GOVERNMENT OF THE REPUBLIC OF ZAMBIA

# ZAMBIA INTEGRATED FAMILY PLANNING COSTED IMPLEMENTATION PLAN AND BUSINESS CASE (2021-2026)

Courtesy of Advance Family Planning

## FOREWORD

The 2018 Demographic Health Survey indicates that Zambia has made gains in contraceptive knowledge and use from 9% in 1992 to 48% in 2018. Under five mortality declined from 61 in 1992 to 42 while maternal mortality rates have declined from 649 in 1992 to an average of 278 per 100,000 live births in 2018, respectively, although there are variations across provinces. However, other reproductive health impact indicators such as teenage pregnancy rate is still a challenge. Furthermore, contraceptive prevalence rates for modern methods across the country increased to 42% in 2018, from 9% in 1992 although there is still wide variation across districts and provinces. For adolescent in particular, this increased from 10.2% in 2014 to 14.2% in 2018.

As Zambia strives to reach middle-income status by 2030, the Health Sector will play a major role in contributing to healthy families and individuals that will be able to contribute to the socio-economic development of the country. This will be achieved through strengthening integrated Family Planning and Sexual Reproductive Health (SRH) services as an integral part of the universal health coverage agenda. Against this background, the Ministry of Health (MOH), in collaboration with partners, has developed the Zambia Family Planning Costed Implementation Plan and Business Case (2021-2026) as a document to provide national guidance for increased knowledge of and access to Family Planning interventions. This will be implemented in synergy with many policy and guidance documents that have emphasized the need for investment in family planning programs. These include the Agenda 2063, Vision 2030, 7th National Development Plan, National Health Policy 2011, National Health Strategic Plan (2017-2021), and the Zambia Adolescent Strategy.

We believe that our joint efforts will lead to a further decline in the unmet needs for Family Planning and an increase in the modern contraceptive prevalence rate (mCPR) to an impactful level by 2026. This investment will ultimately result in improved health of the citizens and economic benefits of the country. This plan is a call for action to the Government Departments and Institutions, Co-operating Partners, Implementing Partners and Civil Society Organizations to play a collaborative role towards achieving our desired goals of carrying forward the Governments' commitments to Family Planning interventions. The MOH pledges to strengthen all coordination efforts and, calls upon all players to work with us to support and implement the Integrated FP-CIP and Business Case. These concerted efforts will ensure the success of the National Family Planning Programme achieve its intended goal of improving the quality of life and well-being of the Zambian people.

**Hon. Dr. Chitalu Chilufya MP**
**Minister of Health**

## PREFACE

Since 2013, the Government of the Republic of Zambia (GRZ) has been actively working to generate demand, open dialogue, and improve family planning access and quality in a coordinated effort guided by the National Costed Eight-Year Integrated Family Planning Scale-up Plan. The costed implementation plan (CIP) was a response to the 2012 London Summit on Family Planning. At this summit, the Government of the Republic of Zambia made several commitments to the following:

- Double budgetary allocation to family planning commodities with the aim of eliminating the unmet need for family planning and improve universal coverage through an expanded method-mix and increased access, particularly to the underserved population.
- Address policy barriers to allow task shifting to community health assistants (CHAs) and trained Community Based Distributors (CBDs) to increase access to the underserved communities.
- Initiate new dialogue with religious and traditional leaders at local level to generate demand, dispel the myths and 'open up the dialogue' on family planning.

In 2016, the Government completed a midterm review of the CIP. The review reported substantial progress in securing family planning commodities and capacity building of providers, as well as engaging in dialogue with traditional and religious leaders on the issues of child marriage and teenage pregnancy (GRZ 2016). The Government further renewed its commitments at the FP 2020 London summit held in 2017. The Demographic Dividend (DD) study of 2015 recommended the combined (social and economic emphasis investment) scenario to be applied to reap the DD and highlighted family planning as a best buy to achieve sustainable development by 2030. The Government recognized this and built the Seventh National Development (2017 – 2021) around the tenets of the DD. Today, Zambia is looking at repositioning FP as not only a health issue, but a factor in national development. Key to achieving this will be to clearly outline the Return on Investment in FP for the country across the different economic sectors.

In addition, Zambia has committed to the Sustainable Development Goals (SDGs). Many of the 17 SDGs are linked to sexual and reproductive health improvements including access to FP, with its connection to national development, improved health, gender equality, education, and sustainability (UN 2015). The Integrated Family Planning Costed Implementation Plan and Business Case (2021-2026) has outlined the key interventions and investments in FP to support the country's vision 2030 as well as achieving the SDGs. The Ministry of Health is committed to coordinate and provide leadership in the implementation of the plan. Furthermore, this will require concerted efforts from other Government Departments, Co-operating and Implementing Partners, Civil Society Organizations, families, and individuals. We should all ensure that we play our respective roles creating an enabling environment, demand creation, improved service delivery and commodity security.

**Dr Kennedy Malama**
**Permanent Secretary – Technical Services**

## ACKNOWLEDGEMENTS

The Ministry of Health (MOH) would like to express its appreciation to the many partners and groups who supported the development of the Zambia Integrated Family Planning Costed Implementation Plan and Business Case 2021- 2026. This document is the result of extensive consultations with stakeholders working at all levels, including key sector ministries, cooperating partners, implementing partners, professional associations, and for-profit organizations working in aligned areas. The development of this document has been produced with funding and technical support from the United Nations Population Fund (UNFPA)/Zambia under the leadership of the Country Representative, Ms. Gift Malunga and the Deputy Country Representative, Mr. Leonard Kamugisha not forgetting the RHCS Programme Analyst Mr. Chimuka Hampango who was the Task Manager.

Several multisectoral government Ministries and Agencies, Cooperating Partners, Implementing Partners, Civil Society Organizations, and for-profit organizations also provided valuable input and feedback throughout the process through virtual and physical meetings. These organizations included the Ministry of Finance (MoF); Ministry of National Development Planning (MNDP); Ministry of Gender, Ministry of Community Development and Social Services, Ministry of Higher Education, Ministry of General Education, USAID, FCDO (formerly DFID), SIDA, World Bank, JICA, WHO, Churches Health Association of Zambia (CHAZ), GHSC-PSM (CHEMONICS), USAID DISCOVER HEALTH, USAID eSCMIS PROJECT, Clinton Health Access Initiative (CHAI), Options, Copper Rose Zambia, Marie Stopes Zambia, Society for Family Health (SFH), SARAI Project, PATH, Centre for Reproductive Health and Education (CRHE), Midwives Association of Zambia, Planned Parenthood Association of Zambia (PPAZ), Development Media, PSI, Zambia Medicines Regulatory Authority (ZAMRA), Midwives Association of Zambia (MAZ), Pharmaceutical Society of Zambia (PSZ), Zambia Pharmaceutical Business Forum (ZPBF), Central Province PHO, Kabwe DHO, Kapiri DHO, Chawama HC (Kapiri Mposhi), Chibombo DHO, Ndola PHO, Ndola DHO, Kabushi Clinic, New Masala Clinic (Ndola), Chipokotamayamba Clinic (Ndola), Railway Clinic (Ndola), Kabushi Clinic (Ndola), Lufwanyama DHO, Shimukuminani RHC, Kapalamikwa RHC, Nkana RHC and participants that attended the Family Planning 2020 Annual Review Meeting from all the ten provinces.

Special gratitude is made to the FP TWG especially the Task Force for spearheading this process, namely: Mr. Yoram Siame, Dr. Angel Mwiche, Dr. Christopher Mazimba, Dr. Natasha S. Kaoma, Mr. Chimuka Hampango, Ms Anne Mwiche, Ms Dynes Kaluba, Ms. Loyce Munthali and Mr. Maxwell Kasonde.

**Director Public Health**

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| | |
|---|---|
| ANC | Antenatal Care |
| ASRH | Adolescent Sexual and Reproductive Health |
| CBA | Cost Benefit Analysis |
| CBD | Community Based Distributors |
| CEA | Cost Effectiveness Analysis |
| CEmONC | Comprehensive Emergency Obstetric and Newborn Care |
| CHA | Community Health Assistants |
| CIP | Costed Implementation Plan |
| COVID 19 | Coronavirus Disease |
| CSE | Comprehensive Sexuality Education |
| CSO | Civil Society Organization |
| DHMT | District Health Management Team |
| FBO | Faith-Based Organisation |
| FP | Family Planning |
| GBV | Gender Based Violence |
| GDI | Gender Development Index |
| GFF | Global Financing Facility |
| GRZ | Government of the Republic of Zambia |
| HDI | Human Development Index |
| HIV | Human Immuno-deficiency Virus |
| HRH | Human Resources for Health |
| ICPD | International Conference on Population and Development |
| IUD | Intra Uterine Device |
| IMR | Infant Mortality Rate |
| ITNs | Insecticide Treated Nets |
| LARC | Long Acting Reversible Contraceptives |
| LAPM | Long Acting and Permanent Methods |
| MMR | Maternal Mortality Ratio |
| MoH | Ministry of Health |
| NMR | Neonatal Mortality Rate |
| NGO | Non-Governmental organization |
| PLWD | People Living With Disability |
| PMA | Performance Monitoring and Accountability |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PPP | Public Private Partnerships |
| RHCS | Reproductive Health Commodity Security |
| RMNCAH | Reproductive, Maternal, Newborn, Child and Adolescent Health |
| SDG | Sustainable Development Goals |
| SDP | Service Delivery Point |
| SRH&R | Sexual and Reproductive Health and Rights |
| TMA | Total Market Approach |
| UHC | Universal Health Coverage |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organisation |
| ZDHS | Zambia Demographic and Health Survey |

## EXECUTIVE SUMMARY

The Zambia Integrated Family Planning Costed Implementation Plan and Business Case 2021 to 2026 details the country's plans to achieve its FP vision and goals to improve the health and well-being of its population and the nation through providing high-quality, right-based FP information and services. The plan provides critical direction to Zambia's FP programme, ensuring that all components are adequately addressed and budgeted for. More specifically, the FP-CIP and Business Case will be used from 2021 to 2026 to:

1. Ensure a unified country strategy for family planning is followed
2. Define key strategies, activities, inputs and an implementation roadmap
3. Determine demographic, health, and economic impacts of the FP programme
4. Define a national budget for FP
5. Mobilize resources in order to secure cooperating partners, government and private sector commitments for the FP programming.
6. Coordinate activities and monitor progress of activities implemented by multiple stakeholders
7. Provide a framework for inclusive and broad-based participation of stakeholders within and outside of the MoH

The challenges facing Zambia Family Planning programme include teenage pregnancies and women using FP for spacing rather than limiting among others. The Vision of the Zambia Integrated Family Planning Costed Implementation Plan and Business Case 2021 to 2026 is "*A country where citizens enjoy their sexual rights, make informed choices on sexual and reproductive health, have adequate access to high quality contraceptives, information and services on family planning".* The Mission is "*To ensure that citizens have access to high-quality, affordable reproductive health care, comprehensive sexual health education, and the right to manage their reproductive lives.* The Goal is "*As a result of implementing strategic priorities, mCPR among all women will increase from 34.1% in 2020 to 40% in 2026".*

Based on the stakeholder consultation, review of international and national evidences, and consultations with policy makers in Zambia, the study identified key strategies as:

1. Promote and nurture change in social and individual behavior to address myths and misconceptions and improve acceptance and continued use of FP with a special focus on increasing age-appropriate information, access and use of FP amongst young people, ages 10-24 years and population living in low performing areas
2. Strengthen service delivery provision in existing facilities (service coverage to include teenagers, people living with disabilities and those in rural and low performing areas) leveraging on post-partum family planning
3. Enhance skills of new and existing health care workers through adequate practical training in the full FP method mix with emphasis on LARC methods, and empower community-based distributors to provide counselling, referral services and appropriate service provision
4. Improve FP commodity procurement and distribution (current and new FP commodities) and ensure full financing of FP commodities in the public and private sectors to prevent stock-outs
5. Increase the sustainability of FP commodities and services through government commitment, integration of the private sector, and diversification of funding sources
6. Strengthen evidence base for effective program implementation through research and information dissemination to enhance relevant programming
7. Strengthen FP leadership at national and sub-national levels; integrate FP policy, information and services across sectors for holistic contribution to social and economic transformation

The thematic areas, outcome and objective are summarised in Table E1.

**Table E1 Thematic Area, Outcome and Objective**

| Thematic Area | Outcome | Objective |
|---|---|---|
| **Enabling Environment** | ● Mobilize adequate and sustainable financial resources from various sources to fulfil requirements of the FP program | ● To increase allocation and diversify sources of FP funds including core funding from GRZ |
| | ● Adopt and implement policies that improve equitable and affordable access to high- quality FP services and information | ● To strengthen evidence base for effective program implementation through research and information dissemination |
| | ● Strengthen the stewardship, management, and coordination capacity of the GRZ for FP at all levels (national and sub-national) and across sectors | ● To strengthen stewardship and create an enabling environment for FP CIP implementation |
| **Demand creation** | ● Improved demand among populations with high unmet need for modern contraception through a right-based approach | ● To improve sexual and reproductive health care seeking behaviour among populations with high unmet need for modern contraception |
| **Service delivery** | ● Increased access and utilization of quality FP services by all population segments through a right based approach | ● To increase access and utilization of quality family planning services by all population segments |
| **Commodity Security** | ● Have adequate amounts of a range of commodities available at service delivery points: facilities, communities, and outreach settings | ● To increase availability of quality FP commodities |

The estimated costs for enabling environment are ZMK 391,126,647.888 (US$21,096,367.20), Demand creation ZMK 910,060,191.4788 (US$49,086,310.22), Service Delivery ZMK 1,354,502,656.8342 (US$73,058,395.73), Commodity security ZMK 46,605,587.99 (US$2,513,785.76). The FP commodities costs include a US$0.05 per unit cost to cater for the last mile distribution. The total FP commodities cost is estimated to be ZMK 1,780,494,220.2384 (US$ 96,035,286.96).

Zambia has a business case for family planning. Family Planning investments are shown to have significant impact in the health sector, infrastructure, education, agriculture and the economy at large. An aggregate of over 3 million unintended pregnancies will be averted between 2021 and 2026. This translates to about 731,878 more unintended pregnancies that will be prevented under the ambitious scenario compared to the status quo. On the other hand, Family Planning investments will save maternal and infant health care costs of between US$ million 128 and 159 depending on the scenario, additionally averting over 6 million DALYs. Furthermore, with increased investments in Family Planning to increase mCPR and lower fertility rate, the number of additional health professionals to be trained and health infrastructure to be provided will reduce substantially. The country will save on the need to train an excessive number of health professionals and building health facilities. In addition, substantial investment in Family Planning (i.e. the ambitious scenario), the TFR will reduce from 4.7 in 2020 to 3.3 in 2026 with the MMR falling to 136 per 100,000 in 2026, compared to 257 per 100,000 and 197 per 100,000 for the status quo and moderate scenarios respectively. Large average family size makes it difficult for families and the Government to make requisite investment in education that are needed to develop high-quality human capital and achieve higher incomes and socioeconomic development. The number of primary schools and primary school teachers needed to educate

the population will increase with rapid population growth. If the current population growth continues (i.e. under the status quo) over 11,000 primary school classrooms will be needed by 2030 to be able to ensure universal access to education at the primary level. However, with significant investment in Family Planning less classrooms will be required. This also applies to secondary schools and the number of teachers required.

The average cost effectiveness ratio (ACER) is estimated to be US$ 20.16 for 2021, and it increases to US$ 49.05 for 2022, further increasing to US$ 54.88 in 2023, reducing to US$ 54.42, US$ 53.91 and US$ 23.38 in 2024, 2025 and 2026 respectively. The implication of the Cost per DALY Averted for 2021 means that a US$ 20.16 investment in family planning will help avert one disability arising from maternal and child deaths (DALYs Averted). This increases to 49.05 Cost per DALY Averted in 2022, and this is mainly because the costs in 2022 and beyond will be higher attributed to increased FP programme investments costs[1]. The Cost Effectiveness Analysis reveals that Family Planning is highly cost effective in Zambia given that the average cost effectiveness ratios are more than 3 times lower than the GDP per Capita US$ 1,539.90 (World Bank, 2018). Additionally, findings from the Global evidence revealed that investing in RMNCAH is a smart buy, since for an additional US$1 invested in women's and children's health, there would be US$9 of economic and social benefits (Global Strategy for Women's Children's and Adolescent's Health 2016-2030, UN). Therefore, in the case of Zambia, the FP programme investments to be made between 2021 to 2026 amounts to US$ 248,953,679.60 yielding returns of up to US$ 2,240,583,116.4 in terms of economic and social benefits.

The primary source of funding for the Family Planning programme in Zambia is the cooperating partners mainly USAID, UNFPA, UNDP and DFID. The contribution from GRZ has been low and fluctuates over time as a result of Zambia's fiscal policy position that will further weaken due to maturing debt and inadequate fiscal space. The total financing commitment made for Zambia Integrated Family Planning Costed Implementation Plan and Business Case 2021 to 2026 is US$ 4,278,205 for 2021, US$ 263,601 for 2022 and US$ 333,267 for 2023. More commitments are expected including for periods where no commitments were made. The Family Planning Financing gap is estimated to be US$12.7 million in 2021, US$ 43.5 million in 2022, US$ 51.3 million in 2023, US$ 52.3 million in 2024, US$ 52.7 million in 2025 and US$ 24.5 million in 2026.

To increase the sustainability and national ownership of the FP programme in Zambia, substantial domestic resources will be required to fill the financing gap that is imminent as the effects of COVID 19 and associated economic downturn takes toll on the revenue generation capacity of cooperating partner countries. Zambia could leverage facilities like the Global Financing Facility to finance Family Planning since investments in family planning is a good buy. Several other financing options exists for Zambia's Family Planning programme: including matching funds with cooperating partners; Total Market Approach and the National Health Insurance Scheme.

[1] Preparation of Zambia FP-CIP & Business Case 2021 to 2026 was done towards the end of 2020, hence stakeholders in the FP space had already prepared their budgets for Fiscal Year 2021

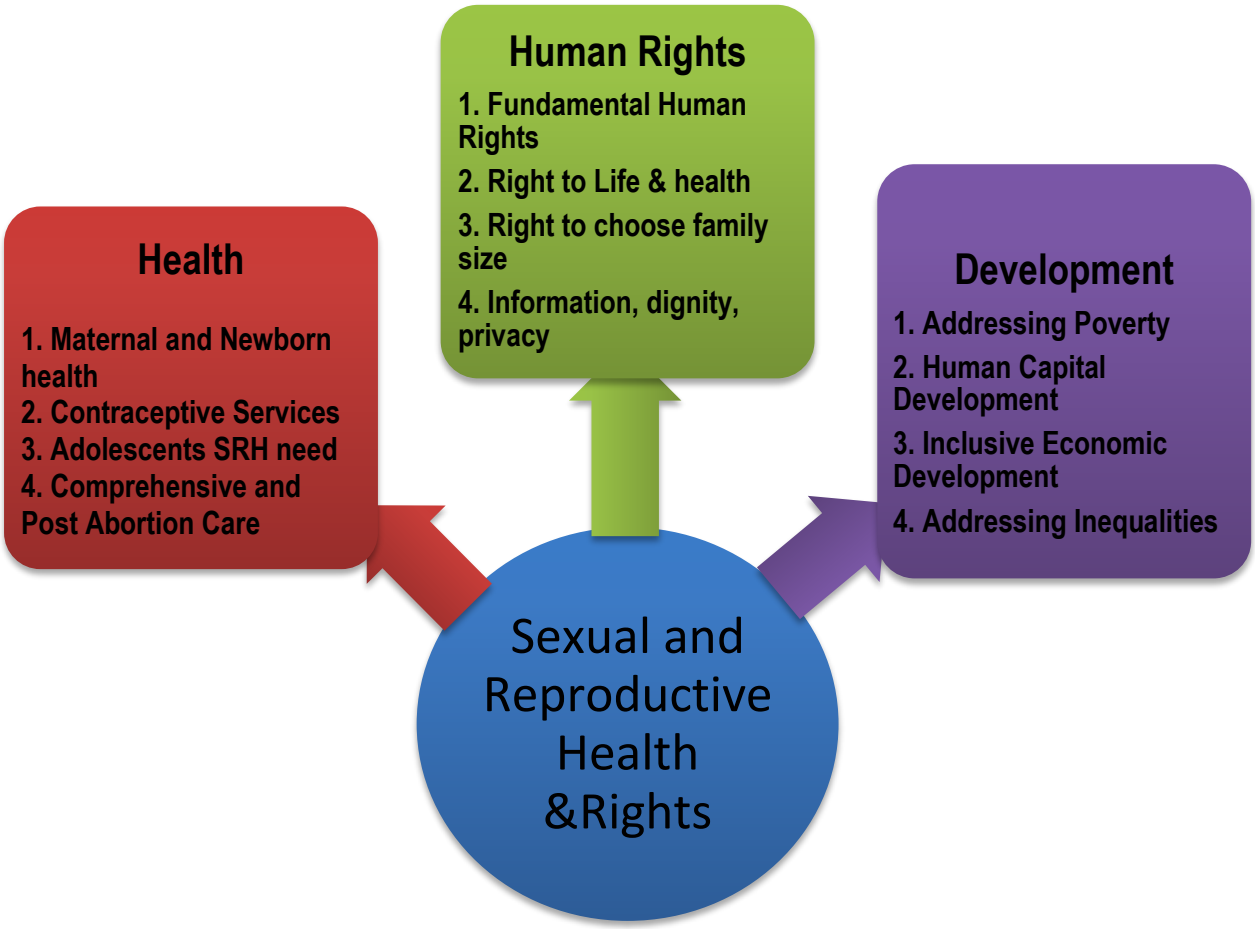
## 1.0 INTRODUCTION

### 1.1 General Overview

Family Planning (FP) is an important intervention that can help curb rapid population growth and spur economic development. In recognition of these links, the Government of the Republic of Zambia (GRZ) has put in place various strategies and policies that are aimed at accelerating achievement of the Family Planning and Sexual & Reproductive Health outcomes. FP is a central pillar of Zambia's Sexual & Reproductive health (SRH) programme and the wider national health priorities as outlined in the Zambia National Health Strategic Plan (ZNHSP) 2017-21, the Seventh National Development Plan 2017-21, and Zambia Vision 2030. The central role of FP is also emphasized in various policy documents including "The future Zambia wants for its population" by the Ministry of Finance and UNFPA. The Policy identifies rapid population growth and a youthful population structure as key issues that if poorly managed will pose challenges in the realization of Vision 2030.

The Government has also fully committed to fulfilling the Sexual and Reproductive Health and Rights (SRH&R) for all people by ratifying 11 instruments of law. The elements of the Sexual and Reproductive Health and Rights are presented in Figure 1.1.

**Figure 1.1 Elements of Sexual and Reproductive Health and Rights**




In addition to ratifying global and regional treaties, Zambia has also committed to achieving Sustainable Development Goals (SDGs). Some SDGs directly relate to SRH&R. These are: Goal 3: Ensuring healthy lives and promoting well-being for all at all ages; Goal 4: Ensuring quality education for all; Goal 5: Achieving

gender equality and empowering all women and girls; Goal 10: Reduced inequalities; Goal 17: Enhancing partnerships to achieve SDGs. Other SDGs have an indirect effect on SRH&R. These include: Goal 8: decent work and Goal 16: Peace, justice, and strong institutions. The Government is therefore obligated to ensure that it respects, protects, and fulfils every person's rights.

Zambia made the following commitments on accelerating the promise of ICPD in the 2019 Nairobi meeting:

1. We commit to invest in primary health care, particularly health promotion, robust and sustainable healthcare financing mechanisms
2. We also commit to position Family Planning as a key development agenda for Zambia to Harness the Demographic Dividend
3. We commit to eliminate all forms of discrimination, and strengthen humanitarian preparedness and response
4. We further commit to strengthen equitable access to resources to reach the most vulnerable of our population
5. We commit to end all forms of discrimination against women and girls by domesticating international and regional instruments such as the CEDAW and SADC protocol on gender and development
6. We further strongly commit to end child marriage by taking all necessary measures to accelerate implementation of the National Strategy and other policy and legislative frameworks to end child marriage by 2030
7. We commit to promoting meaningful participation of adolescents and young people in national development by including them in development planning and implementation, monitoring and evaluation
8. Our Government further commits to promote people centered development in all sectors by integrating population dynamics into development planning at the national and sub-national levels, and enhance rural industrialization and development by advancing implementation as enshrined in our Vision 2030
9. We commit to promote generation and use of data to achieve sustainable development and make climate change a core part of economic development
10. We want to provide financing for the outlined commitments, and as such we pledge to create fiscal space by broadening our tax base, exploring alternative financing mechanisms, and implementation of the debt sustainability strategy

Zambia is also among the countries that have pledged commitment to FP2020 and is looking to make further commitments around Family Planning beyond 2020. Zambia is dedicated to improving sustainable access to family planning and achieving the goals it set out in 2012. Specifically, the Government of the Republic of Zambia (GRZ) committed to the following;

i. Double budgetary allocation to family planning commodities, striving to eliminate the unmet need for family planning, and improve universal coverage through an expanded method mix and increased access, particularly to the underserved population.
ii. Address policy barriers to allow task shifting to community health assistants (CHAs) and trained community based distributors (CBDs) to increase access to the underserved communities.
iii. Initiate new dialogue, led by the MCDMCH, with religious and traditional leaders at local level to generate demand, dispel the myths and 'open up the dialogue' on family planning.

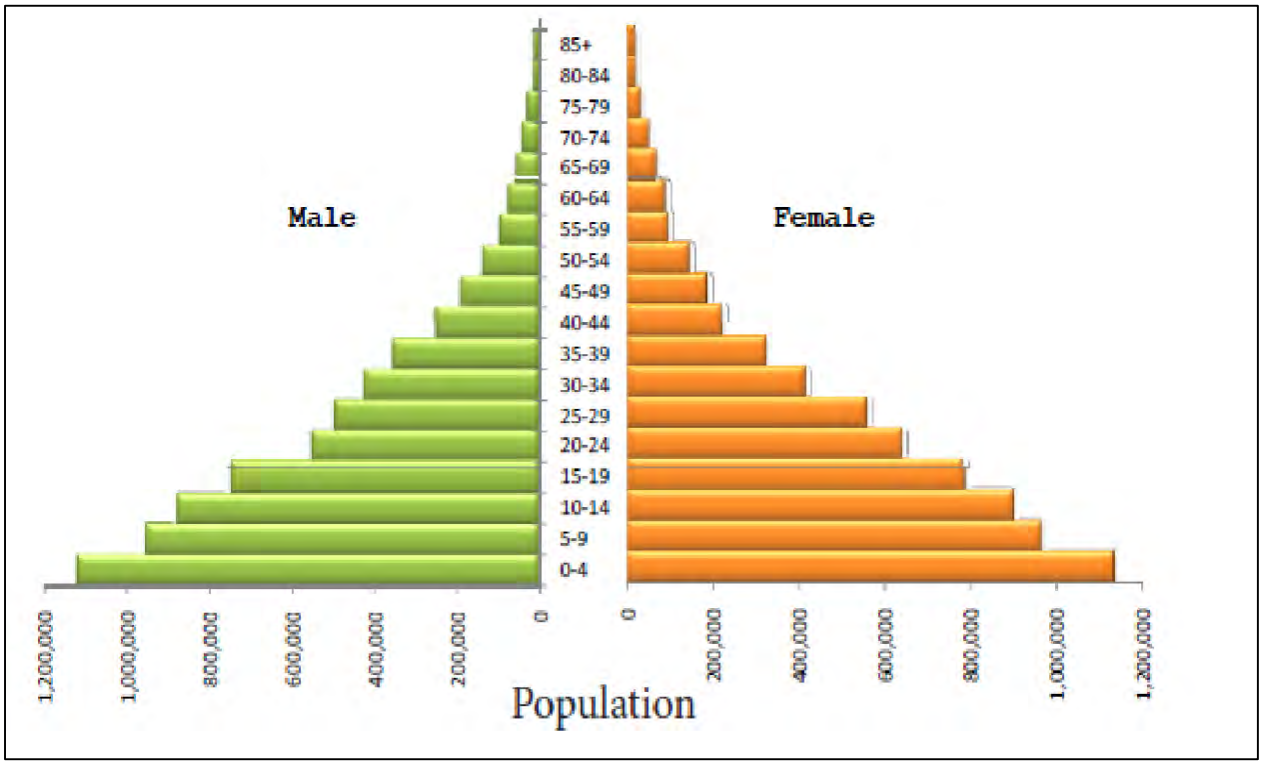
In 2016, midway through the implementation of the 8-year (2013-2020) FP scale-up plan, the government completed a midterm review of the CIP and the review reported substantial progress in securing family planning commodities and capacity building of providers, as well as engaging in dialogue with traditional and religious leaders on the issues of child marriage and teenage pregnancy. The Government further renewed its commitments at the FP2020 London summit held in 2017. Specifically, in 2017, GRZ committed to the following:

i. Ensuring that by 2020, Government contribution to the family planning commodities will have increased by at least 50% from the 2016 levels.
ii. Providing an enabling policy environment for Rights based Sexual and Reproductive health service delivery
iii. Scale up access to Rights based family planning by improving availability of method mix, collaborating with traditional and other leaders and strengthening task shifting

Progress has been made in meeting the above commitments with an increase in GRZ's contribution to FP and an enabling policy environment for rights-based FP. However, more needs to be done to ensure sustainability in domestic financing of FP programme and reviewing laws to ensure that adolescents access contraceptives based on their sexual and reproductive rights.

Zambia is also keen on harnessing the demographic dividend since it has a population that is largely youthful. Demographic dividend arises when the share of the working-age population (15-64 years) is larger than the non-working- age share of the population (14 years and younger, and 65 and older), hence the great potential for economic gains. However, for economic growth to occur the younger population must have access to economic opportunities, quality education, adequate nutrition and health including access to sexual and reproductive health. Zambia's population is largely youthful as presented in (Figure 1.2).

**Figure 1.2 Population Pyramid, Zambia**




**Source: UN Population Division, 2019**

Significant steps have been taken to reach adolescents and youth through the creation of Comprehensive Sexuality Education (CSE) and partner outreach efforts in and out of schools. In 2014, the government launched CSE which was integrated into the national education curriculum targeting 10 to 24 year olds for grades 5 through 12. In addition, youth friendly spaces have been established and strengthened at a number of government clinics to offer sexual and reproductive health information and services.

## 1.2 Rational for and Use of National CIP and Business Case for Family Planning

The national FP-CIP and Business case details the country's plans to achieve its FP vision and goals to improve the health and well-being of its population and the nation through providing high-quality, right-based FP information and services. The plan provides critical direction to Zambia's FP programme, ensuring that all components are adequately addressed and budgeted for. More specifically, the FP-CIP and Business Case will be used from 2021 to 2026 to:

i. Ensure a unified country strategy for family planning is followed
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iv. Define a national budget for FP
v. Mobilize resources in order to secure cooperating partners, government and private sector commitments for the FP programming.
vi. Coordinate activities and monitor progress of activities implemented by multiple stakeholders
vii. Provide a framework for inclusive and broad-based participation of stakeholders within and outside of the MoH.

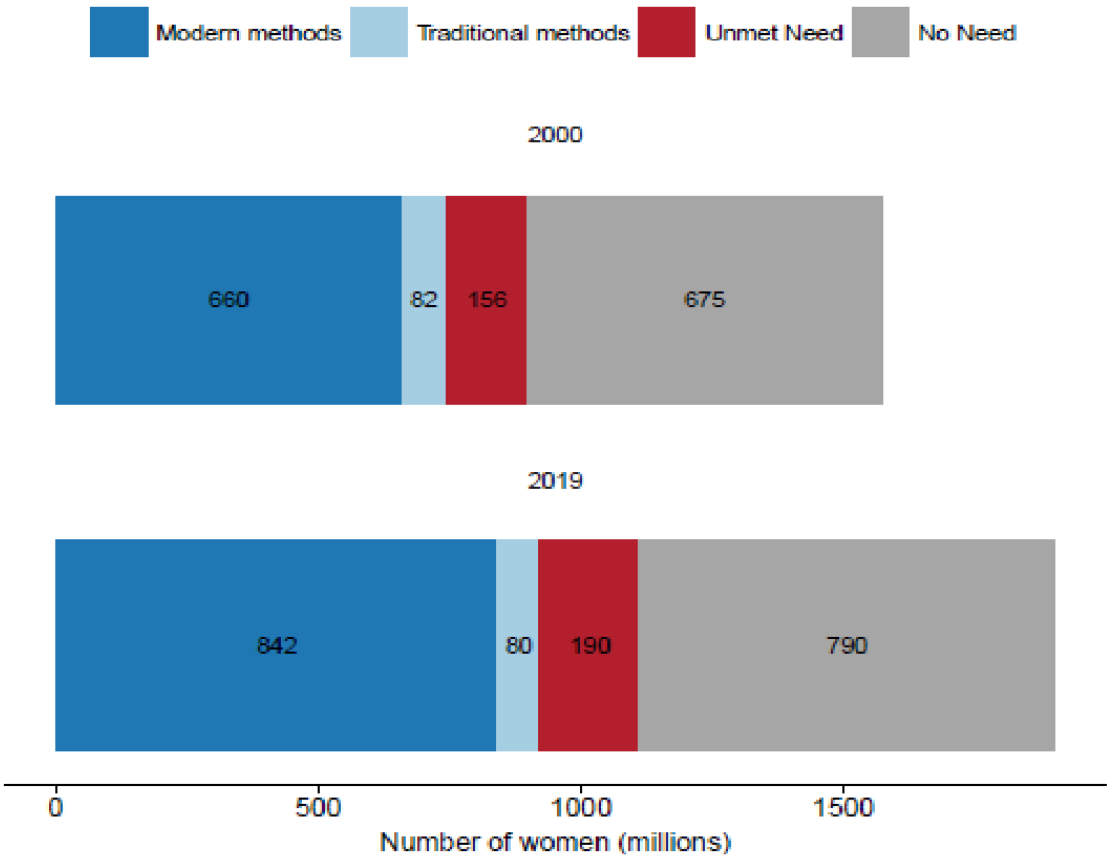
## 1.3 Economic and Other Benefits of Investing in Family Planning

The multi-sectoral nature of family planning can be understood by enumerating the economic and other benefits of investing in family planning. Family planning allows people to decide when they want to have children, attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and treatment of infertility (WHO, 2015). Compared to other interventions, investments in Family Planning have been shown to be highly cost effective. It is inexpensive and the return on investment is high. Family planning interventions have powerful poverty reduction effects in addition to providing health and human rights benefits (Bongaarts and Sinding 2011). The promotion of family planning in countries with high birth rates such as Zambia has the potential to reduce poverty and hunger and prevent 32 percent of all maternal deaths and nearly 10 percent of childhood deaths (Grant, 2016). It would also substantially contribute to the empowerment of women, achievement of universal primary schooling, and long-term environmental sustainability. Chapter five of this FP-CIP and Business Case presents the envisaged benefits of investing in Family Planning in Zambia.

## 1.4 Global Status of Family Planning

Target 3.7 of the Sustainable Development Goals (SDGs) calls on countries “by 2030, to ensure universal access to sexual and reproductive healthcare services, including for family planning information and education, and the integration of reproductive health into national strategies and programmes”. Trends in contraceptive prevalence and need for family planning satisfied with modern methods indicate where increased investments and commitments by governments and international organizations are needed for the realization of reproductive rights for all people, and to help fulfil the pledge of the 2030 Agenda for Sustainable Development that “no one will be left behind” (United Nations, Department of Economic and Social Affairs, Population Division, 2019). Available evidence reveals that despite the progress made, unmet need for family planning is increasing as presented in Figure 1.3.

**Figure 1.3** **Number of women using modern and traditional contraceptive methods, having unmet need for family planning and no need for family planning, 2000 and 2019**




**Source: United Nations, Department of Economic and Social Affairs, Population Division, 2019**

In 2019, 190 million women of reproductive age (15-49 years) worldwide who wanted to avoid pregnancy did not use any contraceptive method, up from 156 million in 2000. The proportion of women with unmet need for family planning stands at 10 percent, a proportion that has remained unchanged since 2000. Modern contraceptive prevalence among married women of reproductive age (MWRA) increased worldwide between the year 2000 and 2019 by 2.1 percentage points from 55.0% to 57.1% (Kantorová, et-al, 2020). Some of the reasons for the slow increase include: limited choice methods, limited access to services, particularly among young, poorer and unmarried people; fear or experience of side effects; cultural or religious opposition; poor quality of available services; users' and providers' bias against some methods; and gender based barriers to accessing services.

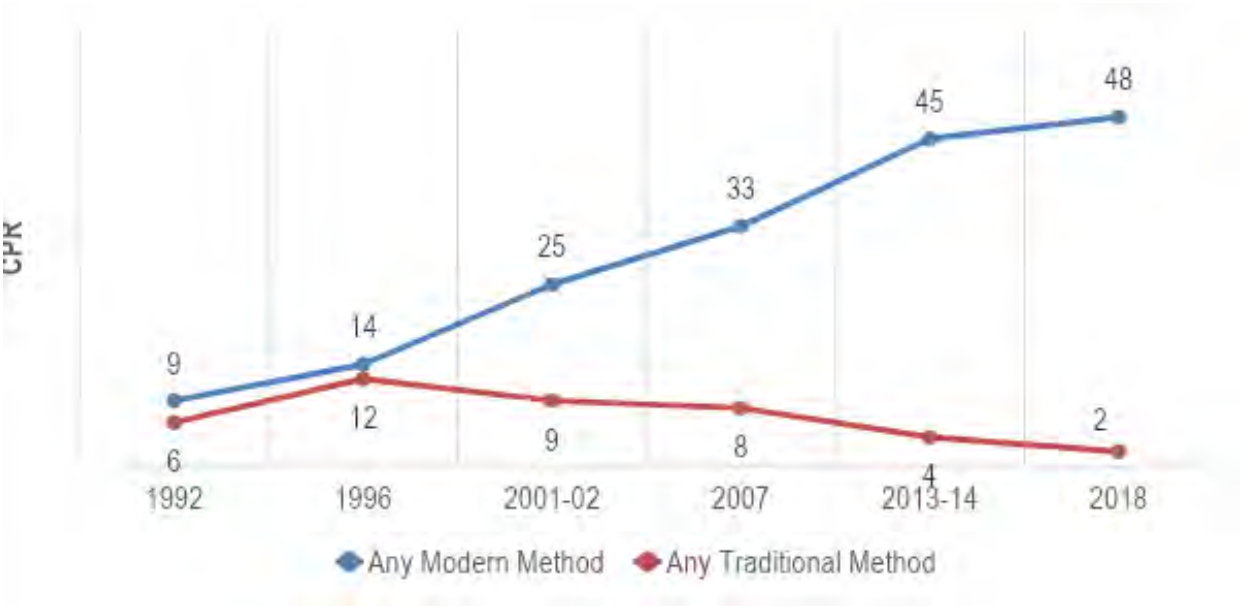
Ensuring access for all people to their preferred contraceptive methods advances several human rights including the right to life and liberty, freedom of opinion and expression and the right to work and education, as well as bringing significant health and other benefits. Use of contraception prevents pregnancy-related health risks for women, especially for adolescent girls, and when births are separated by less than two years, the infant mortality rate is 45% higher than it is when births are 2-3 years and 60% higher than it is when births are four or more years apart (Kantorová, et-al, 2020). It offers a range of potential non-health benefits that encompass expanded education opportunities and empowerment for women, and sustainable population growth and economic development for countries.

## 1.5 Overview of Family Planning in Zambia

### 1.5.1 Contraceptive Knowledge and Use

Knowledge and use of modern methods of family planning remains an important determinant of empowering couples and women in particular to decide when and how many children to have (ZDHS, 2018). Despite the sustained increases in the knowledge of modern methods of family planning, only 48% of married women 15-49 use modern methods of family planning. Zambia has however, recorded a sustained improvement in use of modern methods among married women over the years from 9% in 1992 to 48% in 2018 (Figure 1.4).

**Figure 1.4 Trends in Family Planning Use: Percent of married women 15-49 using family planning**

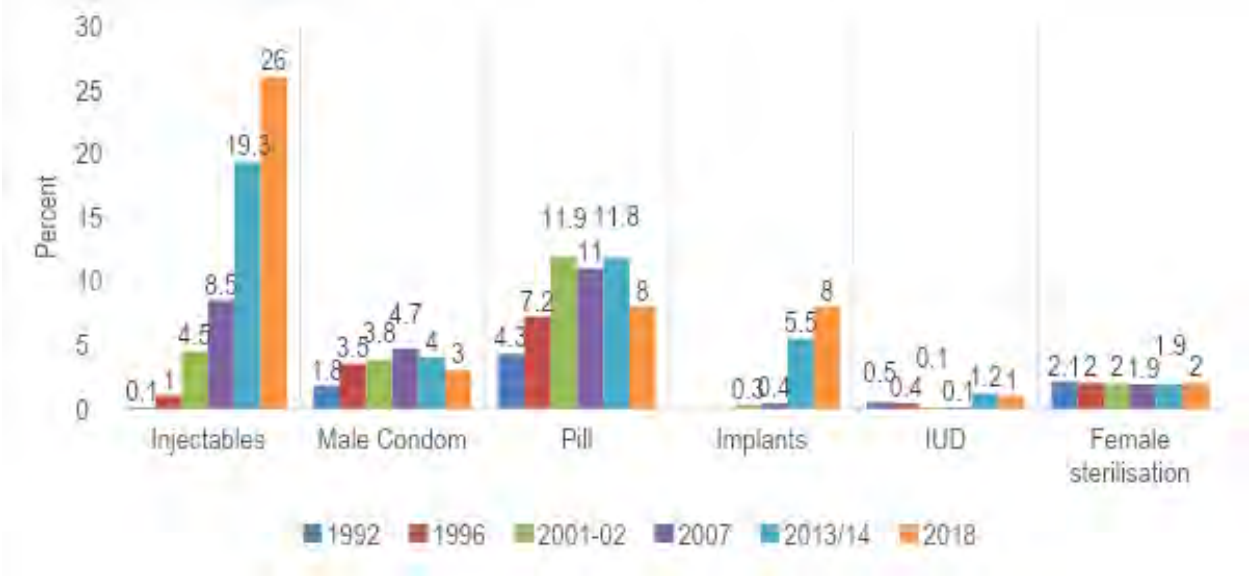



**Source: ZDHS, 2018**

Zambia's mCPR for all women stands at 34.1, with variations across provinces and districts (ZDHS, 2018). There is need for more investments in the FP programme across provinces and districts, especially the ones that report poor outcomes. These investments would involve equitable distribution of FP commodities, medical equipment for insertion and removal of implants and IUDs, and health care workers with skills to provide LARCs. The underserved areas would need more attention since investments in these areas have the potential to increase mCPR significantly. Moreover, social and religious norms are also affecting the performance of the FP programme. For instance, misconception about FP methods resulting from lack of proper education about FP methods, acts as obstacles in popularizing the FP programme. In some provinces and schools, norms/ stigma are hurdles to FP method expansion. Along with the knowledge gap of users, there exists some knowledge gap among health providers regarding side effects of LARCs and PM, especially female and male sterilization. There is need to increase awareness regarding the effectiveness and convenience of LARCs, especially IUD and implants compared to the short-acting contraceptive methods.

The trends in method mix reveals that the use of injectables and implants are gaining popularity among currently married women. There is however a declining trend in Male condom, pill and IUD whereas female sterilisation manifests a slight increase (Figure 1.5).

**Figure 1.5 Trends in Family Planning Method Mix, Zambia**




**Source: Zambia Demographic and Health Surveys 2013/14 & 2018**

However, the proportion of implants in the total method mix is still minuscule. Key informants reported that for implants and IUDs, there are inadequate numbers of trained healthcare workers and a high percentage of Ministry of Health facilities that are not equipped to provide LARCs. There is need for GRZ to increase the allocation for the FP programme and also involve the private sector in the provision and financing of family planning.

### 1.5.2 Contraceptive Knowledge and Use at First Sexual Intercourse

Variations in knowledge of contraceptive methods by age of women at first sexual intercourse are very minimal across the different contraceptive methods. Generally, nine out of ten women are aware of either any or a method of contraception (ZDHS 2018). Even with minimal variations between age at first sexual intercourse and contraceptive knowledge, knowledge of contraceptive methods appears to improve with increasing age at first sexual intercourse across all contraceptive methods. Nevertheless, regardless of age at first sex among women the knowledge of a method of contraception appear to be universal. There is need to increase contraceptive knowledge especially among adolescents since data reveals that they seek FP after their first child. This implies that conception was an accident hence the urgency to provide them with method choice under the sexual and reproductive health and rights (SRH&R).

### 1.5.3 Age at first intercourse and use of contraceptives Methods

The use of contraception at first sexual intercourse appears to vary by age at first intercourse and method of contraception used, 41% of women who had first sex at age 15 used any method of contraception and 40% used a modern method (ZDHS 2018). The use of contraception appears to improve with age at first sex. Injectables, implants and male condoms are the popular methods of contraception used at first intercourse among women (Table 1.1).

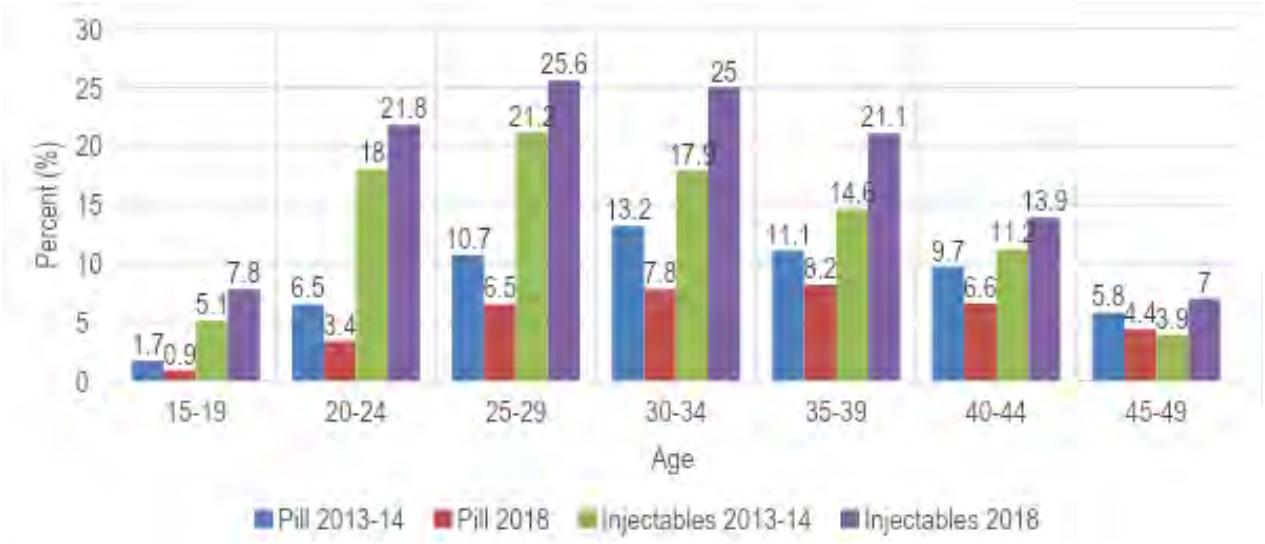
**Table 1.1 Use of contraceptive methods by age at first sexual intercourse**

| Age at first Sexual Intercourse | Use of Contraceptive Methods | | | | | |
|---|---|---|---|---|---|---|
| | Any Method | Modern Method | Male Condom | Injectables | Pill | implants |
| At age 15 | 41.3 | 39.8 | 2.2 | 22.4 | 5.0 | 7.3 |
| At age 18 | 43.6 | 42.0 | 2.7 | 23.4 | 5.5 | 7.9 |
| At age 20 | 43.9 | 42.3 | 3.3 | 22.6 | 6.1 | 7.9 |
| At age 22 | 44.3 | 42.6 | 3.3 | 21.9 | 6.5 | 8.0 |
| At age 25 | 44.6 | 42.7 | 3.6 | 21.0 | 7.0 | 7.7 |
| All Women (Total) | 35.4 | 34.1 | 3.0 | 18.0 | 4.9 | 6.1 |

**Source: ZDHS 2018**

The injectables are popular among youth (15 to 25 years) with rates between 21.0 and 22.4 percent, where this may imply that they use injectables at the expense of condoms hence exposing them to the risk of contracting HIV. Further interrogation by method and age confirms that injectables become more popular across the various age groups including 15-19 years between 2013/14 and 2018 (Figure 1.6).

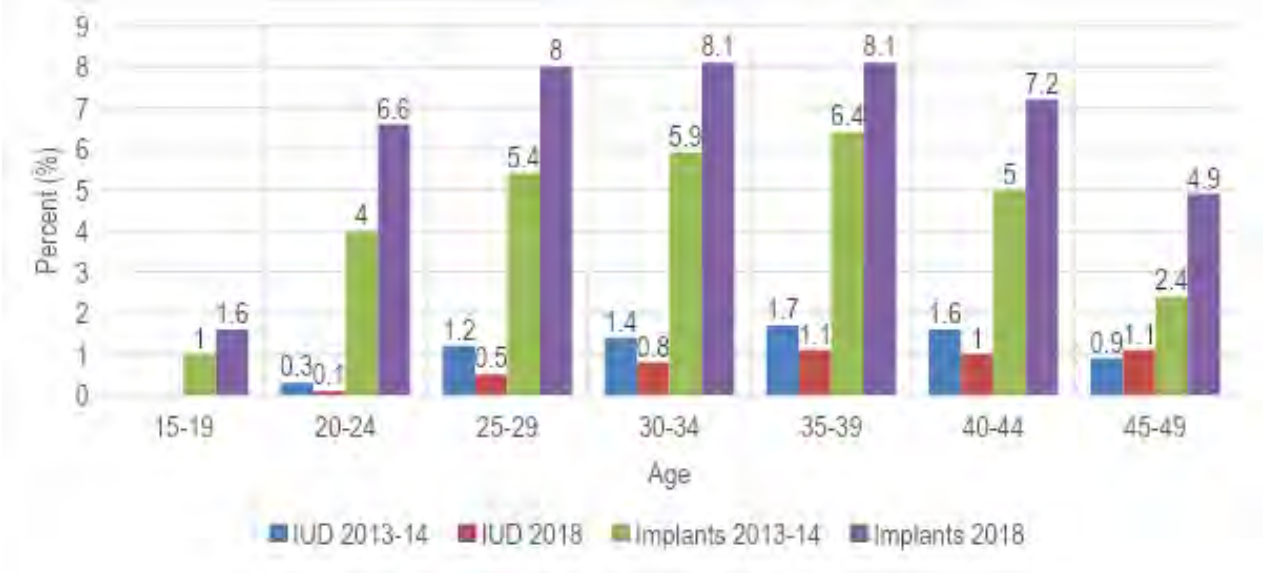
**Figure 1.6 Trends in Pills and Injectables by Age, Zambia**




**Source: ZDHS 2013/14 & 2018**

As for implants and IUDs, implants are more popular, though the use of IUDs has increased between 2013/14 and 2018 (Figure 1.7)

**Figure 1.7 Trends in Implants and IUD by Age, Zambia**

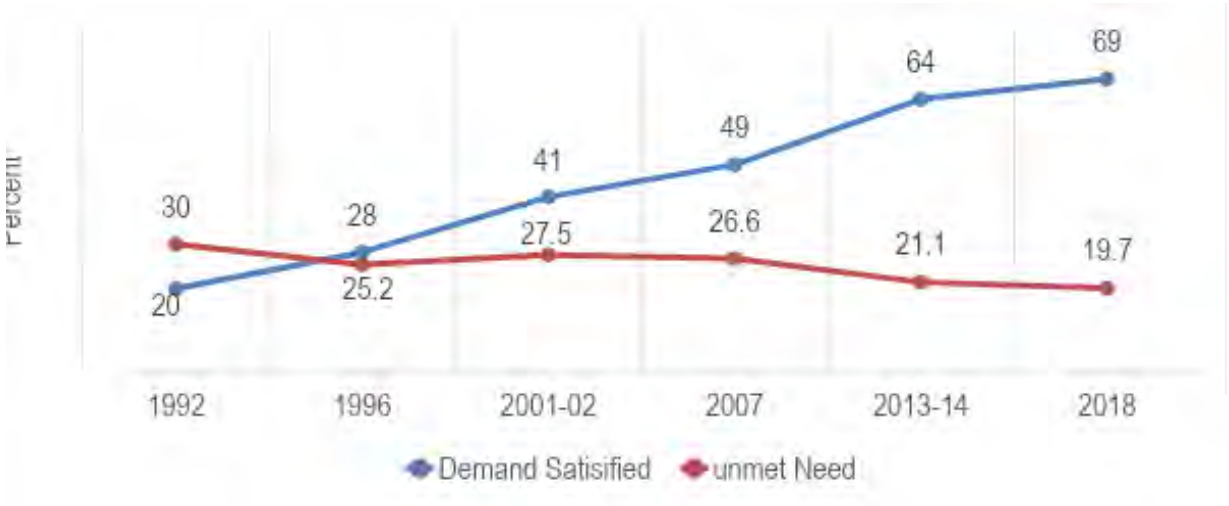



**Source: ZDHS 2013/14 & 2018**

### 1.5.4 Demand for Family Planning

The proportion of demand for family planning that is satisfied shows the degree to which family planning investments are keeping pace with people's desires to prevent pregnancy in a country (ZDHS 2018). In Zambia, 69% of currently married women 15-49 have a demand for family planning with 42% wanting to space births and 28% wanting to limit births. The demand for family planning has increased from 45% in 1992 to 69% in 2018, the unmet need has decreased from 30% to 20% in the same period (Figure 1.8).

**Figure 1.8 Trends of Unmet need and Demand for Family Planning satisfied by modern methods**




**Source: ZDHS, 2020**

The distribution of the demand for family planning (spacing and limiting) among women age 15-19 by knowledge of contraceptive methods is presented in Table 1.2.

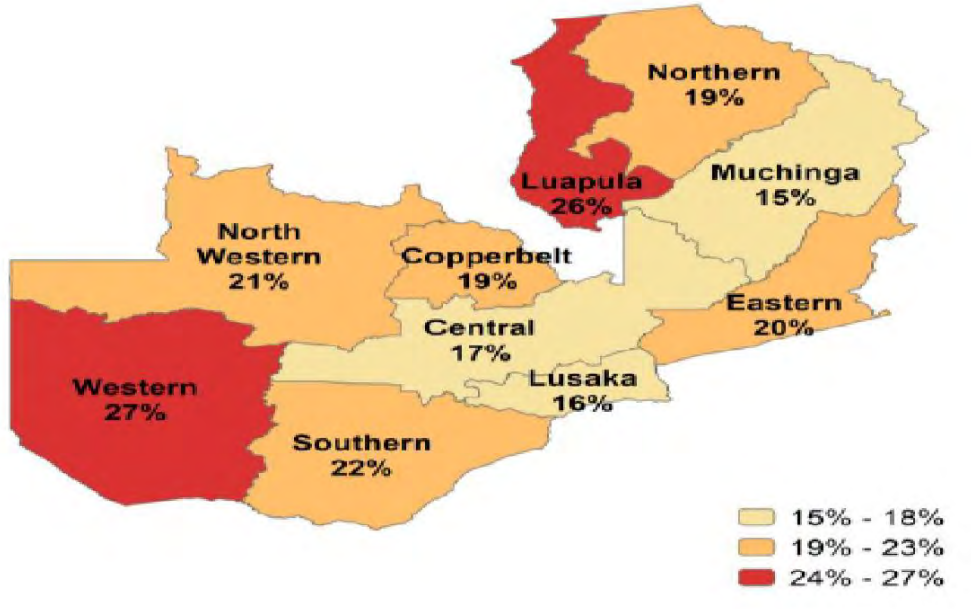
**Table 1.2 Demand for Family Planning: For Spacing, For Limiting by knowledge of Contraceptive Methods**

| Demand for Family Planning | | For Spacing | For Limiting | Total Demand |
|---|---|---|---|---|
| Knowledge of Contraceptive Methods | Any Method | 41.6 | 27.8 | 69.4 |
| | Modern Methods | 41.6 | 27.8 | 69.4 |
| | Injectables | 41.7 | 27.9 | 69.6 |
| | Implants | 41.6 | 28.2 | 69.8 |
| | Pill | 41.6 | 28.1 | 69.6 |
| | IUD | 41 | 31 | 72 |
| | Female Sterilization | 40 | 32 | 72 |
| | Male Sterilization | 35.5 | 35.9 | 71.4 |
| | Emergency | 39.6 | 31.4 | 71 |
| | Male condom | 41.8 | 27.9 | 69.7 |

**Source: ZDHS, 2018**

Generally, more currently married women (42%) age 15-49 demand either any method or a modern family planning method for spacing compared with 28% of women who demand for limiting. This has an implication for the TFR, which reduced from 5.3 to 4.7 between 2014 and 2018. Across the different methods of contraception, injectables, implants, pill and male condom are among the popular methods demanded for either spacing or limiting of births.

**Figure 1.9 Disparities in Unmet Need by Provinces, Zambia**




**Source: Zambia Demographic and Health Survey; 2018**

Unmet need is highest in the Western province (27%) followed by Luapula province (26%) and is lowest in Muchinga province (15%) followed by Lusaka province (16%). As mentioned earlier, there is need to focus more FP investments in rural and underserved areas.

### 1.5.5 Teenage Pregnancies and Use of Contraceptives

Teenage pregnancies continue to manifest themselves in Zambia. Many adolescents remain at risk for unplanned pregnancies despite advances in contraceptive technology, knowledge and availability of birth control options. The modern Contraceptive Prevalence Rate (mCPR) among adolescents rose marginally from 10.2 percent in 2014 to 12.1 percent in 2018 (ZDHS, 2018). This achievement fell short of the target of 38 percent in the National Health Strategic Plan 2017 to 2021. Contraceptive knowledge and use in adolescence is affected by many misconceptions, general lack of motivation to use them and in some cases, many adolescents are exposed to first sexual intercourse earlier than their exposure to any method of contraception.

The distribution of women age 15-19 who have had a live birth and began childbearing by contraceptive methods used is presented in Table 1.3. The use of modern contraceptive methods appears to be relatively high (41%) among teenagers who have had a live birth compared with those who had begun childbearing (34%). Injectables are the most common method of contraception, in both categories at 30% and 25 % respectively.

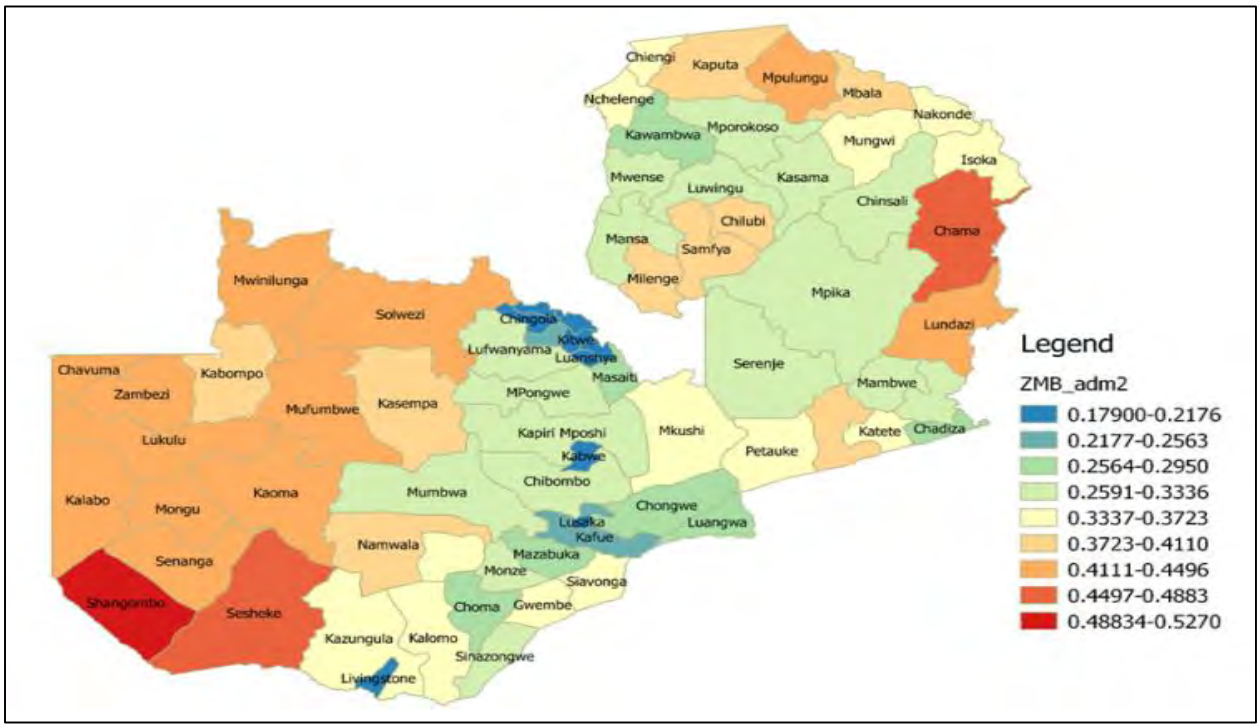
**Table 1.3 Use of contraceptive methods: Any Method, Modern Method, Male Condom, Injectables, Pill and Implants by Teenage Pregnancy and Motherhood**

| Teenage Pregnancy | Use of Contraceptive Methods | | | | | |
|---|---|---|---|---|---|---|
| | Any Method | Modern Method | Male Condom | Injectables | Pill | Implants |
| Teenage(15-19) have had live birth | 41.1 | 40.9 | 1.9 | 30.0 | 3.2 | 5.4 |
| Teenage (15-19) begun childbearing | 33.9 | 33.7 | 1.6 | 24.8 | 2.6 | 4.5 |

**Source: ZDHS, 2018**

As revealed above, the use of modern contraceptives is much lower for adolescents compared to the national average as per ZDHS (2018). Moreover, regional disparities exist in many indicators. It is found that adolescent pregnancies are much higher in rural areas compared to urban areas (Figure 1.10).

**Figure 1.10 Teenage Pregnancies by Districts, Zambia**



**Source: Zambia Demographic and Health Survey; 2018**

The districts with the highest teenage pregnancies are Shangombo, Sesheke and Chama. Since teenage pregnancies are high and especially in rural areas, there is need for more FP investments targeting teenagers, especially those in the rural areas. Also, teenage rights to contraceptives need to be guaranteed under the sexual and reproductive health and rights, through adjusting downwards the age of consent. This coupled with a robust referral system from Comprehensive Sexuality Education to service delivery points would lead to better outcomes.

### 1.5.6 Informed Choice for Modern Contraceptive Use

Effective family planning interventions rely on the principle of providing informed choice as a basis of ensuring that clients choose a method that best meets their needs. Informed choice for contraceptive use emphasizes that clients select the method that best satisfies their personal, reproductive and health needs based on a thorough understanding of their options (ZDHS 2018).

Generally, continuation of contraceptive use can be enhanced through informed choice and counselling (FP, 2020). This is based on two principle attributes of information provision about potential side effects of the chosen method and information about other methods of family planning (Table 1.4).

**Table 1.4 Informed Choice about Modern Methods of Contraceptives: Informed about side effects, what to do if experience side effects and other methods, and informed by a health or family planning worker**

| | Percentage who were informed about side effects or problems of method use | | Percentage who were informed about what to do if experienced side effects | | Percentage who were informed by a health or family planning worker of other methods that could be used | |
|---|---|---|---|---|---|---|
| **Method/ Year** | **2013/14** | **2018** | **2013/14** | **2018** | **2013/14** | **2018** |
| **Female sterilisation** | 72.2 | 74.8 | 66.5 | 71.8 | 60.0 | 78.4 |
| **Pill** | 68.2 | 79 | 67.5 | 73.9 | 74.6 | 82.2 |
| **IUD** | 85.5 | 98.7 | 85.1 | 79 | 97.3 | 87.4 |
| **Injectables** | 80.8 | 79.8 | 79.1 | 75 | 84.9 | 83.4 |
| **Implants** | 91.9 | 88.7 | 89.1 | 85.7 | 89.7 | 89 |
| **Initial Source of method** | | | | | | |
| **Public sector** | 83.4 | 83 | 81.4 | 78.5 | 86.6 | 85.8 |
| **Private sector** | 61.7 | 66.9 | 62.2 | 60.9 | 65.8 | 68.3 |
| **Other source (Shop etc)** | 33.8 | 48 | 36.3 | 42.6 | 43.3 | 50.7 |
| **Total** | 79.0 | 81.6 | 77.4 | 77 | 82.7 | 84.3 |

**ZDHS 2013/14 & 2018**

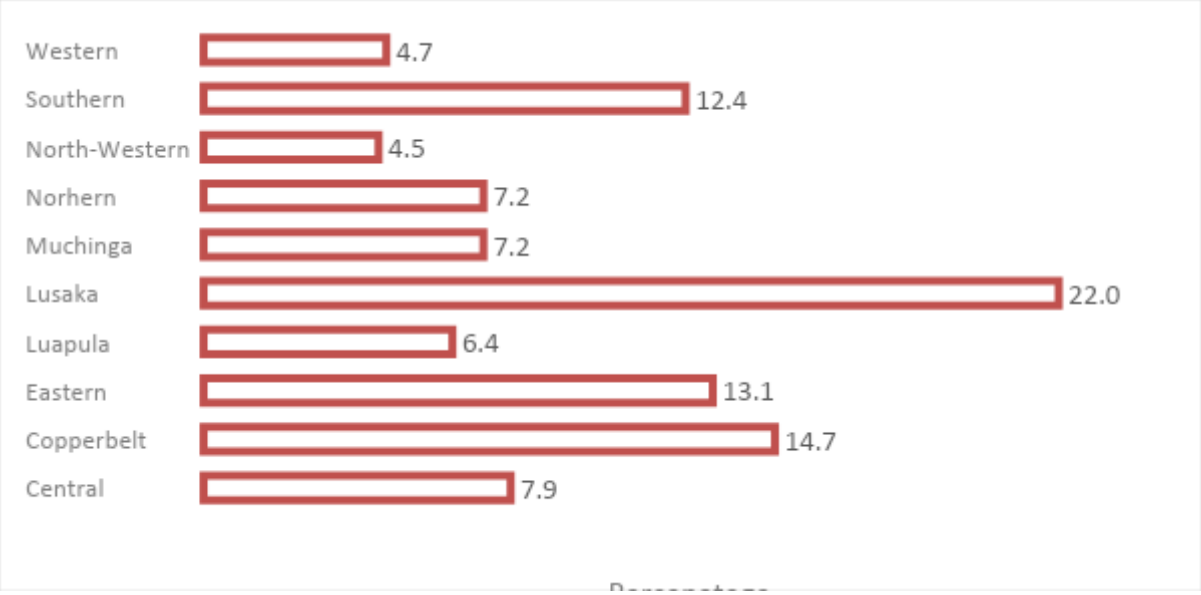
Informed choice of contraceptive methods appears generally to be high in Zambia. 81.6 percent of women currently using modern methods of contraception were informed about side effects associated with the method of choice in 2018, increasing from 79 percent in 2013/14. Seventy-seven percent were informed about what to do if they experienced side effects in 2018 as opposed to 77.4 percent and 84.3 % were informed about other alternative methods to use by a health or family planning worker in 2018 as opposed to 82.7 percent in 2013/13. In terms of initial choice of method, the public sector has the largest share given that it is the major provider of family planning services. However, the private sector and other sources have

also increased as a source of information between 2013/14 and 2018, hence the need to support and incentive the private sector in the provision of FP services.

### 1.5.7 Discontinuation of Contraceptives

Contraceptive discontinuation among women age 15-49 poses a risk to halt and negate the achievements Zambia has attained in reducing fertility and improving other related development goals over the last decades as well as harnessing the demographic dividend. The Zambia Demographic and Health Surveys (1992 to 2018) shows that the country has experienced a steady fall in fertility rates from 6.5 in 1992 to 4.7 in 2018. Despite the steady decline, Zambia has one of the highest TFRs in the sub-Saharan region after Madagascar, Eritrea and Guinea at TFR of 4.8 (ZDHS 2018). The level of contraceptive discontinuation can have a bearing on the level of fertility decline. Among women age 15-49 years who started an episode of contraceptive use in the five years prior to the survey, 36% of the episodes were discontinued within 12 months. Discontinuation rates were high for the pill (51%) and male condoms (45%) and lowest among implants (12%) (ZDHS, 2018). The common reason for discontinuation is wanting to become pregnant (30%) followed by health and side effects concerns (29%). The desire to become pregnant as a reason for discontinuation was high among women in the age groups 25-29 and 30-34 (35%) and lower among women age 15-19 (12%) and 45-49 (11%) (ZDHS 2018). Similarly, 32% of women in rural areas discontinued the use of a family planning method because they wanted to become pregnant. The fear of side effects or health concerns is higher among women who are in their late reproductive years. Regional variations in discontinuation of contraceptive use as presented in figure 1.11.

**Figure 1.11 Discontinuation of contraceptive methods in the 5 years preceding the survey (any reason stated for discontinuation) by province**




**Source: ZDHS, 2018**

The regional variations show that women in Copperbelt and Luapula provinces (41%) respectively were concerned about the side effects of the methods of family planning whereas 36 percent of women in Muchinga and Central provinces discontinued on account of wanting to become pregnant (ZDHS, 2018).

### 1.5.8 Family Planning Commodity Security

To sustain the gains made in improving access to FP in Zambia, it is necessary to assure the sustained availability and expanded mix of contraceptive methods in the country. However, this may not be attained in view of the current financing gaps the country is experiencing. Over the past five years, the Government of the Republic of Zambia has introduced a budget line and increased its budgetary allocation for contraceptives. However, this amounts to only about 10% of the current total commodity need which stood

at US$18,372,024 for 2018(Zambia Family Planning Financial Sustainability Concept Note, 2019). The country had a shortfall of approximately US$ 5,000,000 for 2018 mainly regarding condom procurement which had received relatively less support. The contraceptive commodity needs for 2019 has been forecasted at US$ 18,767,812. With the donor financing landscape showing a gradual decline, it is anticipated that the funding shortfall for contraceptive commodities will increase in the coming years unless other sources of funding are secured. This will lead to widespread stock-outs of contraceptive commodities including condoms.

The government continued to build capacity in forecasting and quantification at the national and subnational level through a national team that included provincial Commodity Security Managers (e.g. Pharmacists), MoH officials and other stakeholders such as bilateral and multilateral partners and NGOs (MTR-FP-CIP, 2017). Annual forecasting and quantification meetings are held to determine national contraceptive needs. By 2020, an electronic Logistics Information Management System (eLMIS) had expanded to all districts to ensure commodity security and reduce stock outs at clinics. With this development,, facility-reported consumption of family planning products could be captured from a central eLMIS as national aggregated report..

In the 2013-2016 CIP, there were reported variations between the CIP estimated cost and actual expenditures. Figure 1.12 provides the actual expenditures on commodities per year compared to projections in the CIP, both in terms of commodities costs and total costs of the scale-up plan.

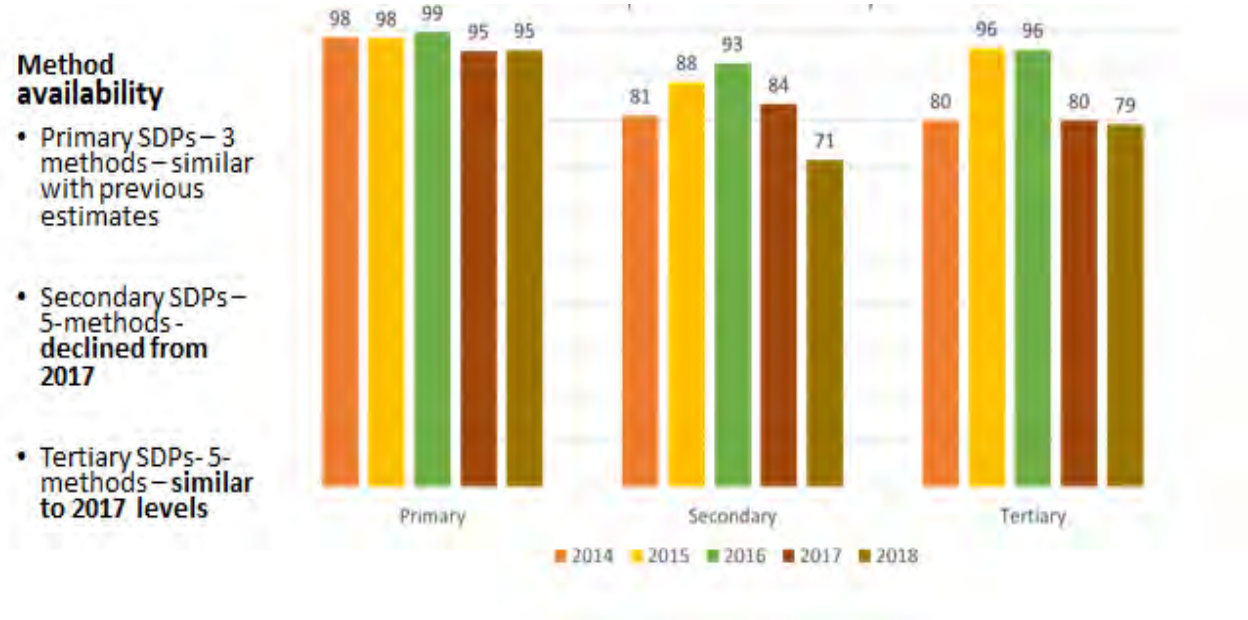
**Figure 1.12 Actual Commodities Costs Compared to CIP Projected Commodities Costs and Total Costs: 2013-2016**


The projected costs do not reflect fluctuations in currency, which would further exacerbate differences in actual verses projected costs. Expenditures on commodities have consistently exceeded the projected commodities costs, even exceeding the total projected costs of the entire scale up plan in 2013. Differences in actual and projected contraceptive costs were highest at US$ 10.4 million in 2014 but dropped to US$ 3.9 million in 2015.

In terms of availability of contraceptives per Zambia's national protocol, evidence available from the Reproductive Health Commodity Security Service Delivery Point Survey (RHCS SDP Survey) reveals that contraceptives are more available in primary service delivery points than in secondary and tertiary levels (Figure 1.13).

**Figure 1.13 Availability of Contraceptives per National protocol, Zambia**

**Sour**




**Source: Reproductive Health Commodity Survey-Service Delivery Point Survey, 2018**

The primary level service delivery points have higher methods availability compared to secondary and tertiary levels. From 2016, method availability has been falling in both secondary and tertiary levels.

### 1.6 Political/ policy/legal Environment

Zambia is addressing policy barriers adversely impacting the delivery of sexual and reproductive health services for adolescents and young people and is scaling up access to family planning through a variety of contraceptive methods and services in the hardest to reach places. The Government is poised to increase domestic financing for the procurement of contraceptives and committed to addressing policy barriers adversely impacting the delivery of sexual and reproductive health services for adolescents and young people.

Some of the key policy options that have been undertaken by the Government of the Republic of Zambia since 2015 include:

i. Accelerating Fertility Reduction
   - Reinforce political will and investments in FP, including Public Private Partnerships (PPPs) and FP2020 commitments
   - Pay attention to underserved groups, including youth and male involvement
   - Improve quality and coverage of FP programs, with focus on LARC

ii. Improving child survival
   - Intensify cost effective interventions on child survival: immunization, integrated management of childhood illnesses (IMCI), ITNs, eMTCT of HIV, deliveries by skilled birth attendants and improve child nutrition

iii. Keeping girls in school; preventing Child marriage and teenage pregnancies
   - Address cultural and economic barriers to access
   - Enforce laws on the legal minimum age of marriage
   - Implement innovative schooling options
   - Scale-up comprehensive sexuality education (CSE) and services for in and out of school adolescents

iv. Improving Health Status of the Labour Force

- Increase political will and commitment to improved health sector performance access, quality of care, financing, HRH, PPPs, etc
- Health Promotion on emerging lifestyle diseases

v. Advancing Education & Skills development Reforms
- Enforce a paradigm shift towards universal early childhood and secondary education, and increased enrolment in tertiary institutions;
- Increase formal and informal education quality, access and management - school facilities, trained teachers, and learning materials at all levels;
- Match formal and informal school curricula with labour market needs.

vi. Accelerating inclusive Economic Growth and Job Creation
- Diversify the economy and reduce overdependence on the extractive industry, for example modernize agriculture sector, prioritise value-additions;
- Fast-track investments in gender-sensitive economic infrastructure transport, communication and energy;
- Enhance efficiency and lower the cost of doing business;
- Mainstream the informal sector and promote small and medium sized enterprises

vii. Improving strong Governance and Accountability systems
- Strengthen governance and anti-corruption systems
- Enhance accountability in the delivery of public service
- Fast track decentralization policy implementation
- Adopt policies and laws that empower women and enhance equitable participation in the labour force
- Improve coordination across sectors

Another notable achievement is the enabling environment which has been provided by the MoH through the Family Planning Technical Working Group which has provided a platform for engagement with all stakeholders in the FP space. This has improved coordination and governance significantly at national level and there is need to replicate this at sub-national level. Besides, there is need to revisit the policy on reducing the financial barrier to access on FP services including the costs to cover distances to SDPs. The GRZ should also look at providing contraceptives free of charge in in the private sector where there is still a cost attached. Additionally, there is need to introduce laws that guarantee adolescents' access to SDPs for sexual and reproductive health and rights despite the barrier introduced by age of consent.

### 1.7 Zambia's Economic Environment

Real GDP growth slowed to an estimated 2% in 2019, down from 4.0% in 2018. Zambia's economy was hit by drought in the south and west that lowered 2018/19 agricultural production and hydropower electricity generation considerably. Severe electricity rationing followed, and long periods of electricity load shedding dampened activity in almost all economic sectors (Africa Development Bank, 2020). Zambia also faces slower mining, with reduced output and lower copper prices. Economic activity is expected to be negative, with 2020 projected Real GDP (% change) of -3.5 (Source: https://www.imf.org/en/Countries/ZMB). Public infrastructure investment has severely strained public finances.

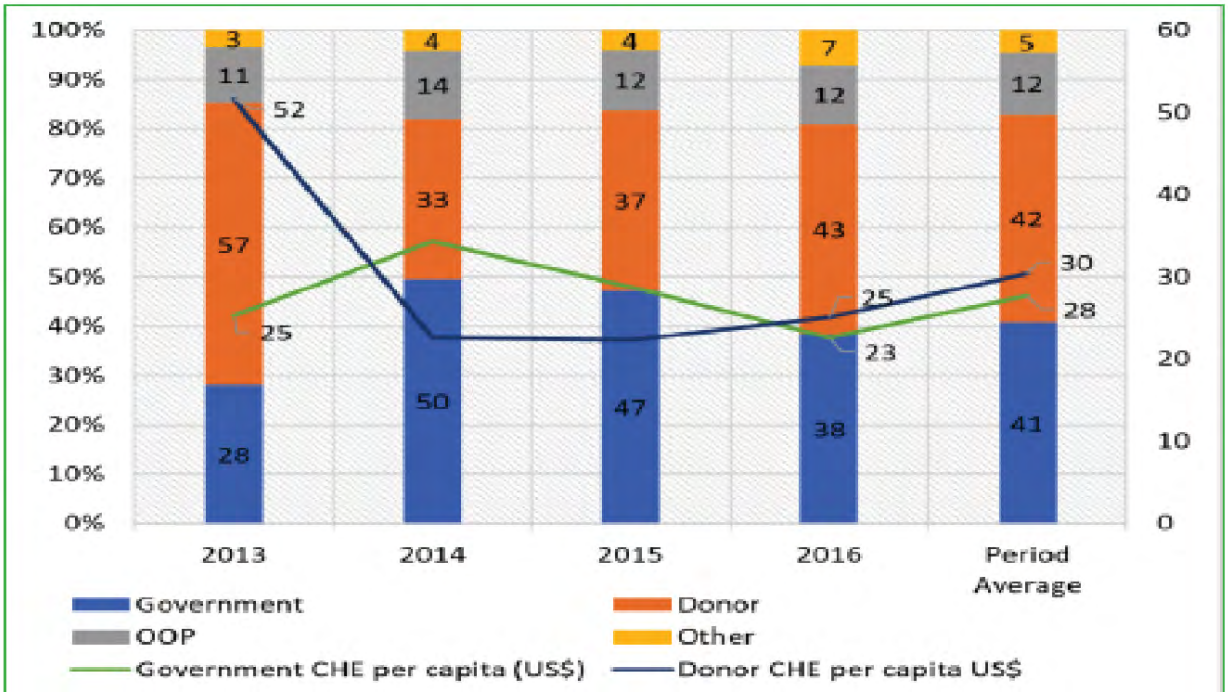
Over reliance on non-concessional external borrowing since 2012 to finance large-scale infrastructure projects has resulted in large fiscal deficits since 2014 (going from 6.5 percent of GDP in 2013 to 12.1 percent in 2015, 10.5 percent in 2018, and 7.7 percent in 2019. Large domestic payment arrears have also accumulated (9.7 percent 2019). The rapidly increasing public debt (80 percent of GDP at the end of 2019, up from 35 percent at the end of 2014) places Zambia at a high risk of debt distress.

Inflation rose from 7.5 percent in 2018 to 9.2 percent in 2019 and increased to 15.5 percent in August 2020 to further projected to increase, pushed by large exchange rate depreciations and food price increases. This has prompted monetary policy tightening, with the Bank of Zambia raising the policy rate by 50 basis points to 10.25 percent. The current account deficit is expected to widen to 2.8 percent of GDP in 2020-21 due to

increased public investments and mining sector imports, and higher debt- service payments reduced foreign reserves to 1.6 month of imports at the end of 2019(Bank of Zambia Monetary Policy of August 2020).

This scenario significantly diminishes the Government's role in financing health care in Zambia, which has been reportedly low for some time and it may worsen given that there is no fiscal space attributed to low revenue collection, further worsened by COVID 19 restrictions and public debt service commitments. According to Zambia's National Health Accounts 2013-2016, donors remain the major financiers of healthcare in the country (Figure 1.14).

**Figure 1.14 Sources of Total Current Health Expenditures, Zambia**




**Source: Zambia National Health Accounts 2013-2016**

FP program in Zambia has relied heavily on cooperating partners namely DFID, USAID and UNFPA. Other partners such as SIDA provide capacity building support in form of health systems strengthening. Government financing of FP has remained low in the last FP-CIP, with the amounts expended revealing fluctuations over time. Figure 1.15 presents the GRZ's financing of FP commodities in the FP-CIP 2013 to 2020.

**Figure 1.15 Government Financing of Family Planning Commodities, Zambia**


**Source: Ministry of Health, Zambia**

The above figure shows that GRZ financing has been fluctuating over the period of the previous FP-CIP. Since there is evidence that cooperating partners heavily support the FP program, it suffices to conclude that with increases in GRZ's financing to FP, it will be more sustainable and achieve better outcomes in the different sectors of the economy.

## 1.8 Beneficiary Profile Analysis

Zambia has a population growth rate at 2.8 percent, one of the highest in the world. The total fertility rate (TFR) in Zambia is 4.7 children per woman. The TFR is lower in urban areas (3.4 children per woman) than in rural areas (5.8 children per woman). Age- specific fertility rates peak at age 20-24 (203 births per 1,000 women) and are lowest among women less than age 15 (3 births per 1,000 women) and those age 45-49 (12 births per 1,000 women) (ZDHS, 2018). The average number of children per woman declines with increasing education. Women with no education have an average of 6.4 children, as compared with 2.4 children among women with higher education. Additionally, women with the lowest wealth quintile (6.7) have almost four more children than those in the highest wealth quintile (3.0).

## 1.9 Impact of COVID 19 on Family Planning in Zambia

It is known that pandemics, natural disasters, and complex emergencies, such as COVID 19 can reduce access to contraception and contribute to declines in contraceptive use. Zambia is currently grappling with increasing cases of Corona virus, currently at 15,224 on 8th October 2020. The results of scenario analysis are presented in Table 1.5.

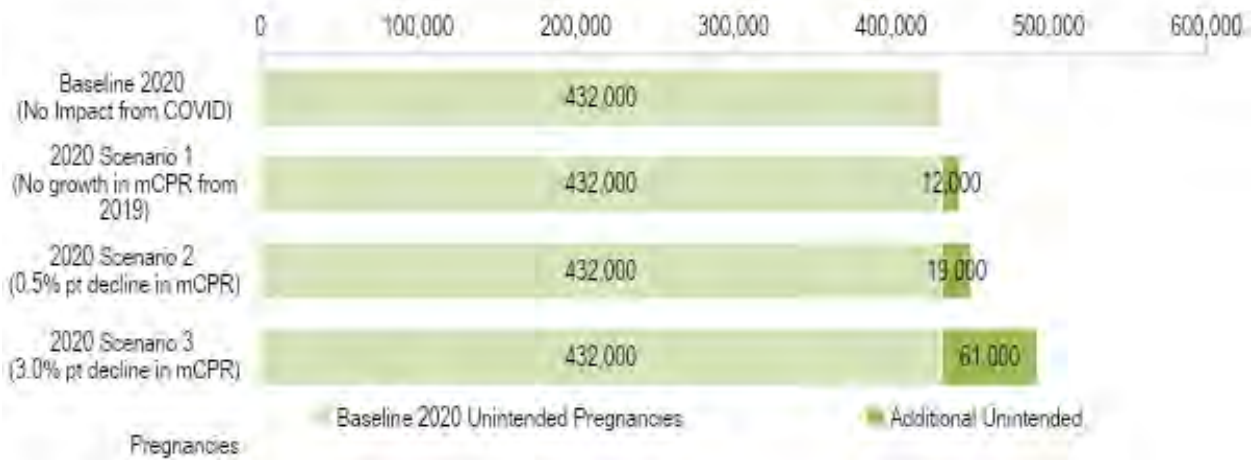
**Table 1.5 Scenarios and Impact of COVID 19 on Family Planning, Zambia**

| **Scenarios for Estimating the Impact of COVID-19 on Contraceptive Use** | | *% Percent Change in mCPR from 2019 to 2020* | *mCPR (AW) 2019* | *mCPR (AW) 2020* |
|---|---|---|---|---|
| *Baseline 2020* | *Assume mCPR continues to grow normally* | *0.6%* | *35.2%* | *35.8%* |
| 1 | Assume no growth in mCPR from 2019 | 0.0% | 35.2% | 35.2% |
| 2 | Assume a decline in mCPR (AW) from 2019 | -0.5% | 35.2% | 34.7% |
| 3 | Assume a greater decline in mCPR (AW) from 2019 | -3.0% | 35.2% | 32.2% |

**Source: T20 Model, FP2020**

Assuming mCPR grows normally at a rate of 0.6 percent, the T20 Model estimates that it will grow to 35.8 percent in 2020, from 35.2 in 2019. With COVID 19, assuming stagnation, the mCPR (AW) will remain at 35.2 percent in 2020. Assuming declines of -0.5 and further -3 percent arising out of supply chain, service delivery and demand side disruptions, the mCPR (AW) will decrease to 34.7 and further 32.2 percent respectively. This will result in unintended pregnancies as presented in Figure 1.16.

**Figure 1.16 Unintended Pregnancies Arising out of COVID 19, Zambia**




**Source: T20 Model, FP2020**

The unintended pregnancies will be highest at 61,000 with a decline in mCPR of 3 percent.

## 2.0 ISSUES AND CHALLENGES FACING CURRENT FP PROGRAM IN ZAMBIA

In 2013, the Ministry of Health in collaboration with various stakeholders developed the Integrated Family Planning Scale-up Plan 2013-2020. The Government of the Republic of Zambia committed to increasing the mCPR (married women or in union) from 33% in 2007 to 58% by 2020. The development and implementation of the eight-year plan aimed at achieving the following objectives:

1. FP demand generation and behaviour change communication: "To strengthen demand for family planning services by repositioning FP as a key driver in development, and providing targeted, easily-accessible and accurate information to the population"
2. Adolescents and youth: "To more effectively target and serve adolescents and youth with quality accessible sexual and reproductive health information and services in and out of school"
3. Staff and training: "To build capabilities of providers and increase capacity to deliver high quality contraceptive services, including long-acting reversible contraceptives
4. Rural and underserved access to FP services: "To increase coverage and access to quality integrated FP services available to those living in rural and underserved areas"
5. Stock outs at service delivery points: "To improve the distribution, availability and security of family planning commodities from the central level to service delivery points, including both contraceptives and consumables"
6. FP governance structure and program coordination: "To strengthen the central provincial and district level FP structures to better coordinate and monitor government and partner activities, in order to deliver services efficiently"

### 2.1 Performance of Family Planning Programme

The National Health Sector Strategic Plan (2017-2021) aimed to scale up family planning (FP) services with a focus on capacity building community-based distributors, scale-up of long-acting reversible contraceptives (LARCs) and post-partum family planning (Mid-Term Review of NHSSP 2017-2021 Report, 2020).The summary of the performance of key family planning indicators is presented in Table 2.1.

**Table 2.1 Performance of Key Family Planning Indicators**

| Indicator | Baseline (year) | Target 2018 | Achievement | Comments |
|---|---|---|---|---|
| Reproductive health | | | | |
| Fertility rate (per 1000 women) | 152 (2014) | 132 | 134 (ZDHS 2018) | Fertility rate declined by 18 per 1000, nearly reaching the target |
| Fertility rate among adolescents (per 1000 girls) | 141(2014) | 121 | 135 (ZDHS 2018) | Fertility rate among adolescents declined slightly, and not quite halfway to the target |
| Women in sexual union with FP need satisfied with modern methods (%) | 63.8 (ZDHS 2013/14) | 76 | 68.5 (ZDHS 2018) | 5 percentage point increase- steady progress |
| Contraceptive prevalence rate (% modern methods) | 32.5 (ZDHS 2013/14) | 56 | 34.5 (ZDHS 2018) | Minimal progress made and this fell short of the target |
| Contraceptive prevalence among adolescents (% modern methods) | 10.2 (ZDHS 2013/14) | 38 | 12.1 (ZDHS 2018) | The 2018 achievement fell short of the target |
| Percentage of clients accessing Long Acting Reversible Contraceptives | 4 (2016, HMIS HIA2) | N/A | 4.1 (HMIS, HIA2) | This is a complementary indicator to the overall CPR and recorded a very minimal improvement |
| Couple Years of Protection Rate (CYP) | 33.3 (2016, HMIS HIA | 40 | 35.6 (2018, HMIS HIA 2; | Minimal progress made but short of the target |

| | | | | |
|---|---|---|---|---|
| | 2; 2018 CSO Pop.Proj.) | | 2018 CSO Pop. Proj.) | |

**Source: Mid-Term Review of NHSSP 2017-2021 Report, 2020**

The performance of the family planning program is sufficiently mixed given that some indicators are depicting over achievement and others the converse. The issues that stand out are as follows:

- Teenage pregnancy is still a challenge. The higher prevalence of unmet need among adolescent compared to adults exacerbates the situation.
- The injectables are popular among the youth implying that they could be disregarding condom use increasing their susceptibility to HIV/STI infections
- The contribution of LARCs to the method-mix is still very small. The persistent lower proportion of implants and IUD in the method mix is small and remains a significant challenge
- The rural areas are still under-served as per the findings of the ZDHS 2018
- Discontinuation in the use of contraceptives is evident. The rates were high for the pill (51%) and male condoms (45%) and lowest among implants (12%). The common reason for discontinuation is wanting to become pregnant (30%) followed by health and side effects concerns (29%). The desire to become pregnant as a reason for discontinuation was high among women in the age groups 25-29 and 30-34 (35%) and lower among women age 15-19 (12%) and 45-49 (11%)
- Inadequate funding of FP program from GRZ raises financial sustainability concerns especially commodity security

## 2.2 Program Performance Analysis

Zambia's Family Planning program performance analysis is based on the situational analysis and the feedback from the key informant interviews and focus group discussions conducted with various actors in Zambia.

### 2.2.1 Family Planning Demand Generation and Behaviour Change

The total demand for family planning has increased considerably over the last two decades in Zambia. The proportion of unmet need for family has also declined moderately because of the increase in the use of modern family methods and an increase in the proportion of women who want their next child later. To sustain the use of family planning methods, enhance the health and well-being of women and adolescent girls calls for a concerted effort in providing family planning services to all who wish to use them and for the purpose they desire to use them for. To reduce the unmet need and increase the total demand for family planning satisfied by modern methods further, there is need to invest in women and girl child education, information sharing on the methods and general empowerment of women. To avert discontinuation of the methods of contraception, there is need to scale up sensitization to allay the misconception associated with the use of family planning methods, particularly in rural areas.

The key challenges facing demand generation and behaviour change include:

- Inadequate funding for the comprehensive communication strategy at national level hence low visibility of FP in service delivery points
- Demand generation efforts are not met with commensurate availability of commodities
- High cost of engaging Community Based Distributors (CBDs) in demand creation
- Weak FP services seeking behavior
- Lack of appealing and accurate information targeting women of different ages
- Absence of link between Comprehensive Sex Education (CSE) and Service delivery points

### 2.2.2 Adolescents and Youth

Teenage pregnancy is a major problem and it is highlighted as a national priority in several policy documents. The use of contraceptive methods at first sexual intercourse is low and is a potential contributing factor to the teenage pregnancies, and early motherhood surge Zambia has witnessed and a momentum for high fertility. Major disparities in teenage pregnancies are revealed between provinces and districts in Zambia. In a bid to arrest this problem, the Ministry of General Education introduced CSE in all schools. While the policy framework is in place, implementation is more mixed, relying heavily on financing from cooperating partners hence raising sustainability concerns in deploying the activities. In addition, limited coordination exists at the provincial and district level due to the lack of MoH-designated adolescent health staff and the lack of information regarding young people's access to family planning services.

The key challenges facing adolescents and youth include:

- Reaching out to nulliparous adolescents especially in the rural areas remains a challenge
- Decline in Comprehensive education on HIV, which is getting worse as reported in the ZDHS for 2013/14 and 2018
- Disconnect between CSE and FP services
- No appraisal studies based on monitoring and evaluation data on the CSE and other FP interventions being implemented
- Lack of sufficient method-mix on the supply side to match demand creation especially in the rural setting
- Religious and cultural issues e.g. adolescents should not be taking contraceptives
- Age of consent hence adolescents cannot receive services in health facilities
- Lack of adolescents TWG especially at sub-national level

### 2.2.3 Staff and Training

The 2015 National Youth Policy promoted mainstreaming youth by training medical staff on youth-friendly health services, instead of separating them in youth corners. However, not all providers have received training to work with young people. In some instances, mainstream providers seemed dismissive of adolescents seeking services, particularly as most maternal and child health clinics offer family planning services to married women (Zambia Human Rights Commission et al. 2016:41). Those under the age of 16 required parental or guardian consent to access these services and to test for HIV and face additional stigma when trying to access these services (Zambia CIP 2013-2020 MTR Report). The Health Management Information System (HMIS) does not disaggregate data by age, which makes it difficult to know which services young people are able to access or utilize

Youth friendly spaces have been formed and strengthened at a number of government clinics to offer sexual and reproductive health information. The *Zambia Health Strategic Plan: 2017-2021* outlines providing a minimum adolescent health service platform in all districts, increasing adolescents' awareness of the available adolescent health services from 13.5 percent to 60 percent and strengthening leadership and governance of an adolescent- responsive health system in 60 percent of the districts by 2021. As of 2020, only 48 percent of districts had a minimum adolescent health package. While most youth friendly corners are staffed by MOH staff who are only administratively appointed to support the spaces despite having their other substantive duties at the same facility. Those that are staffed by private or donor-funded projects will often lose staffing once the funding ends, indicating some gap in government support. In addition, limited coordination exists at the provincial and district level due to the lack of MOH-designated adolescent health staff.

In addition, capacity has been built on community-based distributors (CBDs) to enable them distribute contraceptives, including injectables, and refer clients to health clinics for appropriate contraceptive services; and integrating family planning within other health services to increase the number of family planning access

points. Databases of long-acting reversible contraceptives (LARC) trained staff and trained CBDs issuing injectables provides key information on availability of family planning services and gaps in service delivery.

Needs assessments have been conducted in some districts and facilities through partner support, although family planning equipment needs and staffing levels at facilities remains broadly under-addressed. A pre-service and in-service family planning training plan and curriculum has been developed and implementation has been ongoing through support from cooperating partners. A policy framework is in place to ensure targeted services to adolescent and youth, but the implementation is more mixed, relying heavily on donor financial support and initiatives. Integration of Family Planning and HIV services has been implemented in all 10 provinces of Zambia though not all facilities have been covered.

The key challenges facing staff and training include:

- Low uptake of LARCs attributed to HCW availability and behavior (Check study by Population Council on use of IUD).
- Capacity building is done but HCW are transferred to other departments
- Lack of mentorship and coaching on provision of LARCs
- HCW trained in provision of LARCs are concentrated in urban areas
- HCW are not friendly to adolescents
- Weak integration of SRH&R services for young people at facility level

### 2.2.4 Rural and Underserved Access to FP Services

There have been reports of inadequate health staff able to provide some methods in health facilities, especially in rural areas in Zambia. The distribution of health workers with competencies in family planning need to be revisited. It is reported that policies barriers have been addressed to allow task-shifting (also called "task sharing") to CHA and trained CBDs to increase access to contraceptives in underserved communities. The MoH has endorsed policy change to allow CBDs to provide injectable contraception and the revised CBD Strategy and Guidelines is awaiting incorporation in the broader national Community Health Workers Strategy. The CHAs can provide all contraceptives, except LARC and permanent methods such sterilization. GRZ is also looking at the feasibility of Clinical Officers providing voluntary female sterilization. In addition, LNG-IUS, DMPA-SC, and Implanon have been introduced to increase method mix. However, Zambia still faces challenges to scale up of these commodities nation-wide.

The key challenges facing rural and underserved access to FP services include:

- Some facilities do not want CBDs within their vicinities because they reduce the number of visits from FP clients
- CBDs don't have methods because of lack of predictability in replenishing of stocks at the health facilities
- Variation in the density of CDBs across Zambia
- Contraception out of Schools is not doing very well
- Some CBDs have not been supported adequately to function e.g. motorbikes, commodities, ID Cards, vest
- Lack of incentives for CBDs
- Attrition of CBDs because they are not motivated
- CHAs not allowed to provide injectables

### 2.2.5 Stock outs at Service Delivery Points

Family planning commodity security has been ensured by strong central level quantification, forecasting, and procurement. However, stock outs persist at service delivery points, particularly in rural areas, due to limited capacity of clinical staff responsible for local procurement and inadequate warehousing and storage of commodities, supervision, and transportation. Less focus has been placed on addressing challenges with

distribution and requisition of family planning commodities and collecting real time family planning consumption data (Zambia Reproductive Health Commodities Survey, 2018).

The key challenges facing commodity security include:

- Districts are not empowered to distribute to the last mile
- Stock-outs at SDPs- Commodities are available at the central level but not available at the facilities point at challenges with transport and logistics to the last mile
- Coordination at sub-national level is weak
- Low quality of data from downstream hence affecting forecasting and quantification, and later utilization
- Method mix not backed by research- some commodities included in the method mix have a huge demand internationally making them unavailable in Zambia
- Weaknesses with commodity security at the last mile
- Some districts receive excess while others receive less
- Challenges with MSL moving stocks and in some cases does not stick to the schedule
- Lack of sufficient domestic financing for FP commodities

### 2.2.6 FP Governance Structure and Programme Coordination

Activities to ensure effective management and governance of family planning activities have been partially implemented. A Family Planning Technical Working Group (FP TWG) to implement the FP-CIP meets regularly and updates tools to track high level indicators and commitments (Zambia CIP 2013-2020 MTR Report). It is further reported that coordination at the central level has been made possible by recruitment of two dedicated family planning program staff. The FP TWG meets regularly to review proposed family planning activities and advise the MOH. For example, it successfully helped the MOH develop policy to allow CBDs to provide LARC and instituted a committee to ensure CBDs adhere to safety measures. An annual national review process brings together sub-national and national family planning players to review progress and share best practices. However, regular sub-national coordination has only partially been implemented, most significantly through donor initiatives.

The key challenges facing governance structures and programme coordination include:

- Dysfunctional FP TWGs at sub-national levels
- Coordination at sub-national level is weak
- Lack of adolescents TWG especially at sub-national level

## 3.0 NATIONAL COSTED IMPLEMENTATION PLAN FOR FAMILY PLANNING

### 3.1 Overall Vision, Mission and Goals

The vision, mission and goal specifically bring out the expectations of the Zambia Family Planning Costed Implementation Plan and Business Case 2012 to 2026 with regard to family planning. It is designed to provide an overall framework into which FP priorities and actions are derived. Its strategic focus is as follows:

Vision

*A country where citizens enjoy their sexual and reproductive health rights, make informed choices on sexual and reproductive health, have adequate access to high quality contraceptives, information and services on family planning*

Mission

*To ensure that citizens have access to high-quality, affordable reproductive health care, comprehensive sexual health information, and the right to manage their reproductive lives.*

Goal

*As a result of implementing strategic priorities, mCPR among all women will increase from 34.1% in 2020 to 40% in 2026*

### 3.2 Priority Action Areas

Based on the stakeholder consultation, review of international and national evidence, and consultations with policy makers in Zambia, key strategies and activities required for achieving FP goals were identified. These seven strategies are:

1. Promote and nurture change in social and individual behavior to address myths and misconceptions and improve acceptance and continued use of FP with a special focus on increasing age-appropriate information, access and use of FP amongst young people, ages 10-24 years and populations living in low performing areas
2. Strengthen service delivery provision in existing facilities (service coverage to include adolescents, people living with disabilities and those in rural and low performing areas).
3. Enhance skills of new and existing health care workers through adequate practical training in the full FP method mix with emphasis on LARC methods, post-partum family planning and empower community-based distributors to provide counselling, referral services and appropriate service provision
4. Improve FP commodity procurement and distribution and ensure full financing of FP commodities in the public and private sectors to prevent stock-outs
5. Increase the sustainability of FP commodities and services through government commitment, integration of the private sector, and diversification of funding sources
6. Strengthen evidence base for effective program implementation through research and information dissemination to enhance relevant programming
7. Strengthen FP leadership at national and sub-national levels; integrate FP policy, information and services across sectors for holistic contribution to social and economic transformation

### iii.3 Thematic Areas, Outcomes and Objectives

To achieve the goals of the Zambia family planning program for the period 2021 to 2026, several activities are recommended in this Family Planning Costed Implementation Plan & Business Case and these are costed as well for the five years. The details of the key activities and sub activities are presented in Annex 1 of this plan. The thematic areas, outcomes and objectives are summarised in Table 3.1.

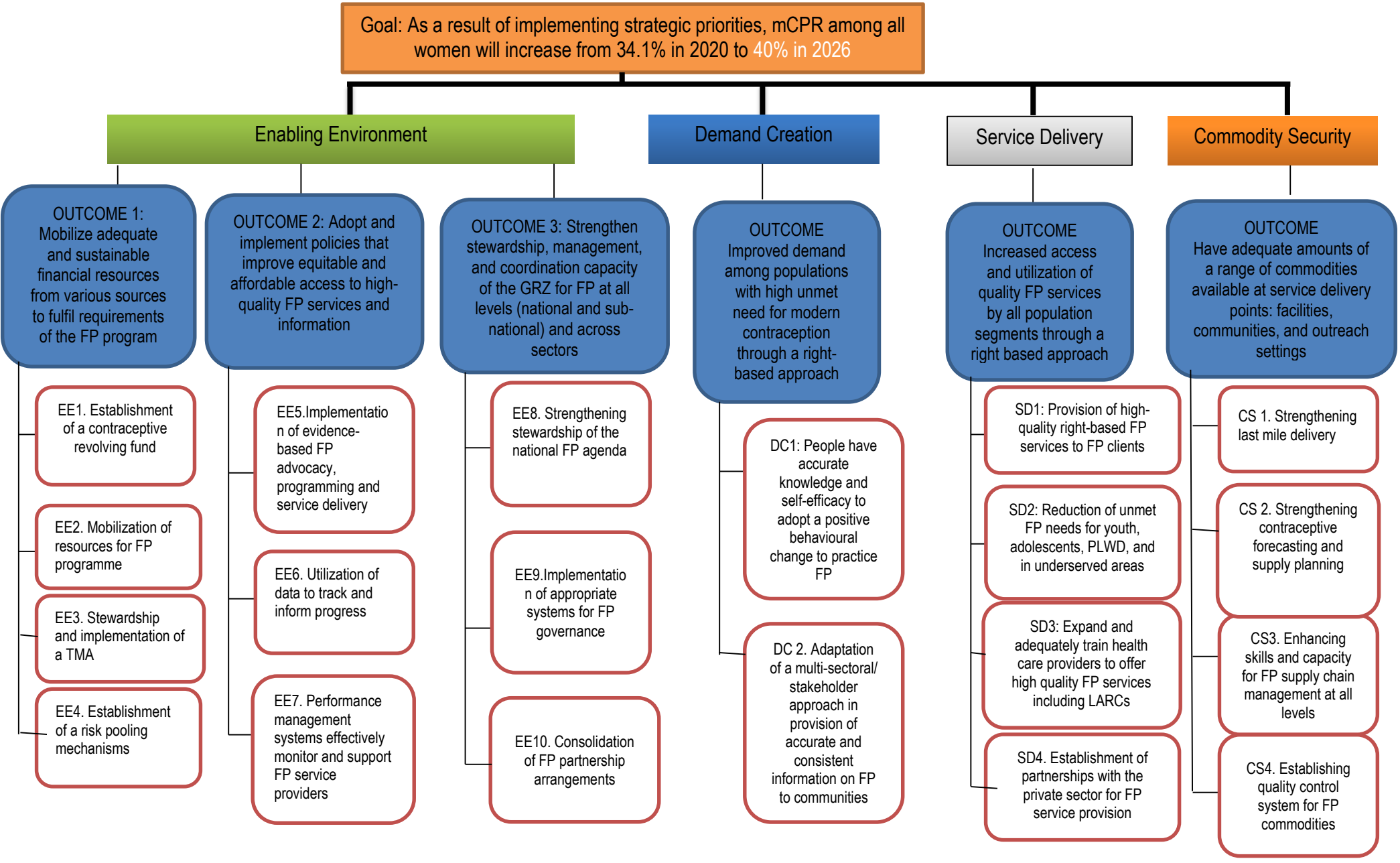
**Table 3.1 Thematic Areas, Outcomes and Objectives**

| Thematic Area | Outcome | Objective |
|---|---|---|
| Enabling Environment | ● eAdequate and sustainable financial resources to fulfil requirements of the FP program are mobilized | ● To increase allocation and diversify sources of FP funds including core funding from GRZ |
| | ● Policies that improve equitable and affordable access to high- quality FP services and information are adopted and implemented | ● To strengthen evidence base for effective program implementation through research and information dissemination |
| | ● The stewardship, management, and coordination capacity of the GRZ for FP at all levels (national and sub-national) and across sectors is strengthened | ● To strengthen stewardship and create an enabling environment for FP CIP implementation |
| Demand creation | ● Improved demand among populations with high unmet need for modern contraception through a right-based approach | ● To improve sexual and reproductive health care seeking behaviour among populations with high unmet need for modern contraception |
| Service delivery | ● Increased access and utilization of quality FP services by all population segments through a right based approach | ● To increase access and utilization of quality family planning services by all population segments |
| Commodity Security | ● A method mix of FP Commodities is available when and wherever there is need for the commodities in adequate quantities to support service delivery | ● To increase availability of quality FP commodities at SDPs i.e. facilities, communities and outreach settings |

### iii.4 Results Framework

The results framework summarises the key program areas of Family Planning in Zambia. It is summarised in Figure 3.1.

**Figure 3.1 Results Framework for Zambia Family Planning Programme**



## 4.0 COSTS OF FAMILY PLANNING

The costing analysis applied the Family Planning Costed Implementation Plan Costing Tool by Health Policy Plus that uses an activity-based approach to cost FP services. Three data inputs were used: i) population in need of FP services; ii) coverage targets; and iii) unit costs.

### 4.1 Population in need of Family Planning

The projections for population in Zambia are based on the 2010 Census of Population and Housing data which were used by the Central Statistical Office to produce the Population and Demographic Projections 2011-2035. The proportion of Women of Reproductive age together with the proportion of married women was obtained from the Zambia Demographic and Health Survey 2018. The proportion of unmarried sexually active women was extrapolated from the ZDHS 2018. The population data used for costing the CIP is presented in Table 4.1.

**Table 4.1 Population in need of FP, Zambia**

| | Year prior to Start | Plan Start | | | | | Plan End |
|---|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| **Population** | 18,616,232 | 19,190,396 | 19,778,848 | 20,381,778 | 20,999,266 | 21,631,572 | 22,279,318 |
| WRA | 2,547,255 | 2,634,410 | 2,721,837 | 2,810,515 | 2,899,756 | 2,990,649 | 3,083,842 |
| Married WRA | 2,001,414 | 2,069,893 | 2,138,586 | 2,208,262 | 2,278,380 | 2,349,795 | 2,423,019 |
| Unmarried WRA | 3,138,582 | 3,245,969 | 3,353,692 | 3,462,956 | 3,572,914 | 3,684,906 | 3,799,734 |
| Sexually Active Unmarried WRA | 5,685,836 | 5,880,379 | 6,075,529 | 6,273,471 | 6,472,670 | 6,675,555 | 6,883,576 |
| (married WRA + sexually active WRA) | 2,547,255 | 2,634,410 | 2,721,837 | 2,810,515 | 2,899,756 | 2,990,649 | 3,083,842 |

**Source: Zamstats & Zambia Family Planning CIP Costing Tool, 2020**

### 4.2 Coverage Targets

The annual increases in coverage are based on impact outputs from the FP-SDGs model and discussions with the FP-CIP Taskforce with concurrence from the Family Planning Technical Working Group. The married women WRA, method mix and mCPR are presented in Table 4.2.

**Table 4.2 Married WRA – modern CPR and Suggested Method Mix**

| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| CPR | 51.2% | 52.4% | 53.5% | 54.9% | 56.0% | 57% | 58.6% |
| MCPR | 49.2% | 50.5% | 51.7% | 53.1% | 54.4% | 55.8% | 57.3% |
| | | | | | | | |
| Male Sterilisations | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Female Sterilisations | 2.00% | 2.01% | 2.02% | 2.03% | 2.04% | 2.05% | 2.06% |
| IUDs | 1.00% | 1.02% | 1.04% | 1.06% | 1.08% | 1.10% | 1.13% |
| Implants | 8.20% | 8.36% | 8.53% | 8.70% | 8.88% | 9.05% | 9.23% |
| Injectables | 27.00% | 27.81% | 28.64% | 29.50% | 30.39% | 31.30% | 32.24% |
| Pills | 8.00% | 8.16% | 8.32% | 8.49% | 8.66% | 8.83% | 9.01% |
| Male condoms | 3.00% | 3.09% | 3.18% | 3.28% | 3.38% | 3.48% | 3.58% |
| Other traditional methods | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |

**Source: FP-SDGs Model, Zambia & Family Planning Estimation Tool, Track20, 2020**

The unmarried women WRA, method mix and mCPR are presented in Table 4.3.

**Table 4.3 Unmarried sexually active WRA – modern CPR and Suggested Method Mix**

| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| CPR | 44.0% | 45.1% | 46.3% | 47.5% | 48.8% | 50.0% | 51.3% |
| MCPR | 43.0% | 44.1% | 45.3% | 46.5% | 47.8% | 49.0% | 50.3% |
| | | | | | | | |
| Male Sterilisations | 0.0% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Female Sterilisations | 0.0% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| IUDs | 1.0% | 1.02% | 1.04% | 1.06% | 1.08% | 1.10% | 1.13% |
| Implants | 9.0% | 9.18% | 9.36% | 9.55% | 9.74% | 9.94% | 10.14% |
| Injectables | 21.0% | 21.63% | 22.28% | 22.95% | 23.64% | 24.34% | 25.08% |
| Pills | 5.0% | 5.10% | 5.20% | 5.31% | 5.41% | 5.52% | 5.63% |
| Male condoms | 7.0% | 7.21% | 7.43% | 7.65% | 7.88% | 8.11% | 8.36% |
| Female condoms | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| Lactational amenorrhea | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| Other traditional methods (e.g. massage) | 0% | 0% | 0% | 0% | 0% | 0% | 0% |

**Source: FP-SDGs Model, Zambia & Family Planning Estimation Tool, Track20, 2020**

## 4.3 Contraceptives Cost

The estimated cost of contraceptives for the FP-CIP period 2021 to 2026 was computed using data from section 4.1 to 4.3 and used the following formula:

Cost of Contraceptives = Population in need of FP X mCPR Target X Unit Cost

Where

- Population is the number of persons who need Family Planning
- Coverage target is the suggested mCPR by method mix
- Unit cost per method (including distribution cost)

The FP commodities costs are presented in Table 4.4

**Table 4.4 FP Commodities Costs, Zambia**

| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|
| **Contraceptives Cost (US$)** | 13,820,542.86 | 14,606,924.17 | 15,485,597.08 | 16,403,242.57 | 17,371,467.54 | 18,395,512.74 |
| **Contraceptives Cost (ZMK)** | 256,232,864.62 | 270,812,374.11 | 287,102,969.86 | 304,116,117.25 | 322,067,008.19 | 341,052,806.20 |

**Source: Zambia FP Costing Model, 2020**

They include a US$ 0.05 per unit for distribution to the last mile.

## 4.5 Summary of Costs by Thematic Area and Year

The Family Planning Costed Implementation Plan costs by thematic areas and year are presented in Table 4.5.

**Table 4.5 Family Planning Costs by Thematic Areas and Year**

| Thematic Area/Year | Enabling Environment | Demand Creation | Service Delivery | FP Commodities | Commodity Security | TOTAL COSTS (US$) | TOTAL COSTS (ZMK) |
|---|---|---|---|---|---|---|---|
| **2021** | 521,836.00 | 124,689.40 | 2,516,056.00 | 13,820,542.86 | 8,119.80 | 16,943,244.06 | 314,127,744.89 |
| **2022** | 5,924,158.67 | 5,722,824.82 | 16,366,242.87 | 14,606,924.17 | 1,104,306.24 | 43,724,456.76 | 810,651,428.42 |
| **2023** | 5,184,486.18 | 13,728,891.09 | 16,610,597.41 | 15,485,597.08 | 603,292.15 | 51,612,863.89 | 956,902,496.61 |
| **2024** | 4,799,307.89 | 13,825,299.95 | 16,980,291.61 | 16,403,242.57 | 333,543.33 | 52,341,685.37 | 970,414,846.70 |
| **2025** | 4,170,655.82 | 13,825,299.95 | 16,937,516.42 | 17,371,467.54 | 346,551.52 | 52,651,491.26 | 976,158,647.90 |
| **2026** | 495,922.64 | 1,859,305.00 | 3,647,691.43 | 18,395,512.74 | 117,972.72 | 24,516,404.52 | 454,534,139.89 |
| **TOTAL (US$)** | 21,096,367.20 | 49,086,310.22 | 73,058,395.73 | 96,035,286.96 | 2,513,785.76 | 241,790,145.87 | |

*Exchange Rate is US$1=ZMK18.54

**Source: FP-CIP Costing Worksheets, Zambia; 2020**

The estimated costs for enabling environment are ZMK 391,126,647.888 (US$21,096,367.20), Demand creation ZMK 910,060,191.4788 (US$49,086,310.22), Service Delivery ZMK 1,354,502,656.8342 (US$73,058,395.73), Commodity security ZMK 46,605,587.99 (US$2,513,785.76). The FP commodities costs include a US$0.05 per unit cost to cater for the last mile distribution. The total FP commodities cost is estimated to be ZMK 1,780,494,220.2384 (US$ 96,035,286.96).

## 5.0 BUSINESS CASE FOR FAMILY PLANNING IN ZAMBIA

### 5.1 Introduction

A robust business case for investing in Family Planning is important in the context of a country like Zambia that is facing rapid population growth. Globally, investment in Family Planning and related maternal and child health activities is the driving force for lowering fertility. This has the potential to improve population health and boost the economy.

This analysis used a couple of models developed and used in other countries to assist countries in understanding the benefits derivable from reducing fertility rates and improving the uptake of modern contraceptives by investing in Family planning.

The report uses three broad models: The Impact-Now model, the RAPID model, and the FP-Sustainable Development Goals (SDG) model. These models use projections and simulation to inform decision- makers about future scenarios for a given country and to identify areas of interest. It is important to note that we ensured that these models are coherent such that results from all models can be compared. These models are described below.

#### 5.1.1 Impact Now Model

The Impact-Now model will be used to demonstrate the benefits of investing in Family Planning with a short- to medium-term focus (up to 10 years). It was developed by the Health Policy Project supported by USAID (Health Policy Project *et al.,* 2014). It will be used to estimate gains in different aspects/areas as a result of increases in Contraceptive Prevalence Rate (mCPR) or reductions in Unmet Need for Family Planning.

The aspects that will be assessed include:

i. Unintended pregnancies avoidable
ii. Unplanned births preventable
iii. Abortions (including unsafe abortions) that can be prevented
iv. Maternal and child deaths that can be avoided
v. Financial savings to the healthcare system (e.g. infant and maternal healthcare costs averted)

#### 5.1.2 RAPID Model

The RAPID Model uses demographic information such as population size, age, and sex distribution over some time to generate projections of the socioeconomic impacts of population change across different sectors. It is part of the Spectrum suite *(*https://www.avenirhealth.org/ *software-spectrum.php).*

These sectors include the economy, education, health, infrastructure (urbanisation) and agriculture. The model can estimate these impacts up to projections to estimate the effects up to 150 years into the future, but realistic effects must be within a relatively manageable future. Results will include requirements for the labour force, primary school enrolment and teachers, the number of nurses and doctors required to meet the needs of the population, etc.

#### 5.1.3 FP-SDG Model

The FP-SDG model allows for assessing the impact of increases in CPR on many indicators that are related to the Sustainable Development Goals. It was designed by Health Policy Plus (Health Policy Plus, 2017). The indicators related to SDGs include:

i. Poverty headcount
ii. Food security
iii. Maternal mortality ratio and under-five mortality rate
iv. Adolescent birth rate, etc.

### 5.1.4 Policy Targets

The policy targets by scenario including the contraceptive prevalence rates, modern contraceptive prevalence rate, fertility rate and unmet need that were used in modelling are presented in Table 1.

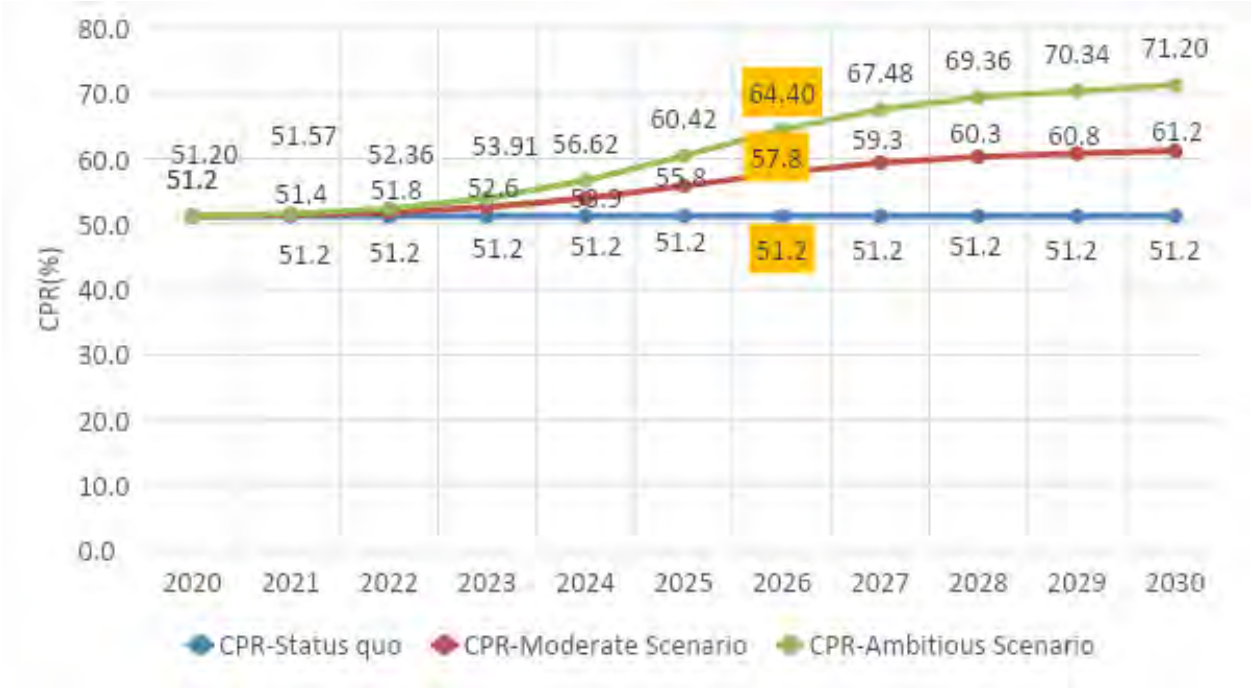
**Table 5.1 Policy targets, contraceptive prevalence rates, fertility rate and unmet need**

| | Status quo | | Moderate | | Ambitious | |
|---|---|---|---|---|---|---|
| | 2025 | 2030 | 2025 | 2030 | 2025 | 2030 |
| **CPR (%)** | 51.2 | 51.2 | 55.8 | 61.2 | 60.42 | 71.2 |
| **mCPR (%)** | 49.2 | 49.2 | 53.9 | 59.5 | 58.74 | 69.90 |
| **Fertility rate** | 4.63 | 4.55 | 4.17 | 3.57 | 3.71 | 2.59 |
| **Unmet need (%)** | 20 | 20 | 17 | 15 | 13 | 10 |

*Unmet need for Family Planning was set at 20% (2020) based on the ZDHS 2018 data.

The CPR projections by the different scenarios based on the FP-SDGs model is presented in Figure 1.

**Figure 5.1 CPR Projection by Scenario, Zambia**




**Source: FP-SDGs Model, Zambia**

The CPR associated with the status quo plateaus across the years up until 2030, whereas the one associated with the moderate scenario picks up in 2023, increasing moderately to 61.2 percent in 2030. The ambitious scenario yields a CPR of 71.2 percent in 2030. The projected mCPR and CPR benefit from the Family Planning estimation tool estimates[2] that provide probabilities of Zambia achieving them within the specified period. Table 5.2 presents a median and 95 percent confidence interval for CPR and mCPR for Zambia for the year 2020 and 2030.

[2] Bietsch, K., and Sonneveldt, E., 2019, The Maximum CPR Model: a demographic tool for family planning policy, Gates Open Research 2020, 3:1736 Last updated: 08 JUL 2020

**Table 5.2 CPR and mCPR (Median and 95% Confidence Interval**

| Indicator/ Year | | 2020 | 2030 |
|---|---|---|---|
| CPR | Married WRA | 51.8 (46.8-59.7) | 58.8 (39.8-76.1) |
| | All WRA | 37.0 (31.8-42.1) | 41.8 (29.6-53.9) |
| mCPR | Married WRA | 49.5 (42.4-57.1) | 57.5 (39.0-74.3) |
| | All WRA | 35.6 (30.6-40.6) | 41.1 (29.2-52.9) |

**Source: Bietsch, K., 2020, Zambia CPR Growth Potential**

The target CPR and mCPR are within range.

## 5.2 Assessing the Benefits of Investing in Family Planning in Zambia

### 5.2.1 The Health Sector

Zambia has recorded significant progress in the uptake of contraceptives over the past years (ZDHS, 2018). However, Zambia's total fertility rate and the consequent child dependency burden undermine the capacity of families and the Government to provide quality social services including health and education. This section reveals how investment in Family Planning would help Zambia achieve positive health outcomes and reap other substantial benefits to the health sector. These benefits could be short, medium or long- term.

The additional users of modern contraceptives will increase from 480,000 in 2019 to 562, 000 in 2020. Under the ambitious scenario, users of modern contraceptives will increase from 1.19 million in 2021 to 1.31 million in 2026, accounting for 898,906 additional users. The benefits of investing in Family Planning in the health sector are presented in Table 5.3.

**Table 5.3 Benefits of Investing in Family Planning in Zambia's Health sector (Aggregated from 2021 to 2026)**

| | Aggregated benefits (2021-2026) | | | Benefits gained compared to the status quo | |
|---|---|---|---|---|---|
| | Status quo (a) | Moderate (b) | Ambitious (c) | Moderate (d)=(b)-(a) | Ambitious (e)=(c)-(a) |
| **Unintended pregnancies averted** | 3,003,901 | 3,259,474 | 3,735,779 | 255,573 | 731,878 |
| **Unplanned births averted** | 1,679,489 | 1,822,380 | 2,088,683 | 142,891 | 409,195 |
| **Abortions Averted** | 885,300 | 960,621 | 1,100,996 | 75,321 | 215,697 |
| **Unsafe Abortions Averted** | 673,568 | 730,875 | 837,678 | 57,307 | 164,110 |
| **Maternal deaths averted** | 4,583 | 4,926 | 5,566 | 343 | 983 |
| **Child deaths averted** | 72,281 | 78,431 | 89,892 | 6,150 | 17,611 |
| **DALYs averted** | 6,380,686 | 6,920,788 | 7,927,433 | 540,102 | 1,546,747 |
| **Maternal & infant health care costs saved (US$)** | 128,392,588 | 139,316,256 | 159,674,474 | 10,923,668 | 31,281,886 |
| **Unmet Need (%)** | 20.07% | 16.77% | 13.47% | | |

**Source: ImpactNow Model; Zambia, 2020**

Teenage pregnancies continue to manifest themselves in Zambia. Many adolescents remain at risk for unplanned pregnancies despite advances in contraceptive technology, knowledge and availability of birth control options (ZDHS 2018). The use of modern contraceptive methods appears to be relatively high (41%) among teenagers who have had a live birth compared with those who had begun childbearing (34%).Teenage pregnancies result in school drop-out, diseases and deaths. The model indicates that, between 2021 and 2026, investing in Family Planning could help to prevent between 3.0 and 3.74 million unintended pregnancies.

Overall, as shown in Table 5.3, an aggregate of over 3 million unintended pregnancies will be averted between 2021 and 2026. This translates to about 731,878 more unintended pregnancies that will be prevented under the ambitious scenario compared to the status quo. On the other hand, Family Planning

investments will save maternal and infant health care costs of between US$ million 128 and 159 depending on the scenario, additionally averting over 6 million DALYs.

Rapid population growth increases the number of health professionals required to meet current health service delivery levels. More health professionals of all cadres will be required to meet the needs of a growing population. This means that more investment in critical human resources for health (training doctors, nurses, etc) and health infrastructure (building and equipping hospitals and health centers) is required.

However, with increased investments in Family Planning to increase mCPR and lower fertility rate, the number of additional health professionals to be trained and health infrastructure to be provided will reduce substantially. The country will save on the need to train an excessive number of health professionals and building of health facilities. The estimated number of health professionals and health infrastructure for Zambia is presented in Table 5.4.

**Table 5.4 Health professional and health infrastructure required**

| | Status quo | | Moderate Scenario | | Ambitious Scenario | |
|---|---|---|---|---|---|---|
| | **2025** | **2030** | **2025** | **2030** | **2025** | **2030** |
| *Doctors required* | 1,794 | 2,073 | 1,784 | 2,005 | 1,774 | 1,925 |
| *Nurses required* | 17,224 | 19,903 | 17,130 | 19,256 | 17,032 | 18,482 |
| *Health canters required* | 1,692 | 1,955 | 1,683 | 1,891 | 1,708 | 1,815 |
| *Hospitals required* | 175 | 201 | 174 | 195 | 176 | 187 |

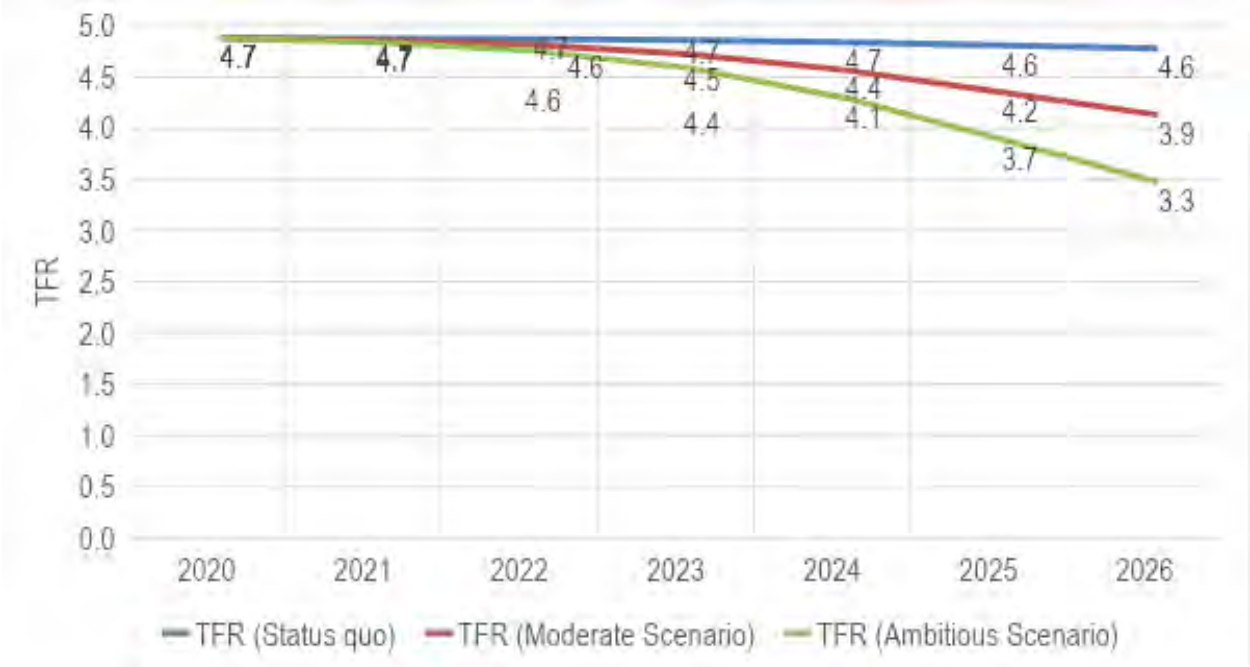
According to the Zambia Medical Council, Zambia has 800 registered doctors (2020). Under the status quo, about 2,073 doctors will be required by 2030 compared to 1,925 doctors with substantial investment in Family Planning (i.e. ambitious scenario). Similarly, in 2020, Zambia has about 24,920 nurses practising in both public and private sectors (MoH, 2020). By 2030, as shown in Table 3 over 19,903 nurses will be needed if under the status quo scenario compared with 18,482 nurses under the ambitious scenario where mCPR increases to 71.2 percent.

In addition, the MoH remains mainly in charge of setting up new healthcare infrastructure (hospitals and health centres). With higher mCPR and lower fertility, fewer hospitals and health centers will be needed compared to the numbers required to cater to a larger population when the fertility rate is high. In 2019, there were approximately 151 hospitals, 1,464 health centers and 1,053 health posts Zambia (MoH, 2018). As the population increases, Table 3 shows that about 2,156 (201 hospitals and 1,955 health centers) health facilities will be needed by 2030 under the status quo. However, substantial investment in Family Planning (i.e. the ambitious scenario), only about 187 hospitals will be required, meaning that the cost of constructing 36 hospitals and 351 health centers could be saved in 2030 if there is substantial investment in Family Planning to attain the ambitious scenario.

The total fertility rate (TFR) in Zambia is 4.7 children per woman. The TFR is lower in urban areas (3.4 children per woman) than in rural areas (5.8 children per woman). Age- specific fertility rates peak at age 20-24 (203 births per 1,000 women) and are lowest among women less than age 15 (3 births per 1,000 women) and those age 45-49 (12 births per 1,000 women) (ZDHS, 2018). The average number of children per woman declines with increasing education. Women with no education have an average of 6.4 children, as compared with 2.4 children among women with higher education. Additionally, women with the lowest wealth quintile (6.7) have almost four more children than those in the highest wealth quintile (3.0).

However, substantial investment in Family Planning (i.e. the ambitious scenario), the TFR will reduce from 4.7 in 2020 to 3.3 in 2026 as presented in Figure 2.

**Figure 5.2 Impact of increasing CPR on Total Fertility Rate, Zambia**

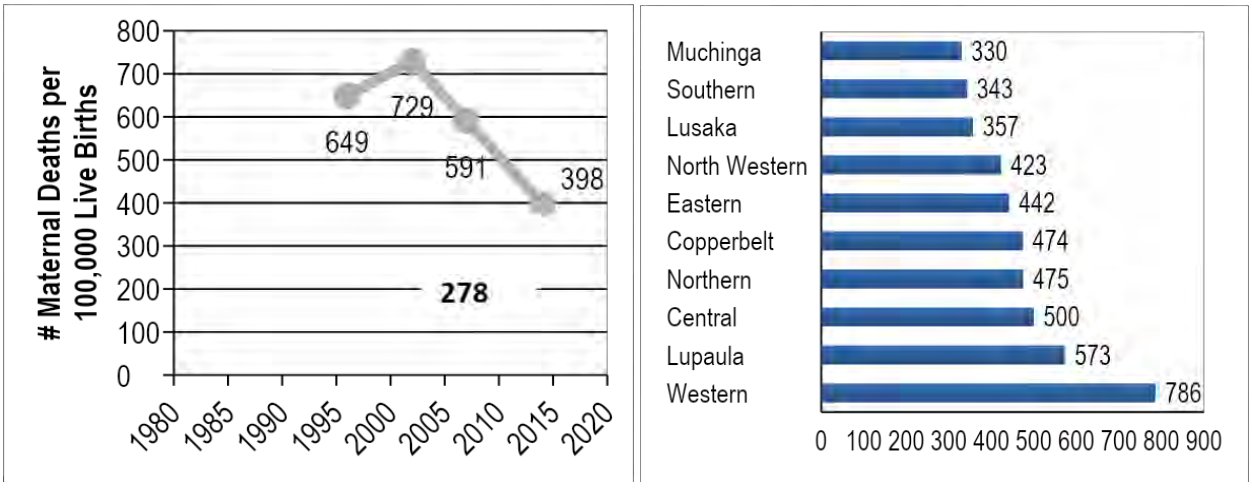



**Source: FP-SDGs Model, Zambia; 2020**

The status quo and moderated scenarios would lead to declines in TFR of 4.6 and 3.9 in 2026 from 4.7 in 2020.

In Zambia, maternal deaths are declining though there are variations across provinces as shown in Figure 5.3.

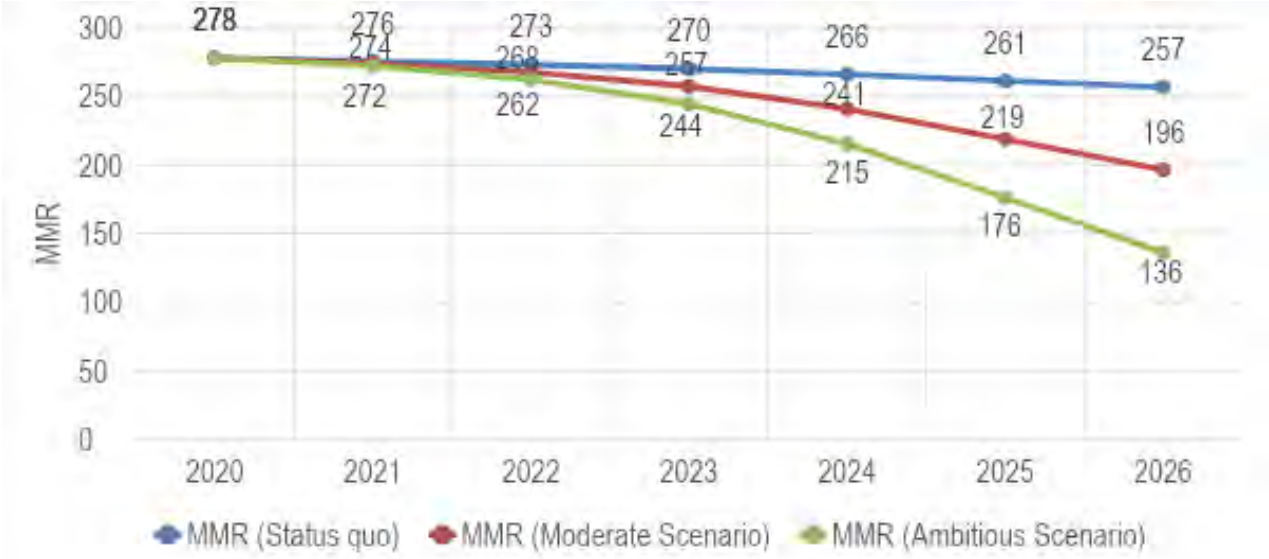
**Figure 5.3 Maternal Mortality Rate, Zambia**




**Source: Zambia Demographic and Health Survey; 2018**

The MMR has been consistently falling from an initial high of 729 per 100,000 live births in 2001-02. Western province has the highest MMR at 786, with Muchinga having the lowest. However, with more investment in Family Planning (ambitious scenario), the MMR would fall to 136 per 100,000 in 2026, compared to 257 per 100,000 and 197 per 100,000 for the status quo and moderate scenarios respectively.

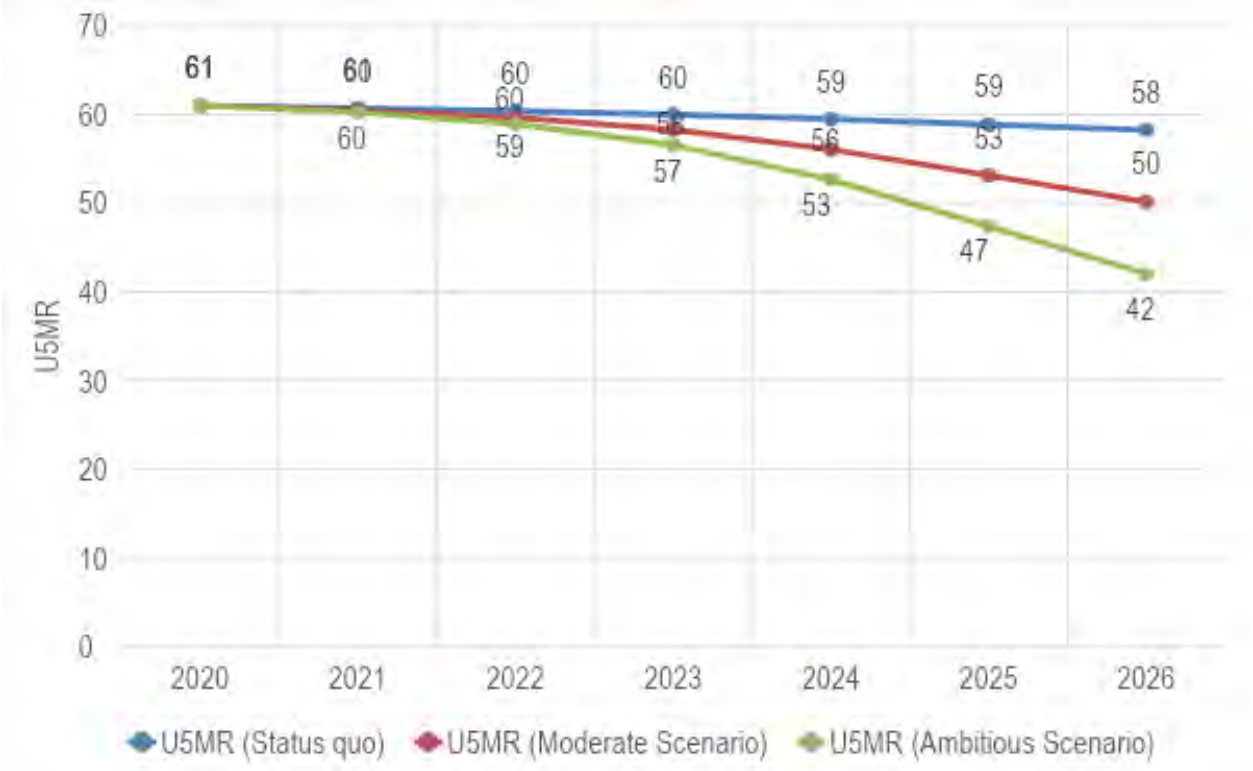
**Figure 5.4 Impact of increasing CPR on Maternal Mortality Ratio, Zambia**




**Source: FP-SDGs Model, Zambia; 2020**

Under- 5 mortality rates have declined since 1992. Currently, about 1 in 16 children in Zambia does not survive to their 5th birthday. Nonetheless, with more investment in Family Planning (ambitious scenario), the U5MR would fall from 61 to 42 per 100,000 between 2021 and 2026, compared to 58 per 100,000 and 50 per 100,000 for the status quo and moderate scenarios respectively.

**Figure 5.5 Impact of increasing CPR on Under Five Mortality Rate, Zambia**

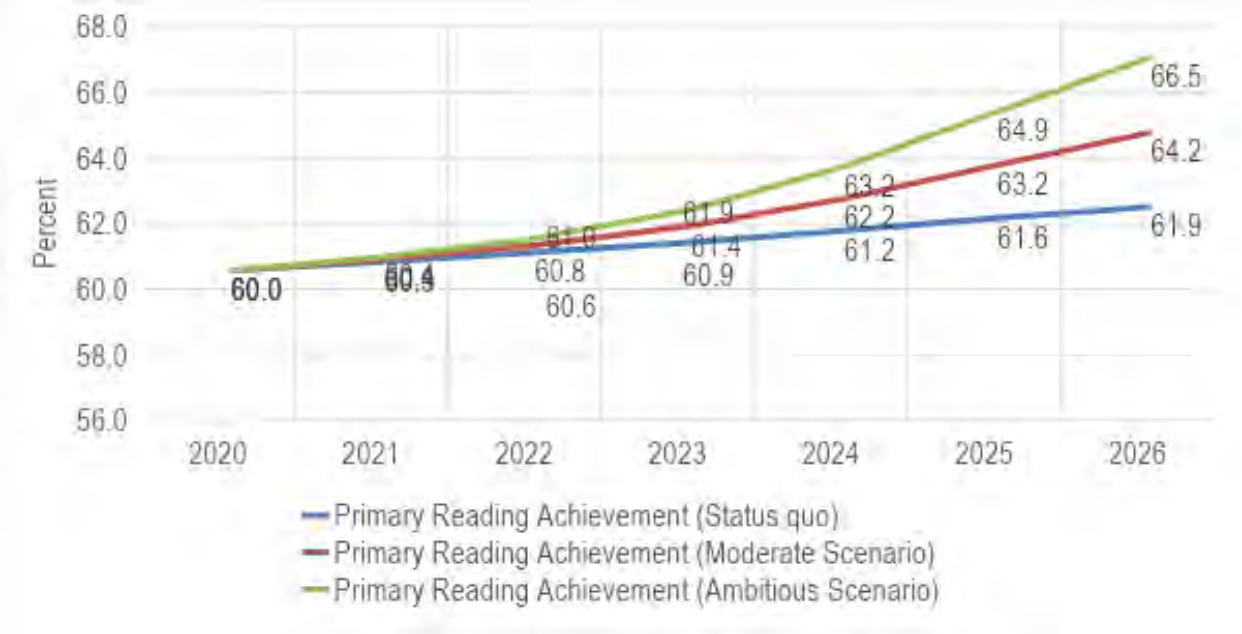



**Source: FP-SDGs Model, Zambia; 2020**

### 5.2.2 The Education Sector

The GRZ as a signatory to the Sustainable Development Goals has identified education as an essential component for development. Investment in Family Planning will significantly increase the proportion of people completing primary school who will be able to read. It was estimated that this proportion would increase to about 66.5 percent by 2026 under the ambitious scenario (Figure 5.6).

**Figure 5.6 Impact of increasing CPR on Primary School Reading Achievement, Zambia**




**Source: FP-SDGs Model, Zambia; 2020**

Marginal improvements were recorded under the status quo.

Large average family size makes it difficult for families and the Government to make requisite investments in education that are needed to develop high-quality human capital and achieve higher incomes and socioeconomic development. The number of primary schools and primary school teachers needed to educate the population will increase with rapid population growth. This translates to an increased number of primary and secondary school classrooms that need to be constructed to achieve universal primary education and also secondary education in Zambia. The estimated number of teachers and education infrastructure for Zambia is presented in Table 5.5.

**Table 5.5 Teachers and Education infrastructure required**

| | Status quo | |
|---|---|---|
| | **2025** | **2030** |
| *Primary school Teachers Required* | 84,844 | 95,366 |
| *Primary schools required* | 9,831 | 11,050 |
| *Primary school expenditure required (ZMK)* | 3,029,672,091.23 | 3,405,432,766.7 |
| *Secondary school teachers required* | 59,163 | 66,845 |
| *Secondary schools required* | 1,556 | 1,758 |
| *Secondary school expenditures required (ZMK)* | 1,749,188,965.81 | 1,976,322,723.24 |

As shown in Table 5.4, if the current population growth continues (i.e. under the status quo) over 11,000 primary school classrooms will be needed by 2030 to be able to ensure universal access to education at the primary level. However, with significant investment in Family Planning less classrooms will be required. This also applies to secondary schools and the number of teachers required.

### 5.2.3 The Infrastructure Sector

Increasing access to water and sanitation infrastructure is among the priorities of the GRZ. Improved water and sanitation have a significant impact on health outcomes, especially with communicable diseases as recognized in public health. Investments in family planning has the potential to improve coverage with safely managed sanitation (Figure 5.7).

**Figure 5.7 Impact of increasing CPR on Safely Managed Sanitation, Zambia**

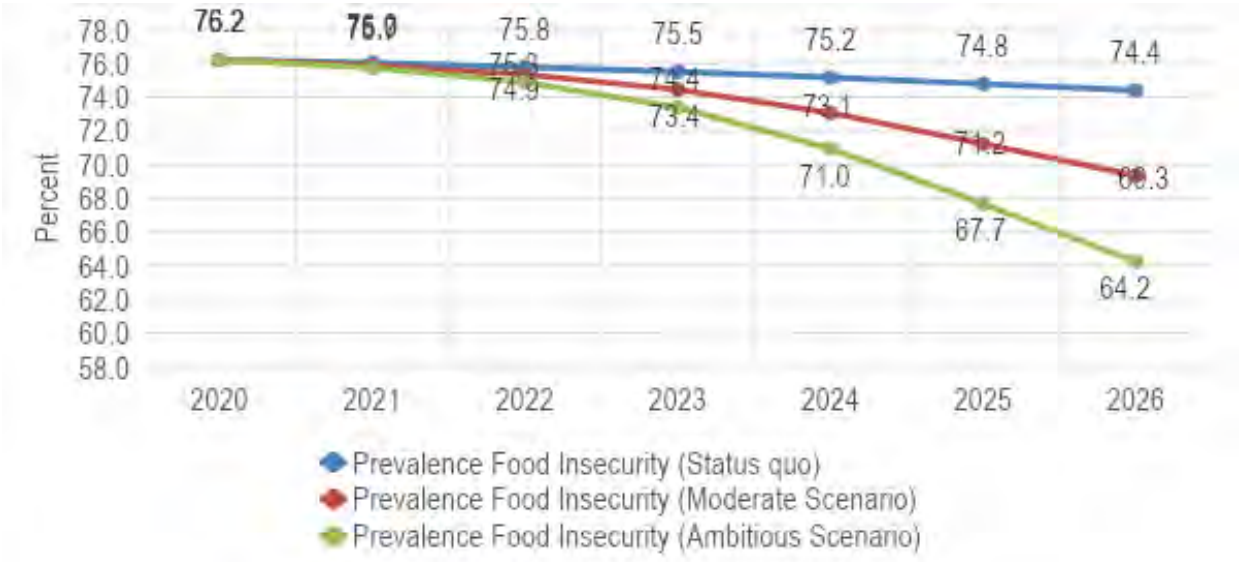

**Source: FP-SDGs Model, Zambia; 2020**

Under the ambitious scenario, coverage with safe sanitation would increase to 46.1 percent. It is modeled to worsen over time under the status quo, where coverage will increase slightly from 33 percent in 2020 to 34.9 in 2026. With substantial investment, coverage level can be increased to about 46.1 percent.

### 5.2.4 The Agriculture Sector

Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life (UNFAO, 2003). Food insecurity occurs when people do not have adequate physical, social or economics access to food. Food insecurity is particularly concerning for the poorest households. Investing in Family Planning increases food security in Zambia (Figure 5.8).

**Figure 5.8 Impact of increasing CPR on Food insecurity, Zambia**



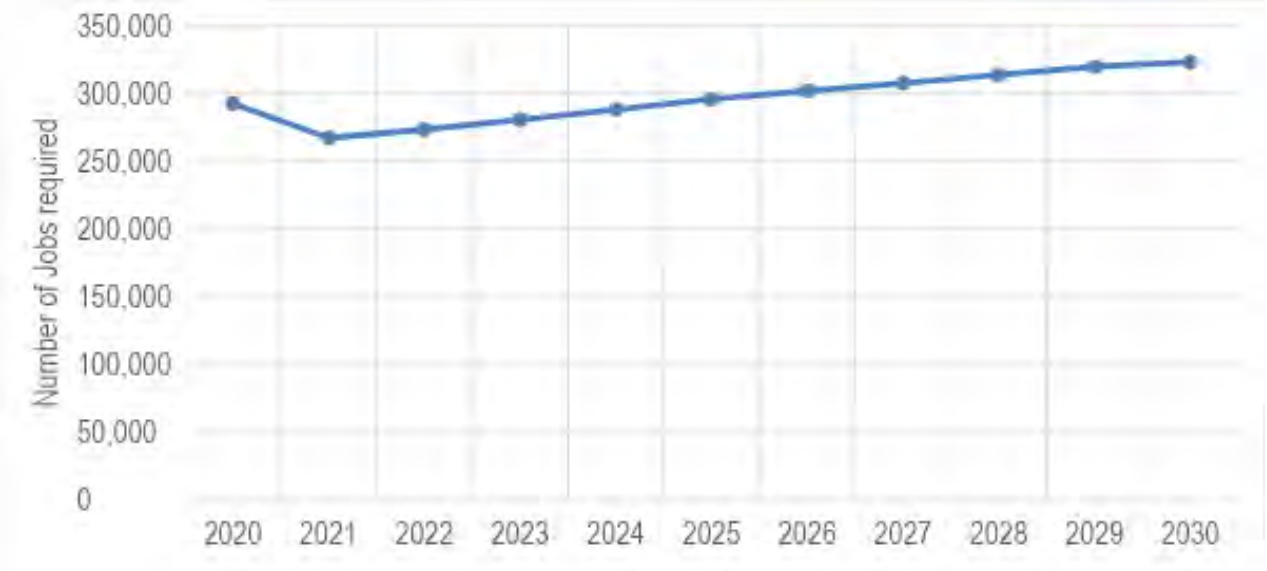

**Source: FP-SDGs Model, Zambia; 2020**

Thus, investment in Family Planning has the potentials to address these challenges especially in guaranteeing access to quality food. Under the ambitious scenario, food insecurity is reduced from 76.2 percent to 64.2 percent.

### 5.2.5 The Economy

Investment in Family Planning has a positive impact on the economy. Increasing population will mean that more jobs need to be created. This is because millions of young people will enter the labour force over the next years. Most of the new and young entrants to the labour force for the next two decades already have been born. This translates into significant savings in terms of wage bills.

**Figure 5.9 Number of Jobs Required, Zambia**

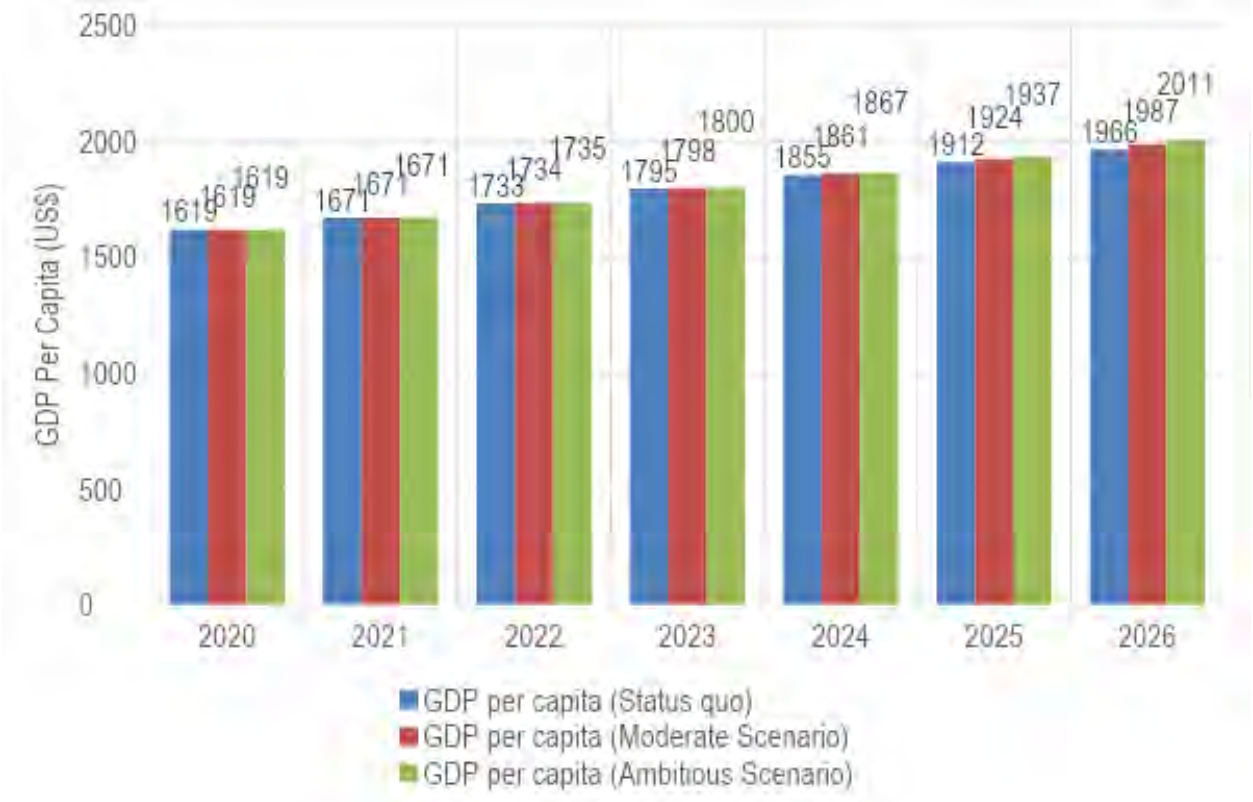



**Source: RAPID Model; Zambia, 2020**

As shown in Figure 5.9, under the status quo, about 323,038 jobs will be required by 2030 to accommodate the growth in population. However, with substantial investment in family planning, fewer jobs will be needed by 2030.

It is important to note that investment in Family Planning alone will not have a very substantial impact on economic growth unless this is accompanied by improvements in productivity and other income-generating activities. In terms of growth in real GDP per capita, Zambia will record positive impacts over time, especially with increased investment under the ambitious scenario (Figure 5.10).

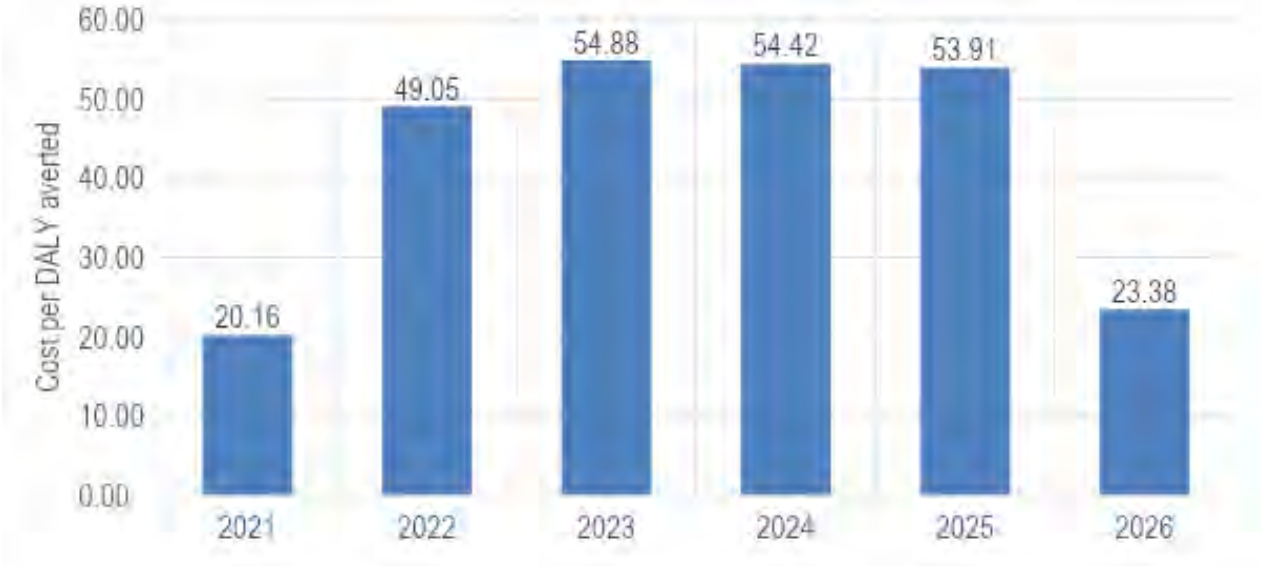
**Figure 5.10 Impact of increasing CPR on GDP per Capita, Zambia**




**Source: FP-SDGs Model, Zambia; 2020**

Cost effectiveness analysis (CEA) involves measuring and comparing costs and consequences of various interventions, revealing their relative efficiency. The only difference with cost benefit analysis is that the outcome measure is not expressed in monetary terms. Cost per DALY Averted was estimated using the results from the ImpactNow and the costs from the Costed Implementation Plan (CIP) Costing Tool developed by USAID Health Policy Plus (HP+).

**Figure 5.11 Average Cost Effectiveness Ratios for Family Planning, Zambia**




**Source: ImpactNow Model; Zambia, 2020**

The average cost effectiveness ratio (ACER) is estimated to be **US$ 20.16** for 2021, and it increases to **US$ 49.05** for 2022, further increasing to **US$ 54.88** in 2023, reducing to **US$ 54.42**, **US$ 53.91** and **US$ 23.38** in 2024, 2025 and 2026 respectively. The implication of the Cost per DALY Averted for 2021 means that a **US$ 20.16** investment in family planning will help avert **one** disability arising from maternal and child deaths (DALYs Averted). This increases to **49.05** Cost per DALY Averted in 2022, and this is mainly because the costs in 2022 and beyond will be higher attributed to increased FP programme investments costs[3]. The Cost Effectiveness Analysis reveals that Family Planning is highly cost effective in Zambia given that the average cost effectiveness ratios are more than 3 times lower than the GDP per Capita US$ 1,539.90 (World Bank, 2018) as provided for in the thresholds for the cost–effectiveness of interventions: alternative approaches (http://www.who.int/bulletin/volumes/93/2/14-138206/en/)

A review of literature search identified seven studies on cost-effectiveness of contraceptives published since 2000; one additional study was obtained from a supplemental search adding the term "couple-year protection" as an economic term. The literature on cost-effectiveness of family planning is well established, given that lending and aid for family planning has been available since at least the 1970s. Recent studies focus on the cost-effectiveness of extending benefits to under-served countries and on newer family planning methods. Four studies use cost per life-year saved, examining primarily the benefits to the mother's health from pregnancies averted; the other four use cost per CYP. The four studies focusing on mother's health (Afghanistan, India, and two from Nigeria; see Horton, Wu, and Brouwer 2015) conclude that modern contraceptives are very cost-effective in that cost per life-year saved was less than per capita gross domestic product (GDP). Additionally, findings from the Global evidence revealed that investing in RMNCAH is a smart buy, since for an additional **US$1** invested in women's and children's health, there would be **US$9** of economic and social benefits (Global Strategy for Women's Children's and Adolescent's Health 2016-2030, UN). Therefore, in the case of Zambia, the FP programme investments to be made between 2021 to 2026 amounts to US$ 248,953,679.60 yielding returns of up to US$ 2,240,583,116.4 in terms of economic and social benefits.

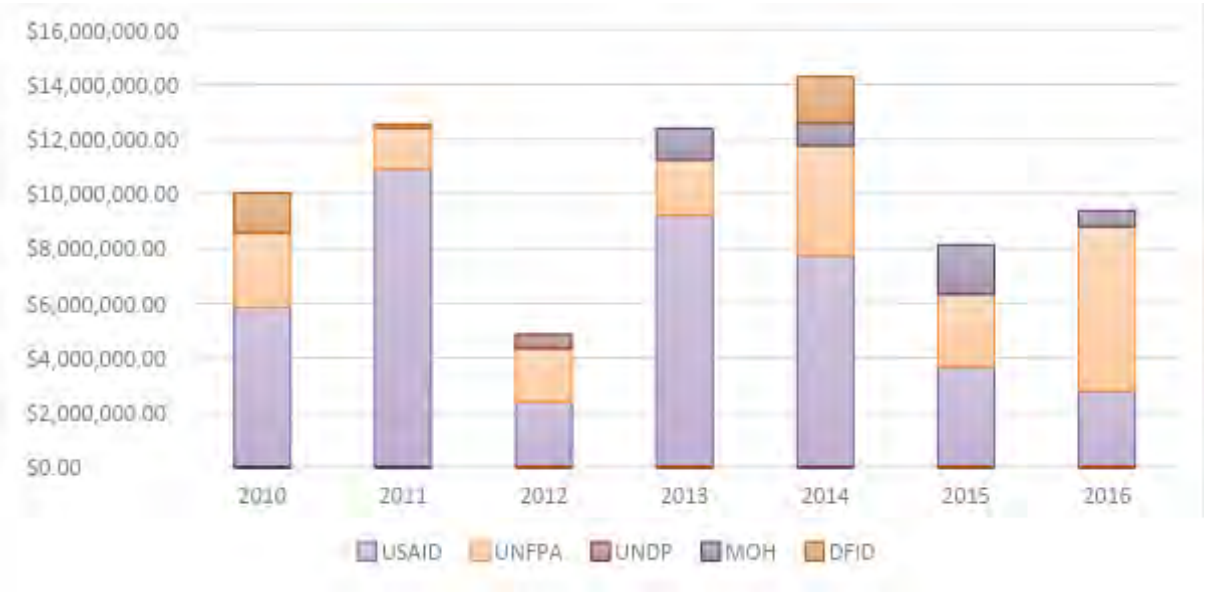
[3] Preparation of Zambia FP-CIP & Business Case 2021 to 2026 was done towards the end of 2020, hence stakeholders in the FP space had already prepared their budgets for Fiscal Year 2021

## 6.0 SUSTAINABILITY PLAN FOR FAMILY PLANNING FINANCING IN ZAMBIA

### 6.1 Family Planning Financing in Zambia

In Zambia, the Family Planning programme is funded from various sources including GRZ, non-governmental organizations, bilateral and multilateral agencies. Available data show that expenditure trends varied, among other things, by fiscal year and funder (Figure 6.1).

**Figure 6.1 Annual Family Planning Expenditures by Funder: 2010-2016, Zambia**




**Source: Mid-Term Evaluation of Zambia CIP 2013-2020**

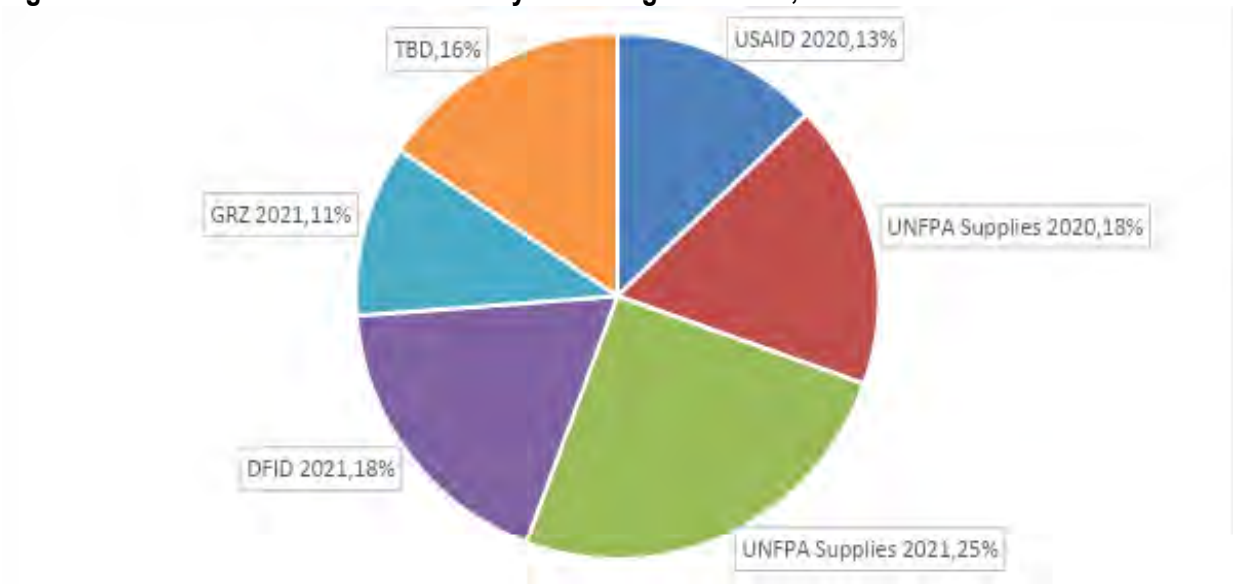
The primary source of funding for the Family Planning programme in Zambia is the cooperating partners, mainly USAID, UNFPA, UNDP and DFID. The contribution from GRZ has been low and fluctuates over time as a result of Zambia's fiscal policy position that will further weaken due to maturing debt and inadequate fiscal space (Figure 6.2).

**Figure 6.2 Family Planning Financing by Government of the Republic of Zambia**


**Source: Ministry of Health, 2020**

GRZ's financing of Family Planning has ranged between US$ 100,217 and US$ 190,210 from 2014 to 2020. The amount peaked in 2020 signaling further increments in resources from GRZ in the coming years.
FP commodities financing by source for 2020 and 2021 is presented in Figure 6.3.

**Figure 6.3 Forecasted FP Commodity Financing 2020-2021, Zambia**




**Source: Family Planning Supply Plan 2020-2021, Zambia**

Figure 6.3 shows that the FP commodities budget for 2020 and 2021 is mainly supported by cooperating partners, with GRZ providing 11 percent of financing.

To increase the sustainability and national ownership of the FP programme in Zambia, substantial domestic resources will be required to fill the financing gap that is imminent as the effects of COVID 19 and associated economic downturn takes toll on the revenue generation capacity of cooperating partner countries. Zambia could introduce earmarked taxes to raise necessary revenue to finance Family Planning among others.

## 6.2 Commitments from Ministry of Health, Cooperating Partners and Donors

The process of development of the Zambia Integrated Family Planning Costed Implementation Plan was participatory and involved family planning stakeholders (See Annex IV and V). The Zambia FP-CIP was costed and the cooperating partners and donors together with the Ministry of Health were approached to provide their financing commitments. The financing commitments that were made are summarised in Table 6.1.

**Table 6.1 Family Planning Financing Commitment and Funding Gap (US$)**

| S. No | MOH/Cooperating Partner/ Donor | Amount Committed (US$) | | | | | | Total Commitments |
|---|---|---|---|---|---|---|---|---|
| | | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1 | MoH | 59,471.00 | 63,323.00 | 65,280.00 | | | | 188,074.00 |
| 2 | NHIS | | | | | | | |
| 3 | FCDO ( DFID) | 3,500,000 | | | | | | 3,500,000 |
| 4 | USAID | | | | | | | |
| 5 | SIDA | | | | | | | |
| 6 | CHAI | 300,000.00 | | | | | | 300,000.00 |
| 7 | WB/GFF | | | | | | | |
| 8 | Global Fund | | 200,278.00 | 267,987.00 | | | | 468,265.00 |
| 9 | MSL (DRF) | | | | | | | |
| 10 | UNFPA | 9,000,000.00 | 6,500,000.00 | 6,000,000.00 | | | | 21,500,000.00 |
| 11 | WHO | | | | | | | |
| 12 | CHAZ | | | | | | | |

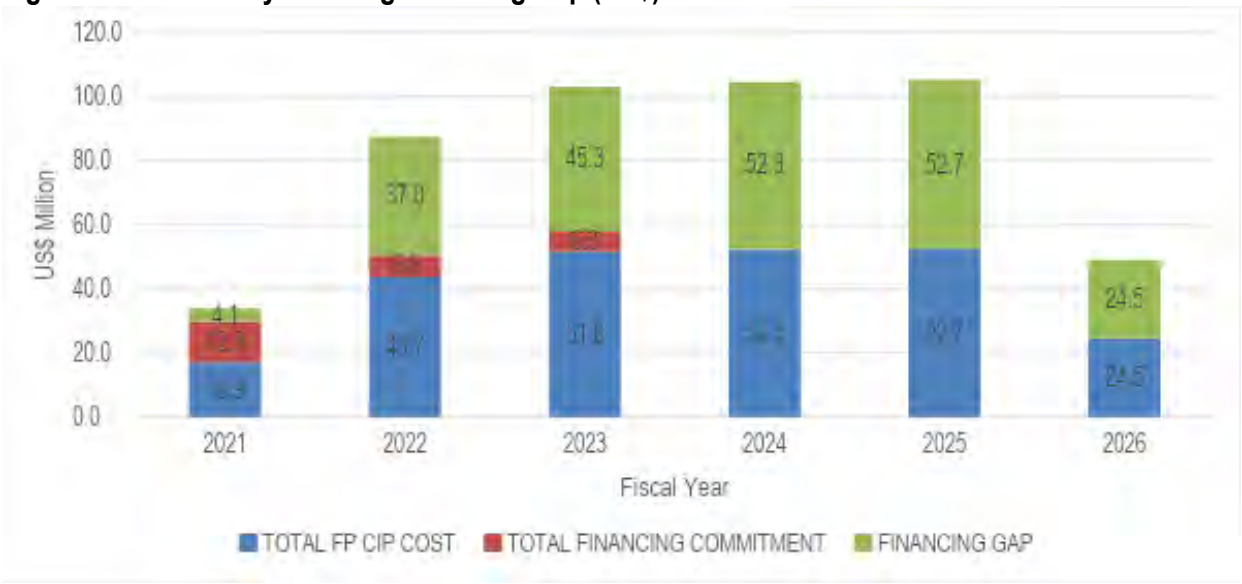
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | TOTAL COMMITMENT | 12,859,471.00 | 6,763,601.00 | 6,333,267.00 | | | | |

The total commitment as per Table 6.1 was US$ 12,859,471 for 2021, US$ 6,763,601 for 2022 and US$ 6,333,267 for 2023. More commitments are expected including for periods where no commitments were made.

## 6.3 Family Planning Financing Gap

The financing gap is based on the difference between the financing commitment and the cost for the particular year as per the Zambia Integrated Family Planning Costed Implementation Plan and Business Case 2021 to 2026. The estimated financing gap is presented in Figure 6.4.

**Figure 6.4 Family Planning Financing Gap (US$)**




The Family Planning Financing gap is estimated to be US$ 4.1 million in 2021, US$ 37 million in 2022, US$ 45.3 million in 2023, US$ 52.3 million in 2024, US$ 52.7 million in 2025 and US$ 24.5 million in 2026.

## 6.4 Funding Options for FP Programme in Zambia

Several financing options exists for Zambia's Family Planning programme.

### 6.4.1 Matching Funds with Cooperating Partners and Donors

The other financing mechanism that would guarantee sustainability of FP programme in Zambia over the period of the FP-CIP and Business Case 2021-2026 is introduction of matching funds based on a memorandum of understanding (MoU). The Ministry of Health and cooperating partners such as FCDO (formerly DFID), USAID can enter into a matching fund agreement that will also improve accountability and national ownership. For example, the matching ratios may include 1:1.5 for 2022, 1:1 for 2023, 1:0.5 for 2024. The graduated input on the cooperating partners' side speaks to national ownership of family planning financing and sustainability beyond 2026.

### 6.4.2 Global Financing Facility

The Family Planning programme can utilize resources from the Global Financing Facility (GFF), since FP investments achieve results and also support achievement of SDGs as presented in the business case. GFF was established to close the financing gap for reproductive, maternal, newborn, child, and adolescent health and nutrition. GFF is a mechanism that uses modest amounts of grant resources catalytically, bringing programs to scale by leveraging far great sums of domestic government resources, IDA and IBRD financing, aligned external financing, and resources from the private sector. GFF emphasizes smart financing, getting

more value for money from each of these sources by improving efficiency. With GFF, Zambia will reduce its reliance on cooperating partners to finance Family Planning by progressively replacing it as the financing source needed to improve the health of women, children, and adolescents.

### 6.4.3 Total Market Approach

The Total Market Approach (TMA) for FP would ease the burden on the government for financing and delivery of Family Planning services and programming. Discussions around a TMA for contraceptives in Zambia kicked off early 2017 under the leadership of the Ministry of Health. The TMA Landscape Assessment Team published a report in 2017 revealing that mid-market commercial condom brands were available and gaining popularity (ZMK 7-15), indicating opportunity for commercial market growth among consumers in upper wealth quintiles. This would also apply to other FP commodities. The strength of the social marketing program built a strong urban market accustomed to private sector sourcing of condoms where 60 percent of condom users across all wealth quintiles sourced condoms from the private sector. It was reported that Maximum was the market leader in urban areas. This presents an opportunity for Zambia to grow the market for FP contraceptives starting with male condoms.

### 6.4.4 National Health Insurance Scheme

Over the past two years, GRZ has been preparing to launch its first-ever National Health Insurance Scheme (NHIS) as a key step toward UHC. One of the foundational components of this policy reform was deciding which services, medicines, supplies, and facilities the health insurance scheme would cover at primary through tertiary facilities nationwide. The Universal Health Coverage (UHC) benefits package covers contraceptive pills, implants, injectables, intrauterine devices (IUDs), and emergency contraception. As the government implements coverage through a nationwide health insurance scheme, Zambian women will receive covered family planning methods for free at all accredited facilities in the program. This would work for FP financing if the resources for FP commodities and services are ring-fenced.

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## ANNEX I IMPLEMENTATION PLAN

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|---|---|---|---|---|---|---|
| **THEMATIC AREA 1: Enabling Environment** | | | | | | |
| **OUTCOME1: Mobilize adequate and sustainable financial resources from various sources to fulfil requirements of the FP program** | | | | | | |
| **OBJECTIVE: To increase allocation and diversify sources of FP funds including core funds from GRZ** | | | | | | |
| **Strategic Issue** | **Expected Results** | **Key Activities** | **Sub-Activities** | **Output Indicator** | **Timeline** | **Responsible** |
| EE1. Establishment of a contraceptive revolving fund | Independent centralised FP funding mechanism in place | EE1.1. Advocate for establishment of FP fund leveraging on The Zambia Medicines and Medical Supplies Agency Act, 2019, Section 22(2)(a) | EE1.1.1. Conduct buy-in meetings with GRZ, Zambia Medicines and Medical Supplies Agency (ZMMSA), donors and cooperating partners for the establishment of FP revolving fund | Number of meetings held | 2021 | MoH/ Partners |
| | | | EE1.1.2. Develop partnership framework for FP revolving fund | Partnership framework developed | 2021 | MoH/ Partners |
| | | | EE1.1.3. Establish the FP revolving fund | FP revolving fund established | 2022 | MoH/ Partners |
| | | | EE1.1.4. Mobilize seed capital from GRZ, donors, cooperating partners and existing facilities such as GFF | Proportion of FP commodity budget funded through the FP revolving fund | 2022 | MoH/Partners |
| EE2. Mobilization of resources for FP programme | Increased resources for FP programming | EE2.1. Develop and implement advocacy tools for increased FP funds, transparency and accountability from Ministry of Health, Ministry of Finance, donors and Cooperating partners | EE2.1.1. Develop an advocacy strategy for FP programme financing | Advocacy strategy developed | 2021 | MoH/ Partners |
| | | | EE2.1.2. Mobilize funds from donors, cooperating partners and existing facilities such as GFF to fill funding gap | Proportion of FP funds received from donors and cooperating partners | 2021 | MoH/ Partners |
| | | | EE2.1.3 Implement the advocacy strategy in collaboration with Civil Society Organizations and Partners | Implementation Report | 2022-2026 | MoH/ Partners |

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| EE3. Stewardship and implementation of a TMA | Enhanced equity in provision of FP commodities through market segmentation | EE3.1. Conduct and disseminate TMA studies on FP and ways of improving FP market | EE3.1.1. Conduct and disseminate FP market segmentation analysis | Market segmentation analysis adopted and used to inform decisions | Annually | MoH, Partners |
| | | | EE3.1.2. Disseminate willingness to pay for FP studies | Willingness to pay for FP study report disseminated | 2021 | MoH, Partners |
| | | | EE3.1.3 TMA modelling | TMA Model for Zambia | 2021 | MoH, Partners |
| | | EE3.2. Conduct a comprehensive review of policies, strategies, and actions that contribute to market distortions and inefficiencies | EE3.2.1. Review of policies, strategies and actions that contribute to market distortions and inefficiencies | FP policy landscape analysis report | 2021 | MoH, Partners |
| | | | EE3.2.2. Hold meetings to disseminate briefs on strategies | Policy briefs developed and disseminated | 2021 | MoH, Partners, DHMT |
| | | EE3.3. Develop, implement and monitor policies and strategies that enhance TMA | EE3.3.1. Revise policy that allows private sector access free commodities | Copy of revised FP policy | 2021 | MoH |
| | | | EE3.3.2. Develop a transition plan from free supplies to for-pay products through a phased approach | Copy of Transition plan developed | 2021 | MOH |
| | | | EE3.3.3 Pilot TMA in selected districts | Numbers of subsidized products sold to richer women. | 2022-2023 | MOH, Partners, DHMT |
| EE4. Establishment of risk pooling mechanisms | Contraceptives and FP services included in health insurance schemes | EE4.1Build rationale for inclusion of full contraceptive method mix in insurance schemes packages (for National and Private Health Insurance) | EE4.1.1. Develop an investment case for insurance companies to include full contraceptives method mix in the insurance schemes | Investment case developed | 2021 | MOH, Partners |

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| | | EE4.2. Advocate for inclusion of FP services and contraceptives in private insurance schemes | EE4.2.1. Convene consultative meetings with Zambia UHC Team and private sector insurance stakeholders to discuss and plan for inclusion of FP full method mix in the cover | Number of FP methods included in UHC and private insurance covers | 2021 | MOH, Partners |
| **OUTCOME 2: Adopt and implement policies that improve equitable and affordable access to high- quality FP services and information** | | | | | | |
| **OBJECTIVE: To strengthen evidence base for effective programme implementation through research and information dissemination** | | | | | | |
| **Strategic Issues** | **Expected Results** | **Key Activities** | **Sub-Activities** | **Output Indicator** | **Timeline** | **Responsible** |
| EE5.Implementation of evidence-based FP advocacy, programming and service delivery | Evidence through operational research, to promote programming is generated | EE5.1 Develop and promote a national FP research agenda | EE5.1.1 Engage a consultant to develop the FP national research agenda | National research agenda is developed | 2021 | MoH |
| | | | EE5.1.2 Disseminate the research agenda nationally | Number of districts aware of national research agenda (117 Districts) | 2021 | MoH |
| | | EE5.2. Implement research on key FP issues | EE5.2.1 Conduct research on aspects of policy that require review e.g., population policy for resources allocation; provision of FP by community-based distributors (CBD); TMA, etc | Number of studies conducted | 2021-23 | MoH/MoE/ |
| | | | EE5.2.2 Conduct research on aspects that promote FP service uptake and delivery e.g., contraceptive use among various populations; CSE in and out of Schools, Adolescents and Contraception | Number and type of studies on FP service delivery | 2021-22 | MoH |
| EE6. Utilization of data to track and inform progress in FP programming | Use of data to track progress in FP is strengthened at all levels | EE6.1. Collect HMIS data on FP indicators | EE6.1.1. Conduct DHIS2 mentorship and refresher trainings for FP coordinators and HMIS officers | Number of FP coordinators trained (target: 117); number of HMIS officers trained (target: 117) | 2021-26 | MoH/ Partners |

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| | | | EE6.1.2. Disseminate FP reports | Number of FP reports disseminated (target: 1 per year) | 2021-26 | MoH/ Partners |
| | | EE6.2. Implement social accountability mechanisms, such as community scorecards, citizen report cards, and social audits to engage clients to provide feedback on the quality of FP services | EE6.2.1 Conduct bi- annual national-level monitoring and data validation for FP and develop FP-specific scorecards | FP- specific scorecards developed | 2021 | MoH/Partners |
| | | EE6.3. Support FP learning opportunities | EE6.3.1 Disseminate FP best practices during national FP meeting | National FP meeting held | Annually | MoH/ Partners |
| | | | EE6.3.2 Assess FP programme periodically, including at mid and end-term to inform future FP activities and programming. | Reviews conducted | 2021-26 | MoH/Partners |
| EE7. Performance management systems effectively monitor and support FP service providers | The performance management system is operationalised | EE7.1 Operationalise the performance management system for FP health care workers | EE7.1.1 Evaluate current performance management system to identify gaps and challenges and the barriers to implementation | Current performance management system evaluated | 2021 | MoH |
| | | | EE7.1.2 Review current supervision and monitoring tools | Supervision and monitoring tools reviewed | 2021 | MoH |
| | | | EE7.1.3 Train CHAs and health facility managers on supervision and monitoring | Number of CHAs and health facility managers trained on supervision and monitoring | 2022-2026 | MoH |
| **OUTCOME 3**: **Strengthen the stewardship, management, and coordination capacity of the GRZ for FP at all levels (national and sub-national) and across sectors** | | | | | | |
| **OBJECTIVE: To strengthen stewardship and create an enabling environment for FP CIP implementations** | | | | | | |
| **Strategic Issue** | **Expected Results** | **Key Activities** | **Sub-Activities** | **Output indicator** | **Timeline** | **Responsibility** |

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| EE8. Strengthening stewardship of the national FP agenda | Management capacity of MoH/RMNCHN is built around implementation of its FP mandate | EE8.1 Develop and institutionalize transparent and comprehensive FP resource tracking information system to provide timely information to national MOH, provinces, districts and stakeholders on financing requirements, expected inputs, funding gaps, and actual disbursements | EE8.1.1 Disseminate ZamStats Reports on FP resource tracking for evidence-based planning and budgeting, including for budget analysis and tracking studies | Training conducted | 2021 | MoH |
| | | | EE8.1.2 Develop (& monitor) annual work plans at National, Provincial and District level guided by the National Health Sector Strategic Plans | Annual work plans developed | 2021-2026 | MoH |
| | | EE8.2 Orient and support CBDs on stewardship for FP | EE8.2.1 Train and supervise CBD officials on leadership of FP programme | Number of districts with at least 80% of DHMT members supported on strategic leadership | 2021-2026 | MoH |
| EE9. Implementation of appropriate systems for FP governance | Regulatory and legal functions in place | EE9.1 Lobby Parliament for development of specific laws on FP | EE9.1.1 Hold bi-annual meetings with National assembly | number of meetings held | 2021-2026 | MoH |
| | | | EE9.1.2 Draft FP specific bills e.g., | Drafts completed | 2023 | MoH |
| | | EE9.2 Mainstreaming special needs population in policies, regulations, norms and standards, planning and M&E | EE9.2.1 Develop District FP Strategic Plans with special needs groups analysis incorporated | District FP Strategic Plans developed | 2021 | MoH |
| | | EE9.3 Build capacity in social accountability approaches at CBDs, health facilities & community levels | EE9.3.1 Train/orient (stakeholders, CBDs, facility staffs, community units) on Social Accountability guidelines | Trainings conducted | 2021-26 | MoH/ Partners |

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| EE10. Consolidation of FP partnership arrangements | An inter-agency coordination council (ICC) mechanism is strengthened | EE10.1Establish and operationalize FP- ICC committee at national level | EE10.1.1. Create and structure partnerships based on the National importance of Family Planning | Partnership structure created | 2021 | MoH |
| | | | EE10.1.2. Constitute committees and sub-committees on a need basis to address inter-ministerial coordination and the private sector | At least 2 committees and sub-committees constituted annually | 2021-26 | MoH |
| | | | EE10.1.3. Undertake capacity building of stakeholders to improve capacity to engage in effective collaborations | Stakeholders trained | 2021 | MoH |
| | | | EE10.1.4 Form a coordination forum to enhance policy dialogue between the public and private sector stakeholders at national and sub-national levels | Forum membership defined | 2021-2023 | MoH |

| **THEMATIC AREA 2: Demand creation** | | | | | | |
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| **OUTCOME: Improved demand among populations with high unmet need for modern contraception through a right-based approach** | | | | | | |
| **OBJECTIVE: To improve sexual and reproductive health care seeking behaviour among populations with high unmet need for modern contraception** | | | | | | |
| **Strategic Activity** | **Expected Results** | **Key Activities** | **Sub-Activities** | **Output indicator** | **Timeline** | **Responsibility** |
| DC1: People have accurate knowledge and self-efficacy to adopt a positive behavioural change to practice FP | FP communications strategy in place | DC 1.1. Implement & monitor Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Communication and Advocacy Strategy 2018-2021 to increases acceptability of FP by all target populations | DC 1.1.1 Produce standard communication materials that are specific for the different FP users (adolescents, couples, divorcees etc) for use by all stakeholders (soap episodes, print media, social media, digital and FM media, mass mobile text messages, etc) | Communication materials produced | 2021-2022 | MoH/ Partners |
| | | | DC 1.1.2 Monitor implementation of the Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Communication and Advocacy strategy (bi-annually) | Bi-annual Monitoring Report | 2022-2026 | MoH |

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| | | DC 1.2. Address myths and misconceptions around modern contraceptives | DC 1.2.1 Train and deploy group of FP champions in each District to address myths and misconceptions | FP champions trained, No. of outreaches conducted | 2022-2024 | MoH/Partners |
| | | | DC 1.2.2 Evaluate the impact of messaging on myths and misconceptions | Evaluation conducted | 2022 | MoH |
| DC 2. Adaptation of a multi-sectoral/stakeholder approach in provision of accurate and consistent information on FP to communities | Multiple stakeholders promote FP in their communities | DC 2.1. Identify, engage and support diverse stakeholders to back use of modern contraception within communities | 2.1.1 CBDs identify and engage couples, youths and adolescents who support the use of modern contraception within villages | Number of couples identified and supported | 2021-2026 | MoH/ partners |
| | | | 2.1.2 FP coordinators engage traditional/religious leaders to promote FP in their communities | Number of religious and cultural leaders sensitized | 2021-2026 | MoH/ Partners |
| | | | DC 2.1.3. FP coordinators to support adolescents and youth to promote FP among peers | Number of ToTs trained | 2021-2026 | MoH/ Partners |
| | | | DC 2.1.4. National FP TWG to identify and engage prominent personalities to promote FP as champions: (e.g., musicians, artists, politicians, sports personalities). | Type and number of personalities identified and supported | 2021 | MoH |
| | | DC 2.2 Enlist support of different sectors to promote FP | DC 2.2.1. Engage other Ministries'( e.g., Education, Agriculture, Environment) community workers/ frontline workers for FP promotion | Number of community workers engaged for FP promotion | 2021 | MoH |
| | | | DC 2.2.2. District FP coordinators to conduct bi-annual supportive supervision trips to the other Ministries' frontline workers | Number of support supervision trips conducted | 2021-2026 | MoH |

**THEMATIC AREA 3: Service delivery**

| **OUTCOME: Increased access and utilization of quality FP services by all population segments through a right based approach** | | | | | | |
|---|---|---|---|---|---|---|
| **OBJECTIVE: To increase access and utilization of quality family planning services by all population segments** | | | | | | |
| **Strategic Activity** | **Expected Results** | **Key Activities** | **Sub-Activities** | **Output indicator** | **Timeline** | **Responsibility** |
| SD1. Provision of high-quality right-based FP services to FP clients | Quality of FP services for clients are enhanced | SD 1.1 Health care workers (HCW) capacity is built around rights to FP information and services, including availability, accessibility, quality, equity, non-discrimination and informed choice | SD 1.1.1 Train health care workers on the rights of clients | Number of HCWs trained and refreshed on client's rights | 2021-2026 | MoH/Partners |
| | | | SD.1.1.2 Introduce new methods to improve on FP methods choice for Clients | Number of new FP methods offered | 2021-2026 | MoH/Partners |
| | | | SD.1.1.3 Develop and implement mentoring programmes on effective provision of FP services including LARCs for HCW | Mentoring Programme | 2021-2026 | MoH/Partners |
| | | | | Number of HCWs in mentoring Programme | 2021-2026 | MoH/Partners |
| | | | SD 1.1.4. Quality assurance teams (National, Provincial and District) to conduct follow-up supervision visits | Number of quality assurance supervision trips conducted | 2021-2026 | MoH /Partners |
| SD2. Reduction of unmet FP needs for adolescents, youth, People Living with Disabilities (PLWD) and those in underserved areas | Increased access to quality FP services adolescents, youth, PLWD and in those in underserved areas | SD 2.1 Strengthen health care workers' (HCWs) capacity on provision of services to adolescents, youth, PLWD and those in underserved areas | SD 2.1.1. Train/ re-train HCWs on provision of services to adolescents, youth, PLWD and those in underserved areas | Report on training needs for HCWs on special needs population | 2021 | MoH /Partners |
| | | | SD 2.1.2 Initiate outreach services targeting adolescents, youth, PLWD and those in underserved areas | Report on Outreach services | 2021-2026 | MoH/ Parters |
| | | | SD 2.1.3. Train FP coordinators and District health department officers on supervision & monitoring of health care workers | Number of people trained | 2021/22 | MoH /Partners |

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| | | | SD 2.1.4 FP coordinators and District health department officers to conduct quarterly supervision visits to facilities | Number of supervision visits | 2021-2026 | MoH /Partners |
| | | | SD 2.2.2. Design and implement FP information materials and service delivery infrastructure for adolescents, youth, PLWD and those in underserved areas (e.g., YF centres, specialised equipment and facilities for PLWD and those in emergency situations; strategies for underserved areas e.g., mobile outreaches) | Number and type of materials/infrastructure developed | 2021-2026 | MoH/partners |
| | | | SD 2.2.3. Train/recruit additional HCWs to provide FP services to youth, adolescents, PLWD and in underserved areas | Number of additional HCWs trained | 2021-23 | MoH/partners |
| SD3. Expand and adequately train health care providers to offer high quality FP services including LARCs | Human resources and skills to provide FP services and information are strengthened at all levels of providers | SD 3.1 Train and support different cadres of health workers on FP provision | SD 3.1.1 Train CBDs and Community CHAs on provision of information on the full method mix and to provide clients with the FP method of their choice, within the context of their service provision guidelines | Number of CBD trained | 2021-20 | MoH /Partners |
| | | | SD 3.1.2. Nurses Association to train retired midwives (at least 1 for every 2 facilities) to provide FP information and services, including pills, condoms, implants, and injectables to the community | Number of retired nurses oriented on FP | 2021-26 | MoH/ Zambia Nurses Association |
| | | | SD 3.1.3. District FP coordinators and representative from nurses association to provide quarterly supportive supervision for mid-wives & monthly support for CBDs | Number of supervisory visits conducted | 2021-2026 | MoH/ Zambia Nurses Association |

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| | | | 3.1.4 Introduce FP pre-service practical skills for nurses | Internship mandate implemented | 2021-2026 | MoH |
| SD 4. Integrate FP services into other health services | FP services are integrated into other services[4] | SD4.1 Disseminate the national FP integration protocol | SD4.1.1 Conduct integration studies to inform challenges with the roll out of FP integration protocol | Integration studies conducted and harmonised | 2021 | MoH/ Partners |
| | | | SD4.1.2 MoH to support integration of FP with other services | Integration support provided | 2021 | MoH |
| | | | SD4.1.3 Train Facility In charges and FP coordinators on integration protocol | Number of FP coordinators trained per District | 2021 | MoH |
| SD5. Establishment of partnerships with the private sector for FP service provision | Coverage of quality FP services through private sector stakeholders is increased | SDA 5.1 Enhance capacity of private sector actors in provision of quality FP services (Pharmacies, Chemists, Labs) | SD 5.1.1 FP coordinators to identify suitable private sector partners including chemists and pharmacies | Private sector actors mapped out | 2021-22 | MoH |
| | | | SD 5.1.2 Train private sector stakeholders identified on providing quality FP information and services including LARCs | Number of stakeholders trained | 2022-23 | MoH/Partners |
| | | | SD 5.1.3 MoH to conduct bi-annual supervision visits to monitor private sector FP service provision | Number of field visits | 2022-26 | MoH |

| **Thematic Area 4: Commodity Security** |
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[4] STI screening, treatment, and care,• Immunisation, • Infant and young child feeding and malnutrition programmes• Routine childhood vaccination • Cancer screening Cervical cancer screening • Antenatal care (FP counselling only) • Postnatal care • Postpartum care

| **Outcome: Have adequate amounts of a range of commodities available at service delivery points: facilities, communities, and outreach settings** | | | | | | |
|---|---|---|---|---|---|---|
| **Objective: To increase availability of quality FP commodities** | | | | | | |
| **Strategic Issue** | **Expected Results** | **Key Activities** | **Sub Activities** | **Output Indicator** | **Timeline** | **Responsible** |
| CS 1. Strengthening last mile delivery | National, Sub-national and district FP supply chains aligned to Service Delivery Points (SDPs) | CS1.1 Review FP Supply Chain system design | CS1.1.1. Review existing supply chain system and advise on system redesign (&develop an implementation plan) | Recommendations for new FP supply chain system ; Implementation plan for FP supply chain system redesign | 2021 | MoH, Partners, DHMT |
| | | | CS1.1.2. Review contraceptive reporting system to incorporate data from the government, NGO, and private sector and to ensure reporting requirements are streamlined | Number of consultative meetings held | 2021 | MoH, Partners, DHMT |
| | | | CS1.1.3 Review and update FP dashboard (visuals and analytics) | Number of consultative meetings held | 2021 | MoH, Partners |
| | | | CS1.1.4 Train FP managers, FP coordinators, pharmacists and data managers on using FP reporting system and dashboard as well as use of analytics and visualization to make strategic and operational decisions | Number of FP managers, FP coordinators, pharmacists and data managers on using FP reporting system and dashboard as well as use of analytics and visualization | 2021 | MoH, Partners |
| | | CS1.3. Coordinate FP stakeholders at Sub-national, district and SDP levels | CS.1.3.1. Hold meetings with FP stakeholders to discuss and agree on a coordinated FP supply chain | Coordinated FP supply chain system defined and agreed upon. | 2021 | MoH, Partners, |
| | | | CS 1.3.2 Hold quarterly Inter Agency Coordination Committee (ICC) meetings | Minutes of ICC meetings | 2021-2026 | MoH, Partners |
| CS 2. Strengthening contraceptive forecasting and supply planning | Data are available on contraceptive commodity usage and used to accurately forecast | CS2.1. Audit FP stock status at all levels of supply chain **(**Both Public and Private sector stocks) | CS2.1.1. Undertake FP stocks Gap analysis at all levels of supply pipeline | FP stocks Gap analysis report | 2021 | MoH, Partners |

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| | commodity quantities for procurement | CS2.2. Build capacity of FP Coordinators at district on forecasting and supply planning | CS2.2.1. Train national, provincial and District level FP Coordinators on quantification of FP commodities | Number of national, provincial and district level FP and health managers trained on quantification of FP commodities | Annually | MoH, Partners, DHMT |
| | | CS2.3. Conduct annual forecast and semi-annual reviews of contraceptive forecast, supply plan and procurement plan | CS2.3.1. Conduct annual quantification for FP commodities | FP quantification report | Annually | MoH, Partners, DHMT |
| | | | CS2.3.2. Review FP supply plans | Updated supply plan report | Semi annually | MoH, Partners, DHMT |
| | | CS2.4. Procure, warehouse and distribute to last mile | CS2.4.1. Procure full range of contraceptives as per forecast, warehouse and distribute to SDPs | % of FP commodities procured per supply plan | Annually | MoH, Partners; MSL |
| | | CS2.5. Facilitate regular FP supply pipeline monitoring | CS2.5.1. Build capacity for pipeline monitoring at all levels of the supply chain | Number of target staff trained on FP pipeline monitoring | Annually | MoH, Partners, DHMT |
| CS3. Enhancing skills and capacity for FP supply chain management at all levels | Stock-outs are minimized | CS3.1Train and/or sensitize health care workers on FP commodity management and reporting | CS3.1.1. Conduct a skills gap analysis | Skills gap report | 2021 | MoH, Partners, DHMT |
| | | | CS3.1.2. Train health workers on FP commodity management and reporting based on identified gaps | Number of identified health workers trained based on need | 2022 | MoH |
| CS4. Establishing quality control system for FP commodities | Increased availability of quality FP products including LARCs | CS4.1. Avail FP SOPs, guidelines and job aids | CS4.1.1. Review and avail FP commodity management SOPs, guidelines and job aids | Number of SOPs, guidelines and job aids printed and disseminated | 2021-2026 | MoH, Partners, DHMT |
| | | CS4.2. Products inspection | CS4.2.1. Conduct regular warehouse and facility visits | Report of warehouse and facility visits conducted | Quarterly | MoH,Partners, DHMT |
| | | CS4.3. Conduct pharmacovigilance | CS4.3.1. Conduct annual data review on adverse effects of FP products. | FP ADRs data review report | Annually | MoH |
| | | | CS4.3.2. Sensitize health facility in charges on tools and procedures for adverse reactions to medicine (ADR) reporting | Number of health workers sensitized on FP ADR reporting | 2022 | MoH, Partners, DHMT |

**ANNEX II UNIT COSTS**

| S.No | Item | Unit Cost (ZMK) | Unit | Unit (US$) |
|---|---|---|---|---|
| 1 | Male sterilisations | 850.00 | *per procedure* | *45.84681769* |
| 2 | Female sterilisations | 850.00 | *per procedure* | *45.84681769* |
| 3 | IUD - Copper-T Contraceptive | 10.4473 | *per piece* | *0.5635* |
| 4 | IUD Insertion service | 180.00 | *per insertion* | *9.708737864* |
| 5 | IUD Removal | 200.00 | *per removal* | *10.78748652* |
| 6 | Hormonal IUCD | 147.1149 | *per piece* | *7.935* |
| 7 | LNG IUS Insertion | 2,000.00 | *per insertion* | *107.8748652* |
| 8 | LNG IUS Removal | 200.00 | *per removal* | *10.78748652* |
| 9 | Jadelle implant contraceptive | 155.55 | *per piece* | *8.389967638* |
| 10 | Implanon Implant Contraception | 155.55 | *per piece* | *8.389967638* |
| 11 | Levoplant contraception | 126.27 | *per piece* | *6.810679612* |
| 12 | Implants Jadelle Insertion | 200.00 | *per insertion* | *10.78748652* |
| 13 | Implants Implanon/Levoplant Insertion | 200.00 | *per insertion* | *10.78748652* |
| 14 | Implants Removal | 180.00 | *per piece* | *9.708737864* |
| 15 | Depoprovera | 14.64 | *per piece* | *0.789644013* |
| 16 | Implant Insertion kit | 221.98 | *Per kit* | *11.97297735* |
| 17 | IUCD Insertion kit | 393.45 | *Per kit* | *21.22168285* |
| 18 | BTL (Female Sterilisation) Kit | 1,184.93 | *Per kit* | *63.9118123* |
| 19 | Vasectomy Kit | 304.70 | *Per kit* | *16.43446602* |
| 20 | Male Circumcision Kit | 507.46 | *Per kit* | *27.3710356* |
| 21 | Scalpel handle#3 | 10.61 | *per piece* | *0.572491909* |
| 22 | Pocket Mask | 50.33 | *per piece* | *2.714401294* |
| 23 | Oxygen Face mask | 32.03 | *per piece* | *1.727346278* |

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|---|---|---|---|---|
| 24 | Pregnancy test strip-Dip strip | 0.66 | *per piece* | *0.035533981* |
| 25 | Pregnancy test strip-Mid stream | 4.21 | *per piece* | *0.227022654* |
| 26 | Injectables (Service) | 100.00 | *per injection* | *5.393743258* |
| 27 | Pills – contraceptive | 4.21 | *per cycle* | *0.227022654* |
| 28 | Pills (service) | 50.00 | *per procedure* | *2.696871629* |
| 29 | Male condoms | 0.65 | *per piece* | *0.034924488* |
| 30 | Adhesive Tape (zinc oxide plaster) nonsterile | 14.00 | *per piece* | *0.755124056* |
| 31 | Bandaid (wound plaster, waterproof) | 0.32 | *per piece* | *0.017259978* |
| 32 | Blade, surgical, no 10, sterile disposable (removal only) | 0.95 | *per piece* | *0.051240561* |
| 33 | Gauze bandage, non-sterile | 0.34 | *per piece* | *0.018338727* |
| 34 | Gloves, non-sterile, size Medium | 4.40 | *per piece* | *0.237324703* |
| 35 | Gloves, surgical, sterile Size 7.5 | 4.60 | *per piece* | *0.24811219* |
| 36 | Infusion Set with catheter or meedle, 14-16 gauge | 3.50 | *per piece* | *0.188781014* |
| 37 | IV Solution x 1000cc Soduim Chloride | 34.00 | *per piece* | *1.833872708* |
| 38 | IV Solution x 1000cc Dextrose | 15.00 | *per piece* | *0.809061489* |
| 39 | IV solution x 1000cc Ringers lactate | 34.00 | *per piece* | *1.833872708* |
| 40 | Lidocaine hydrochloride 2% | 22.00 | *per piece* | *1.186623517* |
| 41 | Povidone | 83.00 | *per bottle* | *4.476806904* |
| 42 | Needle, disposable, sterile, 21 Gauge | 0.30 | *per piece* | *0.01618123* |
| 43 | Syringe, disposable, sterile, 5ml | 0.55 | *per piece* | *0.029665588* |
| 44 | T-shirt | 165.00 | *per piece* | *8.899676375* |
| 45 | *Mass messaging* | 390.00 | *per sms* | *21.03559871* |
| 46 | *Pen* | 1.65 | *per piece* | *0.088996764* |
| 47 | Pen | 1.65 | *per item* | *0.088996764* |
| 48 | Notepad | 10.00 | *per item* | *0.539374326* |

| | | | | |
|---|---|---|---|---|
| 49 | Didatic materials | 0.00 | *per item* | |
| 50 | Drink | 10.00 | *per person per day* | *0.539374326* |
| 51 | Refreshments | 65.00 | *per person per day* | *3.505933118* |
| 52 | Lunch | 110.00 | *per person per day* | *5.933117584* |
| 53 | Lunch per diem/person - capital | 110.00 | *per person per day* | *5.933117584* |
| 54 | Lunch per diem/person - regional | 110.00 | *per person per day* | *5.933117584* |
| 55 | Lunch per diem/person - district | 110.00 | *per person per day* | *5.933117584* |
| 56 | Hotel per diem/person - capitol | 800.00 | *per person per day* | *43.14994606* |
| 57 | Hotel per diem/person - regional | 700.00 | *per person per day* | *37.7562028* |
| 58 | Hotel per diem/person - district | 600.00 | *per person per day* | *32.36245955* |
| 59 | Travel per diem per person - National | 750.00 | *per person per day* | *40.45307443* |
| 60 | Travel per diem per person - Regional | 750.00 | *per person per day* | *40.45307443* |
| 61 | Technical Allowance | 0.00 | *Per person per day* | *200* |
| 62 | *Facilitator allowance county* | 1,000.00 | *daily* | *53.93743258* |
| 63 | *Stationary* | 0.00 | *per person per session* | *10* |
| 64 | *Bed and Breakfast county* | 660.00 | *per person per day* | *35.5987055* |
| 65 | *Facilitator allowance national* | 1,000.00 | *per person per day* | *53.93743258* |
| 66 | Vehicle - truck (Hilux) | $ 33,657.00 | *$42,000 including VAT* | *1815.372168* |
| 67 | Vehicle - 4X4 SUV (Prado) | $ 67,893.00 | *$111,600 including VAT* | *3661.97411* |
| 68 | Examination table | 4,750.00 | | *256.2028047* |
| 69 | Tent | 54,150.00 | *2 Room MSZ service delivery Tent* | *2920.711974* |
| 70 | Laptop | 18,500.00 | | *997.8425027* |

**Source: MoH & Partners, Zambia**

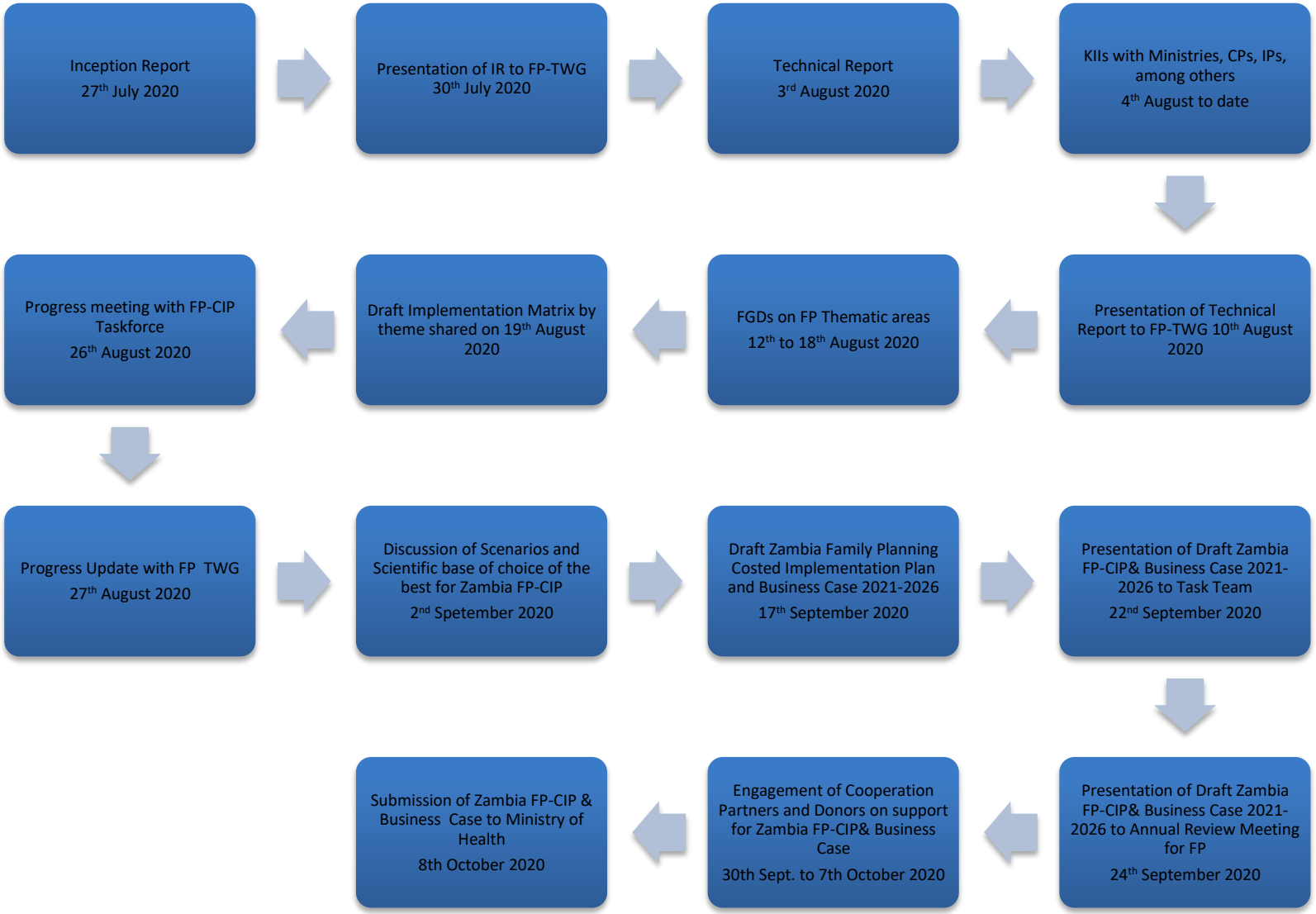
## ANNEX III DEFINED ROLES AND RESPONSIBILITIES OF FAMILY PLANNING STAKEHOLDERS

| Organization | Agency | Role and Responsibilities |
|---|---|---|
| ***National Level*** | Government of the Republic of Zambia | ● Governance and stewardship of the FP-CIP & Business Case 2021-2026<br>● Institutionalize the Inter-agency Coordination Council (ICC) mechanism that will include high level representation from the Office of the President, the Ministries of Planning and National Development, Finance, Education (General and Higher Education), Health and Cooperating Partners in the Family Planning space |
| | MoH | ● Lead the FP programming in Zambia by providing technical guidance/support in:<br>i. Formulation, review and implementation of policy and guidelines,<br>ii. Stakeholders coordination (including the private sector)<br>iii. Leading review of progress of FP-CIP & Business Case implementation against key indicators<br>iv. Advocacy for financing of FP-CIP & Business Case<br>v. Procurement of FP commodities |
| | | |
| ***Other Government Ministries & Institutions:*** | Ministry of National Development Planning | ● Policy formulation on Population and demographics<br>● Resource allocation<br>● Identify mechanisms (through health Minister and Principal Secretaries) to engage with national treasury for allocation of funds for FP program<br>● Lobby for inclusion of FP in the national and district budget and inclusion in supplementary budgeting process |
| | Ministry of Education (General and Higher Education) | ● Support on policy implementation on youth and adolescents SRH<br>● Ensure that Girls are kept in School up to Grade 12<br>● Foster an enabling environment in school systems to support implementation of comprehensive sexual education at all levels<br>● Train teachers on implementation of life skills including FP and support the referrals to SDPs |
| | Ministry of Finance | ● Provide adequate financing to support education of vulnerable girls in Zambia (enable them attain grade 12 level of education)<br>● Provide technical support to MOH in budgetary planning processes e.g. MTEF including disbursement of funds, and accounting for expenditures<br>● National guarantor to FP Contraceptive Revolving Fund |
| | Ministry of Gender | ● Policy support for addressing socio-cultural factors related reproductive health enhancement<br>● Mainstreaming ASRH policy issues in policies and plans. |
| | Ministry of Sports, Youth and Child Development | ● Ensure primary investments for empowering youth to prevent unintended pregnancies |
| | Research and academia institutions | ● Increase the use of FP services through technical guidance, research, and training of future professionals |

| | | |
|---|---|---|
| | Zambia Medicines Regulatory Authority (ZAMRA) | ● Ensure the quality, safety, and efficacy of contraceptive commodities by regulating their production, importation, distribution, and use.<br>● Post market surveillance and quality checks; Pharmacovigillance |
| | Zambia Human Rights Commission (ZHRC) | ● Monitor government efforts to ensure universal access to rights-based family planning |
| | Ministry of Community Development and Social Welfare | ● Policy support for addressing socio-cultural factors related to reproductive health enhancement<br>● Mainstreaming ASRH policy issues in policies and plans. |
| | Ministry of Water Development, Sanitation and Environmental Protection | ● Support advocacy to strengthen population-health-environment programming e.g., educate the linkage between FP, population, resources and climate<br>● Promote policies and programming to develop communities' appreciation of the linkages between informed natural resource management and their families' long term well-being. |
| | Medical Stores Limited | ● Ensure an efficient "procurement", storage, distribution, and warehousing system for contraceptives and other reproductive health commodities<br>● Support reliable RH commodity need projections |
| | National assembly | ● Foster general awareness on population issues at all levels in Zambia<br>● Lobby for inclusion of FP issues in government priority programmes<br>● Advocate for an enabling environment, including promoting investments in FP program. |
| | National Health Insurance Scheme (NHIS) | ● Provide a risk pooling mechanism for FP commodities and services |
| ***Partners*** | Cooperating partners | ● Support provision of technical assistance and expertise for FP programming<br>● Support financing of FP program |
| | Implementing partners | ● Support service provision, capacity building and advocacy:<br>i. FP services provision<br>ii. Social marketing<br>iii. Training of health care workers<br>iv. Health system strengthening |
| ***Private sector*** | Private Enterprises | ● Provision of FP Services (Pharmacies, Chemists and Private Hospitals and Clinics)<br>● FP commodity procurement and distribution<br>● Financing FP through formation of FP public private partnerships agreements / (PPP contracts with the government) e.g. Banks, Mining Companies, Health/ Medical Insurance Companies, Farmers etc |
| | Suppliers | ● Ensure product availability.<br>● Provision of products Information.<br>● Information on product safety and ADR. |

| | | |
|---|---|---|
| | | ● Continuous product improvement (UNFPA, formulations, presentation).<br>● Involvement in setting up of FP repository |
| ***Professionals Associations*** | Professionals Associations | ● Monitor compliance to the laws and set standards<br>● Provide technical inputs for policies' formulation/review and implementation |
| ***Provincial/ District level*** | DHMT/FP Focal Point | ● Lobby for inclusion of FP financing at sub-national and district levels<br>● Pay for the FP commodities and services<br>● Track and monitor progress towards implementing the sub-national and district -level activities on FP<br>● District level stewardship<br>● Coordinating of cross-sectoral collaboration efforts<br>● Supportive supervision and mentorship |
| | NGOs/FBOs/CSOs | ● FP services provision<br>● Advocacy for transparency and accountability in FP Financing<br>● Community mobilization<br>● Support of Community Units<br>● Contribute service data for M&E of the FP CIP to assist the MoH in maintaining a comprehensive picture of national CIP implementation and for identifying needs and opportunities to expand services |
| ***Private Actors*** | Private facilities | ● Form partnerships for service delivery<br>● Provide data for decision making and M&E |
| | Media | ● Awareness creation and community mobilization |
| | Community members | ● Mobilization on FP services uptake<br>● Consumers of FP services and products<br>● Lobby for FP services |
| | Community Leaders<br>● Chiefs and headmen/ Village elders<br>● Religious leaders | ● Mobilization on FP services uptake<br>● Lobby for FP services<br>● Sensitization on drawbacks of teen pregnancies<br>● Advocacy on importance of Schooling up to grade 12 for girls |

## ANNEX IV PROCESS OF DEVELOPMENT OF ZAMBIA FP-CIP & BUSINESS CASE



## ANNEX V LIST OF CONTRIBUTORS

| S. No | Name | Organization | Contact (Phone/Email) | District |
|---|---|---|---|---|
| 1 | Dr. Angel Mwiche | Ministry of Health | amwiche@yahoo.com | Lusaka |
| 2 | Dyness Kaluba | Ministry of Health | 0977697513<br>Dkaluba2002@gmail.com | |
| 3 | Anne Mwiche | Ministry of Health | 0978957591<br>nnemwiche@yahoo.com | Lusaka |
| 4 | Zamiwe Sakala (Budget Analyst) | Ministry of Finance | 0979246227<br>zamiwe.sakala@mof.gov.zm | Lusaka |
| 5 | Mutinta Kalembwe | National Development Planning | 0966954798<br>mutintakalembwe@gmail.com | Lusaka |
| 6 | Maybin S. Luulu | Ministry of General Education | 0977629009<br>Maybin.luulu@yahoo.com | Lusaka |
| 7 | Binta Bah Chuunga | Ministry of Higher Education | 0979411767<br>Bintabah2007@yahoo.co.uk | Lusaka |
| 8 | Bonaventure Mutale | Ministry of Higher Education | | Lusaka |
| 9 | Costa Chibwe | Ministry of Higher Education | | Lusaka |
| 10 | Nicholas Goma | MCDSS HQ | 0977928433<br>nicosguk@yahoo.co.uk | Lusaka |
| 11 | Mrs Munga C | MCDSS HQ | | Lusaka |
| 12 | Phillip Chilambwe | Ministry of Gender | 0977465949<br>Phillip.chilambwe@gender.gov.zm | Lusaka |
| 13 | Loyce Munthali | USAID | lmunthali@usaid.gov | Lusaka |
| 14 | Silke Seco-Grutz | DFID (FCDO) | S-Seco@dfid.gov.uk | Lusaka |
| 15 | Ulrika Hertel | SIDA | Tel: +260 (0) 211 42 61 47<br>Mobile: +260 (0) 977 770259<br>ulrika.hertel@gov.se | Lusaka |
| 16 | John Bosco Makumba | World Bank | 0977795381<br>jmakumba@worldbank.org | Lusaka |
| 17 | Tsukakoshi Tatsusushiko | JICA | tsuka-3@gf7.so-net.ne.jp | Lusaka |
| 18 | Sarai Malumo | WHO | malumos@who.int | Lusaka |
| 19 | Prof. Dhally M. Menda | Churches Health Association of Zambia (CHAZ) | 0977794101<br>dhally.menda@chaz.org.zm | Lusaka |
| 20 | Liyoka Liyoka | Medicines Research and Access Platform | 0977870640<br>Liyokaliyoka70@yahoo.co.uk | Lusaka |

| | | | | |
|---|---|---|---|---|
| 21 | Nchobeni Kagula | GHSC-PSM (CHEMONICS) | 0968768091<br>nluundu@ghsc-psm.org | Lusaka |
| 22 | Natasha Kowa Matafwali | GHSC-PSM (CHEMONICS) | 0964061618<br>NkowaMatafwali@ghsc-psm.org | Lusaka |
| 23 | Mika Mwambazi Bwembya | USAID DISCOVER Health | 0962145452<br>_mika_bwembya@zm.jsi.com | Lusaka |
| 24 | Yoram Siame | Churches Health Association of Zambia | 0974404071<br>Yoram.siame@chaz.org.zm | Lusaka |
| 25 | Gift Malunga | UNFPA, Zambia | malunga@unfpa.org | Lusaka |
| 26 | Leonard Kamugisha | UNFPA, Zambia | kamugisha@unfpa.org | Lusaka |
| 27 | Dr. Lilian Nyirenda | Ndola DHO (Clinical Care Specialist) | 0969177455<br>lilianshams@gmail.com | Ndola |
| 28 | Lilian Chishiba (CBD) | Kabushi Clinic Ndola | 0969939483 | Ndola |
| 29 | Ireen Chisanga (CBD) | New Masala Clinic Ndola | 0961047990 | Ndola |
| 30 | Elina Phiri (CBD) | New Masala Clinic Ndola | 0760305886 | Ndola |
| 31 | Euphrasia Mulenga (CBD) | New Masala Clinic Ndola | 0975608456 | Ndola |
| 32 | Medson Silengo (CBD) | New Masala Ndola | 0966198757 | Ndola |
| 33 | Kelvin Chabu Mwewa (CBD) | Chipokotamayamba Ndola | 0968553731/0977753377 | Ndola |
| 34 | Tamara Mkandawire | Nkana Health Centre, Lufwanyama | 0961959417 | Lufwanyama |
| 35 | Nshimba Bupe (Nurse) | ZEM Lumfwanyama | 0968841893/0978821976 | Lufwanyama |
| 36 | Margaret Phiri (Midwife) | Shimukunami RHC Lumfwanyama | 0968577878 | Lufwanyama |
| 37 | Beatrice Yikona Gondwe(MCH) | Chipokotamayamba Clinic Ndola | 0964910905<br>bk.yikona@yahoo.com | Ndola |
| 38 | Kayula Mwape (Enrolled Nurse) | New Mansa Clinic Ndola | kayulamwape85@gmail.com | Ndola |
| 39 | Flaviour C. Chewe (Nurse) | Kabushi Ndola | 0977285431<br>cheweflaviour10@gmail.com | Ndola |
| 40 | Ngolofwana Doreen | Railway Clinic Ndola | doreenngolofwana13@gmail.com | Ndola |
| 41 | Catherine Nambule | Masaiti Boma Clinic | 0967940897<br>nambulec93@gmail.com | Masaiti |
| 42 | Dr. Natasha S. Kaoma | Copper Rose Zambia | natashask@copperrosezambia.org | Lusaka |
| 43 | Hellen K. Mwenya(Nurse) | Chibuli Health Post Mpongwe | 0976215790<br>Hellenmwenya09@gmail.com | Mpongwe |
| 44 | Cilia Phiri | Twapia Clinic Ndola | 0955460350<br>Ciliaphiri1@gmail.com | Ndola |
| 45 | Clemmy N. Sooka | Kabwe DHO | 0977431218<br>clemmy_sooka@yahoo.com | Kabwe |

| | | | | |
|---|---|---|---|---|
| **46** | Grace Lufungulo | Kapiri DHO | 0977329933 | Kapiri Mposhi |
| **47** | Agness M. Miselo | Chawama HC Kapiri | 0966261314/09771400088<br>Agnessmtambo026@gmail.com | Kapiri Mposhi |
| **48** | Swema Banda | Kabwe DHO | 0979308786<br>swemabanda@gmail.com | Kabwe |
| **49** | Christine Mwape | Masaiti Council Clinic | 0762499801<br>Christinemwape.cm58@gmail.com | Masaiti |
| **50** | Bulian Mwansa Chimpinde | Lyobeka HP Mpongwe | 0966657075<br>bulian_mwana@yahoo.com | Mpongwe |
| **51** | Racheal Mwandila (CHA) | Masaiti | 0977512337<br>Rachealmwandila12@gmail.com | Masiati |
| **52** | Barbra Lutangu | Masala Clinic Incharge | 0979728091<br>barbrahmashebelutangu@gmail.com | Ndola |
| **53** | Dr. Chalwe K. Kabuswe | Kabwe PHO | 0979200672/0955100672<br>kckabuswe@gmail.com | Kabwe |
| **54** | Joy Mukatimui Masheke Manengu | UNFPA | manengu@unfpa.org | Lusaka |
| **55** | Sibeso Mululuma | UNFPA | mululuma@unfpa.org | Lusaka |
| **56** | Dr. Christopher Mazimba | Options | cmazimba67@gmail.com | Mansa |
| **57** | Ms. Joy Lyempe | Health Financing Advisor | | Lusaka |
| **58** | Mr. Amos Mwale | Centre for Reproductive Health and Education (CRHE) | amosza@gmail.com | Lusaka |
| **59** | Mr. Chimuka Hampango | UNFPA | hampango@unfpa.org | Lusaka |
| **60** | Ms. Mulenga Ching'ambo | | | Lusaka |
| **61** | Ms. Ethel Kopulande | | | |
| **62** | Ms. Florence Mulenga | FHI360 | | Lusaka |
| **63** | Mrs. Inonge Wina | Marie Stopes Zambia (MSZ) | | |
| **64** | Mr.James Mdala | Marie Stopes Zambia | James.mdala@mariestopes.org.zm | |
| **65** | Monica Mutesa | PATH | mmutesa@path.org | Lusaka |
| **66** | Mr. Jessie Nalungwe | Centre for Reproductive Health and Education (CRHE) | | |
| **67** | Mr.Kwesi Formson | Marie Stopes Zambia | 0968793919<br>formsonk@mariestopes.org.zm | Lusaka |
| **68** | Mr. Levy Mkandawire | Clinton Health Access Initiative (CHAI) | | Lusaka |

| | | | | |
|---|---|---|---|---|
| **69** | Mr. Mulenga Ching'ambo | CRHE | | Lusaka |
| **70** | Dr. Peggy Chibuye | Midwives Association of Zambia (MAZ) | peggychibuye@ymail.com | Lusaka |
| **71** | Mrs. Ruth Litaba | Copper Rose Zambia | | Lusaka |
| **72** | Ms. Sally-Rose Mwachilenga | | sally.rosem100@gmail.com | |
| **73** | Mr. Rabson Zimba | CHAI | rzimba@clintonhealthaccess.org | Lusaka |
| **74** | Mr. Maxwell B Kasonde | MoH | 0977628146<br>makasonde@gmail.com | Lusaka |
| **75** | Mrs. Alice Chembe | Planned Parenthood Association of Zambia | chembealice@gmail.com | Lusaka |
| **76** | Mrs. Ethel Kopulande | | ethel.kopulande@yahoo.com | |
| **77** | Mr. Charles Kalonga | USAID Community Radio | ckalonga@populationmedia.org | Lusaka |
| **78** | Thandiwe Sibulinjase | PATH | tsibulinjase@path.org | Lusaka |
| **79** | Ms. Georgina Francis | Development Media | georgina.francis@developmentmedia.org | Lusaka |
| **80** | Mr. Jessie Nalungwe | Centre for Reproductive Health Education (CRHE) | nalungwej@gmail.com | Lusaka |
| **81** | Mr. Ngalande Ngalande Jr. | CHAZ | ngalande.ngalande@chaz.org.zm | Lusaka |
| **82** | Ms. Nana Zulu | Options | n.zulu@options.co.uk | |
| **83** | Gina Smith | PSI | ginasmith@psi.org | |
| **84** | Ms.Florence Mulenga | | | |
| **85** | Mrs. Inonge Wina | | | |
| **86** | Mr.Jessie Nalungwe | | | |
| **87** | Mr. Womba Wanki | | | |
| **88** | Mr. Mulenga Ching'ambo | | | |
| **89** | Mrs. Ruth Litaba | | | |
| **90** | Mrs. Elizabeth Kalunga | UNFPA Provincial Coordinator | | |
| **91** | Faith Suwilanji Kaoma | Copper Rose Zambia | | Lusaka |
| **92** | Mr. James Lungu | | | |
| **93** | Dr. Namuunda Mutombo | | | |
| **94** | Emeldah Mwelwa | Chubuli HPMpongwe | 0966604928<br>emeldahmwelwa@gmail.com | Mpongwe |

| | | | | |
|---|---|---|---|---|
| **95** | Dr Stephen Mupeta | UNFPA<br>Technical Specialist(Maternal Health/Midwifery) | +260977809134<br>mupeta@unfpa.org | Freetown |
| **96** | Dr. Robert Zulu | Ndola PHO | | Ndola |
| **97** | Brenda C. Hamoonga | Ndola PHO | 0961079428<br>brendahamoonga@gmail.com | Ndola |
| **98** | Kennedy Kama | Kabwe DHO | 0977866747<br>Kennkam777@gmail.com | Kabwe |
| **99** | Ireen Zulu | Chibombo DHO | 0969483403<br>Ireencelia34@gmail.com | Chibombo |
| **100** | Nyambe Lyoko | ZAMRA | 097761554<br>lnyambe@yahoo.com | Lusaka |
| **101** | Daniel Muma | PSZ | 0979077259<br>muma3m@yahoo.com | Lusaka |
| **102** | Kennedy Saini | Zambia Pharmaceutical Business Forum | 0977296178<br>sykaygroup@gmail.com | Lusaka |
| | | | | |

**PARTICIPANTS - FAMILY PLANNING ANNUAL REVIEW MEETING 2020**

**Dates: 23rd - 25th September 2020**

| No. | **PARCIPANT NAME** | **POSITION** | **STATION OR FACILITY** | **DISTRICT** |
|---|---|---|---|---|
| **1** | Helen Chibi Silumesii | Rapportuer | MoH | Lusaka |
| **2** | Sikazwe George Therem | Rapportuer | MoH | Lusaka |
| **3** | Maybin S. Luulu | SHN – Coordinator | MoGE | Lusaka |
| **4** | Maxwell Kasonde | PH- Pharmacist | MoH | Lusaka |
| **5** | Angel Mwiche | AD-RH | MoH | Lusaka |
| **6** | Charles Banda | DPD | MoNDP | Lusaka |
| **7** | Doreen Bwalya | M & E Officer | MoH | Lusaka |
| **8** | Jojo Mbonyiwe | M & E Officer | MoH | Lusaka |
| **9** | Ndubu Milapo Muliwana | Chief Nursing Officer | LPHO | Lusaka |

| | | | | |
|---|---|---|---|---|
| **10** | Gosa Clive | Snr M& E Officer | LPHO | Lusaka |
| **11** | Abraham Mukesela | Chief Pharmacist | LPHO | Lusaka |
| **12** | Joseph Lungenda | Chief Pharmacist | EPHO | Chipata |
| **13** | Malisheni S. Evans | Snr Health Information Officer | EPHO | Chipata |
| **14** | Esther Namwaba | Ag. PNO – MCH | EPHO | Chipata |
| **15** | Lydia C. Jumbe | Programme Officer | MoH | Lusaka |
| **16** | Mishel Chinyama | Rapportuer | MoH | Lusaka |
| **17** | Modesta Zulu Chileshe | Programme Officer | MoH | Lusaka |
| **18** | Sally S. Mwachilenga | Programme Officer | MoH | Lusaka |
| **19** | Sandrah Mwanamani | Secretary | MoH | Lusaka |
| **20** | Ruth Nkhata | FP/ADH Officer | MoH | Lusaka |
| **21** | Dyness Kaluba | CSMO | MoH | Lusaka |
| **22** | Mputa Ngalande | YAM | PPAZ | Lusaka |
| **23** | Tisha Mumba | YAM | PPAZ | Lusaka |
| **24** | Maxwell Milombe | Driver | MoH | Lusaka |
| **25** | Anthony Chali | Driver | MoGE | Lusaka |
| **26** | Evelyn Mwelwa Mulenga | SAO | PPAZ | Lusaka |
| **27** | Alice Muzyamba Chembe | ADP | PPAZ | Lusaka |
| **28** | Lester Lozani Phiri | CAO | PPAZ | Lusaka |
| **29** | Sharon Nampemba | Nurse/Midwife | PPAZ | Lusaka |
| **30** | Emeldah Chinyama | Laboratory Technician | PPAZ | Lusaka |
| **31** | Kennedy Saini | Private Pharmacist | ZPBF | Lusaka |
| **32** | Kingsley Kapemfu | SHIO | CBPHO | Ndola |
| **33** | Matthew Mwale | Chief Pharmacist | CBPHO | Ndola |
| **34** | Pauline Kahale | SNO | Kitwe DHO | Kitwe |
| **35** | David Kalunga Lungu | Pharmacist | Kitwe DHO | Kitwe |
| **36** | Lwito Salifya Mutale | DHIO | Kitwe DHO | Kitwe |
| **37** | Clemmy N Sooka | PNO-MCH | CPHO | Kabwe |
| **38** | Gloria Ziba Silondwa | SHIO | CPHO | Kabwe |
| **40** | Catherine Mwenda | Chief Pharmacist | NWPHO | Solwezi |
| **41** | Maliseni Mumbuna | SHIO | NWPHO | Solwezi |

| | | | | |
|---|---|---|---|---|
| **42** | Brenda Chinyama Hamoonga | PNO-MCH | CBPHO | Ndola |
| **43** | Hellen Lupili | PNO-MCH | NWPHO | Solwezi |
| **44** | Nthani Masauso | Driver | NWPHO | Solwezi |
| **45** | Godwin K Phiri | Driver | CBPHO | Ndola |
| **46** | Kandandu Chibosha | Chief Pharmacist | CPHO | Kabwe |
| **47** | Mabvuto banda | Driver | CPHO | Kabwe |
| **48** | Dr Robert Zulu | PHD | CBPHO | Ndola |
| **49** | Peter Nyimbili | Driver | CBPHO | Ndola |
| **50** | Mary Simooya | Hub Manager | PPAZ | Kitwe |
| **51** | Emmanuel Wina | M&E Assistant | PPAZ | Kitwe |
| **52** | Thelma Chalwe | YAM | PPAZ | Kitwe |
| **53** | Dr Dirk Willis | Ag. PHD | MPHO | Chinsali |
| **54** | Patience Kunda | PNO-MCH | MPHO | Chinsali |
| **55** | Yonah Sakala | Ag. SHIO | MPHO | Chinsali |
| **56** | Sara Samba Seleji | Pharmacist | MPHO | Chinsali |
| **57** | Joseph Mofu Chimfwembe | Driver (PHD) | MPHO | Chinsali |
| **58** | Elizabeth Monze | AgMNCH-NO | Mpika DHO | Mpika |
| **59** | Gaston Ilunga | Ag. DHD | Mpika DHO | Mpika |
| **60** | Marvin Chali Mwaba | DHIO | Mpika DHO | Mpika |
| **61** | Fabian Mulenga | Driver | MPHO | Chinsali |
| **62** | Beauty Muntanga Maluti | PNO-MCH | NPHO | Kasama |
| **63** | Keegan Mwape | Chief Pharmacist | NPHO | Kasama |
| **64** | Moses Lengwe | Driver | NPHO | Kasama |
| **65** | Yoram Zulu | DHIO | NPHO | Kasama |
| **66** | Martina Ngoma | Chief Pharmacist | LPHO | Mansa |
| **67** | Mercy Lukwesa | PNO-MCH | LPHO | Mansa |
| **68** | Bande Ngulube | SHIO | LPHO | Mansa |
| **69** | Henry Chimfwembe | Driver | LPHO | Mansa |
| **70** | Lumbwe P. C. Walumba | PNO-MCH, PHO | SPHO | Choma |
| **71** | Landa Nambela | SHIO, PHO | SPHO | Choma |
| **72** | Kalizya Sinyangwe | Pharmacist, PHO | SPHO | Choma |

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| **73** | Lupumpaula Hopeday | MRO | LCH | Lstone |
| **74** | Helen Chipukuma Mwiinga | PNO, DHO | LDHO | Lstone |
| **75** | Precious Chibwende | Pharmacist, DHO | LDHO | Lstone |
| **76** | Musole Chinduba | Fp Trainer | Nakatindi Clinic | Lstone |
| **77** | Mary Banda | LARC trainer | LDHO | Lstone |
| **78** | Linda Libingi | PNO, LCH | LCH | Lstone |
| **79** | Elizabeth Chinsubya | DEBs Office | DEBS | Lstone |
| **80** | Avida Munkombwe Mutemwa | Pastor/Change champion | LGMF | Lstone |
| **81** | Miranda Ziba | Project Officer, | Zambia Youth Platform | Lstone |
| **82** | Harriet Kawina | Gender FPP | Office of the DC | Lstone |
| **83** | Shupiwe Phiri | Private Pharmacist | Healthrise Pharmacy | Lstone |
| **84** | Dr Remmy Matipa | Director private Clinic | Mukuni Medical | Lstone |
| **85** | Jessie Kashempa | MCH, Change Champion | LDHO | Lstone |
| **86** | Catherine Kabbudula Matyola | PNO-MCH | WPHO | Mongu |
| **87** | Chumary Munyinya | SHIO | WPHO | Mongu |
| **88** | Catherine Chikweto | Senior Pharmacist | WPHO | Mongu |
| **89** | Mathew Lupale | Driver PHO Western | WPHO | Mongu |
| **90** | Webster Nsahya | Driver PHO Southern | SPHO | Choma |
| **91** | Dr. H.N. Monze | PHD, Southern | SPHO | Choma |
| **92** | Brian Kachana Mufalo | Driver (For PHD) | PPAZ | Lstone |
| **93** | Catherine Bwalya | Hub Manager | PPAZ | Lstone |
| **94** | Ben Muuka | Counsellor | PPAZ | Lstone |
| **95** | Mutafela Imasiku | YAM | PPAZ | Lstone |
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## ANNEX VI SUCCESSES, GAPS AND OPPORTUNITIES FOR ZAMBIA FP PROGRAMME

| Thematic Area | Successes | Gaps | Opportunities |
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| **Social and Behaviour Change Communication** | • Barriers to promote FP have been lowered within the faiths including the Catholics. They have accepted FP to be discussed on their platforms<br>• Better coordination of messaging across partners by MoH<br>• Messaging have transformed the user in terms of how they see family planning<br>• Use of SBCC for introduction of new methods to improve method mix<br>• SBCC has worked in the rural communities in that people are more aware of benefits of family planning<br>• Integration of faith communities in SBCC- different beliefs- agreeing on a definition<br>• Better understanding of what SBCC is<br>• Messaging men on FP and family size has been done through mass media- mass media has been found to be very effective in Burkina Faso- Mass media campaigns led to a 5.9% increase in mCPR | • SBCC getting into curricular and other areas of schooling<br>• No comprehensive communication strategy at national level that is funded hence no visibility for FP in facilities etc<br>• Funding from GRZ for SBCC has been very low. What is seen currently in Zambia is project effort<br>• Not engaged women in different age groups e.g. women start FP after an unintended pregnancy. Men usually feel trapped by pregnancy resulting to increases in GBV. They feel pregnancy is a trap<br>• There has always been an elaborate budget for SBCC but financing was not done<br>• Need to rebrand FP especially to appeal to the youth, divorcees etc<br>• There are tendencies for partners to work in silos among SBCC practitioners-working at program level leads to better outcomes<br>• Lack of documentation on what is happening in SBCC<br>• Challenges reaching out to adolescents and youth before their first pregnancy<br>• Messaging not targeting parents, religious and traditional leaders. Health workers think that adolescents should not be seen in the facilities for FP since they are children<br>• Need to work on messaging between FP and Contraception<br>• No information on FP clients below 14 years of age. No research to inform strategy | • Evaluate the impact of mass media campaign in Zambia<br>• Strengthen sexuality education in schools through inclusion into the curricular and improving the referral to services<br>• Disaggregate the materials for demand creation for the various audiences/ groups<br>• SBCC packaging needs to be specific and should not be general<br>• Demand a certain % of SBCC materials for a project needs to go to the national level<br>• Rebrand FP-SBCC through marrying FP and contraceptives by using proven marketing approaches such as those used by Coca cola that entice clients to use FP services<br>• Develop targeted messages by audience e.g. adolescents<br>• Develop SBCC that will lure couples and adolescents into limiting and not spacing<br>• Improve dissemination and reach e.g. SBCC materials<br>• Have clip arts and youthful champions to bring out more interesting and catchy messages<br>• Bring in key actors, parents, religious leaders<br>• Invest in research on understanding audiences to come up with effective advertisements<br>• Have sustained radio campaigns to saturate the population with messages on FP including churches<br>• Emphasis on cost effectiveness of investing in SBCC i.e. investing US$1 leads to a US$5.3 in savings<br>• Document what works, what doesn't and what needs to be done for SBCC in FP |

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| **Adolescents** | • Strengthening of the Adolescents TWG<br>• Comprehensive Sexuality Education curriculum developed<br>• CSE has been launched and is functional across the country<br>• Availability and roll out of Sayana Press<br>• Outreach to adolescents is reaching out to more than the stand-alone facilities<br>• Separate room in the Health Centers rather than corners for adolescents services including counselling reaches out to more<br>• Chiefs and traditional leaders can stem teenage pregnancies through use of by-laws e.g. paying a cow as a fine if you are caught to have impregnated a girl<br>• | • Reaching out to nulliparous adolescents especially in the rural areas remains a challenge<br>• Decline in Comprehensive education on HIV, which is getting worse as reported in the ZDHS for 2013/14 and 2018<br>• Disconnect between CSE and services<br>• No appraisal studies based on M&E data on the FP interventions being implemented<br>• Lack of sufficient method-mix on the supply side to match demand creation especially in the rural setting<br>• Religious and cultural issues e.g. adolescents should not be taking contraceptives | • Working with the Ministry of Education and the Ministry of Finance is the best contraceptive for adolescents since it will keep girls in school. It is recommended that the Ministry of Finance and that of Education ensure that girls are kept in school up to grade 12<br>• Strengthening the linkage between CSE and services, so that girls are directed to where they can obtain services. This can be thought of as strengthening the referral system from Ministry of Education to Ministry of Health and the CBDs<br>• Adherence to FP guidelines when dealing with adolescents<br>• M&E of all FP interventions including those targeting adolescents is key<br>• Capitalizing on self-injection riding on the availability of Sayana Press for extended use to adolescents in Zambia<br>• Capacity building for strengthening the adolescent TWGs in local areas<br>• Traditional leaders and chiefs to be used for advocacy against teenage pregnancies<br>• Invest in Outreach services targeting adolescents and youths to complement those offered in standalone facilities<br>• Investing in service delivery integration i.e. complementary SRH services<br>• Improve the quality of care to adolescents i.e. counselling through training of peers<br>• Adolescent centers rather than corners since they have many activities<br>• Introduce adolescent days i.e. dedicated days when facilities across Zambia offer services to adolescents<br>• Invest in understanding the demand side of adolescents and youth in terms of what they want, which will greatly improve uptake of FP services. It is time we did things differently. Check study results for ECHO and longitudinal study by NACC & UNAIDS in Zambia<br>• Address the consent as a barrier to access services by the unmarried adolescents i.e. Mozambique don't have age of consent and Ethiopia has a robust CBD arrangement that ensures FP services to all.<br>• Ensure availability of method mix in all corners of Zambia |

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| | | | • Conduct evaluation of CSE which was implemented in 2015 and every year it reaches over over 1.2 million adolescents and youths |
| **Commodity Security** | • Commodities have been there with support from partners<br>• Products get to SDPs<br>• Partners have meetings to understand commodity security<br>• Forecasting and Quantification is well done at the national level<br>• Evidence of method diversification-DMPA-SC, hormonal among others<br>• Functional supply chain committee for FP-TWG<br>• Coordination of commodity availability etc<br>• Supply chain managers at every level who are able to speak on inventory issues<br>• Meaningful engagement of FP-TWG on FP commodities' supply chain issues<br>• Adequate supply of bulk commodities at the regional hubs hence promoting efficiency<br>• There are no gaps in the upstream<br>• At the national level, there is availability of FP commodities<br>• Method mix expansion | • Empower districts not covered by MSL to distribute to the last mile<br>• Stock-outs at SDPs- Commodities are available at the central level but not available at the facilities<br>• Challenges with transport and logistics to the last mile<br>• Coordination at sub-national level is weak<br>• Low quality of data from downstream hence affecting forecasting and quantification and utilization data<br>• Method mix not backed by research- some commodities included in the method mix have a huge demand internationally making them unavailable in Zambia<br>• Weaknesses with commodity security at the last mile<br>• Some districts receive excess while others receive less<br>• Challenges with MSL moving stocks and in some cases does not stick to the schedule<br>• Lack of sufficient domestic financing for FP commodities | • Invest in improving data and triangulation for evidence based decisions<br>• Government of the Republic of Zambia needs to meet its financing commitments<br>• Improve financing of FP commodities from the National Health Insurance<br>• Leverage on the private sector for those clients who have ability to pay<br>• Advocacy for inclusion of FP into private health insurance<br>• Improve on tracking of distribution of FP commodities through use of available technologies<br>• Strengthen transport and logistics of FP commodities to the last mile<br>• Build capacity of pharmacists, pharmacy technicians and lab technologists in the provision of FP methods including LARCs<br>• Ensure availability of method mix include LARCs in the last mile<br>• Improve coordination and distribution of method-mix to health facilities from districts<br>• Make supply chain a priority at national, sub-national and district level<br>• Establish a system at MoH to control and monitor distribution of FP commodities in all SDPs using available technologies<br>• Empower districts and hubs to distribute to the last mile<br>• Need for effective FP-TWGs at the sub-national level |
| **Community Systems Strengthening** | • Policy on Task shifting to community structure already approved<br>• CBDs given right to provide injectables in addition to condoms<br>• Projects based on the Community System affirmed its benefits and importance to FP program | • Some facilities do not want CBDs within their vicinities because they reduce visits hence affecting their utilization rates hence the need to enforce the radius of their catchment area<br>• CBDs don't have methods because of lack of predictability in replenishing of stocks at health facilities<br>• Variation in the density of CDBs across Zambia | • Increase knowledge of FP methods at the Community level<br>• Provide contraception for out of school adolescents in the community<br>• Focus at CHAs by increasing their community presence for better coordination of CBDs<br>• Standardize CBD training to include pharmacy technicians for them to provide injectables |

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| | • CBDs being able to refer patients to the health facilities incase of removal of implants, side-effects etc<br>• CBDs follow up mothers who have delivered for FP<br>• MoH and Partners constituted the CBD safety committee that has worked well<br>• CBDs have decongested the Health Facilities, reducing both the waiting and travel times<br>• Taking services and demand creation to the door step | • Contraception out of Schools is not doing very well<br>• CBDs have not been supported adequately to function e.g. motorbikes, commodities, ID Cards, vest<br>• CBDs have not been motivated through incentives hence they drop off<br>• Attrition of CBDs because they are not motivated<br>• CHAs not allowed to provide injectables | • Standardize and provide incentives and support to the CBDs<br>• Scale-up self-care to include a package that contains injections, pregnancy test-kit, E-Pill etc |
| **Private Sector Involvement** | • Provision of popular methods in chemists around towns<br>• TWG on Family Planning is open to have private sector participation<br>• MoH is open to private sector involvement in terms of public private partnerships e.g. DMPA implementation plan<br>• Chemists and pharmacies will sell the injectables but cannot provide the service<br>• Private sector expands the method mix in the market by selling FP commodities that are fast moving<br>• All commodities in FP covered under national health insurance but not FP service provision | • Private sector contribution has not been high especially in service provision<br>• No data on private sector performance on FP provision in the DHIS<br>• Coordination of the private sector is weak<br>• Private sector not incentivized to attend the FP TWG meetings<br>• The size of the FP market is small<br>• Not all private health insurance companies covering FP<br>• Private sector majorly offers pills and condoms because they are fast moving and they don't involve a service that uses consumables e.g. injecables and IUDs<br>• Exclusion of FP service provision from the both private and National Health Insurance | • MoH should involve the private sector in service delivery especially in the provision of LARC e.g. Lusaka Trust because the method mix is available and they have the know- how<br>• Explore the Total Market Approach for FP in Zambia<br>• Ensure methods are well known by the market for the private sector to offer<br>• Incentive the private sector to provide FP through innovative training that will not require them to be out of their businesses for long<br>• Provide LARC methods initially for free to the private sector and develop innovative cost recovery strategies<br>• Explore PPPs with the private sector<br>• Grow private sector market segment for commodities e.g. IUD, Jadelle for them to be commercially available since the market is too small<br>• Target pharmacies and chemists in provision of FP services<br>• Include FP in both private and national health insurance<br>• Incentivize the private sector to report by introducing simplified reporting forms<br>• Change policy to allow pharmacies and pharmacy technicians to offer methods e.g. injectables<br>• Correct the perception of malpractices in the private sector e.g. theft etc |
| **Service Delivery** | • Diversification of method mix | • Low uptake of LARCs attributed to HCW availability and behavior (Check study by | • Need to invest in outreach services. They are better than static services |

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| | • Training of providers in offering methods and especially LARCs<br>• Task shifting to CHAs and CBDs<br>• Increased access to FP for rural women<br>• Increased access to FP for adolescents and youth<br>• Demand generation activities were evident<br>• Informed choice on FP increased<br>• Standardization of services across FP program, before there used to be sporadic programming<br>• Robust FP-TWG, where every partner coming into FP space needed to make a presentation to the TWG<br>• FP programs aligned to MoH programs and strategy<br>• Standardized training for frontline workers and those in the community<br>• Increase in financial resources committed for FP program<br>• Incentives for community volunteers<br>• TWGs have filtered to the sub-national level- Copperbelt and Luapula<br>• Success in reaching out to remote under-served areas<br>• Quality of FP services have gone up<br>• Supply chain system is decentralized<br>• Change of methods is mainly due to availability of methods in health facilities<br>• FP integration happened, it is talked about a lot in the OPDs. There is also the FP integration register | Population Council on use of IUD). Training was done but they were either transferred to other departments or attrition from work. In some cases provider prefer to offer faster methods/ less laborious to save on time since they have a high workload (convenience). There is also the issue of those trained who cannot offer the methods due to lack of practice and mentorship<br>• Trainees on LARCs don't go to the rural areas, they are concentrated in urban areas<br>• FP services to adolescents are not friendly in terms of infrastructure and human resources<br>• Under reporting from facilities, where reporting needs to be strengthened<br>• Weak referrals from CSE. 1.2 million adolescents and youths trained every year but the number does not translate to service delivery<br>• Weak integration of SRH services of young people at facility level<br>• Previous FP CIP was under institutional development but governance changed to MoH<br>• Laws and policies around age of consent bar adolescents from accessing services directly<br>• Availability of commodities at SDPs is a challenge. They are available at MSL but not at the SDPs<br>• Lack of consumables<br>• Inaccurate message on which methods are short term and which ones are long term e.g. EC is considered a method<br>• Weak SBCC in some areas<br>• Stock-outs on FP does not go to press | • Adopt a positive approach in the provision of FP services to adolescents i.e. include aspirational counselling based on what resonates with the current generation<br>• Incorporate new products and methods in line with international best practices<br>• Capacity building of health care workers on FP should be based on the department/ section they will work in (deployment)<br>• Stabilization of availability of FP methods<br>• Improve SBCC by make it more robust<br>• Improve reporting so that numbers feed to the national level<br>• Strengthen the implementation of policies that support/ protect service providers providing services to minors<br>• Include training on FP at college level so that so that all HCW have the training<br>• Include other traditional/ religious methods on FP<br>• Invest more on mentorship programmes<br>• Ensure that FP program reaches out to adolescents, youth and PLWD<br>• Use braille for BCC targeting the blind and the visually impaired<br>• Triangulate service statistics<br>• Support overall integration of services under the continuum of care<br>• Ensure usage of condoms continues to increase among adolescents and youth for prevention against HIV (ECHO Trial study results)<br>• Reach out to adolescents and youth since they reach out to FP after first child revealing that it was an accident<br>• Distribute HCWs trained on LARCs equitably |
| **Financing** | • Budget line for FP at the MoH<br>• GRZ funds commodities and service delivery<br>• National Health Insurance scheme is picking up and it includes FP commodities | • Budget line for FP receives allocation but no disbursement<br>• Resources in the FP budget sometimes redirected into other areas in 3rd and 4th Quarter | • Increase More emphasis of financing from GRZ for sustainability in FP program financing<br>• Strengthen the mechanisms for budget monitoring and expenditure tracking by CSO<br>• Advocacy on FP financing in Zambia by CSOs |

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| | ● Private health insurance companies e.g. Liberty Insurance cover FP services<br>● UNFPA supporting FP expenditure tracking at ZamStats<br>● Support for collection and management of data on FP expenditures in Zambia is available | ● Weak mechanisms for budget monitoring and expenditure tracking by CSO for advocacy purposes<br>● No transparency on FP financing by GRZ. FP budget is lumped together with RH hence cannot ascertain how much has been spend on FP | ● GRZ needs to be more transparent on how much they have released to FP in a fiscal year<br>● MoH needs to be pushed by CSOs within the FP TWG by following through the MTEF budget cycle<br>● CSO push on FP financing on print and social media<br>● Introduce partnership agreements (e.g. MoUs) with partners on matching funds for FP with GRZ<br>● Use parliamentarians on budgeting and financing of FP in Zambia<br>● Use the output based approach to budgeting for FP<br>● Push for increasing financing to the health sector as a whole, targeting the Abuja declaration<br>● Interrogate opportunities for FP financing at sub-national level<br>● Need for prioritization in the FP-CIP & Business Case 2021-2026 by taking into consideration the high impact interventions or leverage interventions<br>● Engage the private sector through associations such as Zambia Chamber of Commerce, Zambia Private Sector Development Association, Zambia Chamber of Small and Medium Business Association to decongest the public sector owned health facilities<br>● Explore optimization of the drug medical fund established through the Act of 2019 to improve financing of FP commodities |