

Partnership for effective reproductive health services

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Background

It was only until recently that Zambia Health institutions started providing integrated

Reproductive Services. Until 1995 Reproductive Health in Zambia meant the provision of Family Planning Services, Antenatal, Maternity and Gynaecology services separately in separate clinics and on separate days.

A national sensitization workshop in 1996 agreed that Reproductive Health services for Zambia would consist of the following main areas; Safe Motherhood, Family Planning, Adolescent Sexual Health, STD/HIV/AIDS and Abortion. Recently Cancer of the Cervix has been added to the list of priority areas.

These areas are those identified identify as having more of an impact on Maternal Health and thus requiring emphasis. However, other areas within Reproductive Health such as infertility, sexual violence etc would also be catered for. Gender issues are mainstreamed in all areas of RH.

Current situation

There is a saying in Zambia tradition spoken and often referred to by different ethnic groupings in different dialects, which carries the same meaning. The saying states that one, finger can not pick lice. The meaning of this old adage is that no single person or institution can have impact or can record achievements without support. Because the demand for Reproductive Health Services is so high and the resource environment low, the government is not able to meet all the requirements. With this recognition, Mission institutions have set up facilities in areas where no government ones exists. The industrial institutions such as the mines have set up themselves in urbanised areas where these industries operate, to meet the needs of their staff and their families. The other group providing Reproductive Health services are the Non Governmental Organisations (NGOs) such as Planned Parenthood Association of Zambia (PPAZ) and Family Life Movement of Zambia (FLMZ) and Society for Family

Health (SFH). There exists thus a sort of network of organisations that have, found a niche for themselves in the area of need. This is the largest partnership within health services provision. The various organisations do however have difficulty in standardising the quality of services they provide. Government is supposed to provide the major guidelines and set standards. Unfortunately this has not been the case.

The partnership in Reproductive Health exists on a number of levels in various forms.

- Between government and other services such as mines, NGOs and missions and private institutions.
- Between bilateral and multilateral donors and Government and NGOs
- Between health workers and communities

The ultimate aim of course is to provide quality services to the community. Partnership can be said to premise itself on the assumption that where more than two

people or institutions put their efforts together chances of achieving grater results abound. Partnership once entered into takes account of each player's strengths and the role each one can play best to achieve maximum results. This not only produces the desired results but ensures the resources are maximised and well utilised. With minimal wastage or not at all. This in turn helps to improve public health goals and lives of citizens.

Government / multi Bilateral Donors.

The partnership existing between government and multilateral/bilateral donors is one of mutual respect understanding and support. The government has developed a strategic plan through which it aims to improve the overall general health of the population. Included in these strategic plans is provision of Reproductive health services. The plan

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calls for rehabilitation of health institutions, training of staff and provision of equipment and drugs. This plan has been made available to donors some of whom have pledged to support various areas within reproductive health either through support to the common District "Basket" or through direct support to districts and/or maternal level. In turn, government commits itself to utilising the technical or financial support to implement the agreed upon programme. Some of the experiences and lessons learnt from the programme are passed and used/ adopted in other countries.

Government and NGOs and Private Sector

The Ministry of Health, being the custodian of health care provision has normally determined what sort of health services will be provided to the public. This has usually been determined by the burden of disease and the human, financial and material resources available. Because government has determined that it does not have sufficient resources, it has involved the NGO and private sector in Reproductive Health. The ministry has recognised the relative advantage and strength of these groups and formed partnership to take full advantage of these.

A leaf can be taken from the two consortiums that have been created by Planned Parenthood Association of Zambia (PPAZ), Family Life Movement of Zambia and RFSU of Sweden which focus on Adolescent Health, supported by SIDA. The other one is the one supported by UNFPA, which grouped together five NGOs and was executed by the government Department of the Ministry of Youth, Sport and Child Development.

In both projects, much has been achieved owing to the diversity of experiences players in these projects have been able to share and exhibit. The young people for whom these projects are aimed are now able to share useful information with fellow peers. Their personal esteem has also been boosted by the skills they have acquired as peer counsellors. They have also managed to reach many parents about the need for them to acquire skills in the Parent-Elder training workshops which have been run. These and many other achievement catalogued here would not have been scored if each NGO had implemented the project separately. Furthermore, the capacity each and the Government is gaining from this experience can

not obviously be over emphasised.

The various studies in Reproductive Health such as contraceptive needs assessment the Safe Motherhood Situation Analysis and the Demographic Health Survey have all been undertaken with the full participation and involvement of partner organisations of Zambia. These have been provided information for programme planning and for the development of policy. The policy development process has also been a partnership. A good example of this is the Family Planning Policy and the Reproductive Health Policy.

Government and the community

In previous times, programme and implementation was a top down affair. All decisions were made at the centre and then passed down. With the recognition that programs cannot be successful without the involvement of the community, this process has changed. To fully involve the community in decisions regarding their own health centres the Ministry facilitated the creation of neighbourhood health committees. These committees are tasked with determining the community problems and needs, and determining what can and should be done about them. Together with the health staff in health these committees develop action plans with budgets for the district to finance. The community level health practitioners such as the TBA and CHW are also included in this process. The community sometimes develops their own activities and request support from organisations other than the government. The home based care programme is another good example of the government/NGO/Community partnership. This partnership also takes into account rural areas; for example, the influence Chiefs and opinion leaders have and therefore involves them in all the planning and implementation of activities.

In essence for good partnerships to be formed three ingredients are required:

- A recognition of each partner's relative strength and advantages.
- A recognition of the invitation each has.
- A recognition of the need to cooperate and work together.

- Each partner putting in manual respect for the other's contribution.
- An agreement on desired outcome and goals.
- Set clear goals and objectives for partnership
- Develop joint work plan
- Establish adequate governance
- Develop a budget and strictly adhere to it.

Conclusion

Partnership must be encouraged in view of their utility and the impact that joint or complementary efforts can have on achieving greater impact. This is essential in an environment of limited human and financial resources.

Zambia has some good example of this, with government efforts being complemented by the work of missions, mines and private sector and NGOs – with considerable good will and support from cooperating partners, both bilateral and UN.

Gender and Socio-Cultural Perspectives in Reproductive Health Services: a Reflection on Community Considerations

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Abstract

This paper explores gender and socio-cultural perspectives in reproductive health services by providing a reflection of community views. The data was derived from observations and focus group interviews with community members in Lusaka's Chawama township and Chiawa rural settlement. Community members feel that gender related and socio-cultural factors are often overlooked in many reproductive health services. Whilst it is appreciated that the services are tailored along the western model of health care, there seems to be no deliberate efforts, where necessary, to accommodate certain aspects of gender and socio-cultural factors. Although reproductive health services such as family planning have been provided for a long time now, the impact of these services has been very minimal. This may largely be due to the fact that western hegemonic bio-medical culture often fails to take into account the local social cultural milieu. It is suggested that a better understanding and appreciation of gender and socio-cultural perspectives could greatly enhance the quality of reproductive health services and ultimately reduce reproductive health related morbidity and mortality.

Introduction

In Zambia, where about 80 percent of the population live in poverty and in a country where the health infrastructure is poor, females as well as males suffer numerous reproductive health problems (1). However, the women face unique risks because of a number of reasons including their reproductive biology and adverse socio-economic and cultural factors. Owing to the particularly pronounced risks for women, current debates advocate for improved understanding and involvement of men in reproductive health as one of the ways to reducing risks among the females (2). In many communities of sub-Saharan Africa, repro-

ductive health circumstances of both individuals and households as well as access to health services are to a large extent structured by gender and socio-cultural factors (3). Thus gender and socio-cultural perspectives in reproductive health services have become a subject of intense research in recent years (4). Although social and cultural factors have dominated public health research on utilisation or/and non-utilisation of health services for many decades (5, 6), the continued deterioration in the quality of services calls for the re-examination of the social and cultural perspectives. Even more importantly now is the understanding of gender dynamics in access and utilisation of services. There is still a dire need to understand what the communities view as gender and socio-cultural considerations, without which the quality of service is perceived to be poor by the communities.

Health care institutions have played an important role in providing reproductive health information and services such as family planning, maternal health, STD treatment and control (7). This has led to reported widespread awareness about contraception, ante-natal care and other reproductive health services. However, much of this information and the services have been selective. Most men have not fully benefited from the reproductive health services because they have not been provided easy access. Often these services have been verticalised by programme and gender rather than taking a holistic and universal approach (8).

Zambia, like many countries in the sub-Saharan region, faces the daunting task of improving reproductive health services against the background of declining national resources. The reproductive health services aim to reduce: the increasing incidence of sexually transmitted illnesses (STIs) including HIV; high child and maternal morbidity and mortality; high rates of teenage pregnancies, the incidence of unsafe abortions and high fertility rates (9). Since independence the Zambian government has continued to invest in the health sector although in recent years the investments have declined considerably due to economic difficulties. Owing to these investments, Zambia's health care infrastructure is fairly well developed, at least by regional stan-

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dards (10). However, the quality of care provided by most of the health institutions has been poor and public confidence in health care institutions is low and continues to decline. Anecdotal evidence suggests that reproductive health services were launched in the Zambian health institutions without adequate basic longitudinal data on gender and socio-cultural factors including actual practices of the communities. The World Health Organisation (WHO) favoured KAP studies have not been able to elicit sensitive information about the multiple cultural environments and their gender effects. Gender and socio-cultural considerations including the 'why' and 'how' of eliciting such information were not given serious conceptual thoughts.

In this paper an attempt is made to discuss gender and socio-cultural perspectives in reproductive health services by highlighting some community views. Specific examples are drawn from field data.

Material and methods

Study sites

The study reported in this paper was carried out as part of the larger research project on Community Capacity to prevent, manage and survive HIV/AIDS in Chiawa (11). The study was conducted in Lusaka's Chawama compound and Chiawa. Chawama compound is located in the southern part of Lusaka and was included in the study to provide the urban perspective to the Chiawa rural component. Furthermore, some research activities to assess the quality of care for patients with STIs at Chawama urban clinic were on-going at the time of this study (12). This community-based study was seen as complementary to the clinic-based studies. Chawama is one of the oldest compounds in Lusaka and as many other compounds, started as an informal settlement. It has now grown to become a residential suburb with a population of close to 200,000 people. Anecdotal evidence suggests that the majority of the inhabitants of Chawama are self-employed in the ever expanding informal sector of the Zambian economy. The compound is serviced by one urban health centre which provides most of primary health care including reproductive health care. Njanja speaking people constitute the dominant ethnic grouping.

Chiawa, on the other hand, is a rural community in Kafue district, about

150 km south-east of Lusaka. During the 1991 national census the population was estimated to be 8000 and the Goba are the predominant ethnic group. The study area covers 35 villages spread over a 45 km stretch along the banks of the Kafue and Zambezi rivers. The area has two rural health centres separated by a distance of 24 km. Geographical distances render access to health services difficult in an area where the quality of services at these facilities is already poor due to, *inter alia*, persistent drug shortages.

Data collection strategy

The data for this study was collected during different periods of fieldwork in 1995 and 1996. The fieldwork visits for data collection alternated between the urban and rural sites. Qualitative research approaches; namely focus group interviews and observations were used for data collection. The combining of data collection techniques did not only ensure the collection of rich data but also the validity of the data. The study population consisted of members of the two study areas who were selected on the basis of residence and were thus believed to be conversant with the reproductive health problems and the services in the local health facilities.

The selected participants comprised young people aged between 16 - 24 and adults aged between 25 and above. The focus group interviews contained 10-12 participants and each group interview had a facilitator and a note-taker. Categories of groups included separate groups of married men and married women, separate groups of single men and single women and mixed groups. All the group interviews were facilitated by the author with the help of either a female or a male note-taker depending on the sex of the group. Sites for discussions were conveniently selected to provide a free atmosphere conducive for open discussions.

In Chawama, the community welfare centre was used for the interviews and the neighbourhood health committee members were employed to mobilise the partici-

pants. In Chiawa, schools and a local shop were used as sites for interviews and local research assistants mobilise the participants. An interview guide was used for directing the discussions. The guide contained the major areas and themes of the study topic as presented in the results. All the interviews were fully tape recorded and observations were recorded as field notes.

Data Analysis

An interview guide was used to ensure that all the groups were asked similar questions. Content analysis was used for data analysis. During the initial stages of analysis, the data was grouped by question or item number and subsequently categories were developed for each question or item. Matrices were then developed to help with the identification of relationships and variations between response categories for different groups. Tabulations were used to enumerate the number of times specific responses or problems were mentioned or discussed by different groups.

Ethical approval for the study was obtained from the Research and Ethics Committee at the University of Zambia.

Results

Perceptions about some reproductive health problems

A total of 20 group interviews were held in Chawama and Chiawa. There were eight group interviews with the males and another eight with females and four were special groups in which both sexes were represented. Almost all the groups viewed reproductive health problems as prevalent in the two areas. The commonly mentioned reproductive health problems were sexually transmitted illnesses including HIV, teenage pregnancies, abortions and severe abdominal pains among women. There was, however, a difference in the emphasis about some of these problem between the two areas. Abortion was not emphasised in Chiawa. The urban groups reported that abortions were common in their localities. "Abortions are really a problem especially among young girls who become pregnant from untrusted partners". "Abortions are bad because sometimes the victim dies before reaching the hospital". These statements were recorded from the urban groups. A comparison between the male and female groups, showed that the women were more aware and concerned about reproductive health problems than

the men. The men seemed more concerned with STIs and abortions because these threatened their lives more directly. "We are scared of STIs and the women who abort because they are a danger to us men". Infertility rather than high fertility was also seen as a problem.

Community considerations of gender and socio-cultural factors.

Gender and socio-cultural matters were fully investigated through a series of questions. Almost all the groups observed that reproductive services did not fully embrace major aspects of gender and socio-culture. It was noted that health services were tailored along western culture. "These hospitals came with whites, so they are alien to us and that is why communication is in English".

Despite this observation, the groups felt that since these facilities were operating within the local socio-cultural environments, they should consider taking into account local cultural values. "The doctors and the nurses are Zambians and they know about our culture so they should not ignore that".

When it came to specific programmes, there seemed to be differences in opinions. Most male groups and more particularly those from Chiawa were so opposed to male staff attending to females during labour. In Chiawa some men felt that most male staff were more interested in viewing women's privates.

"It is against our culture for a man to be present during delivery". In Chawama, even though the women noted that traditionally it was not appropriate for a woman to be delivered by a man, they said that it was now becoming the norm for women to be delivered by male staff and that the women were beginning to accept that. "These days we are used to being attended to by male doctors and even some of the nurse are too young, but there is nothing we can do". The interaction between the men and reproductive health services was mostly during times when they sought treatment for STIs. Most male groups reported that the men were often uncomfortable with female staff. "If I discover that the one who is going to attend to me is a female staff (particularly a nurse) I will change my mind and go elsewhere to seek treatment". Some of them said they could not stand a woman examining their private parts. Further discussions revealed that the reluctance to be attended to by nurses was due to stigma and lack confidentiality. The males

felt that nurses did not uphold confidentiality. "The problem with our nurses is that as soon as they finish attending to you they rush outside to talk about your illness". These sentiments were substantiated by observations in Chiawa where rumours filtered so easily from the health centre into the community.

Community perceptions of some selected reproductive health programmes.

Access to most reproductive health services was perceived to be problematic in both areas. In Chiawa, access was defined in geographical and financial terms, where as in Chawama access was largely defined in financial terms. In Chiawa people walked distances of about 15 km to come to the nearest health centre. In the minds of the community members, health services were not delineated or dichotomised as reproductive or non-reproductive. However, the groups were able to pinpoint specific activities upon which they based their assessment of reproductive health services. Some of the specific activities were family planning, ante-natal, under-five clinics, treatment of STIs and condom distribution. The females undoubtedly had more experience with reproductive health services than the men. "I had done family planning, it is a long time ago when Mr. X the clinical officer was still at Chiawa clinic. I was given some tablets just after one month of taking them I developed complications, I had pains in my womb so I had to stop using the contraceptive". "Many women who have used the pill say it's not very good because when you have taken the pill for a long time and now you want to have a child you will bear a lame child or a dead child".

The quality of reproductive health care in most health facilities was perceived to be poor. In both areas the groups felt that the quality was affected by the negative attitudes of staff towards the illnesses. There was apathy and victim blaming. The men often cited threats of amputation of the penis when they presented with an STD

The women said "It is better to avoid a pregnancy than to abort. People who abort are never given

proper care at the hospital because the staff feel that it's their fault".

Discussion

Qualitative research approaches make possible the investigation of gender and socio-cultural perspectives because community-derived data provide in-depth understanding of perspectives in a much more contextualised manner. The strength of group interviews is that they can generate detailed and process data that usually elucidate the study participants' perspectives very clearly (13). However, the fact that group interviews may also have inherent limitations especially when dealing with highly sensitive issues such as those in reproductive health should not be overlooked. An earlier study in Chiawa revealed that young men rarely admitted in the presence of others that they had suffered from an STI but rather discussed this matter in an impersonal and evasive way (14). Therefore, when using group interviews as the sole method of data collection matters of validity, reliability and the quality of the data should be given utmost consideration. In this study, careful use of observations as complementary to group interviews took care of data validity and reliability.

This study found that both urban and rural communities were aware of the existence of reproductive health problems and perceived them as a major community health problem. The study also found that, although reproductive health services were available at the local health facilities, gender and socio-cultural perspectives were not often given full attention by the medical staff and thus community expectations were not always adequately met. The commonly mentioned reproductive health problems were STIs including HIV, teenage pregnancies and abortions. All the groups in both sites mentioned these problems although some of the urban groups did also mention abdominal pains among the women which were attributed to past infections. Although family planning programmes exist in all the areas, the participants did not see high fertility as a major problem that needed high levels of interventions. What was, however, mentioned by the urban groups was family planning for economic reasons rather than

family planning for controlling and limiting births. The data demonstrate that, whilst there seemed to be some level of awareness regarding reproductive health in general, the women tended to be more aware than the men about reproductive health. Knowledge among the men was confined to STIs and abortion. Men were concerned with these problems merely for self preservation. There was a fear that some STI could not be cured at the hospital after amputation of the genitals and similarly women who had aborted could cause some illness known as *mfunga* or *nthayo*. These findings are consistent with previous studies in Zambia and elsewhere (8,14). The gaps in awareness levels between men and women are attributable to the fact that men have often not been a subject of reproductive health interventions (8). The present data suggests that because men are the breadwinners and main decision makers, it has erroneously been assumed that they are well informed about reproductive health matters. They are never allowed to go in at the clinic to share information with health care providers. For instance, during data collection the researcher observed a situation where a 'caring' father had brought his child to an under-five clinic but instead of being part of the audience during health education, he was served first and asked to go home. Hence the men have not been part of the primary targets of reproductive health services, their health needs have never been fully assessed and therefore reproductive health services continue to be gender biased against men.

The issues of socio-culture become more relevant in matters of fertility and infertility, family planning and treatment of STI and during child birth. Our study groups believed that reproductive health services have not adequately embraced socio-cultural factors. It was noted that health services were tailored along western culture. "These hospitals came with whites, so they are alien to us and that is why communication is in English".

Despite this observation, the groups felt that since these facilities are operating within the local socio-cultural environments, they

should consider taking into account local cultural values. When it came to specific programmes, there seemed to be differences in opinions. Most male groups and more particularly those from the rural area were so opposed to male staff attending to females during labour. In Chiawa some men felt that most male staff were more interested in viewing women's privates. "It is against our culture for a man to be present during delivery". Indeed observations showed that the number of females coming to deliver at the health centre increased after the posting of a female midwife. In Chawama, even though the women noted that traditionally it was not appropriate for a woman to be delivered by a man, they said that it was now becoming the norm for women to be delivered by male staff and that the women were beginning to accept that. The interaction between the men and reproductive health services was mostly during times when they sought treatment for STIs. Most male groups reported that the men were often uncomfortable with female staff. In Chawama the males reported that there was reluctance by male patients to be attended to by the females when they had an STI. For the women it was more of 'what can we do' than anything else. Given an option they preferred a female staff. One man said, "If I discover that the one who is going to attend to me is a female staff (particularly a nurse) I will change my mind and go elsewhere to seek treatment". Some of them said they could not stand a woman examining their private parts. Further discussions revealed that the reluctance to be attended to by nurses was due to stigma and lack of confidentiality. The males felt that nurses did not uphold confidentiality. These sentiments were substantiated by observations in Chiawa were rumours filtered so easily from the health centre into the community.

In Chiawa, husbands were reluctant to allow their wives to attend ante-natal clinics because they believed that the male staff were more interested in viewing their genitals and they saw that as a contradiction of the local cultural values.

These findings show that culture should be viewed as dynamic and not a static entity. For example, women see changes in the socio-cultural environment as inevitable. There is the problem with trying to account for the relative failure of reproductive health services on the grounds that they have encountered a 'cultural problem'. A form of cultural rela-

tivism is becoming more apparent. This is further sustained by the tendency displayed by some implementers who are convinced that if an argument is made out of culturally-based resistance, the problem has no solution. This view ignores people's capacity to change and underestimates the factors which do not explicitly derive from cultural traditions. Analysing behaviour in purely cultural/social ignores the social and individual resources and the practices actually observed. It is suggested that a better understanding and appreciation of gender and socio-cultural perspectives could greatly enhance the quality of reproductive health services and ultimately reduce reproductive health related morbidity and mortality.

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Towards the realisation of integrated STD and other reproductive health services in Zambia

P Matondo

Back ground

The World Health Organisation's definition of health, reproductive health implies that individuals are able to have a responsible, satisfying and safe sex life; and that they can reproduce and are free to choose if, when and how often to reproduce.

Indeed, reproductive health care is an umbrella for a plethora of health services and activities, which are geared towards ensuring that individuals are able to have a responsible and satisfying sex life, while at the same time can reproduce and are free to choose if, when and how often to reproduce.

The present dichotomy in the provision of STD services and other reproductive health services such as family planning, and antenatal care, to mention just a few, works to the disadvantage of users, health providers and the health institutions. To bring the issues into clear focus, it is pertinent to outline the full range of reproductive health services:

- Promotion of responsible reproductive and sexual behaviour within a given social, cultural and economic setting
- Provision of a wide range of contraceptive methods and services
- Provision of quality, effective and accessible antenatal care and ensuring safe motherhood
- Prevention and control of reproductive tract infections
- prevention and management of infertility
- elimination of unsafe abortion
- prevention and management of genital tract cancers

Current situation:

- Promotion of responsible reproductive and sexual behaviour within a given social, cultural and economic setting: Currently this is being provided for under separate roofs, so to speak.

The promotion of responsible behaviour with regard to fertility regulation falls mainly under the domain of family planning services or the mater-

nal and child health (MCH) clinics. In these settings, matters related to prevention of STDs may not be adequately dealt with, either because of inadequate skills or because it is felt that it is the responsibility of the STD clinics.

Similarly, the STD clinics, where they exist, mainly concentrate on counselling in relation to prevention of infections. Indeed, a recent study at the UTH STD clinic found that only about 7% of women attending the clinic in 1997 had ever used any modern contraception(). Yet the health workers in the STD clinic would not normally deal with this glaring need for contraceptive services either because it is perceived to be somebody else's responsibility, inadequate skills or lack of supplies. Opportunities for natural collaboration between the two services, such as condom promotion have largely been missed. For example, in some surveys of STD facilities, it was found that condom distribution is clearly designated either for MCH clients only or for STD patients only. The STD condom is not to be used by MCH clients and the MCH condom is not to be used by STD patients. This dichotomy exists despite the fact that used properly, the condom protects against pregnancy and STDs.

· Provision of a wide range of contraceptive methods and services: Currently most of the contraceptive, with the exception of condoms, are provided by MCH clinics. Little attention has been paid to the possible link between various types of contraceptives and STD risk. For example, the IUCD increases the risk of ascending infection especially in populations where gonorrhoea and chlamydial infection are very prevalent. Also cervical ectopy, which can occur with use of oral contraceptive pill may increase the risk of acquiring gonorrhoea or chlamydia. However, it is quite likely that the provi-

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sion of contraceptive services presently goes on without much consideration of the potential impact on STD transmission.

Provision of quality, effective and accessible antenatal care and ensuring safe motherhood. An opportunity for integration of STD and antenatal care has presented itself through screening of pregnant women for syphilis. This activity has been performed to varying extents and with different shades of consistency for a long time in Zambia. However, following a demonstration project, the implementation of syphilis screening in pregnancy has gained impetus under the UNICEF supported syphilis screening project in Lusaka, Ndola, Kitwe, Livingstone and Chipata(). A recent evaluation of the project revealed that midwives were quite competent to screen women using RPR(), the use of midwives to screen pregnant women for syphilis represents a key step towards the integration of STD and other reproductive health services.

Prevention and control of reproductive tract infections: Currently there is very little collaboration among the various service providers. For example, the STD treatment guidelines are often not available in gynaecology clinics where most women with genital tract infections present, or urology clinics where some men with complications of STD present. There seems to be no unity of purpose among different health care providers dealing with reproductive tract infections in different various, such as STD clinic, gynaecology clinic or urology clinic.

prevention and management of infertility. infertility that may arise from STDs may be prevented by assiduous STD prevention and treatment, and this aspect is probably seen as lying within the domain of STD services. However, infertility in the male and female are dealt with by the urologist and gynaecologist respectively. Quite often, the STD service provider has no idea how much of the STDs s/he is treating may end up causing infertility. Consequently, information that could be used to advocate strengthening or STD control services is lost.

Elimination of unsafe abortion:

Since the desire for abortion probably is symptomatic of lack or failure of contraception, it is plausible that empowering men with up-to-date information on various methods of contraception and dangers of unsafe abortions

could impact positively on the situation regarding unsafe abortions. It is possible that unreasonable or irresponsible behaviour among some men creates the despair and desperation, which drives some women to unsafe abortions.

Prevention and management of genital tract cancers: cancers such as cancer of the penis, testes or prostate impact negatively on the reproductive health of men and their spouses, since treatment for these usually leave the man infertile. However, presently more is said about cancer of the cervix and not much about the cancers of the male

Why integrate STD and other reproductive health services?

Efforts to integrate STD and other reproductive health services must be grounded in clear objectives about what is to be integrated, where, when, how and by whom. It should also be clearly spelt out clearly the nature of integration to be achieved at the various levels of health care.

How to integrate: way forward Issues:

- STD clinics at tertiary care hospitals: nurses must be trained midwives, and have training in STDs
- Nurses working in ANC/FP clinics at tertiary care hospitals must have training in STDs
- At the HC level all health workers must have basic competences in STDs and other reproductive health services
- ANC: screening for STDs including syphilis ought to be integrated into routine antenatal care. eg at booking, complete examination for ulcers, warts etc
- Emergency contraception to be made available in STD clinics
- Abortions: guidelines on prevention of ascending infections need to be developed after research on prevalence of various STDs among women undergoing termination in various localities
- prevention of genital cancers: women with warts presenting to STD clinics and should have regular screening by pap smear
- STD screening, whether clinical or by tests to be available in FP clinics.

Stakeholders in reproductive health to design reproductive health care education and training programmes that will include men's involvement in women's reproductive health. This is completely necessary as a way forward because a review of studies in Zambia on reproductive Health shows that not much work has been carried out in this area. (17). For example the study by Makayi and others on targeting men for enhanced male involvement in sexual and reproductive health revealed that there is a lot of potential for men to participate actively in family planning programmes but this can not be done without adequately surveying the reproductive health scenario as far as it affects men. (17) However, this potential will remain dormant until something is done to tap it.

In conclusion, there are a lot of to be heard if STD and RH services are integrated, and health workers should be encouraged to be less rigid and more creative in the way they work, to better tap opportunities.

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Perceptions on male involvement in women's reproductive health

Douglas M. Chipoya

Abstract

In the context of WHO's comprehensive and integrated approach to reproductive health, both men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice. In the past, reproductive health programmes focussed only on the needs of women, leaving out men. This has now been identified as a major obstacle to the success of any intervention aimed at improving women's reproductive health. In order to change this, gender activists, development organisations and individuals are now calling for men's reproductive health needs to be addressed as well as involve them in the reproductive health needs of women.

However, little information exists to understand how men and women in different socio-cultural settings feel about the issue of men's reproductive health and involving them in women's reproductive health. This paper reviews existing literature from the international community on perceptions about involving men in women's reproductive health. The paper shows that there is a general consensus that men should not only be involved in women's reproductive health. They are in fact already involved in various ways. Above all, however, it is also recognised that men also have reproductive health needs which if not addressed will continue to impact negatively on any programmes aimed at addressing women's reproductive health.

Introduction

According to the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Training in Human Reproduction Biennial Report of 1990-1991, Reproductive Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to

do so. (1).

According to WHO, implicit in this condition are the rights of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance to have a health infant. (1)

In the past, family planning services and maternal health programmes were designed to meet health needs of women. Not much attention was being paid to the needs of the men-folk. This has now been identified as one of the major causes behind the failure of reproductive health programmes and interventions throughout the world. Providers of reproductive health services have realised that it is unlikely that women's needs will be met until men's needs are addressed as well.

Despite the interest in the role men play in family planning in Zambia, relatively little information on the subject is available, and few studies have explored people's perceptions on male reproductive behaviour.

Much of the recent research on males in Africa has focussed on contraceptive knowledge, attitudes and practices (KAP). Less attention has been directed on male perspectives and how they shape reproductive choices of households.

Focussing on the perceptions of male involvement in women's reproductive health in Zambia is however important for several reasons. First, it might provide an insight into underlying reproductive decision making processes that at present are only partially understood. Because of the influences of lineage based social systems that exist in Zambia, conventional conceptual models based on the assumption that autonomous (or at least semiautonomous) couples with shared resources and responsibilities are the fundamental unit of decision making on fertility may not be applicable to the Zambian society. Second, there is reason to believe that the traditional nuptiality patterns that underlie the country's sustained high levels of fertility may be changing. Recent evidence from some

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countries suggests that socio-economic development and economic crises of the 1980s may be weakening the traditional marital institutions and supports for high fertility.

A study in Zimbabwe (2) demonstrated that both the number of events leading up to pregnancy or the birth of the child vary considerably from couple to couple along a continuum ranging from traditional to modern. These results both illustrate the complexity of prevailing family formation processes and point to the possible weakening of traditional patterns of union formation. In addition, the findings of a 1995 study of population dynamics in Sub-Saharan Africa suggest that information on the reproductive careers of men is crucial to an understanding of the demographic changes that have apparently begun in a number of countries in the region, including Zambia. (2)

Zambia is home to a variety of matrilineal and patrilineal ethnic groups, and sexual relationships follow diverse patterns. In this setting, it is particularly important to explore the attitudes of both men and women and to understand the views of each in decisions about reproductive health.

The Problem

Each year about 430,000 women in developing countries die of complications which are associated with child bearing (3). The factors influencing maternal mortality are high parity, teenage mothers, older mothers, short birth intervals, first birth and abortion. These have a large bearing on infant mortality.

Family planning is the best intervention. Family Planning services by couples are the means of avoiding many of these fertility related health risks. While surveys like the Zambia Demographic and Health surveys and Reproductive and Child Health Surveys may give some indications on reproductive health, these indicators are for females only.

It is important to note that interventions can only work subject to perceptions and behaviours that are deeply rooted in socio-cultural and traditional realities.

Phillimon Nduhani's study, published in this issue, on *gender and socio-cultural perspectives in reproductive health services: a reflection on community considerations* carried out in urban and rural Zambia, explores in detail gender and socio-cultural perspectives in reproductive health by providing a reflection of community views. According to his findings, the impact of many family planning programmes

has been very minimal due to the fact that the western hegemonic biomedical medicine culture often fails to take into account the local social-cultural milieu. The study suggests that a better understanding and appreciation of gender and socio-cultural perspectives could greatly enhance the quality of reproductive health services and ultimately reduce health related morbidity mortality. (4)

Men are an important factor in the reproductive health equation. Hence the need to include them in women's reproductive health programmes and even to address their reproductive health needs. To do this, there is need to investigate the socio-cultural, traditional and modern factors influencing male participation in reproductive health. A review of the existing literature gives an insight of the perception of male involvement in reproductive health.

Males and Reproductive Health: a review of literature

M. A. Labib and P. Matondo in their article published in this issue discuss in detail the issue of putting men's reproductive health on the reproductive health agenda. The authors strongly emphasise the fact that without addressing men's reproductive health, programmes aimed at addressing reproductive health issues in the country will not be as successful as they are supposed to be. According to them, men's reproductive health is a vital ingredient in the implementation of reproductive health programmes.

A review of the existing literature attributes the major cause behind the failure of Reproductive Health programmes and interventions throughout the world to the lack of attention to the needs of men. In Africa, M.T. Mbizvo, (6) for example, suggests that African family planning programmes are severely hampered by their neglect of men. Folbre in 1994 observed that focusing on women alone simply contributes to the overload and exhaustion for women, if they retain all the responsibilities associated with their existing reproductive and productive roles, in an era where the state can be relied upon even less that previously to provide social services. (7) Other authors further add that these programmes are also hindered by

the relative scarcity of information about men's knowledge, attitudes and practices regarding family planning.

Writing on *Better Family planning*, Marc Akumno observes a number of factors have resulted in emphasis by existing Family Planning programmes. These are the real threat which excessive child-bearing poses to the health of women, the strong link between family planning and women emancipation and the political and practical decisions in many countries to deliver family planning as part of maternal child health care have resulted in a female emphasis of existing family planning programmes. On the other hand the situation has resulted in men being effectively excluded from many programmes. (8)

These authors agree with the general view in the international community that most investigations in this area focus only on women, ignoring their partners' role and the interaction between the sexes in fertility behaviour.

The need for a wider involvement of men in women's reproductive health has also been a consistent recommendation emanating from a number of international fora, studies and surveys over the past few years. During the Innocenti Global Seminar held in Italy in 1995, Richardson noted that a UNICEF report concluded that, 'if UNICEF is going to continue to contribute to development goals and gender equality...there will have to be greater efforts to involve men. (9) Similar concerns have been raised by the Ford Foundation, Save the Children, and many other Non Governmental Organisations. (NGOs.)

The Cairo Conference on Population and Development also recommended that men should be involved in reproductive health. The most recent recommendation has come from the 1996 Report of the Independent Commission on Population and the Quality of Life (ICQL) which does not only advocate for the involvement of men in all aspects of reproductive health but also endorses the view that reproductive health is a basic hu-

an right for both men and women.
(10)

These efforts have been and continue to be motivated by the perception that a better understanding is needed of male perspectives on reproductive health, given the considerable empirical evidence that males play a dominant role in decisions regarding childbearing and fertility regulation in traditional societies.

Writing on Africa, Caldwell and Caldwell (11) describe what has been termed the traditional African pattern of male involvement in fertility decision making as follows:

"The African family structure typically places the reproductive decisions in the hands of the husbands and the economic burden mainly on the shoulders of the wife... Thus, when family planning decisions are made, they are likely to be surreptitious decisions by the wife alone or unilateral ones by the husband."

As a consequence, men's role within the private sphere has begun to attract particular attention from organisations on sexual health and reproductive rights. As Chikamata correctly observed, a typical view is that 'men should not only share the benefits but also the hardship of birth control, that is, they must assume their rightful share of reproductive responsibility' (12)

At the same time, because of little information on male perception in reproductive health, a common assumption regarding traditional or modernising societies is that men have little good to say about family planning. This assumption is perhaps most strongly held in Africa, where patriarchy has a long history and families have traditionally been very large. Yet, unfortunately, there is very little data available either to support or refute this contention.

However, a review of literature to date suggests that the views on male involvement in women's reproductive health vary widely. For example, some studies have shown that gender relations which guide the culturally appropriate behaviour of men and women play a prescriptive role in reproductive health in all societies. In most societies, men are the decision makers. As sexual partners, they tend to assume a dominant role, of-

ten deciding or at least influencing their partners choice of contraception. According to Population Reports 1996, (2) in six surveys, many women indicated that they do not use contraception because their husbands are opposed to the practice.

Some survey findings, although limited, suggest that men are interested in reproductive health as much as women. Other findings show that men often give their wives permission to practice contraception in a noncommittal way, without actually making a decision themselves; if anything goes wrong, they can blame their wives. As Sidney Schuler and many others put it, (13) men have authority, but often they are reluctant to take responsibility.

In some cases however, like in Bangladesh, men do get directly involved in discussing and making family planning decisions, bringing their wife contraception pills from the market, taking the initiative in getting their wife to use a contraception method, or even getting sterilised or beginning to use condoms.

A Knowledge, Attitudes and Practices (KAP) survey of 603 men in Ouagadougou, the capital of Burkina Faso, revealed that 75% of men knew of at least one method if they were prompted with a brief description of the method and 90 percent recognised at least one modern or traditional method. (14)

Some experts on gender violence and reproductive health are of the view that men's superior strength and their control over economic resources is another factor that makes women's struggle for dignity and sexual determination difficult. In Kenya, Silberschmidt claimed that men have become increasingly involved in what were regarded as minor and personal decisions taken by women and this tends to make them violent. (15) A woman in a Kissi community in Kenya put it thus 'women became very busy, men took the back seat and so they began to fight'. (15) It is noteworthy that some wives are sometimes killed just because they refuse sexual intercourse with their husbands.

All these views contend that male violence is an enemy of reproductive choice that exists in most personal relationships and is one that does not often enter into official discussion on reproductive choice. This is why women's groups world-wide are saying that reproductive freedom will remain a distant goal unless women's rights to control their own bodies has meaning within the personal sphere of

relationships. It is for this reason that advocates and activists have realised that gender violence and reproductive health issues are closely linked.

As we have noted above, because most family planning programmes are focussed on women, studies show that men often feel uncomfortable and unwelcome in family planning clinics that are oriented to women. In areas where programmes have focussed on men and addressed their interests, this has increased their contraception use, increased women's use of contraception and improved continuation rates.

Reproductive health decision-making is a complex process that differs from one setting to another and from couple to the next. While men often have more say than women in the decision to use contraception, in some places women have more responsibility for family planning than they do for decisions. Sometimes women use contraception without telling the husband and this may cause the husband to oppose the decision when he finds out.

Husband-wife communication is an important factor that plays a role in determining male involvement in reproductive health. Yet little is known about how husbands' views on family planning differ from those of the wife. A study in Tanzania found that younger husbands and wives increasingly agree that family interests and responsibilities should be shared. (2) It is likely that if more couples talk to each other about reproductive health, many would find that they agree about it and thus would be more likely to meet their shared reproductive goals.

The nature and current interest in men as key to achieving changes in sexual behaviour should no longer be questioned. The typical language used 'involving men' should now be questioned as being inappropriate because men in fact are already involved in reproductive health in various ways. For example, they are already involved as medical practitioners, as manufacturers and suppliers of contraceptives and as sexual partners who may give a negative answer to women's request to use contraceptives. (16)

Fathers and men in families also represent one of the most important resources for children's well being. Social services, including development interventions that have hitherto failed to take into consideration the major role of men in families and its effects on women, on children and on the men themselves have

recorded very little success. According to a Family Impact Seminar (15) there are four major contributions that men make to family life. These are taking economic responsibility for children, building a caring relationship with children, reducing the chances of 'unpartnered fertility' and ensuring gender equality in the family. All these have significant implications on the reproductive health of women.

However, while men may not be an obstacle as often thought, they still need to be convinced both that family planning is socially acceptable and that male involvement in the reproductive health of women is desirable. According to DHS data from 15 countries, most in Africa, men are more likely than women in the same country to report knowledge and use of contraception or, if not using it, that they intend to use it. This therefore calls for measures to ensure that men's involvement in the reproductive health of women and the promotion of their own reproductive health needs are addressed as being key issues to the success of any RH programme.

Way forward

From the foregoing, there is every reason to suggest that male involvement in reproductive health and male reproductive health problems are issues that need to be integrated into reproductive health programmes if power relations between sexes are to be changed for the better, and the potential of both men and women in contributing to informed reproductive choices is to be realised. It is unlikely that women's reproductive health needs will be met until men's needs are also addressed. In order to meet needs of men, the following may be done:

- Conduct research on the attitudes of women, government, policy makers, co-operating partners, men and health workers on the involvement of men in women's reproductive health
- Assess whether Zambia's health system and health infrastructure provides an enabling environment for involving men in women's reproductive health
- Review the Reproductive health policy and the Plan of Action for Integrated Reproductive Health in Zambia to find out whether they facilitate men's involvement in women's RH or maintain the status quo.
- The findings from such research/sur-

vey would enable government, NGOs, and other stakeholders in reproductive health to design reproductive health care education and training programmes that will include men's involvement in women's reproductive health. This is completely necessary as a way forward because a review of studies in Zambia on Reproductive Health shows that not much work has been carried out in this area. (17) For example the study by Makayi and others on targeting men for enhanced male involvement in sexual and reproductive health revealed that there is a lot of potential for men to participate actively in family planning programmes but this can not be done without adequately surveying the reproductive health scenario as far as it affects men. (17) However, this potential will remain dormant until something is done to tap

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Reproductive health needs of the chronically-ill adolescent and Youth

FM. Goma & AJM Mweembe

Introduction

The two major indicators of growth and development with regard to sexual maturity are progressive attainment of an adult body habitus and sexual function. In the female this is manifested mainly by breast development and onset of menses (1). This period of change called puberty normally starts as early as 8 years of age but before 16 years (1). However, the adolescent below 16 years of age is not considered to have acquired discernment in matters of sex and reproduction legally. Ignorance of reproductive health is one of the major problems encountered in this age group, and in the youths in general. (2).

Against the backdrop of the above mentioned factors, it is known that there are adolescents who are HIV positive. This suggests early onset of sexual activity. Indeed, the Zambia Sexual Behaviour Survey of 1998 reports that 37.3% of boys and 27.2% of girls have had sex by the age of 15 years.

This rises to 83.3% of boys and 84.6% of girls by the age of 19 years (2). The above evidence implies that adolescents and youths are exposed to similar concerns and risks that attend sexual activity whether chronically ill or not. Thus there does exist a real need to examine the needs of this group of young people.

Of the numerous chronic illnesses that afflict the young those that are commonly encountered in Zambia are diabetes mellitus (DM), sickle cell disease (SCD), Asthma, congenital and acquired heart disease, seizure disorders, neuromuscular and other handicaps, psychiatric illness and mental retardation, and HIV. These illnesses present several problems in the individual in relation to reproductive health. These illnesses affect growth and development if onset is early in life and may significantly affect the reproductive capacity of the individual. This may be in terms of delayed maturation of the reproductive processes or in the development of pathophysiological processes that may preclude sustenance of pregnancy or may complicate processes that are

utilised in preventing conception (child spacing or family planning).

1. *Delayed puberty and fertility*

Chronic ill health has in many diseases been shown to retard both physical and sexual development (3). Poorly controlled asthmatics are smaller than their matched healthy controls or well-controlled counterparts (3). Congenital and rheumatic heart diseases, and SCD also cause delayed puberty. It is postulated that in heart disease too much energy is spent on the work of cardiovascular function leaving little for growth and development. In SCD this delay is apparently due to anaemia. In the sickler on hypertransfusion regime, not only is there markedly reduced marrow expansion and incidence of strokes, there is also greatly improved development, approaching normal. However, the complications seen in the management of beta thalassaemias may then be encountered. A delayed puberty may cause quite an emotional upset in a girl who is already conscious of her chronic condition. Thus there may be need for some emotional support for those who vary from "normal".

The period of adolescence is associated with problems of identity and self-image. Thus the chronically ill adolescent with tardy development will be anxious about their own physical and sexual development and later also about sexual function especially so as they observe normal development in their healthy peers.

Attainment of sexual maturity also brings with it questions concerning fertility. In patients with cystic fibrosis males are universally infertile while females can conceive. In the spectrum of the chronic illnesses seen in Zambia, there is no specific relationship of any illness with infertility. This, nevertheless, does not imply an absence of anxiety in this sphere.

Medically, attention should be paid to optimal care to realise as near normal growth and development as

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possible. Treatment should be properly monitored using reliable indicators. Should the care be optimal, the sex maturity ratings will approach or fall within normal range. This may then reduce the concerns to be answered at this stage.

Counselling:

The reproductive health concerns of the chronically-ill youths are best handled in an environment that is not intimidating by sympathetic non-judgmental staff. This obviously requires interest and training in the reproductive health needs of youths in general. There is a place for a clinic or corner that deals with adolescent medicine but this is perhaps not feasible with the current manpower and fiscal constraints.

The best staff to explore the anxieties concerning reproductive health are the familiar paediatric staff rather than the unfamiliar expert. This problem could be appreciated in the light of difficulties experienced in the handing over of cystic fibrosis patients from paediatricians to physicians. As such it is advised that the chronically ill adolescent or youth be handled cautiously by a health provider who the patient is familiar with. Support groups, where they are available, make this problem easier to address because there is the support and testimony of others similarly afflicted.

The anxieties of these young people should be seen in the context of their illnesses. Diseases like sickle cell disease (SCD) and rheumatic heart disease (RHD) have a high morbidity and mortality. Thus these concerns may easily overshadow those of the reproductive health. There is need therefore for tact in exploring these anxieties and their relationships. Diabetes affects several organ systems and is known to cause reproductive dysfunction (7). A dysfunction of the hypothalamus-pituitary-ovarian axis is said to be apparent well before pregnancy in the diabetic women as evidenced by a decrease in the concentration of gonadotropins with low level of oestrogens. An appropriate management of the same would prevent subsequent gynaecological and obstetrical problems (8). In most of these individuals there is a delay in physical development, puberty growth leap may be absent and there may be delayed menarche. That is why familiar staff are best placed to do this.

While these disorders may lead to infertility, some of the adolescents progress to relatively normal fertility and are able to sustain pregnancy.

2. *Appropriate contraception*

Since it can be reasonably assumed that some percentage of the chronically-ill

youths are sexually active, contraception becomes an important aspect of reproductive health. The legal and ethical concerns that impact this subject will be discussed later. There is need for preconception counselling in many of the chronically ill adolescents. Consideration must be made of conditions in which pregnancy may be contra-indicated. Conditions where pregnancy may cause serious pathophysiological changes that warrant specialised care, conditions where pregnancy may worsen the primary pathology or conditions where outcome of pregnancy may not be so good (fetal wastage or maternal death). Full details need be discussed with the patient in the light of a comprehensive risk-benefit analysis. The patient needs to be guided towards making an informed decision that is in their best interest. Certain conditions would need intervention before pregnancy can be allowed. For example, in severe mitral stenosis pregnancy is contra-indicated in cases where the mitral valve area is less than 1-2 cm². Thus before pregnancy can be allowed, mitral valve surgery needs to be done.

Patient education should be central in addressing the matter of reproductive health in this group of individuals. They need to take more responsibility for the management of their own health condition commensurate with their level of maturity, developmental stage and understanding of their illness. Thus the health worker acts as a mere facilitator of this process by providing the background information and giving the support needed at every stage. The health worker further helps by monitoring their condition, assessing indicators of change and /or exacerbation, and appropriately referring them for specialised care.

Contraception:

A comprehensive understanding of the pathophysiology, and attendant consequent complications of each disease state determine the appropriateness of the choice of contraception. The following is a brief description of what is known about the different conditions:

i) Oestrogen-containing hormonal contraceptives predispose to vascular thrombosis whereas progestin-

only pills do not. Therefore in diseases like SCD which is complicated by strokes and CHD with prosthetic valves, combined hormonal contraceptives are contra-indicated (9).

ii) Intra-uterine contraceptive devices (IUCDs), like instrumentation and surgery, can breach the immunity of an individual. The resultant bacteraemia may lead to colonisation of heart valves causing infective endocarditis. Thus these devices are contra-indicated in CHD and RHD (9).

iii) Patients with seizure disorders present two major problems. Anti-epileptic drugs like phenytoin and phenobarbitone induce liver enzymes which increase metabolism of drugs such as the contraceptive pill, and also result in congenital malformations. Thus use of hormonal contraception may result in contraceptive failure. In this situation barrier methods and IUCDs become very important choices (4). Periodic abstinence and coitus interruptus are possible alternatives but these require a level of motivation and commitment that would be too ambitious to expect from this age group. Therefore advice in this group should focus on the former methods. However, high rate of expulsion of IUCDs has been reported in nulliparous teenagers and the causation of heavy bleeding may preclude their use in patients with anaemic syndromes.

iv) The mentally retarded suffer sexual abuse at rates higher than in the rest of the population. Thus pregnancy is a real risk in this class. The provision of contraception in this class would be both difficult and contentious and so needs debate and a legal framework to support it. Injectable progesterin, Methylprogesterone (Depo-provera) is advisable and preferable in adolescents with poor compliance and in the mentally retarded teenagers. It causes a

cessation of menses but is completely reversible in its anovulatory action.

v) The IUV positive youth is not precluded from sexual activity. In this group, Barrier methods of contraception are needed to prevent the spread of the disease.

3. Genetic counselling

The chronically-ill youth who falls pregnant has a significant risk of transmitting defective disease genes or producing offspring with congenital malformations of varying degrees of seriousness.

The locus for the sickle cell gene is on the 11th chromosome. The sickler has inherited two abnormal genes and will pass one of these to her offspring. Since the prevalence of this gene in Zambia is between 12 - 15%, the risk of producing offspring with SCD is greatly increased.

In CHD the genetic aberrations may be obvious or subtle. However, in this group, there is an increased incidence of CHD in the offspring (6). Malformations in epilepsy are increased by the disease itself and the anti-epileptic therapy which is said to be teratogenic. Ventricular septal defects, spinal dysraphisms and cleft lip and palate are caused by phenytoin and sodium valproate (4,6). The case for genetic counselling is very strong and so there is need for a service with adequate diagnostic facilities to enable detection of malformations should they occur. This is important for both monitoring and consideration of options.

4. Complications of pregnancy

Pregnancy induces haemodynamic and endocrine changes. As the pregnancy advances, there is an increase in blood volume, altered carbohydrate metabolism and ligamentous laxity. In the patient with mitral stenosis, for example, a cross-sectional area of less than 1-2 square centimetres implies severity that precludes pregnancy. A valvotomy would have to be performed before or early in pregnancy to enable uneventful pregnancy (6). The abnormal glucose metabolism in a diabetic may lead to a macrosomic baby, difficult delivery, increased fetal wastage, neonatal morbidity and mortality, and congenital malformations notably septal hypertrophy (5). Neuromuscular disorders such as poliomyelitis and kyphoscoliosis have a mechanical imbalance which is worsened in pregnancy. Unfortunately there is little intervention that can be instituted during pregnancy except supportive measures.

Apart from the above disease-specific complications, spontaneous abortions, still births, difficult labour, pregnancy induced hypertension and other ante-natal,

peri-natal and neonatal complications are greatly increased in adolescence.

Conclusion

The chronically-ill youth is already, disadvantaged by his medical condition or handicap. For this reason, the health delivery system and the legal framework should deliberately work in the interests of these young people. This should provide adequate reproductive health care.

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Creating demand for Family Planning and other Reproductive Health Services in Zambia

Elizabeth T. Sermitsos & Uttara Bharath

Introduction:

The Family Planning in Reproductive Health Policy Framework, Strategies and Guidelines document, issued in March 1997 outlines the way forward for the implementation of family planning within the context of a comprehensive reproductive health programme. With regard to the creation of demand for family planning, the policy framework states that, "the Ministry of Health will play a leading role in advocating multi-sectoral involvement and collaboration in the promotion and provision of family planning services..."

(1) According to the document, the promotion of family planning includes providing information, education and communication (IEC) regarding the prevention of unwanted pregnancies and sexually transmitted infections to priority groups. Furthermore, there is a specific focus on increasing male involvement in family planning and reproductive health and prevention education among young people through school health programmes and family life education.

One of the specific policy objectives is to use information and education to ensure that all couples and individuals can exercise their "right to decide freely and responsibly the number and spacing of their children." (1) The policy framework clearly supports principles of rights and responsibilities related to family planning, but demand needs to be created among the population to access these services.

Background.

Why Family Planning is Important in Zambia:

The population of Zambia is approximately 10 million people with a density of about 4 people per square mile. Compared to many other developing countries,

Zambia may even be considered underpopulated. Why then is there a need for family planning? Let's look at the growth rate and health indicators.

The population growth rate in Zambia is 3.2%, one of the highest in Africa. It is also one of the few countries in the world where infant mortality rates are on the rise. Furthermore, nearly one in five Zambian children dies before his or her fifth birthday, which represents one of the highest child mortality rates in the world. (2) Since 1982, maternal mortality has increased nearly seven-fold. Lack of family planning is often cited as one of the primary causes of these poor health indicators. In the absence of family planning women are more likely to have too many children (high parity), with a close birth interval (less than the recommended 2 year spacing), start child-bearing too early (before 18) and continue too long (past the age of 35). Babies that are closer than 2 years are more likely to suffer from higher rates of infant and child morbidity and mortality.

Attitude of Zambian Women Toward Family Planning:

When looking at why women are reluctant to practice family planning, research conducted by Johns Hopkins University/Center for Communication Programs discovered that family planning has been associated with limiting family size which is considered both 'uncultural' and a sin. (3) Many Zambians believe that, "a woman should be fully utilised and not die with eggs in her womb." (3)

Child-spacing, on the other hand, does have its place in Zambian culture. The perceived benefits of birth-spacing are that it "protects the mother and the child, there is 'More love for the family,'" and it is easier to "manage the family (financially)." There are a number of traditional methods of birth-spacing, varying in reliability, from the waist bead to periodic abstinence (during the breast feeding period.) The view of modern contraceptives is quite negative. They are viewed as highly unsafe (300% of men and 50% of women think they cause permanent sterility), bad for one's health, and

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that they promote promiscuity.(4)

Zambian Infrastructure, Policy and Support for Family Planning..

Apart from the cultural factors, "a lack of access to a variety and affordable supply of contraceptive methods has also been an obstacle," said Hon. Dr. Katele Kalumba, then Minister of Health noted at the launching of the national family planning logo. At the time of the logo launch, 1996 Demographic and Health Survey (DHS) data indicated that only 9% of Zambian women were using a modern contraceptive method, yet more than half of all married women said they did not want to get pregnant at that time.

Until 1995, the policies and programmes in place with regard to family planning were restrictive and did not make services easily attainable for the average Zambian. For example, a woman needed a signed consent form from her husband before she could get family planning services at a clinic. 1995 saw the launch of the National Family Planning Programme. This was the first concerted effort to make family planning more available and acceptable in the Zambian context. It was following the launching of this programme that great strides were made in Zambia, including the drafting of the national policy and guidelines documents, the development of the family planning logo, and training of service providers at clinic level.

What is Demand Creation?

Studies like the DHS and others normally indicate an "unmet need for family planning". This is defined as those women who do not want another child at the time of the interview, yet they are not practising family planning. These women with "unmet need for family planning" may not know what methods or services are available, where to go for services, etc. These women may not even know that they have "unmet need" and may not equate the solution to their desire not to have a child at the moment, with using a family planning method. Therefore, demand for family planning among these women (and others) needs to be created.

Communication experts around the world have developed various theories and models to describe how one creates demand for a product or service. In this case, we use the Steps to Behaviour Change model developed by the Johns Hopkins University/Population Communication Services.(5) The

five Steps to Behaviour Change are knowledge, approval, intention, practice, and advocacy. The idea is to take a member of the intended audience (in this case, those women who do not want to get pregnant now, but are not practising family planning) through these five stages, to the point where the individual has experienced the benefits of family planning, and advocates for it to other members of the community. (See Box 1)

Box 1 Steps to Behaviour change Knowledge

1. Recalls family planning message
 2. Understands what family planning means
 3. Can name family planning method(s) and/or source of supply
- #### Approval
4. Responds favourably to family planning messages
 5. Discusses family planning with personal networks (family, friends).
 6. Thinks family, friends and community approve of family planning.
 7. Approves of family planning.
- #### Intention
8. Recognises that family planning can meet a personal need
 9. Intends to consult a provider
 10. Intends to practice family planning at some time
- #### Practice
11. Goes to a provider of information/supplies/services.
 12. Chooses a method and begins family planning use
 13. Continues family planning use.
- #### Advocacy
14. Experiences and acknowledges personal benefits of family planning
- Advocates practice to others
Supports programmes in the community

Health Communication: Lessons from Family Planning and Reproductive Health

Demand creation involves using multiple channels to communicate the benefits of family planning and to show people where to go for services. In the case of Zambia those channels have included: mass media, group communication, and interpersonal communication and counselling. (See Box 2 for examples)

Box 2 Examples of Multiple Channels of Communication for Demand Creation in Zambia:

Mass Media Television

- Coverage of the Logo launch event
- Open Forum with Ben Kangwa (2 x 30 minutes panel debate)
- Zambians talk about family Planning (15 minute piece)
- Inside Look

Mass Media -Radio

- Sex, Radio and the Truth
- Love, Courtship and Marriage
- Tell Me Josephine
- Radio news pieces

Mass Media-Print

- There was vast coverage of the launch event and numerous press articles, features and opinions that followed
- Journalist competition

Community/Group Communication

- Circles of Friends for new and continuing users of family planning
- Radio listening groups
- Health education by nurses, community based Distributors (CBDs) and community Health workers (CHWs)

Interpersonal Communication and Counselling

- Service Provider Training
- Use the GATHER Technique

In addition to using multiple channels to encourage public discussion of family planning and to provide positive and accurate information about family planning, it was also necessary to help individuals identify where to go for information and services, hence the need to develop a national logo.

The National Family Planning Logo was created to:

- EMPOWER - women with a clear knowledge of when and where they can go for family planning services;
- ENLIGHTEN - men on their role as supporters of their families in seeking and using reproductive health and family planning services;
- ENLIST community leaders to support family planning use by encouraging members of their communities to utilise existing services;
- ENABLE service providers to reach out to more clients wanting assistance with family planning..
- EDUCATE - programme managers such as the District Health Management Teams (DHMTs) and key Zambian public organisations about the benefits of family planning..

ENGAGE NGOs and private organisations as visible partners; and

ENSURE universal compliance with guidelines and standards of the National Family Planning Programme.

On November 29, 1996, the Ministry of Health launched the new national family planning logo. This logo will help Zambians identify clinics and trained health care providers that offer family planning services. The logo is one component of the comprehensive family planning programme in Zambia.



The logo has a copper circle on the outside and a blue background inside and surrounding a happy, healthy family. The copper circle reminds people that, although traditional copper has been the wealth of the nation, the people are also the wealth of the nation. The blue in the background symbolises love. The logo shows a model family with well-spaced children surrounded by love and harmony.

How was the national Family Planning Logo developed?

The need for a family planning logo was determined by the Inter-Agency Technical Committee on Population, through its Information, Education and Communication Sub-Committee (the IEC Sub-Committee). This group established a logo working group which followed "the P-Process" to successfully, design and launch the national family planning logo.

The P-Process is a planning process designed by the Johns Hopkins University/Center for Communication Programs. The P-Process has five basic steps: 1) Analysis, 2) Strategic Design, 3) Development, Pre-testing and Production, 4) Management, Implementation, and Monitoring, and 5) Impact Evaluation. In the case of the logo, the IEC Sub-Committee began by assessing the existing data, policies and programmes, evaluating communication resources, and initiating new-formative research on gaps identified (i.e. the image of family planning methods and providers)- In step 2 the strategic design of the logo campaign was made. This included identifying the intended audiences, developing communication goals and key messages, developing guidelines for the

use of the logo, selecting media channels and planning for the launch of the logo, as well as planning for monitoring and evaluation. In step 3 the logo and slogan, and all the supporting materials and media were produced, including pre-tests with the audience and revised based on their input. During the implementation phase, the logo working group worked with media, an ad agency, and organisers of the launch event. Output was monitored and exposure and impact were measured. The team assessed the results, discussed lessons learned and planned follow-up activities, including more provider training and wider audience exposure to the logo through broadcast media and outdoor advertising.

Results of the Launching of the Logo.

The objectives of the logo are to:

- 1 Introduce and create awareness of the logo among consumers and service providers;
- 2 demonstrate broad-based, national support for family planning/ birth-spacing by announcing the new programme;
3. identifying clinics where trained providers are offering family planning services and the individual providers that have been trained-;
4. dispel key misconceptions regarding the use of modern contraceptives; and
5. build enthusiasm among providers and policy makers to support and participate in family planning.

It was agreed that the launch event would focus on service providers and policy makers, since there were not yet a critical mass of trained providers in the country and we did not want to create demand in places where it could not be met. Therefore, the focus of the launch event was on objectives 2 and 5.

Over 400 people attended the launch, held in Mulungushi International Conference Centre. These included public and private service providers, policy makers, NGO and community leaders, and members of the press.

One week after the launch event, a clinic-based field survey was done with 164 service provid-

ers in Lusaka. 58% of service providers could identify the logo unassisted and 86% could recall it with assistance. The pool interviewed included those providers who had attended the launch event and those who had not. This figure was significantly higher than our anticipated 50%.

Another measure of the success of the launch was the level of press coverage following the launch event. Approximately 10 news stories came out in the print and broadcast media, but there were significantly more articles and broadcast stories on family planning generated in the weeks following the launch event (approximately 15). This coverage was far better than we had anticipated.

But despite the apparent success of the launch event itself, there are still numerous challenges to be met and work to be done as we move forward. *Challenges and the Way Forward..*

At the time the logo was launched, there were only about 60 trained family planning providers in the country. As mentioned earlier, one does not want to create mass demand for services, if the institutions cannot support the provision of services. Therefore, we opted to wait until there was a higher density of trained service providers before actually using the logo as it was intended- to indicate to people where to go for services.

We started cautiously, by providing each trained provider with a logo pin that would help to identify him or her as a qualified family planning provider. When we reached a critical mass of trained providers (over 300, covering all the major urban areas and many rural areas) we began broadcast advertising of the logo itself- an image of the logo and a message that "this is the copper family planning circle. Where you see it, you can get family planning information and services. Look for it in clin-

ics, pharmacies and other locations in your community." These television commercials ran for about a month during the World Cup, when television viewership was over four million per day, and ran again earlier this year, with an average daily viewership of 1.8 million. These logo promotion spots were accompanied by a set of television commercials featuring the logo but encouraging men to support their wives in practising family planning and increasing couple communication about family planning.

In addition to the broadcast media, wall paintings are being done on clinics with trained providers throughout the country. These wall paintings focus on the services available at each clinic and approach family planning in the context of reproductive health.

Finally, there is still a shortage of trained providers in many locations and great concern that the demand created is not being adequately met. To address this concern, the integrated competency training (ICT), which includes training in modern contraceptives and counselling for family planning, is being field tested as this article goes to press. This training includes how to profile a client. Profiling enables a provider to tailor a counselling session to the specific needs of each client. In addition to profiling, providers will be provided with a set of resources (posters, charts, counselling materials and reference texts) which will equip them to better perform the task of providing family planning information and services. Following the roll out of the ICT, a broad-based mass appeal will go out on the airwaves to ensure that the population knows where to find their nearest trained family planning provider.

The way forward is seldom easy, but the promise Zambia has for a comprehensive and high quality family planning programme cannot be under-rated. With the appropriate mix of trained providers, quality information and a consistent supply of a variety of contraceptives, demand creation will go a long way toward meeting the nation's unmet need for family planning.

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Involving the mass media in the promotion of reproductive health in Zambia: problems and challenges

Douglas M. Chipoya

Abstract

The media influences how we live - and die. Yet despite so many media health campaigns, people continue to live unhealthy lives. Why? Focussing on the media and the promotion of reproductive health, this paper examines how the conflicting interests between the media and public health institutions is going to influence the promotion of reproductive health issues; the implementation of the reproductive health policy and what can be done to improve the effectiveness of the media in the process. This paper has a fourfold focus; firstly, it seeks to increase the understanding on the role of the media in the promotion of reproductive health; secondly; to explore the problems, challenges and opportunities that reproductive health advocates are likely to face when using the media to advance reproductive health education; thirdly; to suggest ways and means of solving the problems and overcoming the challenges. Finally, the paper suggests the way forward to facilitate the promotion of reproductive health issues and the implementation of the Reproductive Health Policy in Zambia.

Introduction

Traditionally, health aspects of human reproduction have been dealt with through the public health approach of "Maternal and Child Health" (MCH). Over the past two decades, however, important socio-demographic changes have taken place that have rendered the MCH approach too narrow to meet all the current concerns in this aspect of health. (1) As Zambia's Minister of Health in the late '90's, Professor Nkandu Luo put it, 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 the traditional Maternal and Child Health/Family Planning to the broader concept of Reproductive Health. The concept looks at an individual more holistically than did the MCH and Family Planning approach (2).

In response to the changed (and changing) global situation, a new broader concept of "reproductive health" emerged during the early 1990s which offers a more comprehensive and integrated approach to the current health needs of all in human reproduction. The new approach implies that men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of regulating fertility which

are not against the law, and the right of access to appropriate health care services that will enable women go safely through pregnancy and child birth and provide couples with the best chance to have a healthy infant. (1)

Against this background, the World Health Organisation (WHO), the World Bank together with other United Nations (UN) agencies came up with a programme to promote reproductive health as a cornerstone of health in all countries.

It is in view of these developments that the Zambian government decided to come up with a comprehensive policy on reproductive health. The policy is a result of wide-ranging consultations, both formal and informal, among a broader spectrum of Zambians and various institutions and organisations.

In order to successfully implement the policy and achieve its goals and objectives, government and other stake holders have to undertake a continuous public health education programme to sensitise members of the public on issues related to reproductive health. This has to be done within the framework of a comprehensive health promotion strategy. Information collection and dissemination is integral to this forward looking process of planning for the future and improving the public's responses and participation in the promotion of reproductive health.

In Zambia, the mass media is considered to be the major disseminator of health information to the public. In order to carry out the promotion of reproductive health, the Ministry of Health and other stakeholders such as UNFPA, NGOs like the Planned Parenthood Association of Zambia (PPAZ) and many others depend on the media for information dissemination.

The media in health promotion

Health promotion has been defined as the process of enabling people to increase control over and to improve their health (3). To reach a state of complete physical, mental and social well being, an individual must be able to identify and to realise his/her aspirations; to satisfy

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needs; to change or cope with the environment. In this light, health promotion is therefore not just the responsibilities of the health sector but goes beyond health lifestyles to well being. A wide range of public and private services and institutions including the mass media therefore influence people's health for good or ill, depending on the role they play.

As noted earlier, like in most parts of the world, in Zambia, the mass media is considered to be the major disseminator of health information. According to Tones and Tilford, well designed and implemented media campaigns have been shown to be useful for recruiting people into community health programmes and even changing people's behaviour (4). In Zambia, the few studies that have been conducted to assess the impact of the mass media on health development indicate that the media is a very positive tool for promoting health education (5). The AIDS and Control and Prevention (AIDSCAP) project reports of successful media campaigns targeted at the youth in the Dominican Republic (6).

In Jamaica, because of well designed programmes, media gatekeepers became more receptive to covering HIV/AIDS issues. They aired 63 radio and television programmes and published 121 newspaper and magazine articles on the subject over two years. Business owners and managers also agreed to work with the Ministry of Health to establish workplace prevention programmes (6).

Another study on the impact of the mass media Vasectomy promotion campaign in three cities of Brazil (Fortaleza, Salvador and Sao Paulo) also showed an initial increase of the use of the vasectomy during the first six weeks of the campaign by 108% in Fortaleza, 59% in Salvador and 82% in Sao Paulo (7). A similar study in Gambia on radio promotion of family planning showed that those who had listened to the programme had significant positive attitudes about family planning (8). Commenting on the results of this study, Valente observed that the radio is an extremely efficient means of reaching large numbers of people and if it can persuade people to

come to family planning clinics, it can enable field workers, clinical assistants, nurses and doctors to spend more time providing quality service and less time recruiting new clients (8).

An analysis of the comparative effectiveness of various means of communication in reaching various target groups (rural women and men, urban population, field workers, village leaders, government authorities, school children and the general public) showed that the radio, followed by television, was the most effective means of reaching these groups (9). According to Jones and Tilford, (4) one major benefit – perhaps the sole benefit – of mass media is their capacity to reach a mass audience and to do so relatively cheaply. Leslie, in 1981 also indicated in her review of mass media and nutrition education that the most firm conclusion suggested by her evaluations is that mass media health and nutrition education projects can reach large numbers of people (up to several million) in a relatively short period of time. The evaluations also indicated that although there is a considerable range in costs among projects, it is possible to achieve this outreach at a cost as low as \$0.01 per person. She further pointed out that between 10% and 50% of the audience remember the main message and that when a specific nutrition message has been designed, there is a reasonable expectation that the target audience could modify their behaviour accordingly and a reasonable could bring about an improvement in health or nutrition status (4).

From August 1998 to March 1999, this Journal hosted a weekly live-phone in radio programme *Health of the Nation* on radio 2 of ZNBC. The programme was aimed at disseminating health information to the public. The programme featured medical doctors who discussed various health topics. The guests who were featured on the programmes were experts in their fields and had knowledge and experience of what they were presenting on. As a result, the programme used to attract a lot of active participation from the listeners. One factor attributed to this is the fact that the guests were able to present the information in a simple language that made it easy for the public to understand. Thus the listeners found it easy to participate in and contribute to the programmes. The lesson from this programme was that the radio is a very effective means of disseminating health information as long as the information is presented in a simple language. From the foregoing, it is clear that the media have a very important role to play in the promotion of health. One of the well known and crucial functions of the mass media is setting the public agenda and conferring status and legitimacy on issues and thereby making it acceptable and easier to discuss these issues. This can be seen in the general case of HIV/AIDS where the word "condom" had never appeared on Zambian televi-

sion. Virtually overnight it not only has been on television but it has now become common currency in open discussions. This power of the mass media to stimulate and frame discussion is what makes it to be the most effective means of promoting public health issues.

However, the realisation that the Zambian media has not been in the forefront of putting various health problems on the public agenda makes it imperative to examine the factors behind this trend as it is likely to affect the promotion of reproductive health in the country.

A review of the mass media in Zambia reveals that despite the importance of the mass media in disseminating health information to the public, the media has not played this role effectively. Equally, a review of the major health policy documents also shows lack of recognition of the role of the mass media in promoting health issues. Apart from the mention of information, Education and Communication (IEC) as a component with the policy documents, the clear role that the mass media is supposed to play in the IEC strategy is not clearly spelt out. A review of the reproductive health policy and the Integrated Reproductive Health Plan of Action documents reveals this apparent lack of a clear strategy on the use of the media in advancing reproductive health education in the country.

In 1997, the Central Board of Health established an IEC working Group, (10) whose responsibility was to analyse policy issues related to health education and IEC in Zambia. However, this has had no documented impact on the role of the media in the promotion of reproductive health education. The question is why?

The current mass media situation in Zambia

Since independence, no clearly defined and nationally recognised information and media policy has existed in Zambia. The first Information and Media Policy was produced in March 1996. According to this policy, the main stream media scene in the country is composed of three daily newspapers, two of which have Sunday editions and owned by Government, while the third is privately owned. There is one television channel and a three-channel radio station, both owned by Government. Other government – owned news media include a news agency (the Zambia News Agency (ZANA) and an information service, the Zambia Information Service (ZIS). (11) The liberalisation of the media industry, however, has enhanced private sector participation in media ownership. This has brought about the establishment of pri-

vate weeklies, radio stations and a joint pay – television station between ZNBC and Multi-Choice. There are also three more privately owned FM radio stations, Ichengelo in Kitwe and Radio Phoenix and Christian Voice in Lusaka.

The Zambia Information Service is the main information service of government. However, its services are supplemented by Information Units in various Ministries and Institutions. There are also printing presses associated with printing newspapers, two owned by government and the other private. There are six Zambian language newspapers published by ZIS, which are aimed at narrowing the information gap left by the commercial-urban-based press.

The wire service sector is serviced by the government – owned Zambia News Agency (ZANA). Created in 1969 following a recommendation of the Siyomunji Commission of 1968, (11) the agency gathers news nationwide for distribution to local and foreign clients. Billboards, posters and leaflets are other means employed to disseminate information to the public. This is the main stream media that the Ministry of Health and other stakeholders depend on to disseminate health information to the public.

Coverage of Public/ Reproductive Health Education in the Zambian media Constraints

Basically, dissemination of health information in the Zambian media is presented in form of news, entertainment and advertising, and public service announcements (PSAs) especially for television. In the print media, health information is disseminated in form of newspaper and magazine articles. A percentage of all articles in the daily newspapers are in some way related to health. Bill boards, posters and leaflets are also used in the dissemination of health information. Of late social marketing has become one of the major strategies being used to promote contraceptive use and other health products and services.

An analysis of the operations of the mass media and public health sector shows that there is a conflict among the functions and goals of the mass communication and health sectors. Charles Atkin and Elaine Bratic Arkin are of the view that these disparate objectives which are outlined in the chart below pose many problems both for health educators utilising the media to influence the public and for media professionals dealing with health topics in coverage of news, creating entertainment and devising advertisements(12) .

Conflicting priorities of mass media versus public health institutions

Mass Media Objectives
To entertain, persuade or inform
To make profit
To reflect society
To address personal concerns
To cover short term events
To deliver salient pieces of material
Public health Objectives
To educate
To improve public health
To change society
To address societal concerns
To conduct long term campaigns
To create understanding of complex information

Source: Mass communication and Public Health-p.16

These conflicting priorities give rise to a number of issues, controversies, conflicts, opportunities and challenges arising in the four basic domains of advertising, journalism, entertainment and information campaigns.

With the liberalisation of the Zambian economy, the Zambian media today rests on a commercial foundation upon which marketers and health professionals operate. One trend that has developed in Zambia today is social marketing, which various institutions have employed in the promotion of various health products. Emerging from the interplay of this development is a fundamental trend toward combining public health messages with commercial messages, in the form of private/public partnerships and health related advertising practices. These new prospects offer the public health community an opportunity for wider dissemination of information but raise questions of accuracy, compromise and control .

For the Zambian media and marketing communities, the changes promise consumer appeal and co-sponsorship by credible non profit sources but pose questions of social responsibility and self regulation. The question on whether advertising of condoms and other products serves public interest or not which is an issue in Zambia among churches and other civil society organisations is one arising from the quest for social responsibility and self regulation.

The growth of private/public partnerships that has developed in Zambia, though has advantages for both, has given rise to problematic issues which are likely to affect the dissemination of reproductive health information. Notably, there is a basic incompatibility between the complexities and uncertainties of medical science versus the need to con-

vey simple health messages in advertisements. Secondly, there is a potential for misleading messages because companies can manipulate scientific information in an irresponsible manner.

Another effect of the liberalisation of the economy which is impacting negatively on health is a decline in government regulation and monitoring of advertising health products and services. A number of advertising practices that have merged of late need to be examined because they could have potentially detrimental health implications. As pointed out in the Reproductive Health policy framework, government must protect the rights of reproductive health clients when obtaining appropriate medical information and services and ensuring maximum confidentiality and privacy (2). Many advertisements for health related products and services have made some claims and presented images that are not only beyond outright inaccuracies but also bring problems of omitting essential information about the product. No one has ever proved the accuracy and truthfulness of some of the claims.

Another area of concern is news coverage of health. Here, the basic conflict is between what gatekeepers judge to be newsworthy and what health specialists believe should be told. More often than not, the news media ignores broad societal issues that are often more significant to public health in favour of more interesting personalised stories about individuals. Stories of male infertility, abortion, adolescent pregnancies and many other reproductive health related issues are usually covered like little human condition stories without bringing out the real issues that society needs to know about and discuss. Wallace points out that progress in promoting public health involves social change to correct system failures. However, the media tend to reduce health issues to individual level concerns and to reinforce existing social and economic arrangements. (13)

Public health problems are linked to social conditions and have strong economic and political components. One of the most consistent research findings in public health is the strong relationship between social class and disease. Social class, not individual; behaviour or medical care is the predi-

cator of illness. According to Wallace, one of the most powerful predictors of morbidity and mortality is the level of income (13). Various authors have also noted that persons in lower socio-economic classes have higher rates of virtually every disease. This kind of information has serious practical and political implications, yet the Zambian media seldom present such issues. Gitlin in 1983 quoted one network executive who noted that 'the media are always mistaking real social issues for little human conditions stories' (12). The media can stimulate discussion on a health problem such as reproductive health. However, the limited treatment the media gives to health problems insures that basic understanding about their causes and solutions is not enhanced.

Health promoters and health reporters have conflicting imperatives, seen most clearly in their attitudes toward repetition. Repeated information is a key to effective health education, but it is antithesis of news and to a lesser extent soft-feature material. The news media believe that rerunning the same basic themes will produce boredom and thus may result in loss of audiences. Yet many ordinary people in Zambia are not very familiar with various health subjects including reproductive health. For them to support the reproductive health promotion and get involved in addressing community reproductive health needs, they need community education and empowerment. This can come about by receiving information on reproductive health on a continuous basis. But because of the noted conflicting imperative, the media may not be willing to disseminate repeated information on a continuous basis and this can hinder empowerment of the people.

With regard to health related entertainment portrayals, there are notable barriers that may hinder the successful use of the media in disseminating reproductive health information to the public. There is no doubt, in urban Zambia, television has become the primary storyteller and the most important agent of informal socialisation. Television's health related themes are presented to an overwhelming majority of the Zambian urban population. Both positive and negative health messages and information are prominently and repeatedly woven into the plot-lines of popular programmes that have been and continue to be shown on television.

Systematic content analyses of some of the programmes focusing on issues such as abortions, teenage pregnancies, HIV/AIDS etc broadcast thus far have delineated certain portrayals that are intentionally or unintentionally featured in soap opera, prime time dramas and other types of programmes. One problem is that television's priority for attracting and satisfying large audiences is not compatible with educational objectives. A second barrier involves the media's policies of self censorship in editorialising on controversial or taboo subjects, such as abortion, birth control, AIDS

and many others. Even when it comes to less controversial issues, the media has a tendency to be very cautious in treating aspects that are considered sensitive to certain segments of viewers.

A number of studies carried out in Zambia confirm these views. In a paper presented at an AIDS conference in 1996, on the role of the media in HIV/AIDS reporting, Reene Hangoma (14) noted that the root cause of all the barriers in using the media to disseminate health information is the traditional taboos which have firmly been implanted in people's minds. According to her, due to traditional barriers, broadcasters can be restricted in using certain words and phrases in reproductive health. Words such as 'penis', 'vagina', 'penetrative sex' and many others may be replaced with broadcast terminology that may not always be understood by a cross section of the audience.

She further noted that another problem is that broadcasters usually makes false assumptions that people will know what they are talking about if they go round words they are not familiar with. She gave an example of a vernacular broadcaster who had trouble describing what goes on during puberty in the series of a play entitled *Friends for Life*. The broadcaster insisted on omitting phrases like 'blood from the female sex organ' and 'milky white fluid from the male sex organ' (14).

A study commissioned by the National AIDS Prevention and Control Programme in 1994 also established that there is a high degree of HIV/AIDS information censorship in the media (15).

Apart from these problems, the power of the press is further limited by a combination of political, economic and social factors. High illiteracy rates in Zambia illustrate the shortcomings of reliance on newspapers and the printed word. In addition, many Zambian languages have no words for such things as viruses and cells. Fewer can describe immunology or virology without resorting to the English language. For example, one Nyanja term for HIV is *kadoyo* which is best translated as very tiny insect. As this author has observed, this translation is accurate, yet fails to convey the rather special threat viruses pose to human beings compared to other micro-organisms. This may affect attitudes about transmission and self-protection (16).

Research in communication fidelity has shown that the language in all extension media including radio, is needlessly

complex and technical. The individual in the community has to confront a host of unfamiliar names of terms, definitions, explanations etc. and a variety of complex scientific explanations.

The non-institutional and often independent mass media present another major challenge for public health officials in our country who try to work with them. The mass media often involve editors and reporters who may or may not have the basic scientific knowledge or background about Reproductive health. They may also have criteria for judging the "newsworthiness" of a story that differs radically from reproductive health workers' own views. Journalists may have little access to accurate, timely or relevant information about reproductive health issues. The media may also be short of basic resources and staff who work under very difficult conditions. This in turn hinders them from carrying out their work efficiently. Hangoma and Nalumango (14, 17) share the same view.

In addition to the above observations, it is also important to note that access to the media in Zambia is a major constraint among the many lower socio-economic status (SES) audience in both the rural and urban areas. As the information policy clearly points out, the current average circulation of newspapers in Zambia is far from meeting the needs of the population as the figures below show for August 1995 (11). From 1995 to date, there has not been much improvement in the Zambian economy to warrant any significant changes in these statistics, so they still apply even now.

Table 1

Frequency	Newspaper	Circulation
Daily	Times of Zambia	25,000 copies
	Zambia Daily Mail	12,000 copies
	The Post	20,000 copies
Weekly	Weekly Express	2,000 copies
	National Mirror	12,000 copies
	Crime News	12,000 copies
	The Sun	14,000 copies

Source: 1998 Information and Media Policy

Television reception is mainly restricted to the line of rail. However, even where the SES have had access to the media, sometimes the main message quality i.e. relevance, de-

sign, and treatment is not tailored to meet their needs. Most of the programmes especially on television, including public health education ones are broadcast in English. This pro-literacy bias can act as a major constraint to the diffusion of reproductive health information to the illiterate communities. The fact is that in most part of the country, the community audiences with low SES have no formal education at all. They constitute a different sample altogether and any message designed for them can not make any prior assumption of their literacy, education and previous knowledge, etc.

TV can increase knowledge of Reproductive health, but many Zambians live in areas where there is no electricity and they therefore do not receive the information that is disseminated through this medium.

The treatment given to radio broadcasts is also not conducive to effective communication. Radio is a good medium for communicating experience but unsuitable for communicating scientific names. An examination of radio scripts for public health education programmes reveals an indiscriminate use of highly technical terms and complex instructions packed into programmes of very short duration. The variety, nature, and quantity of information and facts conveyed are sometimes excessive for a medium that caters for the human ear.

In a study on extension communication, Melkote examined extension media such as pamphlets, posters, booklets and radio scripts used in extension project in India and found that they were laced with pro-literate terms even though the target farmers were illiterate (18). These findings apply to the Zambia situation. A cartoon in the 1996 UN/Zambia report of sustainable development depicts the low degree of comprehension of health information by the illiterates through a picture of a woman looking at a poster on the wall of a clinic but can not understand what is written and wishes that she could.

Government also acknowledges that there are a number of factors that have constrained effective media outreach access to most parts of the country. These include inflation and falling per capital income affecting affordability of media products, poor communication infrastructure, operational problems such as high cost of newsprint and poor equipment generally as well as the high cost of radio and television receivers for listeners and viewers (11). These constraints point to the fact that most parts of Zambia are starved of information no matter how much of it is disseminated through the media.

The above constraints imply that the media can only play an important role in disseminating reproductive health information depending on the existing media infrastructure and influences from a host of other factors.

It is therefore important to note that mass media influences cannot and should not be isolated from a social context in which they interact and sometimes compete with, other sources of information and influences in complex ways. The social context within which the mass media is used to promote public health is therefore very important. Reproductive health advocates need to take all these factors into consideration when using the media.

Challenges

The challenge for the mass media and the reproductive health stakeholders is to make the greatest use possible of the mass media to improve the reproductive health of Zambians. The problem emerges when it becomes clear that simply informing individuals about responsible sexual and reproductive behaviour will not be sufficient to stimulate the type of change advocated for in the reproductive health policy that is necessary to significantly improve people's reproductive health. Public health is not just an individual responsibility. The health of Zambians, including reproductive health is to a large extent governed by the physical, social, cultural and economic environment in which Zambians find themselves today. To cajole the individual into positively taking responsibility for his or her health while at the same time ignoring the social and environmental circumstances which conspire to make them ill, is fundamentally a defective strategy and unethical. It is in short, victim blaming.

One of the constraints within which reproductive health officials must plan and develop a reproductive health strategy is the simple reality that the goals of a corporate society, which unfortunately Zambia is, are often in conflict with public health.

The Zambian mass media continues to grow and as such it should continue to be used to set the public agenda and confer status on reproductive health issues. What is required is reproductive health professionals to work closely with media professionals to bring reproductive health issues high on the public agenda.

The greatest gain will not come from changing people's/individual behaviour but from improvements in the country's economic conditions and social justice across the society. The understanding of the social and economic generation of public health problems, including reproductive health must receive greater emphasis in the media than individual level explanations such as reckless sexual behaviour.

Mass media professionals must be

more willing to examine critically theories of disease causality / people's reproductive behaviour and health promotion derived from the needs of a mass-consumption oriented society abuses a product but not the ethic of consumption that is skilfully promoted by marketers through advertising.

Medical services frequently do not meet the health needs (including reproductive health) of the public. They often treat the people as passive recipients of care and they are thus fundamentally de-powering. The main *modus operandi* of reproductive health promotion should be one of enabling not coercing. The focus should be on co-operation rather than compliance. The mass media should therefore contribute to the development of reproductively knowledgeable people who are empowered and not disabled by the information they receive. People may not need increasing amounts of reproductive knowledge as much as they need skills for better analysing and using reproductive health knowledge.

As the future role of the mass media in promoting reproductive health issues in the country is further reconsidered or discussed, it will be important to note some of the opportunities that exist in the mass that can be tapped to improve the promotion of reproductive health in the country.

Opportunities

The positive role that the Zambian mass media currently plays in Zambia's health reforms should be identified and expanded. From the time the mass media started to be used as a major disseminator of health information in the country, health professionals and the media personnel have learned a great deal about the mass media as a positive social institution, and these lessons should be integrated into the strategy for involving the media to promote reproductive health.

Over the years, there have been certain TV programmes that

have been dealing with significant social issues, usually as a result of a key gatekeeper's championship. An example is press freedom, human rights, gender issues and many others. These have been championed by people from various sectors of the Zambian society who have felt a strong commitment to the issue. Today, these issues have been debated and even received a lot of public support as a result of media coverage.

In the same way, herein lies an opportunity for reproductive health advocates to use the same strategy to put reproductive health issues high on the public agenda through wide media coverage. This can be achieved by employing an initiative of 'corporate consultation' techniques working with media people to improve the portrayal of proper reproductive behaviour.

In order to enhance the treatment of reproductive health issues under the limitations of the Zambian mass media, a first step is to make entertainment gatekeepers more aware of reproductive health issues and reproductive health specialists more aware of media needs. Before effectively educating the public, individuals working in both fields must themselves become better educated about the processes and priorities of the other fields. The reproductive health specialists ought to be more sensitive to the realities of the media, mass media should be more aware of the public's fascination with health and more cognizant of the influence they have on the audience and the value of presenting appropriate reproductive health behaviours and consequences. This can be facilitated by high level networking.

In addition, efforts are needed to teach the public to be more discriminating consumers of entertainment portrayals. This should involve both sensitisation to the positive health messages available in the media and inoculation against dysfunctional influences.

The way forward

In the complex and dynamic context of the Zambia environment discussed above, there is a variety of approaches that can be pursued more effectively to educate the public about reproductive health using the media. After distilling the experiences of the media and the health profes-

sionals, this paper proposes the following recommendations to improve the effectiveness of the media in the promotion of reproductive health:

- Educate the reproductive health specialists regarding opportunities and restrictions in using the media to communicate reproductive health messages to the public including multiple facets (advertising, news, public affairs, entertainment) and differences between channel (e.g. TV, radio, newspapers, magazines)
- Identify common interest among health organisations (especially those with an interest in reproductive health) and form coalitions to increase 'clout' with the media.
- Seek media co-operation at all levels from corporate leadership to individual reporters, through personal contacts over time, not just in regard to reproductive health needs, and to seek their involvement in the programme planning stages to interest them in the cause of reproductive health, not just the message.
- Recognise the conflicts as well as the convergences in interest between the Reproductive health community and the mass media, set clear, realistic expectations for reproductive health programmes involving the media, and solicit broad participation by the media and support from corporations that advertise through the media.
- Develop guidelines for collaboration between media and Reproductive health specialists to direct and safeguard co-operative advertising through the media
- Plan data collection and programme tracking for all media efforts, to increase what is known about the effects of communicating health information through the media.
- Support the establishment of media resource centres to share effective media materials, including PSAs to maintain contacts with journalists and to share advise and case studies illustrating effective media strategies.
- Educate the public (especially children) to be informed consumers of Reproductive health information in the mass media, including product health claims, conflicting news reports etc.
- There is need to recognise that the mass media are not obligated to edu-

cate the public about reproductive health. It is incumbent on the Reproductive Health specialists as one of many interest groups seeking co-operation of the media to understand the motivations of the media gatekeepers, to convince them of the importance of covering reproductive health issues and initiate collaborative ventures.

Conclusion

Encouraging people to change their reproductive behaviour is not enough; it provides only a partial solution to societally based health problem. By enabling mass media and reproductive health specialists better understand each other and thus to work more effectively, the point is made that the understanding that in the promotion of reproductive health in the country, the mass media people should not be used as passive participants but as active partners.

If the Zambian society is serious about promoting reproductive health, then the mass media must redefine the fundamental problem so that sufficiently broad strategies can be brought to bear. Even with constraints of the mass media in a poverty stricken society like ours, there is potential for progress in this area. The country's mass media are too valuable a resource to be used as simple information and entertainment machines. They must be tools to enhance understanding, including understanding of reproductive health issues.

Edward R. Murrow, speaking of television, explained " this instrument can teach, it can illuminate; yes, and can even inspire. But it can do so only to the extent that humans are determined to use it to those ends. Otherwise it is merely wires and lights in a box " (13)

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