

Women's health and sexual and reproductive health in Zambia:

A review of evidence



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Executive summary

In 2012-3, building on work done on health literacy and the EQUINET pro4equity network to strengthen communication between health workers and communities, TARSC is implementing a programme with HEPS Uganda and Lusaka District Health Management Team (LDHMT), Zambia, with Cordaid support. The programme will extend health literacy in Uganda and Zambia, using the skills built to promote dialogue and accountability between health workers and communities, including women's health and sexual and reproductive health (SRH). As part of this work, LDHMT and TARSC commissioned a review paper on SRH in Zambia.

Grey and published literature on women's health and SRH in Zambia were reviewed and literature related to public health, women's health, and SRH was searched in Pub Med, OVOID, MEDLINE, CINAHL, EBSCO databases and Google search engine. The publications were reviewed to present information on:

- i. The public health situation and women's health, including important trends in women's health and SRH since 2000;
- ii. The causes and determinants of the patterns above, including gender inequalities in norms, roles and resources and social determinants;
- iii. The policies, services, personnel and programmes within and beyond the health sector that promote and respond to women's health and SRH and the three delays and their causes in accessing and using those services; and
- iv. The implications for communities and health systems.

The review highlights the right to health, to quality health services and other underlying social determinants of health. There are factors that affect the realisation of this right in relation to women's health and SRH. Although maternal mortality in Zambia decreased from 729 to 591 per 100,000 live births, the rate is still high and far from the target of 120/100,000 by 2015 (CSO et al 2009) Cervical cancer, the second most common cancer amongst women in Africa, is a rising threat to women's health. Early marriages lead to early childbearing, short birth intervals and unplanned and unwanted pregnancies. These lead to unsafe abortion and a variety of infections including HIV. In addition, women are affected by a range of conditions that include non-communicable diseases (NCDs), such as stroke, cancer, diabetes mellitus, sickle cell anaemia, alcohol and substance abuse and nutritional problems. Women experience mental health problems such as depression, anxiety and suicide.

Extreme poverty is a factor in women's health. Poverty is concentrated in rural areas with 76.8% of the rural population living below the poverty datum line (UN 2011). Women's control in rural areas is restricted to household work. Urban women often work in marginal positions as traders, and their rural counterparts in subsistence farming. Women are vulnerable due to their low education levels and young age at marriage. Women's infection rate with HIV is higher, reflecting in part their poor socio-economic and cultural position, which also limits their ability to access treatment. Gender-based violence is closely linked to women's socio-economic status and to patriarchal beliefs that reinforce men's and boys' dominance over women and girls. Lower education levels mean that women have fewer employment opportunities.

Gender-based violence against women is perpetuated by cultural orientation, initiation ceremonies and payment of bride price, allowing men to feel superior over women. Women may become submissive and obedient even when they are physically, sexually and mentally abused. Physical violence (wife battering) is a major cause of injuries, ranging from minor cuts and bruises to permanent disability and death. Sexual abuse results in unwanted pregnancies,

sexually transmitted infections including HIV, undermines women's sexual autonomy and jeopardises their health. The Zambia National Child Policy states that the situation for the Zambian child remains unfavourably affected by child labour, neglect, prostitution, defilement, child trafficking, early pregnancies and marriages, and vulnerability to HIV/AIDS infections (Ministry of Sport, Youth and Child Development 2006).

Social and institutional factors also act as barriers to using health care services. About 94% of women have access to antenatal care services, although with late bookings in the second or third semester of pregnancy. Family planning knowledge is near universal (96%) but contraceptive acceptance prevalence is low (33%) for modern family planning methods and 12% for traditional methods. Institutional deliveries were at a low rate of 47% in 2007 from 43% in 2001, with 48% of births occurring at home with assistance from unskilled traditional birth attendants. Women delay in seeking health care because they or their families may not recognise signs of risk in pregnancy or because beliefs delay uptake of maternal services (CSO et al 2009).

The Zambia Reproductive Health Policy of 2008 addresses Safe Motherhood conditions as essential for sustainable human development. A 2005 National AIDS Policy further responds to the negative effect of AIDS on the health of women. A Community Development Policy adopted in 2003 incorporated maternal and child health in 2011. Policy implementation however faces gaps. Zambia established youth friendly services in the 1990s to cater for youths, but these are building materials, but these have been difficult to sustain due to limited resources.

Despite the persistence of social determinants, resource barriers to service delivery and social barriers to uptake of services, the gains in maternal and neonatal and child survival, morbidity and mortality remain high. Because women's health is determined by the environment and social and economic circumstances in which they live, addressing women's health is a key element reducing poverty and inequity in wealth in Zambia.

1. Introduction

In 2012-3, building on work done on health literacy and in the EQUINET pro4equity network to strengthen communication between health workers and communities, TARSC is implementing a one-year programme with HEPS Uganda and Lusaka District Health Management Team (LDHMT) Zambia with Cordaid support. The project will extend health literacy in Uganda and Zambia and use the skills built to promote dialogue and accountability between health workers and communities, including women's health and sexual and reproductive health (SRH). As part of this work and the development of health literacy materials, LDHMT and TARSC have commissioned a review paper on SRH and women's health situation and services in Uganda and Zambia as background to the health literacy module and work in this area.

Gender inequalities are important causes of inequality in health and health care. It has been argued that gender inequalities are one of the most important determinants of health. This is because gender roles, which are socially and culturally determined, influence the different behaviour, roles, responsibilities and expectations of men and women (UNDP, 2011a). These expectations influence access to resources and information and the ability to make decisions, individually and within communities. In relation to health, gender roles influence nutrition, educational opportunities, employment and income, which are all important determinants for good health. They also influence whose needs and priorities are addressed; within the health system this can mean that the needs of women and girls are not addressed. Access to sexual and reproductive health is important for both men and women. However, provisions of effective and accessible maternity services are vital to prevent women from dying during childbirth.

TARSC and LDHMT commissioned and supported production of this desk review of secondary evidence and published literature and a technical review paper on women's health and sexual and reproductive health in Zambia in terms of:

- The public health situation and women's health, (including but not limited to maternal health and Millennium Development Goal (MDG) 5, in Zambia, identifying and providing up-to-date evidence on the key patterns of women's health and SRH, in terms of health (communicable and non-communicable diseases, SRH, nutrition, morbidity and mortality, key differences in health by sex, and the distribution of women's health and SRH across age groups, geographical areas, rural and urban areas, socio-economic groups and other key factors. It will highlight important trends in improvement or worsening of women's health and SRH over the past decade, based on population survey or facility data.
- The causes and determinants of the patterns above, including the relationship to gender inequalities in norms, roles and resources, including determinants at levels of social, cultural, living environment, community environment, employment income and wealth, policies, laws, institutions and governance.
- The policies, services, personnel (and health workers) and programmes within and beyond the health sector, both public and private, that aim to promote and respond to women's health and SRH, the distribution of availability, access, acceptability, uptake and effective coverage of these services and programmes, noting any areas where coverage is inverse to need and the facilitators and barriers to such services. The three delays and their causes will be given attention in this section. The section

will also give attention to involvement of communities, particularly women, in planning and implementing services and programmes.

- The implications for communities and health systems in terms of information, awareness, social participation and action at community and primary care levels, of support or services input from higher levels of the health system and other authorities, organisations and implications for resource allocation.

2. Methods

A desk review was implemented in September 2012 of unpublished and published literature on women's health and sexual and reproductive health in Zambia. The inclusion criteria for the review were literature related to the public health situation and women's health and SRH, causes and determinants of patterns shown, including gender inequalities in norms, roles and resources, and social determinants. Issues related to policies, services, personnel and programmes within and beyond health. Pub Med, and Medline, databases and Google search engine were used to retrieve the required information. The grey literature was sourced from government ministries, national archives and research resource centres in various organisations. Reports on women's health, sexual and reproductive health are not readily accessible.

3. Women's SRH in Zambia

The population count from preliminary results of the October 2010 Census of Population and Housing for Zambia is 13,046,508. Zambia has made steady progress along a number of MDG, such as reducing the rate of infant mortality from 78/1000 births in 2007 to 68.9/1000 in 2010 (CSO, 2012), improving access to education and in child malnutrition.

Health is a fundamental human right, encompassing access to quality health services and other underlying social determinants of health (CSO et al 2009). The greatest gains in health worldwide have been achieved through improvements outside health service provision, such as education, working conditions, accommodation and housing, food safety, water supplies, waste management and the physical environment, including improved transport and access (WHO, 2005).

Maternal health is a key part of the right to health, for both mother and unborn child. Safe Motherhood means creating circumstances that ensure:

- A pregnant woman is able to receive care for prevention, detection and treatment of pregnancy complications;
- A woman in labour has access to skilled birth attendants; and
- If they need it, mother and newborn have access to emergency obstetric care and care after birth to prevent death or disability from any other complication.

Zambia has made some strides in improving maternal health as seen in the 2007 Zambia Demographic Health Survey (CSO et al 2009). The maternal mortality ratio (MMR) decreased from 729/100,000 to 591/100,000 live births. This rate is still high and needs to be reduced to 120/100,000 by 2015 to meet MDG 5. The maternal mortality ratio for Zambia is one of the highest in sub-Saharan Africa. A decline in maternal mortality rates depends on scaling up and

making universally accessible well-proven maternal and newborn interventions, such as increasing access to emergency obstetric and newborn care, skilled attendants during pregnancy, childbirth, and postnatal period and access to family planning. As noted later, this access to and uptake of services is yet to be achieved.

The prevalence in Zambia of HIV is 14%, and for STIs 17%, mostly affecting the reproductive age group (15-49 years). Women are more vulnerable to HIV transmission than men because of their biological makeup as there is more exposed surface area in female genitals. Approximately 14.3% of Zambians are living with HIV, estimated at almost one million adults (15-49 years) (CSO et al 2009). Urban areas have higher HIV prevalence (20%) than rural (10%) areas do and females (16.1%) are more likely to be HIV positive than males (12.3%) are. About 39.5% of babies born to HIV-positive mothers are HIV positive (WHO, 2005). A quarter of infected people, 250,000, are receiving antiretroviral treatment. More than 1.3 million orphans and children are socially disadvantaged due to either due to loss of their parents or being born with HIV. At community level, the AIDS epidemic has led families to absorb orphaned children and to care for chronically ill people, mainly increasing the burden on women in the community.

Zambia has the second highest incidence of cervical cancer in sub-Saharan Africa (52.8/100,000 women per year). Cervical cancer is the leading cause of cancer deaths amongst women and more than 60% of women with cervical cancer will die of the disease due to late detection. The National Cancer Register in Zambia indicated that 22.8% of the total cancers were cervical cancer (MoH, 2004a). In addition to cancer, women aged 15 to 49 years are dying from non-communicable diseases like diabetes mellitus, cardiovascular disease, nutritional deficiencies, injuries and chronic respiratory diseases (WHO, 2005; Alwan, 2004). Women also experience mental health problems such as depression, anxiety, substance abuse and suicide (Office of the President 2000).

4. Determinants of SRH

One of the greatest challenges facing Zambian women is poverty, higher in rural than urban areas. Despite an annual growth of 5.7%, an estimated 64% of the population live under the poverty line of US\$1 per day (UN, 2011) and 39% of the population live in extreme poverty with insufficient consumption to meet their daily minimum food requirements (UNDP, 2011a).

Extreme poverty is concentrated in rural areas with 67% of the rural population being classified as extremely poor. Women are disproportionately represented among extremely poor populations and face constraints in accessing reproductive resources and essential public services (UNDP, 2011a).

Poverty is associated with malnutrition. Women's poor dietary intake leads to vitamin-A, iron and iodine micronutrient deficiency, which impacts on the total health of a woman. Poor nutrition in pregnant women causes complications in pregnancy and childbirth (Kwofie, 1983). Pregnant women also suffer from serious protein inadequacy. Because of the interdependence between the nutritional health of the mother and the outcome of pregnancy, malnutrition among pregnant women may be responsible not only for lower birth weight and congenital malformation, but also for increased maternal and perinatal mortality and morbidity in Zambia. Poor maternal nutrition is associated with low birth weight, risk of child mental retardation and stunting, and increased risk of complications during delivery and breastfeeding.

Factors leading to vulnerability of women include low education, young age at marriage, high parity and early age of child bearing (Saasa and Kamwaanga, 1994). Women's four roles of childbearing, childrearing, community management and contributing to the economic production of the household place a heavy workload, affecting women emotionally and psychologically (Office of the President 2000).

Women's social status and gender norms also play a major role in their health. Although women play a decisive role in daily life at home, they have less say in reproductive health matters involving their own bodies and sexuality. The husband, considered as head of the family, usually makes decisions in matters of reproduction. Early marriages are common, with 22% of women having had a baby by the age of 19 years, leading to early childbearing, short birth intervals and many births. Teenage pregnancies are a major public health problem despite the availability of free youth-friendly services situated at health facilities at clinics, district and provincial levels. Many teenage pregnancies are associated with obstetric complications. Some unplanned early pregnancies are unwanted and the girls may resort to unsafe abortion (CSO et al 2009). Adolescent mothers who have dropped out of school have no employment and income to support the baby, important further determinants for good health.

Education makes an important contribution to alleviating poverty and hunger and improving people's lives. Yet the literacy rates for women and men are 59.8% and 76.3% respectively (CSO et al 2009) and women have limited access to education and employment opportunities. Most women engage in labour intensive, poorly paying work where they work for long hours and are responsible for household duties, family welfare, provide farm labour and undertake market activities. Gender disparities persist in favour of boys in literacy rates, school enrolments completion rates and education attainment. With poorer education and employment opportunities and lower social status, female adolescents in low-income communities start sexual activity early and sex is often unprotected and associated with risks of HIV, pregnancy and unsafe abortion, further worsening the economic situation and leading to dropout from school (Kabaso, 2012).

Zambia is a multicultural society with 72 different tribes and ethnic groups. Culture shapes people's health and psychological health (WHO, 2002). Community members share cultural values and have common perceptions of what constitutes sexual orientation, disability, sources of ill health and health care-seeking behaviour, conception, pregnancy, labour, birth and the postpartum periods. This perception might be shrouded largely in myth and superstition reflecting lack of basic knowledge of the physiology of the birth process. The National Gender Policy indicated that in Northern and Eastern provinces gender roles in agricultural production are perpetuated. Men engage in land preparation involving bush clearing. Women till the land, heap and burn the chopped shrubs and tree branches, sow the crops, which women and children carry out, harvest and process crops, and gather the produce, treating it and placing it in storage facilities. Men participate in animal husbandry (Office of the President 2000).

'Culture' has however also been used to justify gender-based violence against women. Cultural orientation, initiation ceremonies and payment of bride price have led men to feel superior to women. Women may become submissive and obedient even when they are physically, sexually and mentally abused. Physical violence (wife battering) is a major cause of injuries to women ranging from minor cuts and bruises to permanent disability and death. Sexual abuse results in unwanted pregnancies, sexually transmitted infections, including HIV, undermines women's sexual autonomy and jeopardises their health (Office of the President 2000). Violence against women is linked to the low socio-economic status of women and patriarchal beliefs that reinforce men's and boy's dominance over women and girls. A comparative analysis of the

cases of violence against women and children shows an increase in the number of reported cases of defilement from 366 in 2001 to 865 in 2002. This represents an increase of 136% in one year alone, indicating the gravity of the situation. While information regarding sexual violence against men and boys is scantily available, it may also occur (Office of the President 2000).

Women can be powerful agents of change if they have opportunities to participate in decision making. Few Zambian women hold leadership positions in the public sector and politics. For example, in 2012 women held only 18 of the 158 seats in parliament (National Assembly of Zambia, 2012). This makes it difficult for women to participate in or influence policy. Although women play a decisive role in daily life at home, they have less say in reproductive health matters though it involves their own bodies and sexuality.

5. Policies for SRH in Zambia

Several key policy developments responding to these challenges in and guiding programmes for women's health and SRH have been made.

- The Public Health Act, Chapter 395, of 1930, guides the Zambian Government in its policies. Successive national development plans guide provision of health care services to reduce maternal and child mortality.
- The National Reproductive Health Policy of 2008 (MoH, 2008) addresses Safe Motherhood conditions as they negate efforts to attain sustainable human development.
- A National AIDS Policy provides the framework for addressing the HIV/AIDS/STI/TB (MoH, 2004b). This policy included information for women on access to treatment and strategies for mainstreaming gender in HIV and AIDS programmes to enhance women's role in decision making. In 1997 a re-entry policy was implemented in education to facilitate the re-admission of female dropout students.
- The Community Development Policy was adopted in 2003 and maternal and child health incorporated in 2011.
- The National Gender Policy contains measures, interventions and activities that are put into effect by mainstreaming gender in the public sector. Each sector has a lead actor and a set of gender interventions (Office of the President 2000).
- The National Child Policy addresses factors affecting child wellbeing, including child labour, neglect, prostitution, defilement, child trafficking, early pregnancies and marriages and vulnerability to HIV (Ministry of Sport, Youth and Child Development 2006).
- The National Policy on Community Development calls for culture to be preserved and exploited for development, employment, tourism and economic process, to facilitate socio-economic empowerment of poor and vulnerable people and promote the development and preservation of culture for sustainable development (MCDS 2003). The policy does not explicitly include a strategy for alleviating poverty and unemployment among women or address the risks to SRH among women and children.

During development of the primary health care programme in Zambia, traditional healers, traditional birth attendants, spiritual healers and herbalist were regarded as important community health workers. Close collaboration and communication was established with them as an estimated 80% of the population use traditional and alternative health services for their day-to-day health care. In 2005, the Police Victim Support Unit (VSU) was established to report cases of rape and abuse. At the end of the 1970s a traditional medicine unit was created at the Ministry of Health. Today this unit has been transformed into the Traditional Health Practitioners Association of Zambia (THPAZ).

6. SRH services and programmes and their coverage

While policies are in place, constraints in the institutional and social resources create challenges related to women's health and SRH. Government has made efforts to eradicate poverty and illiteracy through self-help initiatives such as a housing scheme with free building materials. However, this programme could not be sustained due to limited resources. Government is also collaborating with the African Housing Fund (AHF) and Habitat for Humanity to support improved shelter, water and sanitation. Microcredit also supports small-scale women entrepreneurs, employment, improving infrastructure and training in various skills.

The Ministry of Health and the Ministry of Community Development and Mother and Child Health are currently implementing health programmes for women's health, in liaison with other non-state organisations. In rural areas in the last five years, the Ministry of Health and cooperating partners initiated partnerships for increasing investment in services to women. A maternal and newborn committee spearheads maternal and newborn activities, meeting quarterly each year. Examples of other agencies working in SRH are shown in Appendix 1. The Ministry of Health is following the 6th National Development Plan (SNDP) 2011-2015. In a multisectoral approach, the ministries work jointly in pooling resources from various ministries and communities to implement interventions.

The Ministry of Health has implemented comprehensive Emergency Obstetric Care Services in provincial and district facilities that include operative measures for complicated deliveries to prevent maternal and neonatal mortality. The Ministry of Health has trained 300 community health assistants to work in the community. Their scope of practice includes environmental health, i.e. food hygiene, solid waste disposal etc., infectious disease prevention and reproductive health on HIV and AIDS prevention, providing information on Voluntary Counselling and Testing (VCT) and supporting adherence and family planning. They give health education and communicate on health issues affecting the community. Community-based agents called Safe Motherhood Action Group (SMAGs) sensitise communities on issues related to pregnancy, childbirth, and newborn health and they mobilise communities to overcome barriers to care. The sensitisation targets men and women. The SMAGs sensitise communities on cases requiring referrals to health facilities. The SMAGs also play a role in recognising women and newborns needing care, providing referrals, and assisting with transport, as required (MoH, 2011). Beyond this community cadre, the MoH has trained health personnel in emergency obstetric and neonatal care to manage complicated labour and delivery. Government has purchased ambulances to transport women referred to other health facilities. The Ministry of Health and cooperating partners have also invested in training increased numbers of candidates for midwifery so there are enough midwives to attend to birthing mothers.

The Ministry of Health and partners have trained community-based distributors (CBDs) who provide community health activities as outlined by the ministries responsible for health. Mothers'

shelters have been built for expectant women who live far away from a health facility. In addition, mother support groups within the community assist mothers with breastfeeding their newborns. Communities have been sensitised to identify the available mode of transportation for women to reach the facility when need arises.

District action plans begin with community activities through to neighbourhood health committees, whose action plan is integrated into the district, provincial and national health budget. District budgets are discussed with neighbourhood health committees to plan for community activities.

Despite these initiatives, there are many coverage gaps in SRH services. The 2007 Demographic and Health Survey (CSO et al 2009) indicated that while most women (94%) have access to antenatal care (ANC) services, most of the bookings take place late, in the second or third semester, and there is a substantial fall off of ANC coverage with four visits to 70%. Family planning knowledge is universal (96%) but contraceptive acceptance prevalence is low (33%) for modern methods, 12% for traditional methods and the total fertility rate is 6.3 births per woman which is high. High rates may also indicate difficulties for families in some situations to feed and educate their children. This is the case even though family planning services and community teenage health services are provided for free.

Institutional deliveries were at 47% in 2007 up from 43% in 2001; 48% of births occurred at home with assistance from unskilled traditional birth attendants. Postnatal attendance is at 39% coverage (CSO et al 2009).

These still low coverage levels indicate the gap in translating SRH policies to services and service availability to real coverage. In many areas service shortfalls limit coverage, as the Zambian health system is severely resource constrained. The next section discusses this in greater depth.

7. The three delays

The 'Three Delays' provide an explanatory model to identify the barriers to coverage of women's services for SRH (Thaddeus and Maine, 1994). They refer to delays in:

- making the decision to seek care;
- access and getting to care; and
- receiving care at the health facility.

7.1 Delays in making the decision to seek care

The social contexts in which women, their families and communities make decisions on childbirth were discussed in an earlier section on the social determinants of SRH. Many women are illiterate, affected by poverty, and with low social status. As a result they may be poorly informed about their health needs, or may ignore them given the need to devote their time to meeting the daily requirements for their children and family. Women often wait for men or an elderly person to make decisions for them, particularly in areas where medical interventions are needed. The decision to seek health care is usually made by the husband as head of the family and this may delay the decision to seek care. The women and their families may have inadequate knowledge about danger signs in pregnancy and labour, or lack money to get to services (UN, 2011). These factors are discussed in more detail in Section 4 of this paper.

Cultural and religious beliefs, such as the importance of place of birth rituals or disposal of the placenta, can act as barriers to women and their communities to use a facility for delivery. The women may view the care to be inadequate, especially where there are many patients with scarce resources at the health facility. Women may choose not to use services when they feel the case to be inappropriate, inaccessible and unaffordable, to lack privacy and basic supplies in the labour wards, and to have poor hygiene and care during childbirth. Deliveries conducted by males may make women shun a facility as culturally women only have conducted deliveries in Zambia. Time spent waiting at the health facility and at outreach sessions discourages clients from using the service.

In Zambian culture only married women should access SRH services. Unmarried and pregnant adolescents face barriers using services as they are deemed to be still young and 'should not be pregnant'. Provision of contraceptives is culturally restricted to married couples and unmarried women with at least one child. Unmarried pregnant adolescents fail to access the services because they fear being stigmatised by the attitude of health care providers. Societal norms that limit women's mobility or that require women to obtain the consent of a male family member before seeking health care can delay or prevent women's access to life saving care in the event of an obstetric emergence (MoH, 2005).

7.2 Delays in accessing services

Women living in rural areas face geographical and financial barriers to accessing services due to poor terrain and long distances. Distance, cost and lack of transport are contributing factors. Most of the women are not engaged in employment or entrepreneurship as they cannot get loan facilities. Most roads are impassable and the available transports are bicycles and oxcarts. This type of transport may not be comfortable for the women. Women who live far away (>12km) from the health facility may have no transport to reach the facility. The community has a poorly functioning referral system and when a woman needs support for referral to the health facility, nobody may be able to do this. Women may lack independent funds to pay for their own transport.

7.3 Delays in receiving adequate care at services

Women face delays in receiving care at the health facility due to inadequate numbers of skilled attendants coupled with inadequate equipment, supplies and drugs. This is further coupled by poorly motivated staff at facilities.

Safe Motherhood services have been provided but the infrastructure, drug supply and equipment are inadequate, referral services poor and human skills limited. Rural health centres face serious difficulties with regard to staffing, drug logistics and supplies with the result that the majority are unable to provide a basic health care package of primary health care services. For example, there are inadequate basic supplies such as cord clamps,ambu bags (a bag put on the newborn baby's mouth to assist breathing after difficulties in breathing at birth) and suction apparatus for neonates (UNDP, 2011b). Zambia established youth-friendly corner services in the 1990s to provide sexual and reproductive health services but these are mostly non-functional.

The health worker shortage is a major bottleneck. Because of the critical shortage of midwives in labour wards, casual daily employees (and traditional birth attendants) have been delivering women in the health facilities. Environmental health technicians were also carrying out obstetric services. A report by UNDP (2011) estimated that Zambia would need to double the current number of midwives to achieve MDG 5 target of 95% of births assisted by skilled and motivated birth attendants. This would increase the current ratio to 5 midwives to 1,000 births. In some of

the hospitals the only doctor available lacks knowledge and skills for surgical interventions and emergency management of complicated cases of labour and delivery.

Due to this deficit in numbers of midwives the Government of Zambia through Ministry of Health and General Nursing Council and cooperating partners initiated the direct entry midwifery training programme. A World Health Organisation bulletin revealed that Zambia's nurses and midwives' threshold to be at 2.01 per 1,000 population (WHO, 2009). The current clinical health workforce of 16,034 is 1.24 as against the WHO recommended minimum level of 2.3 health workers per 1,000 population and is below the average health worker per 1,000 population of 1.6 for sub-Saharan Africa. Countries with fewer than 2.5 healthcare workers per 1,000 population are unlikely to achieve minimum desirable coverage (80%) for skilled birth attendants and measles immunisation (Chen et al., 2004). Zambia is one of 57 countries that do not meet the 80% threshold. As such Zambia is defined to be in a human resource crisis. The Ministry of Health Workforce optimisation analysis of 2009 showed that more than 10% (185) of the 1,301 public health facilities do not have any health care workers on payroll. The analysis further showed one midwife for every 6,000 persons and one nurse for every 2,000 persons (MoH/WB, 2010; WHO/AHWO, 2010). The current clinical health workforce of the six main cadres of 13,574 is 66.6% of the "optimal number of health workers" as determined during the 2008 workforce optimisation analysis. In addition, the existing clinical health workforce of 16,034 is 40.7% of the MoH-approved establishment of 39,360. According to the 2010 National Health Strategic Plan of 2011-2015, there were 2,671 midwives against an establishment of 5,600, giving a gap to the establishment of 2,929 (52%) (MoH, 2010).

Despite new attention to cervical and other cancers, Zambia has only one cancer diseases hospital (CDH), a tertiary institution providing specialised treatment for cancer patients. The hospital receives patients from all ten provinces. CDH statistics indicate that 60% of cancer patients attending outpatient care are females of whom 32% have cervical cancer (MoH, 2004a). The Ministry of Health has recently introduced in its immunisation programme a vaccination for human papilloma virus to be given to teenage girls to protect them from getting the virus that can predispose them to getting cancer of the cervix later in life.

8. Conclusion

The different barriers raised in the paper will have different weight and influence in different settings. For example, women in remote rural areas may face a mix of all three barriers, while those in urban areas may primarily face cost or time barriers affecting access. The barriers would need to be identified and addressed in each setting. Women's health is determined by the environment and circumstances in which they live and operate. If the same social determinants that lead to risk of poor SRH outcomes also act as barriers to accessing SRH services then greater measures need to be taken to ensure access to care in those most at risk of SRH-related illness. The Zambia government has recognised the challenges in policy and, with partners, is mobilising resources to meet women's health needs. To accelerate progress and overcome the barriers identified calls on a wider spectrum of actors to play a role, including key sectors such as education, trade and agriculture, civil society, traditional leaders, community leaders, families and individuals.

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Appendix 1: Organisations in Zambia working with women's health and SRH

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Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO)	Michelle Wallon - mwallon@jhpiego.net
Ministry of Health (MoH)	Dr Elizabeth Chizema - 095578878 elizabethchizema@yahoo.co.uk
Ministry of Community Development Mother and Child Health (MCDMCH)	Dr Caroline Phiri - 211223909, 0967792600, 0977778854
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Society for Family Health (SFH)	Nomsa Siamwanza, nomsas@sfh.org.zm ,
Central Statistical Office (CSO)	Director, CSO
Centre for Health Sciences and Social Research (CHESSORE)	Dr T.J Ngulube
Mobilizing Access to Maternal Health Services in Zambia (MAMaZ)	Abdul Rakaz Badru - abadru.mamaz@org.zm , abadru.mamaz@gmail.com , +260974303710/
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Southern Africa HIV and AIDS Information Centre (SAFAIDS)	elizabeth@safaids.co.zm ,
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Women for Change	Emily Sikazwe, wfc@zamnet.zm
World health Organisation (WHO)	Patricia Kamanga - 0955887778, 0977773526
Zambia Integrated Systems Strengthening Program (ZISSP)	Dr Nantalile Mugala, nanthalilem@zambiassp.org , - 0965768766
Zambia White Ribbon Alliance for Safe Motherhood	Dorothy Chikampa- zwrasm@yahoo.co.uk
Zambia Association for Research and Development (ZARD)	Priscilla Chileshe, priscila@yahoo.com , +260977607865