reproductive Health Specialist	Health Services and Systems Program [formerly ZIHP]
Edith Bwalya	Consultant	Formerly with ZIHP
Doras Chirwa		CARE International
Dr. Fwasa G. Singogo	Executive Director	Planned Parenthood Association of Zambia (PPAZ)
Elizabeth Serlemitos	STARZ Consortium Program Advisor	National HIV/AIDS/STI/TB Council, Zambia [formerly with ZIHP]
Mary Banda	MCH Coordinator	Lusaka DHMT
Dr. Peter Mijere	Deputy Chief of Party	Support to the HIV/AIDS Response in Zambia (SHARe) [formerly Provincial Health Director, Copperbelt Province]
Mr. Raymond Muchindu	Director	FLMZ
Dr. Christine Kaseba	Head of OBS and GYN Department	UTH
Rosemary Kabwe	Reproductive Health/MCH Program Officer	Churches Health Association of Zambia (CHAZ)
Francis Phiri		Corridors of Hope [formerly Project Coordinator of KARHP]
Mary Shilalukey Ngoma	Head of Pediatrics Department	UTH
Mary Zama Sabina Miti	Project Manager Reproductive Health Specialist	PRP Project, Copperbelt Provincial Health Office
Lillian M. Daka Jane N. Chilongo Judy Chingambo 11 Community volunteers	Health Centre In-Charge Nurse/TOT Nutrition Assistant	Chibolya Health Centre, Luanshya District
Mr. Yotam Musonda Angela Ikowa Dr. Mutambo 30 Community volunteers	Manager of Planning and Development, Masaiti District RH Coordinator, Masaiti District District Doctor	Kishikishi Rural Health Centre, Masaiti District

Cynde Robinson Julie Chilambe	Director Operations Manager	Society for Family Health
John Skibiak		Population Council
Margaret O'Callaghan		UNFPA

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