

Strengthening U.S. Investments in Women's Global Health

A TRIP REPORT OF THE
*CSIS Delegation to
Zambia, March 2013*

Delegation Members

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Introduction

At the end of the day, mothers and women make the difference. Whatever you do should be woman centered. . . . It's the cornerstone for every country.

—First Lady of Zambia Dr. Christine Kaseba Sata, Lusaka, March 27, 2013

U.S. policymakers and private-sector partners increasingly appreciate the importance of targeted U.S. investments in women's health to achieve global health outcomes, especially in sub-Saharan Africa. With budgetary constraints worsening, progress in women's health will require maximizing investments by engaging new partners, identifying program synergies, and aligning with countries' national priorities to meet women's needs. Such strategic coordination—involving maternal newborn and child health, voluntary family planning, and HIV and AIDS services—presents new opportunities to expand the impact of U.S. investments.

In March 2013, the CSIS Global Health Policy Center led a delegation to Zambia to examine the opportunities and challenges of strengthening U.S. policy approaches to women's global health issues. CSIS chose to visit Zambia because of the new level of political will and leadership on women's health issues in the country; women leaders, in particular, are in an exceptional position to drive forward country ownership, including Zambia's first lady and other high-level government health officials.

The CSIS delegation included CSIS staff, senior staff from four congressional offices, and a representative of the Bill & Melinda Gates Foundation.² This is the latest in a series of delegations

¹ Janet Fleischman is a senior associate with the CSIS Global Health Policy Center. Alisha Kramer is a research assistant and program coordinator with the CSIS Global Health Policy Center. The authors would like to acknowledge the valuable support and assistance provided by the U.S. Embassy in Lusaka and the U.S. government agencies, especially the U.S. Agency for International Development and the Centers for Disease Control and Prevention. We also gratefully acknowledge the assistance of the Government of Zambia, including the office of the First Lady, the Ministry of Health, and the Ministry of Community Development, Mother and Child Health. Finally, we would like to thank the Zambian health care workers and community volunteers, and the U.S. government's implementing partners.

² Members of the delegation include Janet Fleischman, senior associate, CSIS Global Health Policy Center; Alisha Kramer, program coordinator and research assistant, CSIS Global Health Policy Center; Cade Clurman, senior policy

that CSIS has led to investigate U.S. global health policy in Africa,³ and it builds on an extensive body of work that CSIS has produced on women's global health and U.S. policy.⁴

The CSIS delegation examined programs focused on three women's health issues—maternal mortality, cervical cancer, and access to voluntary family planning—and explored the opportunities and challenges in how the United States leverages the President's Emergency Plan for AIDS Relief (PEPFAR) and works with its other partners to prioritize women's health. By examining U.S. engagement in a number of new women's health initiatives in Zambia, the report aims to bring forward lessons learned for broader U.S. government programming in global health. The delegation focused particular attention on two recent public-private partnerships: Saving Mothers, Giving Life (SMGL), which addresses maternal mortality; and Pink Ribbon Red Ribbon (PRRR), which integrates cervical cancer screening and treatment with HIV/AIDS services and increases breast cancer awareness. These two initiatives illustrate new ways to make the best use of U.S. investments in women's health, as well as challenges to achieving health goals.

This report from the CSIS delegation comes at a timely and important moment; the U.S. government and its partners have an opportunity to build on the current momentum and incorporate lessons learned into the next phase of SMGL and PRRR planning and implementation. The delegation concluded that these new initiatives, combined with long-standing U.S. investments in voluntary family planning, have considerable promise to improve women's health in Zambia. While the early results are promising, the initiatives will require heightened attention and support by the U.S. and Zambian governments and their partners if they are to achieve scale and sustainability, become integrated with other platforms, and maintain the initial level of enthusiasm.

In some ways, the partnership approach itself creates a paradox: While its short-term impact will depend on U.S. leadership—including greater attention to building sustainable structures, oversight, and financing—its longer-term results will require engaging new funding sources and transitioning to national leadership and direction. This will require the U.S. government and its partners to adopt a nimble, evolving approach based on ongoing evaluations of progress, with a longer-term outlook to reach scale and sustainability.

In addition, all levels of the Zambian government and health system—from health care providers and community leaders to high-level government officials—will need to demonstrate strong leadership and ownership if progress on women's health is to be secured.

adviser for Senator Mark Kirk (R-Ill.); Laura Stevens Kent, appropriations director and deputy chief of staff for Representative Charlie Dent (R-Pa.); Alison MacDonald, health policy adviser to Senator Jeanne Shaheen (D-N.H.); Theresa Vawter, senior policy adviser for Representative Kay Granger (R-Tex.); Jennifer Daves, program officer on the Global Policy and Advocacy Team at the Bill & Melinda Gates Foundation.

³ Suzanne C. Brundage et al., *On the Ground with the Global Health Initiative: Examining Progress and Challenges in Kenya* (Washington, D.C.: CSIS, 2011), http://csis.org/files/publication/110302_Brundage_OnTheGround_Web.pdf; Suzanne C. Brundage, *Terra Nova: How to Achieve A Successful PEPFAR Transition in South Africa* (Washington, D.C.: CSIS, 2011), http://csis.org/files/publication/111205_Brundage_TerraNova_WEB.pdf; Sally Canfield et al., *The Future of the U.S.—South Africa HIV/AIDS Partnership: Trip Report of the CSIS Delegation to South Africa* (Washington, D.C.: CSIS, 2013), http://csis.org/files/publication/130313_Morrison_SouthAfricaHIV_Web.pdf.

⁴ The CSIS Global Health Policy Center has a long record of working on gender-related health issues and U.S. policy, ranging from work on gender and HIV/AIDS, to family planning and maternal child health, to gender-based violence. The center's goal is to work with diverse stakeholders to make U.S. global health efforts more strategic, integrated, and sustainable over the long term.

A Challenging Context for Women’s Health and Gender Equality

[Women’s issues] are not sidebar issues. They affect everything. . . . Women’s health, rights, empowerment, gender-based violence—these affect everything a country can do in development.

—U.S. ambassador Mark Storella, Lusaka, March 26, 2013

One challenge in some communities is . . . the lack of power by women to make decisions about when to have sex, when to have a child, family planning, and the number of children they’ll have.

—Dr. Kenneth Chongo Chibwe, district medical officer, Kalomo, March 25, 2013

The CSIS delegation repeatedly heard several themes that illustrate the complex challenges in advancing women’s health and empowerment. Among the most critical:

- Weak health system: Zambia’s health system faces major deficits, beginning with an acute shortage of health care workers, notably doctors, nurses, and midwives. In addition, the health system suffers from poor transportation, communication, and referral systems between communities and health facilities and between health clinics and referral hospitals, as well as shortages or stock-outs of basic drugs, supplies, and equipment.
- Centrality of community-based services and information: Efforts to train and mobilize community volunteers, such as the Safe Motherhood Action Groups (SMAGs) under SMGL, have successfully increased demand for health services and encouraged women to deliver at facilities. The Zambian government is also considering new ways to use community health assistants to increase access to family planning methods, including the possibility of providing injectable contraceptives. Yet relying on community volunteers requires focused and ongoing support to ensure adequate training, materials, and other incentives to volunteers are sustained over time.
- Expanding access to voluntary family planning as a focus area to improve maternal and child health: Zambia has one of the highest fertility rates in the world; women have an average of 6.3 children, with low contraceptive prevalence of modern methods at 33 percent. New opportunities exist in Zambia to increase access to a range of contraceptive methods and create greater linkages between family planning and HIV/AIDS services. At the London Family Planning Summit in July 2012, the Government of Zambia committed to expand access to family planning and increase contraceptive coverage from 33 to 58 percent by 2020, pledging to increase its budgetary allocation for family planning by 100 percent and to improve service delivery to reach these targets.⁵ This repositioning of family planning was accelerated in February 2013, when First Lady Dr. Christine Kaseba Sata launched the “National Family Planning Campaign,” an eight-year effort to scale up contraceptive use to help prevent unplanned pregnancies, enable women to decide on

⁵ Dr. Joseph Katema, minister of community development, mother and child health, “Zambia’s Announcement at the London Summit on Family Planning,” July 16, 2012, <http://www.youtube.com/watch?v=INXcgJSvsZ4>.

healthy spacing of pregnancies, and reduce maternal and child deaths. The repositioning of family planning, by both the Zambian and U.S. governments, requires increasing access to, information about, and training on contraceptive methods, including increasing access to long-term family planning methods.⁶

- Gender inequality: Issues of gender equality form the essential foundation for advancing the health of women and girls. The subordinate status of women and girls in Zambia is reflected in social, cultural, and economic barriers to women’s ability to access health services and participate in household decisionmaking. High levels of gender-based violence, which contribute to women’s and girls’ vulnerability to HIV infection, underscore the critical need for national and community leaders to engage men, boys, and communities in preventing and responding to violence. Gender-related issues also restrict access to maternal health and family planning services, since women are often unable to make decisions about their own health, including the number, timing, and spacing of their children. Societal norms that support home deliveries with a traditional birth attendant can deter a woman from delivering in a hospital or clinic with skilled care. Progress in these areas will require both the empowerment of women and girls and the active involvement of men and boys to achieve lasting change.⁷

Public-Private Partnerships for Women’s Health

The biggest challenge [for these initiatives] is: at what cost and how sustainable? . . . It’s good to dream, but sometimes we need to be realistic about how to reach the population.

—Professor Elwyn Chomba, Zambia’s permanent secretary for community development mother and child health, March 27, 2013

The delegation held extensive discussions and conducted site visits to assess progress on two relatively new women’s health initiatives, SMGL and PRRR. These initiatives represent useful models for future public-private collaboration toward shared health goals.

Saving Mothers, Giving Life

SMGL is a five-year public-private partnership with the goal of reducing maternal mortality by up to 50 percent in its first year in two countries—Zambia and Uganda. SMGL was launched in June 2012 by the U.S. government, Norwegian government, Zambian government, Ugandan government, Merck for Mothers, the American College of Obstetrics and Gynecology, and Every

⁶ Increasing access to long-term family planning methods is especially important to address gaps in desired and actual family size, especially for women who do not want to have more children.

⁷ Gender equality issues include more than a focus on women and girls; they also include norms related to masculinity. Zambia’s criminalization of same-sex relations and the arrest of a prominent HIV/AIDS and gay rights activist for promoting “indecent activities” in April 2013 highlight the broader challenges that the country faces in the area of gender.

Mother Counts. In its first phase, SMGL is being piloted in four districts each in Uganda and Zambia, with plans to expand to additional districts and 5 to 10 additional countries, with Malawi next.

SMGL efforts focus on the critical 24 hours around labor and delivery, the highest-risk period for maternal complications and deaths. Many of these deaths result from one or more of three delays women face in childbirth: in seeking care; in reaching a health facility; and in receiving appropriate care. To address these delays, SMGL is implementing a package of interventions designed to increase access to high-impact maternal health services; improve the quality of maternal health services; increase community demand for services; and improve the capacity of health care workers in basic and emergency obstetric care.

So far, the U.S. government has taken the lead in driving the SMGL initiative forward as an interagency effort, providing initial funding from existing U.S. government resources.⁸ The initiative leverages existing health platforms and the expertise of U.S. government agencies and implementing partners, building especially on the U.S. Agency for International Development's (USAID's) maternal and child health programs, the work of the U.S. Centers for Disease Control and Prevention (CDC) in preventing mother-to-child-transmission (PMTCT) and safe blood supplies, and PEPFAR's investments in strengthening health systems. Other U.S. government agencies—the Peace Corps and the Department of Defense—are also participating in the interagency effort.

The delegation explored the challenges and needs to ensure SMGL's long-term success.⁹

Pink Ribbon Red Ribbon

Launched in December 2011, the Pink Ribbon Red Ribbon Initiative focuses on increasing access to breast and cervical cancer prevention, screening, and treatment. PRRR is a public-private partnership, led by the George W. Bush Institute, PEPFAR, UNAIDS, and Susan G. Komen for the Cure, with several corporate partners.¹⁰ The initiative aims to reduce deaths from cervical cancer by 25 percent among women screened and treated and to create innovative models for cancer prevention and treatment that can be brought to scale globally.

HIV-positive women who are also infected with specific types of the human papilloma virus (HPV) are four to five times more susceptible to developing cervical cancer than are HIV-negative women. Researchers believe that Zambia is one of the countries with the highest incidence of cervical cancer globally. It therefore makes strategic sense to integrate cervical cancer screening

⁸ For further details about funding for SMGL, see section on “securing short- and long-term financing” below.

⁹ Preliminary data from the first six months of SMGL (June–December 2012) in both countries, released at an SMGL partners meeting in Zambia in April 2013, showed some promising trends: facility deliveries increased by 50 percent; pregnant women receiving antiretroviral treatment (ARVs) and PMTCT services increased by 20 percent; and the number of women who had all four antenatal visits increased by approximately 20 percent.

¹⁰ Other founding corporate and foundation partners include Becton Dickinson, the Bill & Melinda Gates Foundation, Bristol-Myers Squibb, Caris Foundation, GlaxoSmithKline, IBM, Merck, and Qiagen. See Pink Ribbon Red Ribbon, “2012 Annual Report: Partnering for Progress and Purpose,” April 2013, 2, <http://www.pinkandredribbon.org/who-we-are/annual-report/>.

and treatment with the PEPFAR platform; investments made in treatment for an HIV-positive woman are lost when she dies of cervical cancer.

In 2006, Zambia became one of the first countries to screen and treat cervical cancer with PEPFAR's support. The Zambian government has adopted a simple and cost-effective method to diagnose pre-cancerous lesions through the public sector: visual inspection with acetic acid. This involves soaking the cervix in acetic acid (vinegar), taking a photograph using a digital camera, and reviewing the image for abnormal lesions. If the lesions are small, they are removed with cryotherapy (freezing the lesions with nitrous oxide gas). More advanced cases are referred to the hospital.¹¹

PRRR sought to build on these initial investments by the Zambian and U.S. governments, as well as expand cervical cancer services in Zambia. Two visits to Zambia by former president George W. Bush and Mrs. Laura Bush in 2011 and 2012 increased awareness about cervical cancer and boosted demand for services, especially combined with high-level engagement from Zambian first lady Dr. Christine Kaseba Sata.

As of early 2013, over 100,000 women had been screened for cervical cancer; 22 facilities (including mobile units) now offer screen-and-treat services. The African Centre of Excellence for Women's Cancer Control at University Teaching Hospital in Lusaka has trained over 60 health care providers from 13 countries in cervical cancer screening and treatment and expanded its electronic system to support screening for cervical cancer by nurses around Zambia. However, increasing demand puts considerable pressure on limited capacity in the Zambian health system.

U.S. Engagement in Public-Private Partnerships: Questions of Scale and Sustainability

The PPPs in Zambia represent a new way of “doing business,” and they have been largely U.S. driven. The CSIS delegation learned about the challenges that lie ahead in bringing these initiatives to a sustainable scale. The delegation identified three primary areas where the U.S. government's engagement with these initiatives will be critical.

The first area where the U.S. government's engagement will be critical is managing and coordinating public-private partnerships.

Public-private partnerships present time-consuming management burdens and implementation challenges, yet can add value and capacity beyond what individual partners contribute on their own. For example, since the United States does not use PEPFAR funding to fight breast cancer, the PRRR partners the National Breast Cancer Foundation and Susan G. Komen can fill this gap.¹²

¹¹ A total of 25 percent of women screened need treatment, with 80 percent of these cases treated in the clinics by freezing the lesions with cryotherapy (nitrous oxide gas). The remaining 20 percent are referred for more extensive evaluation and treatment (Loop Electrosurgical Excision Procedure, or LEEP; surgery; or radiation), depending on the severity of their disease.

¹² PEPFAR supports work on HIV and cervical cancer in women, given the direct link between the two, but PEPFAR cannot support the work on breast cancer, since there is no known link with HIV.

Likewise, given stricter rules for using U.S. resources to build infrastructure, SMGL partner Merck for Mothers will provide funding for the construction of maternity waiting shelters.¹³

Nevertheless, the CSIS delegation saw that these partnerships need to better coordinate health efforts in Zambia and better communicate among themselves, with the aim of leveraging existing resources and maximizing each partner's added value. In addition, the delegation heard concerns about how the partnerships' coordinating mechanisms can ensure that all commitments—including financial, technical, and in-kind—are fulfilled, and that partners avoid duplication and align priorities with national plans.

To achieve scale and sustainability, it will be critical for these partnerships to incorporate lessons learned, improve efficiencies in management and implementation, and take deliberate steps to lower costs and specify each partner's role. Since most implementation is still through U.S. government agencies—largely USAID and CDC—the U.S. government will need to work strategically across agencies and with its implementing partners and the Zambian national government to evaluate progress and share lessons learned. Increasing efficiencies and avoiding duplicative or redundant efforts should be a particular priority. Ultimately, transferring to national ownership as appropriate to lead and coordinate the partnerships will be essential as the partnerships develop.

The second area where the U.S. government's engagement will be critical is securing short- and long-term financing.

The CSIS delegation found that financing for the new initiatives in Zambia raises important questions about whether donors—including the national government, the range of private partners, and especially the United States—can be consistent and reliable in their financial support, allowing these initiatives to become sustainable and transition to greater national government control. The delegation heard concerns about whether all the partners—including the national government and the range of private partners—will deliver on their commitments to the partnerships.

The sustainability of U.S. government funding for SMGL is a case in point. The initial premise for phase I of SMGL, which aimed to show proof of the concept's viability, involved building on predominantly U.S. government investments. The expectation was that those investments would catalyze others to invest in phase II, which is aimed at expansion. In June 2012, then-secretary of state Hillary Clinton announced that the United States would contribute \$75 million over five years for the larger initiative,¹⁴ drawing on existing PEPFAR resources (\$60 million through CDC and USAID) and maternal child health funds through USAID (\$15 million in the 2013 funding request).¹⁵

¹³ In April 2013, Merck for Mothers awarded nine-month planning and research grants to three organizations to explore ways to build and sustain maternity waiting shelters, which will result in one or two grants to move the projects forward.

¹⁴ This funding covers the current two SMGL focus countries and those to be included in the expansion within that timeframe.

¹⁵ According to the U.S. embassy in Lusaka, the U.S. government funding allocated for SMGL in Zambia during phase 1 (October 2011-May 31, 2013) was \$15.1 million. This includes funds for service support, surveillance and evaluation, training, and enhanced HIV care.

In Zambia, USAID has redirected some maternal child health funding, while CDC provided a one-time contribution of \$9.5 million to kick-start the program.¹⁶ PEPFAR funding for SMGL focuses on HIV/AIDS outcomes; since SMGL encourages women to access antenatal care and to deliver at health facilities, it provides an opportunity to offer counseling and testing for HIV, to prevent mother-to-child transmission of HIV, and to further the goal of creating an AIDS-free generation.

Supplementing U.S. government resources for the broader SMGL initiative, Merck for Mothers committed \$53 million (plus \$5 million in-kind) to serve as the SMGL secretariat, and provide support for the evaluation project and program implementation; the American College of Obstetricians and Gynecologists committed to provide technical support and leverage its members and other professional organizations; and Every Mother Counts committed to raise public awareness and assist in fund-raising. The newest partner, Project CURE, committed to contribute medical supplies and equipment.

For phase II, the Government of Norway is expected to provide \$80 million in new funding to the partnership, even as existing partners fulfill prior commitments and new partners make additional contributions. Norway's contributions for phase II have not been finalized, but may focus on a combination of training for midwives, nurses, and doctors; mobile technologies for health; and commodities in new SMGL countries. Norway's phase II contributions will not necessarily be directed to Zambia.

Nevertheless, the U.S. government's funding will remain key to the initiative's longer-term sustainability, especially since the SMGL programs are being built on U.S. government-funded health platforms with heavy reliance on U.S. government agencies and implementing partners.¹⁷ At this writing, it is unlikely that there will be any significant new U.S. financial contributions to SMGL.

For PRRR, PEPFAR supplied most of the initial financial investments focused on cervical cancer screening and treatment, totaling \$3 million over three years for Zambia. Other PRRR partners have contributed resources or expertise—notably the George W. Bush Institute, Merck Vaccines, Susan G. Komen for the Cure, and UNAIDS. In particular, the Bush Institute is helping to coordinate the partnership, and Merck donated 180,000 doses of the HPV vaccine.¹⁸ The government of Zambia is also supporting the HPV vaccine project and will buy additional vaccines through GAVI. Susan G. Komen for the Cure is supporting training and community education.¹⁹

¹⁶ This funding was redirected from monitoring and evaluation and from administrative funds, not previously designated for Zambia. In total, CDC provided \$17.6 million in non-PEPFAR funds for the two pilot countries, Uganda and Zambia.

¹⁷ The U.K. Department for International Development has expressed interest in adopting SMGL methodologies and the European Union has proposed to adopt them in their new programs in nine districts. If this materializes, it would be a new example of leveraging U.S. investments in other parts of the country.

¹⁸ The vaccine is for 50,000 fourth-grade girls aged 9 to 14 (for the required three doses per person), which will be used in a demonstration program beginning in May 2013. The demonstration project will be school based and will be carried out in Lusaka province (urban) and Chongwe (rural). The goal is to achieve at least 50 percent coverage of all three doses. The launch is planned for May 2013. The demonstration project is a two-year program, with two cohorts of girls. If it succeeds, the national rollout of the HPV vaccine will be supported by GAVI.

¹⁹ Contributions and commitments by PRRR partners in Zambia include the George W. Bush Institute—supported visits by President and Mrs. Bush to Zambia in 2011 and 2012, helped refurbish the Ngungu Health Center, and houses the PRRR secretariat and provides administrative and legal support to the partnership; PEPFAR—\$3 million

The third area where the U.S. government’s engagement will be critical is advancing country ownership.

The CSIS delegation heard repeatedly that a top priority for the U.S. government is promoting country ownership in the health sector. The Zambian government has increased its investment in health—evidenced by a fourfold increase in its HIV/AIDS spending, an increase of over 40 percent in its health budget, and an increase in the number of midwives at SMGL sites. For PRRR, the government supported the development of guidelines for the integration of cervical cancer and HIV services.

One measure of increasing country engagement in the health sector involves tracking and counting government commitments. A particular focus should be on the fulfillment of commitments in areas such as the numbers of health care workers hired, nurses in nursing schools, and the procurement of drugs and commodities.

The delegation realized that greater country ownership also involves increasing the government’s capacity to take on a larger coordinating role, especially related to new partnership initiatives. In this regard, the temporary assignment of CDC personnel to the Ministry of Health as an interim strategy is likely to play a useful part to increase capacity and improve implementation.

Enabling country direction will also require alignment of U.S. government programs with national priorities and plans. Yet the question arises of whether the focus on new initiatives will compel the government to divert resources from other health programs that would otherwise receive support, including the government’s expressed interest in expanding access to voluntary family planning. Considering this question will require an open and honest dialogue to ensure that all partners are aware of where funding is directed and how that fits with national plans.

New Interagency Efforts to Achieve Outcomes in Women’s Health

We need to do the right thing, in the right way, at the right scale.

—Dr. Lawrence Marum, country director—Zambia, CDC, Lusaka,
March 26, 2013

On the ground, U.S. government agencies often engage in turf and funding battles that run counter to a “whole of government” approach. However, the Zambia experience shows that a determined, committed U.S. government country team can overcome endemic interagency tensions, especially when reinforced by in-country leadership at the U.S. agencies and from the

over three years for cervical cancer screening and treatment programs in Zambia; Merck—180,000 doses of HPV vaccine, Gardasil® for 50,000 fourth-grade girls; GSK—3 million doses of morphine for palliative care (1 million per year, though this donation has not been accepted by the country yet); Susan G. Komen—\$200,000 to train high-level providers in breast cancer detection and management; \$20,000 to support NGOs that are working on breast and cervical cancer community education and sensitization; National Breast Cancer Foundation—\$100,000 to hire a National Health Promotion Manager in Zambia.

chief of mission. The SMGL initiative in particular illustrates that U.S. agencies—PEPFAR, USAID, CDC, the Department of Defense, and the Peace Corps—and their implementing partners can find new ways of working together to achieve health outcomes.

Maximizing the PEPFAR Platform

The United States has made a huge investment in PEPFAR in Zambia, totaling \$306 million in fiscal year 2012 and more than \$1.9 billion since PEPFAR's inception. Through PEPFAR, five U.S. government agencies and over 100 partners have made investments in HIV/AIDS prevention, treatment, and care, and systems strengthening.²⁰ Zambia has also benefited from several special initiatives that involve PEPFAR support, including the public-private partnerships focused on women's health.

There are significant opportunities to build on the PEPFAR investments in Zambia to reach women and girls with more comprehensive services. HIV is still the leading cause of death for women of reproductive age. Since some 85 percent of pregnant women access PMTCT services through antenatal care, it is clear that ensuring effective linkages with key services—including maternal, newborn, and child health; cervical cancer; and voluntary family planning—should be a priority that can be accomplished at relatively low additional cost.

PEPFAR's support for integrating HIV with other women's health services benefits a range of health goals. PEPFAR enables programs to reach scale and sustainability and make a difference at the national level, through government health systems. For example, SMGL built on PEPFAR investments in electronic records, laboratory support, and blood supply/transfusion services. PRRR's work on cervical cancer involves a direct link with HIV, so HIV/AIDS programs are an important entry point to encourage cervical cancer screenings for HIV-positive women. Likewise, cervical cancer screening programs also offer HIV counseling and testing in the screening room—an important example of integrated services.

Nevertheless, the CSIS delegation saw that it is often unclear in the field how to most effectively integrate other women's health services, especially family planning, with PEPFAR programs.²¹ The importance of bidirectional integration and colocation of services underscores the need for specific program guidance and reporting guidelines to implement the integration of services. While the delegation saw program efforts to provide referrals from family planning to HIV/AIDS, there were weaknesses in linking family planning information with HIV/AIDS services.²²

²⁰ These PEPFAR investments include awareness, advocacy, and mobilization; infrastructure and human resources for health, including ARVs and PMTCT facilities; training of health care workers; laboratory systems; blood supplies; equipment; supply chains for commodities; medical records, including electronic records; data and information systems; and monitoring and evaluation.

²¹ Growing evidence demonstrates the important program synergies and health benefits that flow from linkages between HIV/AIDS and family planning. As more women living with HIV access ARVs, the HIV platform can be leveraged to provide important information and services women need to decide the number and timing of pregnancies, as well as PMTCT of HIV infection. Similarly, integrating HIV-prevention and treatment services into family planning and maternal child health programs helps prevent HIV infection in women and girls, while increasing access for HIV-infected women to ARVs and to PMTCT programs.

²² An example of a PEPFAR HIV program working to integrate voluntary family planning is the Zambia Prevention, Care, and Treatment Partnership (ZPCT II). While PEPFAR does not allow its funds to be used to purchase contraceptive commodities, they can be used to support family planning counseling and referrals in HIV programs. ZPCT II has shown that more needs to be done to translate support for FP/HIV integration into wider practice.

Global Health Diplomacy

The CSIS delegation saw the value of enhancing global health diplomacy to further U.S. interests and investments. The Lusaka Embassy's involvement in women's health initiatives in Zambia—building on PEPFAR, maternal child health, family planning, and malaria investments—illustrates the value of incorporating global health into U.S. diplomatic engagement with the national government, other donor governments, and the private sector. Ensuring that the U.S. Embassy, with direct engagement from the ambassador, integrates global health issues into regular diplomatic activity is in line with the goals of the State Department's new Office of Global Health Diplomacy (OGHD), which was created in late 2012 after the Global Health Initiative (GHI) office at the State Department was closed in July 2012. The OGHD is led by the U.S. global AIDS coordinator, Ambassador Eric Goosby.

The OGHD is the latest phase of GHI, which included women, girls, and gender equality as the first of seven core principals, and reflected the elevated attention to these issues under President Barack Obama's first term and particularly championed by then-secretary of state Hillary Clinton.²³ Diplomatic engagement on global health issues in Zambia, including women's health initiatives, provides lessons for other U.S. embassies to ensure that women's health and development concerns are a fundamental part of diplomatic portfolios.

The CSIS delegation also saw the important role of global health security in Zambia. This reflects a new level of military-to-military engagement on health issues, which serves the interests of both the Zambian and U.S. governments. What began primarily with U.S. assistance through PEPFAR for HIV services for the Zambian defense forces, which were believed to have high rates of HIV infection, has expanded to include broader health assistance for the civilian populations around Zambian military sites. Since some 350,000 civilians were served by military health services in 2012, this presents the opportunity to engage the military as a nontraditional supporter of women's health, while reinforcing the U.S. approach to using global health as forward defense.

Recommendations

This is an important and timely moment to advance the U.S. partnership with the Government of Zambia on women's health and to build on the new partnership initiatives that are under way. However, this effort will require paying special attention by the U.S. government to reach the next level of scale and sustainability and to plan for the transition to national control.

To carry this progress forward and to achieve real impact in women's health, the CSIS delegation recommends five priority steps:

1. High-level and committed leadership from congressional leaders from both U.S. political parties and from the Obama administration should prioritize women's health and support leadership in national governments and in U.S. government agencies. Secretary of State

²³ President Obama launched the Global Health Initiative in May 2009, as a six-year, \$63 billion program, with a particular focus on preventing new HIV infections, reducing maternal mortality, and averting unintended pregnancies. The initiative quietly expired in July 2012 and was replaced with the Office of Global Health Diplomacy.

John Kerry should use his new position to demonstrate his commitment to women's health and gender equality by holding ambassadors and agencies accountable for results. Members of Congress should travel to countries where the United States is making investments in women's health and become vocal champions to advance U.S. policy and programs.

2. The U.S. government should build on prior U.S. investments in women's health and promote new partnerships. This will require specific personnel—both government staff at headquarters and country team managers—to help manage and coordinate partnerships, engage private-sector partners and national governments, and hold partners to their commitments.
3. Congress and the administration should protect and expand U.S. investments in women's health initiatives; increase linkages between PEPFAR and maternal health, cervical cancer, and family planning; support access to voluntary family planning as a public health priority; and encourage the Zambian government to fulfill the commitments it has made in these areas—including those made at the London Family Planning Summit in July 2012.
4. The U.S. government should measure the impact of the new partnerships and invest where progress is being made toward achieving women's health goals. The government should design implementation strategies and routine reporting mechanisms, coordinate monitoring plans, develop indicators, and share best practices. Disseminating and acting upon preliminary results will be key, both to incorporate into SMGL phase II and the scaling up of PRRR, as well as to build U.S. and private-sector support.
5. The U.S. government, the Zambian government, and their partners should plan for scale and sustainability. More results can be achieved to advance women's global health without substantial new resources. This will require Congress and the administration to focus on how investments can be more strategic and better integrated to achieve positive outcomes, while continuing plans to transition to national control.

Appendix: Delegation Agenda

Delegation Members

Ms. Cade Clurman, Senior Policy Adviser, Senator Mark Kirk (R-Ill.)
Ms. Jennifer Daves, Program Officer, Bill & Melinda Gates Foundation
Ms. Janet Fleischman, Senior Associate, CSIS Global Health Policy Center
Ms. Laura Stevens Kent, Deputy Chief of Staff, Representative Charlie Dent (R-Pa.)
Ms. Alisha Kramer, Research Assistant and Program Coordinator, CSIS Global Health Policy Center
Ms. Alison McDonald, Health Policy Adviser, Senator Jeanne Shaheen (D-N.H.)
Ms. Theresa Vawter, Senior Policy Adviser, Representative Kay Granger (R-Tex.)

Sunday, March 24: Livingstone

Working Dinner on Saving Mothers, Giving Life, Pink Ribbon Red Ribbon, and Family Planning

Ms. Elizabeth Brennan, Deputy Country Coordinator, PEPFAR Zambia
Dr. Fatima Soud, Team Lead, Epidemiology and Surveillance, Global AIDS Program–Zambia, CDC
Dr. George Sinyangwe, Senior Health Adviser, USAID/Zambia
Ms. Patricia Ulaya, the Department of Defense PEPFAR Program Assistant, Zambia
Dr. Jorge Velasco, Deputy Health Team Leader, USAID/Zambia

Monday, March 25: Kalomo District and Choma

Ms. Esnart M. Juunza, District Coordinator, Saving Mothers, Giving Life
Dr. Davidson Hamer, Director of Research and Evaluation, Zambia Center for Applied Health Research and Development (ZCAHRD)
Ms. Irene Miti Singogo, Project Director, Saving Mothers, Giving Life, ZCAHRD

Meeting with Southern Province Provincial Health Office

Dr. Lutangu Alisheke, Provincial Medical Officer, Ministry of Health, Southern Province
Dr. Kenneth Chongo Chibwe, Kalomo District Medical Officer
Dr. Kebby Musokotwane, Communicable Disease Specialist

Site Visits:

Zimba Mission Hospital
Kalomo District Hospital
Namwianga Rural Health Clinic
Siachitema Rural Health Clinic
Zambia National Services

Working Dinner with Peace Corps

Mr. Tom Kennedy, Zambia Country Director, Peace Corps
Zambia Peace Corps volunteers

Tuesday, March 26: Lusaka

Working Lunch with U.S. Embassy Team

Ambassador Mark Storella, Embassy of the United States, Zambia
Dr. Susan Brems, Mission Director, USAID/Zambia
Mr. Tom Kennedy, Zambia Country Director, Peace Corps
Dr. Lawrence Marum, Country Director, CDC
Ms. Kristie Mikus, PEPFAR Coordinator, Zambia
Colonel David Wallin, Defense Attaché, Department of Defense

Meeting with U.S. Ambassador

Ambassador Mark Storella, Embassy of the United States, Lusaka

Meeting with Ministry of Health Officials

Dr. Peter Mwaba, Permanent Secretary, Ministry of Health
Dr. Maximillian Bweupe, Deputy Director, Public Health and Research, Ministry of Health

Working Dinner Hosted by USAID Mission Director with the U.K. Department for International Development and EU Representatives

Mr. Arend Biesebroek, Head of Operations, European Union Delegation of Zambia
Ms. Meena Gandhi, Health Adviser, Department for International Development, United Kingdom

Wednesday, March 26: Lusaka

Site Visit: Chawama Clinic**Meeting with the Ministry of Community Development**

Professor Elwin Chomba, Permanent Secretary, Ministry of Community Development, Mother and Child Health
Dr. Caroline Phiri, Director of Mother and Child Health, Ministry of Community Development, Mother and Child Health

Site Visit: African Center of Excellence, University Teaching Hospital

Working Lunch with CIDRZ, Merck, and PATH

Dr. Sharon Kapambwe, Program Head, CIDRZ Cervical Cancer Training and Prevention Program in Zambia
Ms. Joan Littlefield, Zambia Country Program Leader, PATH

Dr. Groesbeck P. Parham, Co-Director of the CIDRZ Cervical Cancer Prevention Program
and the African Centre of Excellence for Women's Cancer Control
Mr. Victor Sakala, Key Account Manager, Merck

Meeting with the First Lady of Zambia

Dr. Christine Kaseba Sata, Obstetrician Gynecologist, First Lady of Zambia
Ambassador Mark Storella, Embassy of the United States, Zambia

Reception Hosted by U.S. Ambassador with U.S. and Zambian Partners

Thursday, March 27: Kabwe District and Lusaka

Meeting with the Central Provincial Medical Office

Ms. Annie Sinyangwe, Permanent Secretary, Provincial Ministry of Health, Central
Province

Site Visits:

Mahatma Gandhi Clinic

Ngungu Clinic

Makululu Clinic

Medical Stores Limited, Mr. Ian Ryden, Managing Director, Medical Stores Limited

Meeting with Implementing Partners

Ms. Annie Banda, Maternal and Child Health Specialist, World Vision

Ms. Chileshe Chilangwa, Deputy Chief of Party, Zambia Prevention Initiative

Dr. Prisca Kasonde, Director of Technical Support, ZPCTII

Dr. Thierry Malebe, Technical Adviser, ZPCTII

Joyce Mwale, ZPCT II

Mr. Chad Rathner, Chief of Party, FHI360

Mr. Nicholas Shihiva, Society for Family Health

Ms. Batuke Walusiku, Deputy Chief of Party, World Vision

Dr. Michael Welsh, Zambia Country Director, FHI360

Working Dinner CSIS Delegation Internal Debrief



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Cover photo: Gates Foundation photo. A mother and child visit a malaria clinic in the
Zambian city of Chainda. <http://www.flickr.com/photos/gatesfoundation/5075935567/>.