

REPUBLIC OF ZAMBIA

FIRST DRAFT

REPRODUCTIVE HEALTH POLICY

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GUIDING PRINCIPLES OF THE REPRODUCTIVE HEALTH POLICY

The formulation of this policy has been, and its implementation will be, directed by the following principles:-

1. Committing itself to addressing the reproductive health needs of individuals and families, and supporting their physical, mental emotional and social development throughout their life cycle.
2. Committing itself to the concept of Reproductive Health, which encompasses, safe Motherhood, including Safe Abortion care: Family Planning: Adolescent Health: STD/HIV/AIDS: and Gender issues throughout the life of individuals, within the context of population and sustainable development, and reduction of poverty.
3. Committing itself to and advocating for a multi-sectoral approach to reproductive health by involving other government ministries, non-governmental organization, politicians, policy makers, senior managers, the community, church organizations and other concerned bodies and users of services.
4. Creating an enabling environment, for the provision of reproductive Health services, by effective management, training, supervision, essential logistic supplies, infrastructure, and referral system.
5. Guaranteeing that all public and private health facilities will provide the essential Reproductive Health services to all in consistent with the level of experience and training of service providers.
6. Providing Reproductive Health information and services to all regardless of age , gender, and marital or socio-economic status.
7. Taking into account the religious, social and cultural factors in the provision of sexual and reproductive health information and services in the various communities and groups of people.
8. Protecting the rights of the clients in the course of obtaining appropriate medical information and services and ensuring maximum confidentiality and privacy.
9. Strengthening existing pre-service, in service and post graduate training on reproductive Health, and ensuring regular updates according to staff performance and establishing appropriate infrastructure to met the service provision requirements.
10. Involving traditional practitioners /healers in the promotion of safe practices for all aspects of sexual and reproductive health.

PART I

1.0 BACK GROUND AND RATIONALE

The challenge of addressing people's needs throughout their lives and a recognition of the shortcomings of existing health programmes has led to an expansion of maternal/child health, family planning and STD/HIV/AIDS to the broader concept of reproductive Health. The adoption of a comprehensive approach to Reproductive Health is now seen as a necessary response to

expanding needs in Reproductive Health arising for instance, from increased demand for family planning, greater awareness of maternal and neonatal mortality and morbidity, and a growing burden of reproductive ill health. Reproductive ill health will result from reproductive tract infections, cancers, STDs including HIV/AIDS, infertility and the results of violence related to sexuality and reproduction. The urgent need to respond to the threat posed by the AIDS pandemic further encourages the recognition of sexuality and health as a major component of Reproductive Health.

Reproductive Health therefore as defined by the International Conference on Population and Development, is not just the absence of disease, it refers to a spectrum of conditions, events and processes throughout life. These range from healthy sexual development, physical comfort and closeness and the joys of childbearing, to abuse, disease and even death. The Reproductive Health approach offers opportunities to improve not only the health of childbearing women, but also of the next generation, and to involve men in all aspects of Reproductive Health. In addition, Reproductive Health has multidimensional aspects and hence collaboration with other sectors, is vital. The Reproductive Health also raises issues of human rights, equity, and discrimination which must be addressed through participatory and inclusive processes that involve communities, families and individuals. The reproductive health policy will therefore provide guidelines to different sectors involved in the implementation of reproductive health programmes. The policy sets out to respond to the country's prevailing reproductive health situation so as to improve the standard of living and quality of life of Zambians.

PART II

2.0 REPRODUCTIVE HEALTH SITUATION ANALYSIS

2.1 INTRODUCTION

Reproductive Health is a crucial part of general health. Not only is it a reflection of health during adolescence and adulthood, it also sets the stage for health beyond the reproductive years for both women and men and has pronounced inter-generational effects. The health of the newborn is largely dependant on the mother's health status and of her previous access to health care. Reproductive Health needs increase during adolescence and, particularly for women, during the reproductive years. In old age, although general health continues to reflect earlier reproductive life events, other health issues become more important. Although individuals needs differs at different stages of life, there is a cumulative effect across the life span, events at each phase having important implications for future well being.

Further more, the provision of information, guidance and support enables people to have a healthy, safe and fulfilled sexual life. This is a challenging responsibility the health care system shares with families, other sectors and institutions.

2.2 POPULATION SITUATION

Zambia's population has increased rapidly over the last 30 years. The population which was 3.5 million in 1963 increased to 4.1 million in 1969, 5.7 million in 1980 and 7.8 million in 1990. In 1998 Zambia's population was estimated to be 10.2 million.

The fertility situation in Zambia has remained relatively high and is likely to remain so for sometime in the future unless concrete reproductive health intervention are undertaken. The

total fertility rates were estimated at 6.5 and 6.1 in 1992 and 1996 respectively.

Also, mortality levels which declined between 1969 and 1980 started to rise in the 1990s. Infant mortality rate was 98.7 in 1980 and rose to 109 in 1996. The maternal mortality ratio was estimated at 649 per 100,000 live births between 1990 and 1996. The recent increase in mortality have led to substantial declines in life expectancy at birth among Zambians from 52 years in 1980 to 46.9 years in 1990. The life expectancy at birth had further declined to about 37 years in 1998.

2.3 SAFE MOTHERHOOD

Safe Motherhood addresses service delivery for improvement of the health of the mother and the newborn. This means ensuring affordable quality care for the mother and the new born as close to the family as possible. Although safe motherhood services have been provided in the past, there has been no significant impact on health indicators of the mother and the newborn as earlier shown. The quality of safe motherhood services has been poor. This has been attributed to lack of appropriate infrastructure and referral system, inadequate supplies equipment, and drugs, lack of skilled staff, gaps in the content of service provided and lack of policy to guide the service operations. The other factors attributed to poor safe motherhood include, maternal age at first pregnancy, lack of family planning and high parity, lack of knowledge for risk factors and complications, healthy behaviours, poor economic status and unaffordable transport to health facilities, harmful traditional practices during labour and delivery.

In 1972, the Ministry of Health embarked on community-based service provision by introducing a programme for traditional birth attendants (TBAs), in an effort to promote safe motherhood. A substantial number of TBAs have since been trained. Especially through community initiatives. However, according to district health plans of action and district reports, only a limited number of the trained TBAs are reportedly still active, while those that are still active are under utilized.

According to the 1996 DHS, most women rely on a nurse or trained midwife for antenatal care. Less than 1 percent of women received antenatal care from trained TBAs, an indication that TBAs are minimally utilized as a source of antenatal care. 96 percent of all pregnant women interviewed have received at least one antenatal checkup from either a doctor or trained nurse or midwife.

DHS 1996, further indicated that, more than half of the women delivered at home and most of those deliveries were attended by relatives. The relatives might be family birth attendants and are most likely to have no midwifery training. Factors that contribute to the choice of place of delivery include traditional practices and reluctance to be delivered by a male health worker.

The rates of postnatal care attendance in Zambia are very low. The rate of post natal care attendance was estimated at 7.3 percent in 1994 (Family care International 1999). The Safe Motherhood Needs Assessment also reviewed that only 60 percent of the women who attended Ante natal clinic returned to the clinic for delivery and post natal care. Most women do not see the need for a postnatal checkup, or they do not know that such services exist. The study on factors associated with maternal mortality (1998) indicates that only 20.2 percent of women (Cases and Control combined) attend postnatal mostly at either hospitals or clinics. It also reviewed that 60.6 percent of maternal deaths occurred after delivery.

2.4 FAMILY PLANNING

Family Planning in Zambia, was started as early as in the 1960s. Unfortunately contraceptive prevalence is still low. According to the findings of the 1996 DHS, 98 percent of married women in Zambia have heard of family planning, and 59 percent have used a family planning method despite this knowledge, only 26 percent of married women in Zambia are currently using a contraceptive method. 14 percent of married women are using modern methods while 12 percent are using traditional methods. There is a higher percentage of use of family planning methods among urban women than rural women. In addition, contraceptive use tends to increase with increasing level of education. Better educated women are more likely to use modern methods than women with less education.

The "Unmet need for family planning" thus, the number of women who would like to either delay the next pregnancy or stop childbearing but are not doing anything to achieve the desire, declined from 33 percent in 1992 to 27 percent in 1996. Of this number, 19 percent have Unmet need for spacing their next birth and 8 percent for limiting births or stopping child bearing.

The Contraceptive Needs Assessment of 1995 showed that provider bias was evident towards clients and affected their method choices. There was inadequacy of skills in performing certain screening procedures and poor client - provider interaction. In addition, there is poor motivation on the part of providers due to the fact that most of those assigned to family planning duties have little or no training in family planning, and those that are trained have no extra financial incentives. The low prestige for family planning in comparison with other reproductive health areas is another factor of major importance. Management of information and logistics systems, and supervision are also ineffective.

2.5 MATERNAL NUTRITION

Poor Maternal Nutrition has effects on a woman and child's health. Malnourishment in mothers is associated with low birth weight, risk of mental retardation and stunting.

According to 1996 DHS, the average height of mothers measured in Zambia was 158 centimetres. This was above the critical cut off point of 145 centimetres only about 1 percent of mothers are shorter than 145 centimetres. The average Body mass index of the mother was 21.9 Kg/m^2 . This was also above the critical cut of point of 18.5 Kg/m^2 - Only about 9 percent or 1 in every 11 mothers were chronically undernourished or were below the Body Mass Index of 18.5 Kg/m^2 .

Birth weight is also an important indicator of maternal nutrition. According to the 1999. End of Decade Goals Survey preliminary report, the overall prevalence of low birth weight was found to be 8 percent. This indicates an increase from 4.8 percent low birth weight as shown in 1996 DHS. However, internationally a low birth weight prevalence of less than 10 percent does not signify serious problems of public health.

2.6 ADOLESCENT SEXUALITY AND REPRODUCTIVE HEALTH

Adolescent Sexuality is becoming an increasing concern in Zambia. Urbanization and modernization are giving rise to a new pattern of sexual behaviour in adolescents, including pre-marital sex which often leads to early pregnancy, induced abortion, STDs and HIV infection. Adolescents express concern about lack of information and understanding about their own sexuality.

Teenage fertility has increased over the years. The percentage contribution of teenagers to the total fertility rate increased from 9.2 in 1969 to 10.6 in 1980, 12 in 1992 and 13 in 1996. In 1992 and 1996, more than a quarter of adolescents had a child. Despite the increase in teenage fertility,

adolescents pregnancies carry a higher chance of obstetric risk and prenatal loss (abortion). Unfortunately, pregnant adolescents rarely receive special care, assistance or emotional support. Apart from high risk pregnancies, the large number of adolescents who initiate sexual activity at an early age are at high risk of contracting STDs/HIV/AIDS. The population survey on HIV sero--prevalence of 1996 indicated an infection rate of 8.2 percent among girls aged 15-19 years and 14.3 percent among urban girls of the same age group, while the infection rate among both boys and girls were 7.2 percent in rural areas and 9.1 percent in urban areas. The adolescents remain excluded from and are under-served through the current health service delivery system. This could be attributed to health workers who do not receive special training to deal with adolescents. Further, the adolescents remain excluded even from the guidance on sexuality and relationships within their own home environment. Mostly adolescents depend on their peer for information on reproductive health and sexuality.

However, the Government's intervention by introducing Youth Friendly Health services is very promising, though done on a small scale. Family life education has been widely promoted although it is encountering problems. Parents and community members fear that moral values may be lost when talking to adolescent about sexuality and other related topics. Adolescents as a special group require special attention.

SEXUALLY TRANSMITTED DISEASES INCLUDING HIV/AIDS

In Zambia, sexually transmitted diseases (STDs) are a significant problem. Although still a hidden problem, Ministry of Health records are indicating an incidence of 17 per 1000 population. It is estimated that 10 percent of hospital out patient attendances are for treatment of STDs. Sexually transmitted diseases do not only cause acute morbidity and complications, but also contribute to maternal and foetal mortality and adverse pregnancy outcome. WHO reports that in Zambia, 18 percent of early foetal deaths and 43 percent of late foetus deaths are due to maternal syphilis, and 30 percent of perinatal mortality is associated with syphilis. Prematurity is another problem that is often caused by STDs, while ophthalmia neonatorum, congenital syphilis and chlamydial neonatal pneumonia remain frequent causes of infant morbidity and mortality.

It is almost two decades since the HIV/AIDS was discovered in the world and since then it has evolved into a serious global health problem with serious socio-economic consequences, a situation applying for Zambia. The first case of AIDS was identified in the country in 1984. By 1997 there were about 45,000 AIDS related complex cases. About 1.02 million persons were infected with HIV in the same year. Nearly one out of every five adults is infected, or close to 20 percent of the entire adult population of the country. The prevalence rate of HIV among rural adults is 7-15 percent. Between 20-33 percent of urban adults are infected with HIV.

2.8 ABORTION

Unsafe and poorly performed abortions are a major cause of maternal mortality in Zambia. In 1993 Ministry of Health records indicated that over 16,000 hospital admissions nationally were due to illegally performed abortions. Another study on maternal mortality conducted at UTH, Lusaka, 1993, noted that 15 percent of all maternal deaths were occurring among patients with abortion.

Despite the availability of family planning services, many young women and teenagers fail to prevent pregnancies, and in 1993, 23 percent of incomplete abortions were in women younger than 20 years while 25 percent of the maternal deaths due to induced abortion were in girls younger

than 18 years. This might well reflect the lack of information and difficult access to family planning services as is reported from anecdotal data on adolescents. Lack of access to comprehensive family planning and safe abortion services are two of the major reasons why so many women suffer abortion complications and end up dying.

In 1972, Zambia adopted a Termination of Pregnancy Act which is regarded to be liberal. However in terms of its application, abortion services are not widely available, and where available, not easily accessible. This is due to various reasons, such as the requirement of signatures of three doctors for approval. In addition, most people and many health workers do not know about the Act.

2.9 INFERTILITY

The rates of infertility in Zambia are not known but gauging from the prevalence of STDs alone, it is estimated that both primary and secondary infertility rates are of concern. Impaired fertility, variously described as infertility or sub-fertility, may be due to a relative or absolute inability to conceive, or to repeated pregnancy wastage. It affects both men and women in approximately equal proportions, causing considerable personal suffering and disruption of family life.

As in many other societies, in Zambia the inability to conceive and bear a healthy child is considered to be the fault of the female partner rather than a problem of the couple. The lack of access to effective treatment, or to counselling causes much personal suffering and family and social dysfunction. Much infertility is preventable, through measures to reduce reproductive tract infections and improve their management. In contrast, infertility is generally difficult and costly to treat. It is cost-effective to focus on prevention, especially in resource-poor settings.

2.10 OTHER REPRODUCTIVE HEALTH ISSUES

Cervical cancer is the most common cancer among women in most developing countries, and one of the major causes of mortality. In Zambia there were 42 women that died of cervical cancer in 1999 from 1998 figure a total of 35. Certain STDs, in particular the human papilloma virus, increase the risk of cervical cancer. Cervical cancer is potentially curable if detected early and treated adequately. There are inadequate facilities for periodic cytological screening (Pap smear) in order to detect early pre-invasive cancer, especially in health centres. So far only the major hospitals in Zambia are able to provide cervical cancer screening.

Breast cancer is similar to cervical cancer in terms of its impact on women. The risk factors associated with breast cancer are poorly understood although an increased risk is associated with a family pre-disposition, particularly breast cancer pre-menopausally in a mother or sister. Age at menarche, age at first and last pregnancy and age at menopause are also associated with an increased risk, none of which can be easily modified through public health interventions. There is little possibility for primary prevention strategies to reduce either incidence or mortality from breast cancer.

The risk factors for breast cancer suggest that it will increase as development brings changes in fertility and reproductive behaviour in developing countries. Although each individual factor may make only a small contribution to increasing the risk, the cumulative effect in terms of absolute numbers can be high. The organization and implementation of mass screening programmes are far beyond the resources of Zambia, and breast self-examination (BSE) remains the main option.

There were 290 and 33 women admitted at University Teaching Hospital (UTH) suffering from cervical and breast cancer respectively in 1999.

Menopause the permanent cessation of menstruation, generally occurs between the ages of 45-55 (in some women menstruation stops abruptly, in most, many months of irregular bleeding precede the final menstrual period). The median age of menopause is 50-52 in industrialized countries and about one to two years younger in developing countries. The menopausal transition last about four years. Specific diseases associated with the hormonal changes accompanying menopause - include circulatory diseases and osteoporosis.

In addition to irregular bleeding patterns and eventual cessation of menses, pre menopausal and menopausal women may experience vasomotor symptoms (hot flushes, night sweats), urogenital problems and psychological symptoms. Not all women experience or report all these symptoms. Also, some symptoms are experienced more commonly before and during menopause and others after.

Declining estrogen levels which lead to urogenital atrophy (decreased vaginal and bladder muscle tone), a thinner vaginal epithelium and vaginal dryness, making intercourse painful is another post menopausal problem. Urinary problems - urgency of urination, pain on urinating, and incontinence (leaking urine) - are reported to affect 25-50 percent of postmenopausal women. Pelvic floor muscles that have been damaged from repeated pregnancies further compound the problem or urinary incontinence. Certain health risks, including cardiovascular disease and osteoporosis, increase after menopause.

Postmenopausal women have higher cholesterol levels (including total cholesterol, very-low-density lipoprotein cholesterol and low-density lipoprotein cholesterol) than premenopausal women.

Menopause also triggers a process of reduction in bone mass that can result in pain, disability and increased risk of fractures (particularly hip and spine fractures in women aged 60-80). The link between osteoporosis and menopause is related to decreasing ovarian hormone levels, particularly estrogen.

Repeated pregnancies and obstetric trauma can lead to genital prolapse, a painful debilitating condition. Genital prolapse can involve the vaginal wall or uterus descending below their normal positions. It also can involve protrusion of part of the bladder or rectum from the vagina.

As women age, various factors make them more susceptible to urinary tract infections, including decreased bladder tone, incomplete voiding, genital prolapse and in some case, reduced immune function. Prolapse also can compound reproductive tract infections (vaginitis, cervicitis, Pelvic Inflammatory Disease), Little is known about women's relative risk of sexually transmitted disease (STD) as they age, but the vaginal changes (thin, dry epithelium and altered pH) likely make women more susceptible to STD infections.

2.11 HEALTH SERVICE DELIVERY SYSTEMS

In 1991 the Government of Zambia embarked on a radical health reforms process that has been dedicated to providing Zambians with equity of access to cost effective quality health care as close to the family as possible. Despite this vision the Government still faces a number of challenges.

Currently, there are 206 urban centres and 880 rural centres. The urban centres serves a catchment population of about 30,000-50,000 around a 30Km radius and the rural health centres serves the catchment of about 10,000 within the same radius of 30 Km. However, in rural areas most health

centres have serious staff and equipment shortages and are unable to provide a basic package of primary health services or provide 24 hours coverage. This situation is not only true for rural and urban health centres but also true for some hospitals. Though staff may be there in hospitals there are shortages in equipment and supplies.

Furthermore, the health system has an uneven workforce distribution. Some rural health centres have no nurse or midwife. Currently, registration figures indicate that 7051 enrolled nurses, 2901 registered nurses approximately 3,500 nurse-midwives, 531 physicians and 12093 clinical officers exist but it is not clear how many are in practice or where they practice. Also, systems of referral between levels of the health care system are weak, especially in rural areas where health centres are more likely to be inadequately staffed or where staff cannot manage due to, lack of training, equipment, pharmaceutical or supplies. Communication between health centres and hospitals are sometimes not possible due to possibly lack of the telephone or two-way radio communications and transport.

Although information education and communication has been acknowledged as important in reproductive health by many health workers, there has been sporadic EEC activities with little or no systematic documentation or evaluation of activities that exists. Limited information exists at the National level on IEC campaign design, areas of operations and the audiences for which messages and materials were developed.

PART III

3.0 POLICY VISION, OBJECTIVES AND STATEMENTS

3.1 REPRODUCTIVE HEALTH POLICY VISION

To achieve the highest possible level of integrated reproductive health of all Zambians as close to the family as possible so as to promote quality of life.

3.2 POLICY OBJECTIVE AND STATEMENTS

3.2.1 REPRODUCTIVE HEALTH INFORMATION

OBJECTIVES

(Family Planning, Safe Motherhood, Post Abortion Care, Adolescent Health, STU HIV/AIDS, Infertility, cancers related to reproductive health system and menopausal problems).

1. To enhance reproductive health information and service provision so that all individuals and couples will be able to achieve their reproductive intentions while upholding their reproductive rights.
2. To strengthen the concept of integrated reproductive health through advocacy and IEC so as to ensure sustainability of integrated reproductive health programmes.

STATEMENTS

1. Promote information dissemination on reproductive health for all stake holder and sectors through appropriate channels.
2. Provide appropriate information on integrated reproductive health, in order to enhance understanding of the concept and participation by all stake holders.
3. Advocate for a collaborative, coordinated multisectoral approach and political commitment to the provision of Integrated Reproductive Health.
4. Advocate for change of harmful cultural beliefs and practices that have a negative effect on reproductive health of individuals.

3.2.2 SAFE MOTHERHOOD OBJECTIVES

5. To ensure the provision of quality Integrated Safe Motherhood Services which are accessible, acceptable and free at all levels of the health care system.

STATEMENTS

1. Identify and address factors that inhibit/enhance accessibility and acceptability to services in relation to management, social cultural practices, health care providers and client related factors.
2. Provide quality ante natal care for the prevention, early detection and management of pregnancy complications.
3. Provide support for clean and safe delivery attended to by appropriately trained personnel.
4. Establish /maintain appropriate structures and infrastructure within the health care system in order to provide integrated safe motherhood.
5. Provide a range of basic equipment necessary to deliver quality safe motherhood services.
6. Encourage postnatal care attendance for early detection of risks of maternal death after delivery.

3.2.3 FAMILY PLANNING

OBJECTIVES

1. To ensure that procurement of family planning commodities are made on a sustainable basis.
2. To ensure that provision is made for production and distribution of IEC materials for dissemination especially to health institutions at all levels of society.

STATEMENTS

1. Provide for procurement of commodities and for IEC material production and dissemination in Annual Budgets.
2. Provide commodities including contraceptives and every facility in the country to every individual of reproductive age especially women without consent from the spouse or partner.

3. Campaign and Advocate for public support of family planning programmes.

3.2.4 MATERNAL NUTRITION

OBJECTIVE

4. To ensure that the nutritional status of women, and adolescent girls in particular is improved to prevent health problems.

STATEMENTS

1. Support programmes addressing issues contributing to under nutrition.
2. Provide public information on women's nutritional needs.
3. Advocate for income generating activities especially among women.

3.2.5 ADOLESCENT HEALTH AND DEVELOPMENT OBJECTIVES

1. To empower adolescents/youth by equipping them with life skills, including assertiveness, self esteem, value clarification and decision making in order to achieve a positive life attitude.
2. To increase accessibility and availability of affordable Youth Friendly Health Services to adolescents/youth at all levels of the health care system.

STATEMENTS

1. Provide family life education and life skills to all the in and out of school adolescent/youth to enable them make responsible decisions concerning their life.
2. Incorporate family life education in the curriculum of the Vocational Training Centres for out of school youth.
3. Increase the number of service delivery points providing adolescent/youth services as appropriate at each level of the health care system.
4. Define the role of the traditional health care system in adolescent/youth reproductive health.
5. Encourage more collaboration between traditional and formal health care sector.
6. Strengthen inter personal communication and services between young people and peer educators involved in reproductive health services for adolescents/youth.

3.2.6 STIS/HIV/AIDS

OBJECTIVE

1. To strengthen the prevention and effective management of STI/HIV/AIDS.

2. To reduce the rapid spread of HIV/AIDS.

STATEMENTS

1. Promote research on HIV/AIDS cure.
2. Support plans, programme and other initiatives aimed at mitigating the impact of STI/HIV/AIDS on individuals, households, the community national levels through financial and logistical resources.
3. Support plans, programmes and other initiatives aimed at reducing spread of HIV/AIDS
4. Advocate for continuous supply of affordable drugs and alternative therapy in HIV/ADS client.

3.2.7 ABORTION OBJECTIVE

1. To strengthen the quality and availability of post abortion care and counselling services within the context of integrated reproductive health.

STATEMENTS

1. Intensify the provision of family planning, post abortion care services, pre and post abortion counselling.
2. Provide family planning IEC and FLE on the importance of prevention of unwanted pregnancies.

3.2.8 INFERTILITY OBJECTIVE

1. To ensure the provision of appropriate services for overcoming infertility barriers to the achievement of reproductive intentions.

STATEMENT

1. Provide preventive and curative services for couples /individuals with infertility problems.

3.2.9 HEALTH SERVICE DELIVERY

OBJECTIVE

1. To ensure the provision of quality reproductive health services at all levels of the health care system.

STATEMENTS

1. Expansion of reproductive health services
2. Promote equal and even distribution of skilled staff
3. Strengthen referral and communication between levels of care.
4. Promote the provision of adequate basic equipment and supplies

3.2.10 OTHER REPRODUCTIVE HEALTH ISSUES OBJECTIVES

1. To strengthen diagnosis and management of all related reproductive health cancers at all levels of health care system (cancer of the cervix, breast and prostate).

2. To ensure that there is a preventive and curative programme for women after menopause.
3. To ensure gender equality and equity for all individuals in the designing and execution of all laws, policies, plans, projects, programmes and in the utilization of reproductive health services in order to provide gender balanced development.
4. To enhance the knowledge and establish evidence based practice for the population on factors affecting Reproductive Health by undertaking research data collection and usage of the findings.

STATEMENTS

1. Support programmes for prevention, screening and treatment of cervical, and breast cancer including prostate cancer in the males.
2. Strengthen awareness campaigns for screening and early management of reproductive health related cancers.
3. Support for awareness programmes for women on menopausal phase.
4. Provide information and management services for women going through menopausal problems.
5. Sensitize men and women on the existence of gender disparity and the benefits of gender balance in matters related to reproductive health.
6. Empower women with knowledge, and skills to develop their self esteem and assertiveness to enable them make positive decisions regarding their reproductive health.
7. Support male involvement in reproductive health, information, counselling and care.
8. Develop, coordinate and implement a multi-sectoral research agenda for Reproductive Health, with particular emphasis on social behaviour and health system research.
9. Strengthen coordination between the national and regional research institutions and establish a national data bank on reproductive health research.
10. Strengthen national capacity for multi-disciplinary research in reproductive health.
11. Encourage the dissemination and utilization of relevant findings of reproductive health research.
12. Conduct research on special needs of adolescents and youth gender sensitization in order to improve the design and executive of reproductive health interventions.

In order to realize the vision and objectives and effectively pursue the statements of this policy, there is need for an appropriate institutional framework. The institutional framework would also allow for effective monitoring and evaluation of progress towards the implementation of the policy. Part IV of the policy outlines the envisaged institutional framework.

PART IV

4.0 INSTITUTIONAL FRAMEWORK FOR REPRODUCTIVE HEALTH

4.1 MINISTRY OF HEALTH - (MOH)

In the health reform system, the Ministry of Health serves as the overall body for policy formulation, coordination, resource mobilization and forward planning for the whole health sector. The Ministry therefore, shall coordinate, evaluate and monitor the implementation of the policy.

4.2 CENTRAL BOARD OF HEALTH - (CBOH)

As the national executing agency for the Ministry of Health in the overall technical management of the health sector, the Central Board of Health is responsible for overall delivery of quality reproductive health services. The Central Board of Health supervises all other Health Boards in the country i.e. Hospital management Boards, District Health Boards and Statutory Boards and can take over responsibilities of failing boards.

The Central Board of Health shall provide technical advice, guidance, regulatory service and facilitate the network of technical expertise in the implementation of this policy. It shall also assist the Ministry in revision of the policy by providing the required technical inputs.

4.3 REPRODUCTIVE HEALTH UNIT

Reproductive Health Unit in the Ministry of Health, shall carry out the functions of co-ordination monitoring and evaluation on behalf of the Ministry. The unit shall be the secretariate of the reproductive health sub-committee of the Inter Agency Technical Committee on Population and Development.

4.4 PROVINCIAL HEALTH OFFICES

The policy implementation shall be co-ordinated in provinces through provincial health offices. The Provincial Health Offices shall provide technical advice, mediation, enforcement of health related laws and statutory instruments and facilitate the network of technical expertise to all provincial collaborating partners in the area of reproductive health.

4.5 DISTRICT HEALTH MANAGEMENT TEAM (DHMT)

The DHMTs is the executive body of the District Health Board and consists of seven to ten members. The team shall also be charged with the responsibility of over seeing the implementation of the policy at the district level.

4.6 THE REPRODUCTIVE HEALTH SUB-COMMITTEE OF THE INTER-AGENCY TECHNICAL COMMITTEE ON POPULATION AND DEVELOPMENT

The Inter-Agency Technical Committee on Population and Development (ITCP) shall reinforce the

technical base required for the implementation of the policy through the reproductive Health Sub-committee. The ITCP through the Reproductive Health Sub-Committee shall reinforce the institutional capacities for programme design, development, coordination, monitoring and evaluation of the implementation of the policy. Its membership comprise of senior technical officials from appropriate institutions.

4.7 PRIVATE AND NON-GOVERNMENTAL ORGANIZATION

Private, non-governmental organization and religious organizations shall continue to participate in Reproductive health activities. Due recognition and support shall be given to their work, expertise, experience and resource capabilities.

4.8 PARLIAMENT

The Zambia, All Party-Parliamentary Group on Population and Development will play a key advocacy role in implementation of the Reproductive Health policy. It will be important for Members of Parliament to take keen interest and continue to support wide awareness on issues related to Reproductive Health to ensure the enactment of legislation necessary for effective implementation of this policy.

4.9 CO-OPERATING PARTNERS

Donor agencies and international non-governmental organizations will continue to play a vital role in providing support to the implementation of this policy. To achieve this, there will be need for improved co-ordination and collaboration among the donors with Government and Non--Governmental Organization.

5.0 MONITORING AND EVALUATION

The implementation of reproductive health policy will be monitored and evaluated on a regular basis in order to improve the quality of service provision. The monitoring and evaluation plan shall be continuous to measure outcomes, impacts and overall success and ultimately ensure strengthening of the reproductive health programme through field visits and reporting.

5.1 MONITORING

The monitoring of the implementation of the Reproductive Health Policy will be done in following ways:-

- a. Provision of supportive supervision by technically trained managers to re-inforce morale and adherence to accurate record keeping e.g. partograms and registers at all levels.
- b. Regular supervisory safe motherhood committee meeting at facility and community levels
- c. Quarterly and annual progress reports.
- d. Mid-term programme reviews

- e. Institute routine surveillance of all maternal deaths occurring in the community health facilities.
- f. Conducting maternal death audits at facility level to improve quality of maternal health services.
- h. Reviewing and streamlining the standard technical guidelines, record keeping and
- g. Ensure referral systems provide feed back information on outcomes to enable referring medical staff assess the effectiveness of their screening and referral programmes.
- h. Reviewing and streamlining the standard technical guidelines, record keeping and health information system including provision of training in use of data.
- i. Establish an information base/resource centre to provide a basis for monitoring and valuating interventions as well as facilitate information sharing between collaborating agencies.
- j. Use the Reproductive Health Subcommittee of the ITCP (Inter-Agency technical committee) as a forum for collaboration and co-ordination with other sectors.

5.2 EVALUATION

Evaluation will be done through:-

- a. Conducting routine surveys.
- b. Tracking inter-mediate and long term indicators based on programme objectives and national Inter-Reproductive Health Programme.

GLOSSARY

Total Fertility Rate:The average number of children that would be born alive to a woman during her lifetime if she were to pass through her child bearing years conforming to the age -specific fertility rates of a given year.

Life Expectancy at Birth:The average number of years a newly born infant is expected to live if current mortality trends were to continue.

Maternal Mortality Rate:The number of women who die due to pregnancy and child birth complications per 100,000 live births in a given year.

Infant Mortality Rate:The number of deaths of children under one year of age in a given year per 1,000 live births in that year.

Parity: The number of children born live to a woman.

Adolescent: Person aged between 10 - 19 years.

Abortion:Is termination of pregnancy cexpulsion or extraction of embryo/fetus _ before 22 weeks of gestation or below 500gm weight of fetus.

Infertility: Absolute inability of a couple to achieve pregnancy after 12 months of active sexual inter-course.

Sub-fertility: relative inability / difficulty at conceiving.

Fertility: The actual output of births, as opposed to the potential output.

Cervical cancer: Cancer (Malignancy) arising from the neck of the womb (cervix).

Menopause: The normal cessation of menstruation at the end of reproductive age which normally happens at 50^h year and 51st year of life.

Breast cancer: Malignant tumour arising from the breast.

Menarche: The beginning of menstruation.

Menstruation: The periodic flow blood from the cavity of the womb.

Cardiovascular Disease: The disease of the heart muscle and blood vessel.

Osteoporosis: The increased porousness of bone due to lack of calcium salts.

Blood Lipid Profiles: One of a group of fatty substances that are insoluble in water but soluble in alcohol.

Lipo-protein cholesterol: One of a group of fatty proteins that are present in blood plasma.

Progesterone: One of several steroid hormones which have similar functions. It controls female sexual development.

Hormone: Substance which on absorption into the blood influence the action of tissues and organs other than those in which they are produced.

Obstetric Trauma: Injury suffered by the genital (Birth) tract during labour.

Genital Prolapse: Downward displacement from normal position of female genital organs i.e. uterus bladder, rectum to weakening, ligaments that support these organs. This can be mild to complete protrusion through the vagina.

Ante Natal Care: Ante Natal Care is the care provided to pregnant women from conception through to onset of labour.

Postnatal Care: This is the care provided to the woman and her baby at the follow up postnatal visit from the time of discharge from hospital to the end of the puerperium.

Prenatal Loss: Loss of pregnancy/ baby before delivery, this includes abortion and stillbirths

Menopausal transition: (Climacteric) this is a period 5 to 10 years before actual menopause and after.