

# **Country Analysis of Family Planning and HIV/AIDS: Zambia**

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## Executive Summary

This study forms part of an investigation by the POLICY Project on how countries have been managing family planning in the face of high HIV/AIDS prevalence. This report describes recent trends in family planning/reproductive health (FP/RH) and HIV/AIDS service delivery in Zambia.

The study was conducted in two parts. First, the desk review of documents on FP/RH and HIV/AIDS was carried out. The second part involved in-depth interviews with selected stakeholders in FP/RH and HIV/AIDS service delivery. Respondents included representatives from the Ministry of Health/Central Board of Health (MOH/CBOH), National AIDS Council (NAC), donor agencies, nongovernmental organizations (NGOs), and cooperating partners as well as public and private service providers. Questions were asked about the FP/RH and HIV/AIDS programs with regard to the status of the programs, funding levels, staffing and personal issues, the role of NGOs and the private sector, and health sector reform.

Findings about FP/RH and HIV/AIDS service delivery trends in Zambia include:

1. Thanks to the health sector reform process, FP activities in Zambia are now undertaken within the broader framework of reproductive health. Although FP/RH is receiving attention, the findings suggest that more resources and attention target HIV/AIDS. Many stakeholders believe FP/RH and HIV/AIDS can be better integrated. Currently, the strategic framework for HIV/AIDS does not include components of FP/RH whereas the FP/RH strategy clearly defines how HIV/AIDS will be addressed.
2. In all government health facilities and at all levels of health service provision, FP services are integrated within maternal and child health (MCH). Services for the prevention and treatment of sexually transmitted infections (STIs) and counseling services are found in all facilities. However, VCT and PMTCT are, thus far, only found in a few selected institutions. While HIV/AIDS diagnosis is not available everywhere, the general perception is that the prevalence of infection is increasing. It is estimated that persons with HIV/AIDS-related illness probably account for as much as 50 percent of bed capacity in hospitals.
3. Condoms are promoted for both disease and pregnancy prevention at clinics. However, the level of acceptance varies. Older couples visiting FP clinics use condoms for disease prevention and prefer pills for pregnancy control. Donor agencies and other institutions procure contraceptive commodities for other methods, such as IUDs and Norplant, which are available in a few urban channels. The public sector remains the major distribution channel for contraceptives.
4. There is an acute shortage of staff in government health facilities. This has been attributed to the government voluntary separation program. While it can be said that HIV/AIDS and FP/RH services are complemented by those delivered by NGOs, in most cases there has been a major shift—most NGOs now emphasize HIV/AIDS. The private sector currently provides ARV drugs, albeit on a small scale.
5. The unavailability of an institutionalized FP training program and the need for upgrading/refresher training in most health institutions have been factors affecting the inadequate staffing levels for provision of FP services. Training and retraining programs in family planning are not clearly articulated. As a result, health facilities, especially in the private sector, are not able to meet FP needs for their clients. When training does occur, it concentrates on temporary contraceptive methods because long-term methods require expertise and supplies or special equipment.

## Abbreviations

ADB	African Development Bank
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARC	AIDS-related complex
ARV	Antiretroviral
CBD	Community-based distributor
CBOH	Central Board of Health
DFID	Department for International Development
DHMT	District health management team
FHT	Family Health Trust
FP	Family planning
GRZ	Government of the Republic of Zambia
HIPC	Highly indebted poor countries
HIV	Human immuno-deficiency virus
ITCP	Interagency Technical Committee on Population
JHU	John Hopkins University
JICA	Japanese International Cooperation Agency
MCH	Maternal and child health
MOH	Ministry of Health
NAC	National AIDS Council
NGO	Nongovernmental organization
PMTCT	Prevention of mother-to-child transmission
PPAZ	Planned Parenthood Association of Zambia
RH	Reproductive health
SDP	Service delivery point
STI	Sexually transmitted infection
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	U.S. Agency for International Development
UTH	University Teaching Hospital
VCT	Voluntary counseling and testing
ZDHS	Zambia Demographic and Health Survey
ZIHP	Zambia Integrated Health Program

## **Background**

### **Maternal Mortality and Levels of Unsafe Abortions**

In 1989, the *National Population Policy* was launched. One of its objectives was to reduce the total fertility rate from 7.2 children per woman to 6 by 2000. Furthermore, the 1992 *National Health Policies and Strategies* (health reforms) also aimed to reduce maternal mortality by 50 percent through promotion of safe motherhood. In the 1980s, the Ministry of Health (MOH) established the Maternal and Child Health (MCH) Unit, whose main objective was to improve maternal health and reduce infant death. The decentralization policy, the health sector reform process, and the expansion of maternity services into communities are but some of the initiatives undertaken to address the high rates of maternal mortality and morbidity. The safe motherhood initiative aims to bring attention to issues surrounding maternal health. The demographic gains of the 1980s appear to have disappeared in the last decade when the effects of HIV/AIDS became more visible.

The risk of dying from pregnancy and childbirth complications in Zambia is high. According to the 1996 Zambia Demographic and Health Survey (ZDHS), the maternal mortality ratio was estimated to be 649 deaths per 100,000 live births, with variation existing between urban and rural areas. A study conducted by Nsemukila and others (1998) found that pregnancy disorders ranked third, after malaria and accidents, on the list of major contributors to hospital admissions for persons aged 15 and older.

Maternal death occurs at every stage during pregnancy. In 1998, pregnancy-related deaths were attributed to hemorrhage (34%), sepsis (13%), HIV/AIDS (10%), and obstructed labor (8%) (Nsemukila et al., 1998). The majority (60%) of deaths occurred after delivery while 13 percent occurred during labor. Death rates from deliveries and abortions are especially high among those younger than age 18 (JHU, 1996).

Maternal death is an important indicator of the deceased's health status, knowledge of and access to services, and the quality of health service provision (Nsemukila et al., 1998). The Nsemukila study revealed the many factors associated with maternal mortality in Zambia, including antenatal care (ANC), clean and safe delivery, integrated postnatal and FP services, essential obstetric care, and essential care of the newborn. The Central Board of Health (CBOH, 1997) states that the main underlying factors for high maternal mortality are low quality care, a poor referral system, and poor access to delivery care due to lack of transport and long travel distances, especially in rural areas. These factors are further compounded by maternal age at first pregnancy, lack of family planning, and high fertility. Harmful traditional practices during labor and delivery and inadequate supplies of equipment and drugs have also affected safe delivery (MOH, 2000). Despite more than 96 percent of women having received ANC (GRZ/CSO, 1996), 53 percent delivered babies at home and only 47 percent of women had supervised deliveries. Many of these factors have attracted various intervention initiatives because they are identified as areas that require urgent attention at all service delivery points (SDPs).

While Zambia's Terminations of Pregnancy Act, 1972, is one of the most liberal of such policies, abortions continue to contribute to high mortality among women. Even though abortion is legal in Zambia, there are strict procedures to follow before one can have the service performed, and abortions are mostly obtained at the University Teaching Hospital (UTH). Nonetheless, poorly performed abortions are quite common in Zambia. According to the MOH records for 1993, 16,000 hospital admissions were due to abortions performed under unsafe conditions. A study conducted in Lusaka in 1993 also showed that 15 percent of all maternal deaths occurred among patients with abortions (MOH, 2000).

## Prevalence of Major Sexually Transmitted Infections (STIs)

Apart from HIV/AIDS, gonorrhoea, syphilis, and chancroid are the most common STIs in Zambia (CBOH, 1997). Others include trichomoniasis, candidiasis, and herpes. These infections are especially prevalent among young adults and adolescents in all social and economic sectors (CBOH, 1997). STI prevalence by province from 1999 to 2001 is shown in Table 1 below.

**Table 1: Cases of STIs in Zambia by Province, 1999–2001**

District Name	1999		2000		2001	
	Deaths	Cases	Deaths	Cases	Deaths	Cases
Western	12	18,436	12	20,327	8	19,350
Lusaka	–	27,272	2	30,286	–	28,311
Southern	8	22,130	14	22,569	8	23,026
Central	2	14,569	4	22,535	25	24,814
Northwestern	–	7,923	4	15,838	3	18,254
Copperbelt	28	21,863	1	7,928	15	13,893
Eastern	33	13,269	36	21,183	3	8,291
Luapula	3	6,527	6	6,720	6	7,225
Northern	6	7,556	15	7,392	4	8,530
<b>Zambia</b>	<b>92</b>	<b>139,554</b>	<b>94</b>	<b>154,778</b>	<b>72</b>	<b>151,694</b>

Source: Data from the CBOH.

## HIV/AIDS Prevalence

The first HIV/AIDS case was reported in 1984 (Flykesnes et al., 1994). By 1997, about 45,000 AIDS and AIDS-related complex (ARC) cases had been reported to the MOH (MOH/CBOH, 1999). HIV prevalence for Zambia exceeds the sub-Saharan average of 7.8 percent. According to MOH/CBOH (1999), the prevalence among 15 to 49 year-olds stabilized at 19 percent for much of the 1990s. Table 2 shows data from 1999 to 2001 that illustrates trends in deaths and cases arising from confirmed and suspected cases of AIDS.

**Table 2: Confirmed and Suspected Cases and Deaths from HIV/AIDS in Zambia by Province, 1999–2001**

District Name	1999		2000		2001	
	Deaths	Cases	Deaths	Cases	Deaths	Cases
Lusaka	92	7,151	133	6,789	759	10,315
Western	322	2,218	238	4,667	147	8,320
Copperbelt	525	4,822	439	2,724	256	4,197
Central	152	2,770	660	5,470	456	3,035
Northwestern	159	1,513	181	3,186	337	3,804
Southern	396	3,511	334	3,186	197	3,577
Eastern	170	2,466	149	1,502	138	1,357
Northern	100	2,058	118	1,770	132	2,119
Luapula	86	772	66	757	73	1,089
<b>Zambia</b>	<b>2,002</b>	<b>27,281</b>	<b>2,318</b>	<b>30,338</b>	<b>2,495</b>	<b>37,813</b>

Source: Data from CBOH.

The major factors affecting the HIV/AIDS epidemic in Zambia are high prevalence of STIs, multiple sexual relationships, low use of condoms, poverty, poor overall health, low status of women, urbanization, mobility, early sexual activity, and certain cultural practices.

### Contraceptive Prevalence

The contraceptive prevalence rate increased from 15 percent in the 1992 ZDHS to 26 percent in the 1996 ZDHS. It is reported that at least most people have heard of at least one method of contraception, including condoms, with 33 percent of women and 46 percent of men having ever used any modern method (ZDHS, 1996). Ever use of modern methods of family planning was 59 percent for currently married women and 40 percent for sexually active women (ZDHS, 1996). The 1996 ZDHS reports that oral hormonal contraceptives are widely used and only 4 percent of women use condoms. The majority of the men who use modern contraception rely on the pill (11%) and use condoms (8%) (ZDHS, 1996). The condom is the most widely used method among sexually active, unmarried men (36%) (ZDHS, 1996).

Province and level of education are factors that show large differentials with regard to use of contraceptives (ZDHS, 1996). The 1996 ZDHS reports that few people are opposed to family planning on religious grounds.

Public sources supply 60 percent of modern methods whereas 24 percent is supplied by private providers, with 13 percent from other sources such as shops, friends, and relatives (ZDHS, 1996).

Despite the trend of increasing contraceptive prevalence, there is considerable unmet need for FP services. Reportedly, 27 percent of married women have unmet need for FP services, 19 percent for birth spacing, and 8 percent for birth limiting (ZDHS, 1996). Were all married women who had an unmet need to use FP services, there would be a 26–52 percent increase in contraceptive use (ZDHS, 1996).

## **Exclusive Breastfeeding**

Breastfeeding in Zambia is nearly universal and has a median duration of 20 months. A study conducted by Ven den Borne and others (1996) showed that 40 percent of babies were fed within one hour of birth and 87 percent within 24 hours. However, the 1996 ZDHS shows that 58 percent were fed within an hour and 91 percent within 24 hours.

The extent of exclusive breastfeeding has improved in Zambia. There now is a breastfeeding policy that encourages baby-friendly environments in most health facilities. The program to promote exclusive breastfeeding is extensive. It is undertaken by the National Food and Nutrition Commission of the MOH/CBOH with the support of UNICEF (ZDHS, 1996).

## **Findings and Discussion**

This study forms part of an investigation by the POLICY Project on how countries have been managing family planning in the face of high HIV/AIDS prevalence. This report describes recent trends in FP/RH and HIV/AIDS service delivery in Zambia.

## **Methodology**

The study was conducted in two parts. First, the desk review of documents on FP/RH and HIV/AIDS was carried out. The second part involved 26 in-depth interviews with selected stakeholders in FP/RH and HIV/AIDS service delivery conducted in 2002. Respondents included representatives from the Ministry of Health/Central Board of Health, National AIDS Council, donor agencies, NGOs, and cooperating partners as well as public and private service providers. Questions were asked about the FP/RH and HIV/AIDS programs with regard to the status of the programs, funding levels, staffing and personal issues, the role of NGOs and the private sector, and health sector reform.

## **Status of Family Planning**

Currently, there are several national FP/RH and health policies in place in Zambia: the Population Policy, draft RH Policy, National Health Policy, and RH Plan of Action. Almost all respondents agreed that family planning is a major component of the wider RH service delivery at all levels of Zambia's health care services, including the community, rural, and urban health centers, including all hospitals. Family planning is also a part of the essential health care package that was designed as a part of health sector reform, which has benefited FP services, especially with regard to procurement of FP commodities and provision of services on a daily basis.

All respondents said that FP services are needed and are especially critical in view of the HIV/AIDS crisis, the poor state of the economy, and the general health status of families, especially mothers and children. First and foremost, family planning was said to be needed because it enhances quality of life in a number of ways: giving mothers needed rest, providing the opportunity to breastfeed children for at least two years, and avoiding further deterioration of the health status of HIV-positive women. A respondent from the Lusaka District Health Management Board said, "Family planning is needed, yes to plan properly—so that as you plan, you can have children with a better future, better health, nutrition, and better health for the mother. Methods like condoms also help in the prevention of diseases—STIs and AIDS."

In addition, family planning has economic considerations, especially when HIV/AIDS is a factor. HIV/AIDS has economic consequences for families and larger families face greater economic problems, which in turn lead to social and health problems. NGO respondents said,

*The need for family planning, yes. The more reason why family planning must be promoted: people are dying of from HIV/AIDS and if they are having children, when they die who will look after the children? Need to plan on the number of children you can afford. (CARE)*

*With HIV/AIDS, families need to plan for their families. When you have too many people in the family, the family fails to provide for requirements. In the end, this leads to disintegration of the family. Children/family members then start to fend for themselves, and this puts them at the risk of contracting HIV/AIDS through, for example, prostitution. (Family Health Trust)*

Respondents varied with regard to their opinions of the results of FP activities in Zambia. In terms of indicators of success, they identified accessibility and availability of FP services. At the community level, community-based distributors (CBDs), peer educators, and neighborhood health committees actively promote reproductive health, including FP services. At the health facility level, FP services have been integrated into the broader RH services that can be accessed on a daily basis. Also, most clinics have youth-friendly corners. In addition, the introduction of employer-based FP services in some workplaces has been a major factor in the improvement of FP services. Most government and NGO respondents felt results of FP activities are accessible—clients are now able to access FP services within their communities. A respondent from the UTH said,

*We are very happy, as we are offering the best that we can. Our figures on clients have a steady increase. We are now catering to everybody. Our services are throughout the day and daily as our staff have improved... We can even compete with the private sector.*

Respondents also stated that another indicator of success is that more people are now using modern FP methods.

Despite these areas of success, respondents expressed some concerns about FP services. Most respondents from donor agencies, cooperating partners, and private practices said the results could be better. They attributed what they consider to be less than satisfactory results to the context in which family planning is provided. Respondents cited both operational and political issues. When asked about the results of FP services, respondents said,

*Not very satisfactory. Declining state of health services—there is an increase in numbers of deaths, declining human resources and logistical system, and low contraceptive procurement, which has not been given priority. For example, next year June, there are no committed funds to procure contraceptives. (UNFPA)*

*Much not being done. Why? In early the early days, family planning, being a vertical program, was specific and staff and resources were assigned but within the context of other services. The emphasis has now changed. The same staff has to do everything. (USAID)*

*Unsatisfactory, but not completely; but the trend is going up. Why? I think that lately I haven't heard much talk about family planning. At the moment, it is a bit forgotten. (UNAIDS)*

Respondents also identified training, equipment, contraceptive procurement, and support supervision as major areas of concern about FP services. Generally, training in family planning is not focused on health providers. The respondents said that the only training program at Mwachisompola in Chibombo, established to train health providers in family planning, was phased out. Therefore, currently, there is no systematic training in FP services. Moreover, when training is in place, it mostly depends on availability of funds from donors. In the private sector, most SDPs are staffed by persons who have had no specific training in family planning. Some FP methods, such as IUDs and Norplant, are provided at only a few SDPs because of lack of equipment. Where equipment is available, some providers are unfamiliar with its use and/or maintenance. Concerns were also raised with regard to procurement of contraceptives. Although FP activities are taking place, monitoring of these activities is said to be poor.

Respondents of various affiliations identified additional issues that affect FP services. There is an observed shortage of staff in health facilities. Because of the multiple stakeholders in family planning, the issue of coordination was highlighted. In some instances, the acceptance of FP methods was said to be low due to socio-cultural factors. For example, some women have to seek permission from their partners or spouses to practice family planning, sex preference for the expected child contributes to high fertility rates, and practicing family planning is not accepted in some communities because procreation is a traditional norm. Finally, some respondents perceived a shift in focus toward HIV/AIDS that has been at the expense of family planning.

### **Political and Official Support**

Family planning had been a vertical program prior to health reforms, but it has since been integrated within the broader concept of reproductive health, which has been officially identified as a major public health concern. Also, there has been an effort to support FP programs through development of a number of government policies—the RH Policy, National Health Policy, and Population Policy. There are structures in place for service delivery from bigger hospitals down to community health providers. NGO and cooperating partner respondents reported that they collaborate with government ministries and departments. Presently, there is the Reproductive Health Subcommittee of the Interagency Technical Committee on Population (ITCP), which brings all RH stakeholders together with the secretariat within the Ministry of Finance and National Planning. The subcommittee was initially established in 1989 but was inactive for some time; it was revived in the last year.

However, despite some success in political recognition of family planning, nearly all respondents said that there is much room for improvement. Policymakers lack an understanding of what family planning is meant to achieve. Hence, family planning has been regarded as a health issue, not one needing a multisectoral approach. Respondents said,

*Political support is mainly lip service. People don't see this as a problem. If we can relate family planning to resources—this is never thought of in those relations. (NAC)*

*The support is not much. Maybe they do not see the increase in fertility as an issue because of the increased number of deaths in families. (POLICY)*

*We need to integrate services. Family planning should not be a stand-alone component. It is one pillar of safe motherhood, and safe motherhood is an important component of the wider reproductive health. (CBOH)*

In addition to better understanding and a multisectoral approach, respondents suggested that the government should commit resources instead of depending on funds from donors. They also highlighted the need for advocacy, sensitization, and church involvement.

Respondents expressed concern that family planning is being overshadowed by HIV/AIDS. Although there has been no explicit, official shift on the part of the government in terms of support for FP programs given the rising rate of HIV/AIDS prevalence in the country, it is perceived that the emphasis is now on HIV/AIDS. Indeed, HIV/AIDS has attracted attention and resources. At the national level, the government established the NAC to address the AIDS question. NAC is mandated to reduce the number of new infections and investigate the impact of HIV/AIDS.<sup>1</sup> A respondent from the Lusaka District Health Management Team (LDHMT) said, “Unlike HIV/AIDS, family planning has no secretariat to coordinate activities. HIV/AIDS has the National AIDS Council, where funding goes directly to HIV/AIDS activities, making it more organized.”

However, others believed that increased attention for HIV/AIDS is appropriate and necessary. A respondent from the Lusaka District Health Management Board said,

*The national rationale has changed in view of the impending crisis. Therefore, the formation of NAC...The rationale is good for the country because HIV/AIDS is claiming capable men and women who are productive in society. This change will ensure that the lives of men and women are prolonged.*

Currently, two policies govern service provision in the areas of FP/RH and HIV/AIDS: the National HIV/AIDS Strategy and National FP/RH Strategy. The FP strategy is strong and has components of HIV/AIDS whereas the HIV/AIDS strategy has no comprehensive components of family planning. Respondents said that the HIV/AIDS Strategy lacked the integration and implementation aspects of family planning in its outline of HIV/AIDS programs. Respondents were concerned that family planning was not given appropriate attention within the context of HIV/AIDS. They said,

*FP/RH is the cornerstone to the improvement of health by fighting HIV/AIDS. However, the [HIV/AIDS] document does not specify. (NAC)*

*The [HIV/AIDS] strategy does not specifically include components of FP/RH; they are disconnected. There is need for a holistic approach, as family planning is seen as a different area. (Society for Family Health)*

*Family planning is included [in the HIV/AIDS Strategy] but the holistic approach is not strong enough. (UNAIDS)*

## **Service Delivery**

Previously, FP services were vertical—there was a day specified for each service as a stand-alone activity. Now these services are integrated with MCH and provided daily. However, the mode of integration varies with staffing levels. Where there is a problem with staffing, most services are provided by one provider, which in most cases results in increased workload, increased client waiting time, and compromised quality of provider-client interaction. Where staffing levels are adequate, all services are provided by different providers at the same SDP.

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<sup>1</sup> At the time of data collection, the bill for the establishment of the National AIDS Council had not yet been enacted by Parliament. As a result, donors such as DFID, Global Fund, World Bank, ADB, UNDP, and others are still holding onto their funds.

Access to FP services has improved with integration. Services are available daily and, according to the respondents, obtainable at all government hospitals and clinics. All respondents reported that the number of clients has been increasing steadily. However, some respondents expressed concern about the operational aspect of service integration. A respondent from the Planned Parenthood Association of Zambia (PPAZ) said, “What is happening on family planning is positive—there is integration at the clinic level. Though, there is fear of losing direction because of integration; staff playing too many roles.”

It was reported that in all facilities, STI counseling and treatment were the most common services offered. The response has been good among both adults and youth with respect to STI counseling and treatment. Prevention of mother-to-child transmission (PMTCT) and voluntary counseling and testing (VCT) services are only found in selected facilities; in fact, PMTCT services are being piloted. However, respondents reported that the government intends to put VCT sites in all 72 districts. It has been pointed out that PMTCT and VCT require additional staff and their success depends on the volunteers and community participation. There is a steady increase in client numbers with respect to VCT and one respondent said that as a result of VCT, more people are coming for related services. Among the clinics visited, records of HIV/AIDS patients were generally not kept. In the few centers where records were kept, 15–30 percent of tested patients were estimated to be HIV positive. Antiretroviral (ARV) therapy is not being provided in public institutions, but a few private practitioners offer it.

Generally, FP commodities are available. According to various respondents, the only problem is with distribution. Individual government clinics, for example, order their own supplies through DHMTs, which in turn procure supplies on their behalf. In cases where these orders are delayed, SDPs have shortages. Condoms are used for dual protection, although it was mentioned in some interviews that the emphasis was on prevention of STIs, including HIV/AIDS.

## **Funding**

Some respondents said that funding for family planning has been reduced. Other respondents felt that it is difficult to determine the trends because family planning is currently a component of MCH. Documents from the Ministry of Finance and National Planning indicate that funds for family planning are part of the total RH budget (previously family planning had a separate budget). While it could be said that there are efforts to secure funding for FP programs, FP services are in fact integrated within the broader safe motherhood/RH context.

Allocation of funds to HIV/AIDS, however, has increased over the years. Respondents indicated that funding for HIV/AIDS is expected to increase. Most of the respondents reported that HIV/AIDS received more resources and attention from both the government and donors. The government gave the NAC 2 billion kwacha in the last year using highly indebted poor country (HIPC) funds. As previously mentioned, donors are currently withholding funding to the NAC pending its recognition as a legal entity through an act of Parliament. Donors such as DFID, USAID, UNICEF, JICA, UNDP, and UNFPA are supporting various other HIV/AIDS-related programs and activities.

Some respondents reported that HIV/AIDS is perceived to be a more urgent problem and has thus attracted more attention for funding. For example, efforts are being made to obtain funding for HIV/AIDS through the sectorwide assistance programs (SWAP) initiatives. This was not reported for other FP/RH programs. Respondents had different opinions about the shifts in HIV/AIDS and FP funding. A respondent from the NAC stated that addressing the HIV/AIDS crisis takes precedence, saying, “This disease has changed the way you allocate resources.” Others question the efficacy of this allocation of resources. A respondent from UNFPA said, “To run an HIV/AIDS-related program will require laboratories, which is expensive. Family planning will solve future problems: the number of orphans will

be reduced. Family planning contributes to HIV control.” Opinions on the impact on family planning also vary. Respondents said,

*There is lots of attention, more funds going to HIV/AIDS and family planning is losing its momentum. Lots of resources and support go to HIV/AIDS. Family planning providers that have left are not replaced as no one looks at training more providers to go to local clinics. (UTH)*

*It has had an impact on family planning funding. What we are seeing now is that the services that were traditionally family planning are now including VCT, which costs money. (CBOH)*

*Specifically, [funding] for family planning has been decreasing. This has not affected the programs because there is more HIV money and we are flexible to use HIV/AIDS funds. (Society for Family Health)*

Many government and donor respondents reported concerns about the issue of contraceptive security. Most institutions maintain a three-month buffer stock. However, clinic staff said there will soon be a contraceptive crisis in Zambia. Respondents pointed out that the government doesn't currently budget for contraceptives, noting,

*We need GRZ to also budget for contraceptives. All the contraceptives that we are using are all donor-given. Policymakers should also widen the method mix. (CBOH)*

*We rely on donor funding too much. The government must also come in to procure condoms and contraceptives. Funding should not only come from donors. (Lusaka District Health Management Board)*

Notwithstanding, it was reported that condoms are available at health facilities most of the time. Although procurement is done by the DHMTs, other actors complement the supply. In Lusaka, for example, PPAZ, Family Health Trust, and the Zambia Integrated Health Program (ZIHP) supply condoms to health facilities and community-based agents. But this scenario may not be the same for provision of condoms outside Lusaka and for other types of contraception. For example, other FP methods, such as Norplant and IUDs, are only found in a few urban hospitals and some NGO SDPs, whereas efforts are made to supply SDPs with oral contraceptives and condoms.

## **Staffing and Personnel Issues**

Staff shortages, both at central and clinic levels, can be attributed mainly to the loss of staff due to resignations. A major proportion of the workforce is lost due to the voluntary separation program. Some staff are deployed to HIV/AIDS programs, although these programs are integrated into RH activities. A number of health personnel leave employment in public institutions to join NGOs that are involved in HIV/AIDS programs and activities. Others leave to join the private sector. Staff recruitment to countries such as the United Kingdom, Australia, and South Africa are said to be high, although no statistics are available. Other factors include poor working environment. Increased workloads are a problem because of coworkers' absenteeism due to chronic illnesses. Also, inadequate staffing levels have affected staff morale. Available data for 1999 show the percentage distribution of staff who left for reasons of normal retirement and desertion were 26.6 percent and 28.4 percent, respectively.

Deaths have been cited as a second major factor in staff shortages. In 1999, 41 percent of staff loss was due to death. According to interviews with key stakeholders at MOH, CBOH, and UTH, deaths

suspected to be HIV/AIDS-related have affected staffing levels, although there are no supporting statistics or evidence to determine the actual causes of the deaths.

As a result of staff leaving or dying, there is an acute shortage of staff at all levels of healthcare. This has affected FP service delivery. Respondents said,

*We don't offer the best we can as a shortage of staff causes long queues. Hence, you don't find the desired amount of time to sit with a client and discuss all aspects. We have three nurses dealing with six delivery rooms. They can't do all these things. Most complications can be prevented, but there are no people to offer care. Most male doctors are working alone with women without the company of a female nurse. (UTH)*

*There are too few health providers who are not giving much time to clients, especially counseling clients. (UNAIDS)*

Nearly all respondents pointed out that health workers are not appropriately protected against possible infections from patients. The only precautions taken include wearing gloves and avoiding direct body contact with body fluids and excreta. Yet even when precautions are taken, they are not always done correctly. A respondent from the MOH said, "When they are available, they misuse them." In the event that a member of staff is exposed to infection in the course of duty, the instance is referred to a committee responsible for post-exposure prophylaxis. However, respondents noted that there is little knowledge of this committee's existence among health workers. A respondent from the CBOH said, "No protective equipment and no post-exposure prophylaxis protocols" were unavailable.

### ***Role of NGOs and the Private Sector***

Respondents said that the focus, services, and activities provided by traditional FP/RH NGOs have changed somewhat in recent years, primarily because of the changed levels of funding. Respondents said that funding available to actual and potential players has been influenced to a great extent by the advent of HIV/AIDS. Because of the role of NGOs in HIV/AIDS and the increased disease burden, the donor community has given more support to NGOs involved in HIV/AIDS activities. Funding for FP/RH NGOs has also been affected by the gag rule.<sup>2</sup> More recently, through concerted efforts, NGOs have lobbied for debt swap in order to raise money to be used in HIV/AIDS programs. NGOs are involved in running home-based care programs, establishing VCT sites, supporting peer education activities, facilitating training for health providers, and providing contraceptives, including condoms. Respondents from NGOs that are focusing primarily on HIV/AIDS interventions revealed that FP/RH activities are not a major component of their activities.

Respondents noted that changes in funding have negatively affected FP/RH activities in some cases. New NGOs tend to focus on HIV/AIDS because there is greater funding available. Existing NGOs are shifting their focus from FP/RH to HIV/AIDS with the funding shift. For instance, CARE/Zambia was reported to have discontinued its community FP/RH programs due to lack of funds; however, CARE is now involved in HIV/AIDS activities. Respondents said,

*Now [NGOs] are turning attention to HIV/AIDS because there is more money to run the programs. I think they should integrate their services. (MOH)*

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<sup>2</sup> The gag rule is a U.S. policy that denies U.S. population assistance funding to organizations in another country that provide legal abortion services using their own, non-U.S. funds or participate in public debates about abortion using their own, non-U.S. funds, even when abortion is legal in that country.

*There has been a change because the donors are coming in with money for HIV/AIDS...Some are older NGOs who have included family planning; others are new NGOs who are HIV/AIDS proper. (USAID)*

*I think there are many [NGOs] who are just focusing on HIV/AIDS. This is a limitation. (Society for Family Health)*

In other cases, however, FP/RH activities are not sacrificed. Respondents noted that in most cases, a number of NGOs are still involved in FP/RH activities even though a good number of recently instituted NGOs focus primarily on HIV/AIDS. In the case of PPAZ, it was said that the government had not funded them for CBD activities for the past four years. This funding problem has been compounded by the loss of funding from USAID due to the gag rule. However, PPAZ has not changed its focus on FP/RH programs.

Despite significant levels of NGO involvement and good activity results, respondents believed that NGOs could improve their efforts. For example, NGOs could increase their coordination to become more effective. A respondent from the CBOH said, “NGOs are doing a good job, in fact, a tremendous job. But I think we need to get more coordinated. We have realized this and now we have started monthly meetings with all parties involved.”

The private sector is also playing an active role in HIV/AIDS and, in some cases, FP/RH issues. Presently, there are a few private practitioners who offer ARV therapy, and they have been instrumental in supplying ARV drugs in the country. However, respondents worried that drugs could be abused among medical practitioners because there is no mechanism to regulate usage. Private practitioners have also established a forum in which doctors consult and exchange ideas on HIV/AIDS on a monthly basis. The doctors are offering their expertise on a voluntary basis to hospices. Within the wider private sector, respondents said that employer-based HIV/AIDS activities are on the increase. A respondent from PPAZ said, “Big companies are changing and are addressing the HIV/AIDS problem. Why? As companies, they are losing money from deaths of staff and long absenteeism.”

## **Health Sector Reforms**

There is an ongoing health sector reform process in Zambia. Current reforms have raised varying reactions from different stakeholders. Respondents from key public institutions felt that reforms are working well, even in view of the HIV/AIDS problem. Examples cited included the establishment of the NAC. Also, respondents generally felt that, because of the reform process, there has been increased donor support and increased NGO participation. In addition, it was noted that DHMTs are currently meeting community needs and expectations to some extent. A respondent from the LDHMT commented on improved service delivery, saying,

*Formerly, people would come for one service [as these were] located on specific days. Hence, we used to have crowds of about 150 per clinic. For example, pregnant women came on Mondays only. But now all services are offered daily, thus reducing numbers per day. A person can come for one and end up visiting all clinics—sort of the supermarket approach.*

One view among donor respondents was that the reform has created a conducive environment and has made people talk about bringing quality healthcare as close to the family as possible. The health sector reform process advocates for a healthy family through community-level activities related to nutrition, health education, and prevention and treatment of STIs, emphasizing HIV/AIDS.

Other respondents said that while reforms are moving forward, the vision has not been realized because of poor implementation strategies and leadership. Respondents said,

*All the visions have not been realized, but Zambia has done a lot. (USAID)*

*They appear to have no direction; people do not know their roles, and the partnership is not consolidated. Why? People have lacked sensitization, capacity to enhance partnership, and perhaps we just do not understand our expectations...The plans are there, but there are no resources. (PPAZ)*

*Reforms have introduced decentralization. Districts are now planning programs for themselves, which promotes ownership. Capacity building, which was supposed to be effected before decentralization, stalled the implementation. (CBOH)*

Yet other respondents, however, believe the process is getting worse. Some mentioned that the reform process has negatively affected FP/RH programs.

## **Summary and Conclusion**

Thanks to the health reform process, FP activities in Zambia are now undertaken within the broader framework of reproductive health. Although FP/RH is receiving attention, the findings suggest that more resources and attention target the problem of HIV/AIDS. Many stakeholders believe FP/RH and HIV/AIDS can be better integrated. Currently, the strategic framework for HIV/AIDS does not include components of FP/RH whereas the FP/RH strategy clearly defines how HIV/AIDS will be addressed.

In all government health facilities and at all levels of health service provision, FP services are integrated within MCH. STI and counseling services are also found in all facilities. However, VCT and PMTCT are, thus far, only found in a few selected institutions. While HIV/AIDS diagnosis is not available everywhere, the general perception is that the prevalence of infection is increasing. It is estimated that persons with HIV/AIDS-related illness probably account for as much as 50 percent of bed capacity in hospitals.

Condoms are promoted for both disease and pregnancy prevention at clinics. However, the level of acceptance varies. Older couples visiting FP clinics use condoms for disease prevention and prefer pills for pregnancy control. At the moment, donor agencies and other institutions do contraceptive procurement for other methods, such as IUDs and Norplant, which are available through a few urban channels. The public health sector remains the major distribution channel for contraceptives.

There is an acute shortage of staff in government health facilities. This has been attributed to the government voluntary separation program. While it can be said that HIV/AIDS and FP/RH services are complemented by those delivered by NGOs, in most cases there has been a major shift—most NGOs now emphasize HIV/AIDS. The private sector currently provides ARV drugs, albeit on a small scale.

The unavailability of an institutionalized FP training program and lack of upgrading/refresher training in most health institutions have been factors contributing to inadequate staffing levels for the provision of FP services. Training and retraining programs in family planning are not clearly articulated, resulting in a situation in which health facilities, especially in the private sector, are not able to meet FP needs for their clients. When training does occur, it concentrates on temporary contraceptive methods because long-term methods require expertise and supplies or special equipment.

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