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UTILISATION OF FAMILY PLANNING SERVICES IN ZAMBIA AND NORWAY

INTRODUCTION

Family planning services are defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved (WHO, 2010). They are medical and social activities in that professional advice, social acceptance and individual or couple participation is required for the anticipated goal to be achieved (Abedin, 2010).

Family planning is the voluntary planning and action taken by individuals and couples to anticipate and attain their desired number of children in addition to the spacing and timing of their births. It is achieved through the use of contraceptive method (WHO, 2013). Family planning services do not only focus on the planning of when to have children, rather it includes sex education, prevention and management of sexually transmitted infections (STIs), infertility management and preconception counseling and management. Family planning offers a positive view of reproductive life and enables people to make informed choices about their reproduction and well-being. It plays a vital role in the reduction of infant, child and maternal morbidity and mortality by protecting women from the risk of pregnancy and its associated complications. By preventing unwanted or mistimed pregnancies, family planning can also reduce abortions by unskilled providers or under unhygienic conditions that are common in developing countries like Zambia. It is achieved through the use of contraceptive methods which include abstinence, natural family planning hormonal contraception and contraceptive supplies such as condoms, diaphragms and intrauterine devices (WHO, 2013).

As a midwife, I have worked in Public, Military and Catholic owned institutions for the past fourteen (14) years in Zambia under the Maternal and Child Health Department which offers family planning services. Having a chance of studying in Norway with clinical practice in a Gynaecology ward, I have found it relevant to discuss and compare the utilization of family planning services among women in the child bearing age in a developing country (Zambia) and the developed country (Norway).

DISCUSSION

The Zambian population has **tripled** over the past 50 years from 3.5 million in 1964 to 13 million in 2010 (CSO, 2012), while Norway has recorded **39%** population increase during the last 50 years with 3.6 million in 1960 to 5.0 million in 2012 (NSO, 2013). The rapid increase in Zambian population can be associated with poor utilisation of family planning services evidenced by the number of women in Zambia with access to family planning which is as low as 24% (UNFPA, 2013). The differences in the utilisation of contraception in Zambia as compared to Norway can be associated with social and educational empowerment. Lack of educational empowerment has a relation with lack of family planning knowledge, non-supportive attitude and low prevalence of contraceptive use (Abedi, 2010).

Accessibility to Health care services is one of the major challenges faced in Zambia. In remote and rural areas, contraceptives are also not easily accessible because health centres are located very far and it is very difficult for individuals and couples to reach them (Solo et al, 2005). Family planning services are offered on specific days and time making it difficult for some clients to access them when needed. Only condoms are sold almost everywhere but again due to poverty, some people cannot afford to buy them. This is not the case in Norway where almost everyone has access to the General Practitioner and the Public Health Nurse who give advice and contraceptives to individuals and couples (Joffe, 2011). Condoms are also sold in almost all supermarkets and almost everyone can afford to buy.

Zambia is a Christian nation and most Christians believe that life begins at conception and that every human being has a right to life. This is a very controversial issue that has made abortions extremely difficult to obtain despite it being technically legal. The Zambia's Termination of Pregnancy Act of 1972 allows abortions to be carried out on broad health as well as socioeconomic grounds. The Act permits a woman to have an abortion after the approval of three physicians before she can go to one of the few facilities that perform the procedure (Mushabati, 2012). On the other hand, abortion is completely integrated into the Norwegian health care system, paid for like other medical procedures by the government, and available virtually everywhere in the country as long as the pregnancy is below 12 weeks. If the pregnancy is between 13 to18 weeks then a woman has to make an application to a committee which is composed of two physicians (Joffe, 2011).

Unavailability is another reason to poor utilisation of family planning services because not all health institutions are Public owned. For example, quite a good number of health institutions are owned by the Catholic Church which does not stock and distribute contraceptives as they only believe in the use of Natural method of contraception (Solo et al, 2005). Natural Family Planning

(NFP) is a method of periodic abstinence from, and varieties of, sexual contact between the male and female in a couple who desire to plan the timing of the arrival of their children. These are methods for family planning by observing naturally occurring signs and symptoms of the fertile and infertile days of the menstrual cycle (USCCB, 2013). In Norway, almost all Health institutions are Public owned with few privately owned and none is owned by the Catholics (Mo, 2008). This makes contraceptives available and accessible in almost all health institutions.

In Zambia, poor health services discourages individuals and couples to access family planning services especially in public health centres. The waiting time is too long and health care providers have little or no time to giving information to clients concerning family planning (Solo et al., 2005). This can be attributed to overwhelming of work and critical shortage of health care providers. Worse still if it is an adolescent or unmarried person, such a client is usually scolded at by the health care provider because pre-marital sex is considered as a taboo hence they shun the service (Taylor, 2006).

Lack of school service programmes and Youth Friendly corners in all Public Health institutions which are supposed to cater for the adolescents is another challenge in Zambia. This is mainly due to the critical shortage of trained health care providers to run the programmes (Haile et al., 2000). This has greatly disadvantaged the adolescents as they have no access to family planning services because the service in all Health care institutions have specific days and timings when they are offered. This means that the issue of confidentiality is really compromised in that everyone going to the health centre on that particular day and time will be known as accessing family planning. Only condoms are accessed any time as these are just put where anyone can just get. In Norway, Health visitors prescribe contraceptives to girls in schools and one can visit or consult the General Practitioner at any time, making accessibility by adolescents very easy and every individual has the right to choice and same access to family planning whether married, single, adolescent or adult (Hansen and Skjeldestad, 2007).

Due to high illiterate levels among the people of Zambia, there are many myths associated with the use of contraceptives such as developing cancer of the cervix and permanent infertility among others (Creel et at., 2002). Additionally, Gender-based barriers/ Spousal disapproval is so common in Zambia due to the culture which gives men authority over women (Taylor, 2006). This means that, women have very little say even on matters of family planning. The other reason is that men are not so much involved in issues of family planning, making the compliance to birth control and the disseminated of information so difficult. On the other hand, men in Norway are so much involved in issues of maternal and child health. Literacy is almost 100% and with advance in technology which gives easy access to information, the decision and compliance of

Family planning is so effective (Joffe, 2011).

The shortage of trained man power has not spared the Maternal and Child Health section in Zambia making it difficult for all the people in Zambia to be offered the family planning services especially the hardest to reach population. The few trained family planning providers again are not trained in all the methods offered especially the long term ones such as Intra Uterine Device (IUD), Norplant and permanent sterilisation for both women and men (Solo et al., 2005). This means that clients who want to access such methods will be referred to few institutions offering them, making accessibility to long term methods a challenge. On the contrary, in Norway, every method whether short or long term is easily accessed by clients who want them through their General Practitioners (Mo, 2008).

In Zambia and Africa as a whole, children are considered as wealth, meaning that the more children one has regardless of his/her economic status the richer the person. It is also believed that children are a gift from God hence the more children one has the more blessed that person is (Creel et al., 2002). This belief has posed a big challenge in the provision and utilisation of family planning services because people do not see any advantage of having a small family that they can manage effectively especially among the uneducated and the poor as they take the children as their investment. This is one of the reasons why early marriages are so common in Zambia so that one can start a family as soon as possible. Education is somehow considered as a waste of time especially for a girl child in rural Zambia (Conte, 2012). On the contrary, people in Norway and other developed countries give priority to education and starting a family at an early age is considered as a hindrance to progression in education (UNICEF, 2010) .

Impact of low utilization of family planning

Because of poor utilisation of family planning, Zambia has experienced unsustainable population growth as earlier mentioned. This has resulted into negative impact on the economy, environment, national and regional development efforts. This continuous increase in population size has put pressure on an already overburdened socio-economic resource base, particularly in core development sectors, such as education, health and food security (WHO, 2013).

If Zambia was to improve the utilisation of family planning services, she can benefit a lot as education will be enhanced and women will be empowered to participate in public life, including paid employment and this will decrease the gender pay gap. Women's ability to use contraceptives, and to determine whether and when to have children, enhances their education and employment chances (USAID, 2009). This in turn, improves their income, family stability,

mental health and happiness, as well as the well-being of their children. Additionally, having smaller families like in Norway, allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings (SUFP, 2013).

Significantly, more young women would obtain at least some college education and more college-educated women would pursue advanced professional degrees if Zambia was to improve adolescent's access to contraception (SUFP, 2013). Many adolescent girls who become pregnant in Zambia have to leave school. This has long-term implications for them as individuals, their families and communities. Additionally, babies born to adolescents have higher rates of neonatal mortality due to pre-term or low birth weight (WHO, 2013). Adolescent and unplanned pregnancies also increase the cases of unsafe abortions which in turn increases maternal mortality ratio. This is the number of women who die during pregnancy and child birth. The Zambian maternal mortality ratio in 2010 was 440:100 000 live births (World Bank, 2012).

Efforts being made to improve utilisation of family planning in Zambia

The Zambian Government's health vision is to provide health services as close to the family as possible. It has made commitments towards improving access to family planning and commits to increase the contraceptive coverage for modern methods from 33% to 58% (Chanda, 2012). To ensure a steady and adequate flow of reproductive health commodities, including family planning, the Government of the Republic of Zambia formed a Reproductive Health Commodity Security (RHCS) Committee in 2011, comprising of officials from the Ministry of Health, Ministry of Finance and National Planning, Non-Governmental Organisations and Cooperating Partners. This is to ensure continuous flow of reproductive health commodities and services. Zambia has also embarked on the use of community based agents such as Safe Motherhood Action Groups and Community Based Distributors (CBDs) to provide information on the importance of utilisation of family planning services especially in rural areas (Sipangule, 2011).

On 11th July 2012, Zambia and Norway were among the Governments who attended the London Summit on Family Planning. This is where Governments, donors, civil society and other stakeholder came together to support the rise of women and girls to freely decide whether and when to have children. These stakeholders mobilised resources to help developing countries to reach out to 120 million more women and girls access and practice contraception in eight years and Zambia is one of the developing countries to benefit (Chanda, 2012). At the summit, Zambian Minister of Community Development, Mother and Child Health, Dr. Joseph Katema reported that

the Zambian Government has doubled its budgetary allocation for family planning services in an effort to reach the vulnerable majority who need these critical services. The doubling of the family planning funding is a direct Government response that will be complimented by additional contributions from donors (Ibid).

It is at this summit that, the Norwegian Minister of International Development Mr Heikki Holmås announced that "Family planning is about the right of girls and women to control their own bodies. It is for this reason that Norway will provide an additional NOK 150 million for family planning in 2013, and intends to maintain this at the same level each year until 2020". Norway has been ranked the world's best country for mothers for the third year in a row (Royal Norwegian Embassy, 2012). This amount of money together with support from other countries and Non-Governmental Organisations (NGO) can go a long way in helping developing countries like Zambia to improve family planning services.

In February 2013, the Zambian First Lady Doctor Christine Kaseba Sata who is an Obstetrician by profession launched the National Family Planning campaign aimed at scaling up the use of contraceptives among women to prevent unplanned pregnancies. She said during the launch that it was unfortunate that family planning was being misunderstood by many women resulting into myths and misconceptions (SUFP, 2013).

SUMMARY

Every Government should work hard in controlling the growth of its population. In developing countries like Zambia, it is a big challenge because Family planning services are poorly utilized making population growth very rapid. There are so many factors associated with poor utilization of family planning services such as inaccessibility, unavailability, religious and cultural beliefs among others. The impact of having a huge population is that there is competition of too many people against few resources and services like education and health services. It is therefore, a responsibility of every individual and couples to voluntarily utilize the services of family planning on offer. It is good to acknowledge the donor communities like the Norwegian Government who are coming to the aid of developing countries like Zambia in an effort to scale up the utilization of family planning services.

CONCLUSION

From the discussion, it can be noted that, a low rate of contraceptive use and high fertility rate persist in Zambia. The Government is working hard to ensure equity and increased utilisation of family planning services in both urban and rural Zambia. The best way to improve utilisation of family planning services is to eradicate illiteracy. This is because once a woman experiences higher education, the importance of family planning will be appreciated. Education is the best way to change cultural and religious beliefs which play a role in the low utilisation of family planning. If a girl child is encouraged and supported to attain good education, then poverty and early marriages will be eradicated which in turn will have a positive impact on the utilisation of family planning. Additionally, education will expose people to more knowledge on the importance of family planning. Norway has a higher rate of family planning use. This can be attributed to the fact that people are educated, they have the information and they appreciate the importance of having a small family that they can afford, hence poverty is eradicated and economic development enhanced.

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