

Sources of Family Planning

Zambia



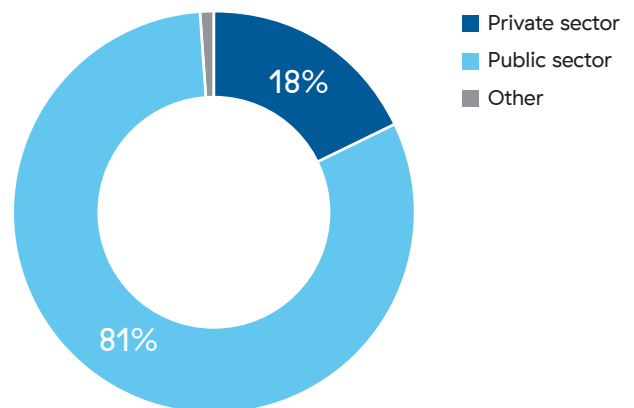
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Understanding where women obtain their family planning methods can help programs to better target their resources and increase overall access to modern contraception. This brief is one in a series of country briefs that examines where women obtain modern contraception by method, geography, age, and socioeconomic status. Through a secondary analysis of the 2013–14 Zambia Demographic and Health Survey, the brief explains where modern contraceptive users obtain their method and examines the contribution of the private sector to family planning in Zambia.

Key Findings

- Nearly 1 out of every 5 modern contraceptive users (18%) obtain their method from a private source.
- Zambia's mCPR increase from 20% to 32% is due to injectable and implant growth, supplied primarily by public sources.
- More than one-third of pill and condom users obtain their method from a private source.
- Private sector reliance is twice as high among urban compared with rural users (24% versus 12%).
- Nearly three-quarters of the wealthiest contraceptive users in Zambia rely on public sources.

Source of modern contraceptives



This is one in a series of briefs that examines sources of family planning methods in USAID priority countries. View the data at PrivateSectorCounts.org.

Modern contraceptive prevalence rate and method mix

Among all women of reproductive age in Zambia, nearly one-third (32 percent) use modern contraception. Among married women, the modern contraceptive prevalence rate (mCPR) is 44 percent. This brief focuses on all women, married and unmarried, to accurately portray contraceptive sources among all users. The recent growth in Zambia's mCPR, from 20 to 32 percent, is largely driven by increases in two methods: a substantial injectable increase, Zambia's most widely used method (from 6 to 14 percent), and more than a ten-fold implant increase (from 0.3 to 4 percent).¹

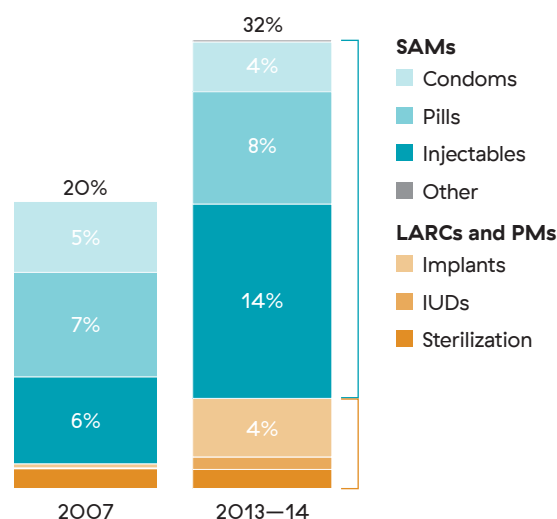
Sources for family planning methods

The public sector is the primary source of modern contraception in Zambia (81 percent). Eighteen percent of users rely on the private sector.² The growth in Zambia's mCPR can be attributed to increased public sector use, from 13 to 20 percent for short-acting methods (SAMs) and from 1 to 6 percent for long-acting reversible contraceptives and permanent methods (LARCs and PMs). While the private sector has responded to increases in population growth, its contribution to the mCPR remained stable between 2007 and 2013–14.

Similar to many countries in the region, the public sector is overwhelmingly the dominant source for injectables, LARCs, and PMs. The large increase in public sector use of injectables may be the result of a new task sharing policy in 2010 that allowed public community-based agents to provide injectables (Child Fund 2013).

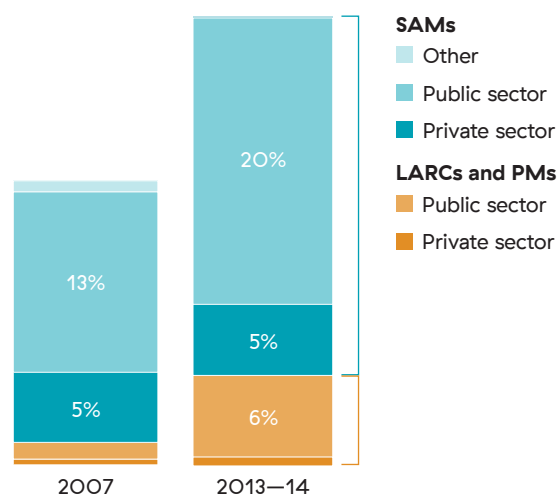
Surprisingly, more women in Zambia rely on the public sector than the private sector to obtain condoms and pills. Among pill users—the second most popular method in Zambia—the private sector plays a larger role than for LARCs and PMs (39 percent), though public sources remain dominant. Similarly, among condom users, the public sector is also dominant (62 percent), which is unlike most other countries in the region.

Zambia's mCPR increase is largely due to higher use of injectables and implants



Note: Numbers may not add due to rounding.

Zambia's mCPR increase is primarily driven by public sector growth



¹ SAMs include injectables, contraceptive pills, male condoms, female condoms, and fertility-awareness methods. LARCs and PMs include IUDs, implants, and male and female sterilization. The lactational amenorrhea method and "other modern" methods are excluded from this analysis, as the Demographic and Health Survey does not systematically ask women about sources for these methods. This analysis shows which methods women use. It does not reflect which methods women might choose if they had access to all methods.

² Public sector sources include hospitals, health centers, health posts, mobile hospitals and clinics, family planning clinics, community based agents, and fieldworkers. Private sector sources include hospitals, clinics, and doctors; nongovernmental and faith-based organizations, including mission hospitals, churches, community-based agents, and fieldworkers; and pharmacies and shops. Other sources include friends, relatives, and women who did not know or report the source. This analysis shows where women obtained their most recent method. It does not reflect where women might choose to go if they had access to all sources of care.

Private sector sources

Among private sector users, 70 percent obtain their method from a pharmacy or shop, 16 percent from a private hospital or clinic, and 14 percent from a nongovernmental or faith-based organization. In line with global patterns, the two methods most commonly sought from the private sector are pills and condoms.

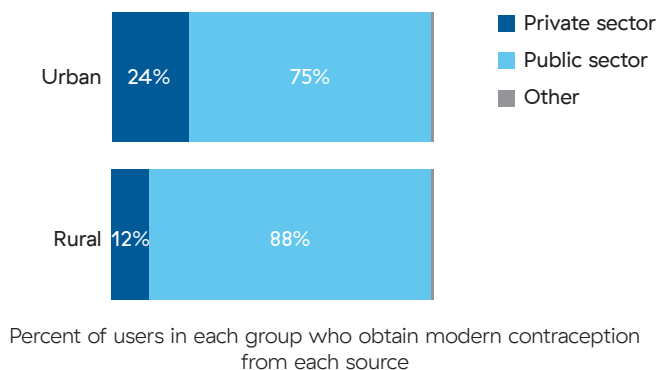
Pharmacies and shops are the primary private sector sources



Contraceptive source by geography

The mCPR is slightly higher in urban (34 percent) than rural (30 percent) areas. Urban contraceptive users are twice as likely to purchase their method from the private sector (24 percent) as rural users (12 percent). Method mix also varies by urbanity: pills and condoms are more popular among urban users, and injectables are more common among rural users. Sources of family planning differ across regions in Zambia as well. For example, in Copperbelt, North Western, and Lusaka, more than 20 percent of contraceptive users rely on private sources compared with just 8 percent of users in the Northern region.

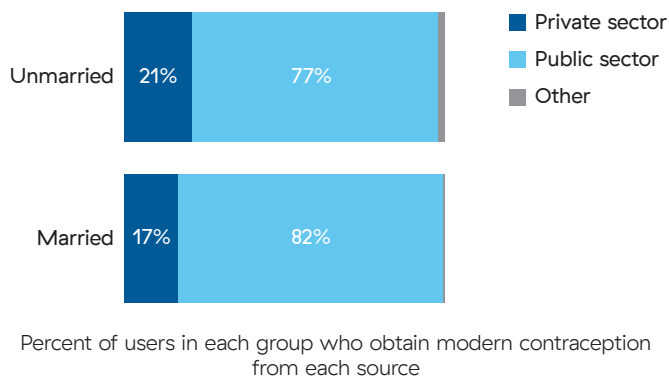
Urban users are twice as likely to use the private sector as rural users



Contraceptive source by marital status and age

Unmarried contraceptive users are slightly more likely than married users to rely on private sources (21 versus 17 percent). There are some differences in method mix as well. Condoms are more common among unmarried than married users (21 versus 9 percent), and married users are more likely to rely on pills (27 versus 17 percent). Injectables are the most popular method for both married and unmarried women. Contraceptive source patterns in Zambia are similar across age groups.

Private sector use is slightly higher among unmarried users



Contraceptive source by socioeconomic status

In Zambia, the poorest women are less likely to use modern contraception than the wealthiest women (28 versus 34 percent).³ Among the poorest users, one in ten rely on private sources. One quarter of the wealthiest users obtain their method from the private sector and 74 percent from the public sector. The wealthiest users rely on the private sector for SAMs (29 percent) more than they do for LARCs and PMs (11 percent).

1 in 10 of the poorest contraceptive users in Zambia rely on the private sector



More than 7 in 10 of the wealthiest contraceptive users in Zambia rely on the public sector



Implications

The government of Zambia is committed to providing affordable family planning services to all. The public sector is the primary contraceptive source for all population segments and is responsible for the country's vast mCPR increase since 2007. Though private sector use is relatively higher among urban and wealthier users compared with other demographics, its contribution is lower than in neighboring countries. The government aims to promote public-private partnerships in health service delivery, which could help expand the private sector's contribution (Republic of Zambia 2012). In contrast with most sub-Saharan African countries, only one-third of pill and condom users in Zambia rely on a private source, indicating substantial opportunity to switch some SAM users to private sources and reduce the public sector burden.

Similarly, opportunities exist to shift wealthy, urban populations who rely on public sources to private sources for injectables and LARCs. Social franchising models and faith-based organizations such as the Churches Health Association of Zambia could complement government approaches and help sustain demand for and supply of injectables and LARCs in urban areas. These strategies could allow the government to allocate more resources to rural and underserved communities, a Family Planning 2020 goal, and sustain demand for LARCs (Republic of Zambia, n.d.).

References

Republic of Zambia. 2012. *National Health Policy: A Nation of Healthy and Productive People*.

Republic of Zambia. n.d. *Family Planning Services: Integrated Family Planning Scale-up Plan 2013–2020*.

Child Fund. 2013. *Provision of Injectable Contraception Services through Community-Based Distribution in Zambia: Implementation Handbook*.

³ The poorest women are those in the lowest two wealth quintiles as defined by the Demographic and Health Survey's asset-based wealth index. The wealthiest women are those in the top two wealth quintiles.



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