



ECSCA-HC

East, Central and Southern
Africa Health Community



EXPANDING ACCESS TO FAMILY PLANNING SERVICES AT THE COMMUNITY LEVEL:

ZIMBABWE ASSESSMENT

**EAST, CENTRAL AND SOUTHERN AFRICAN
HEALTH COMMUNITY
AND
ZIMBABWE MINISTRY OF HEALTH AND CHILD
WELFARE**

November 2011

ACKNOWLEDGEMENTS

The East, Central, and Southern African Health Community (ECSA-HC) led this assessment, in collaboration with the Ministry of Health and Child Health (MOH&CH) of Zimbabwe. FHI provided technical assistance. Dr. Odongo Odiyo led the ECSA multi-country assessment project, including the assessment in Zimbabwe. Others on the Zimbabwe assessment team were: Edward Kataika and Doreen Malanda of ECSA; Maureen Kuyoh, a consultant for FHI; and the following representatives of the Zimbabwe MOH&CH: Cynthia Chasokela, Director of Nursing Services; Margaret Nyandoro, Director of Reproductive Health and Child Welfare; Edwick Mvere, Seke District Nursing Officer; Brine Mosvikeni, Health Information Officer; and Lucy Mbiri, Sister In-charge of RH at Harare City Health Services. Morrisa Malkin and Elena Lebetkin of FHI provided assistance with the desk review. ECSA Director General Dr. Josephine Kibaru-Mbae and Dr. Baker Maggwa of FHI supported and assisted with the overall project. Bill Finger of FHI provided editorial assistance for the report.

ECSA and the MOH express appreciation to all of the respondents who supported the project by providing the valuable information, especially to the community health workers in the selected community units who participated in the group discussions.

This work was made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). The contents of this report are the responsibility of project partners and do not necessarily reflect the views of USAID or the United States Government. Financial assistance was provided by USAID under the terms of GPO-A-00-08-00001-00, Program Research for Strengthening Services (PROGRESS).

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS	3
EXECUTIVE SUMMARY	4-5
1.0 INTRODUCTION	6-8
1.1 BACKGROUND	
1.2 OBJECTIVES	
1.3 METHODOLOGY	
2.0 RATIONALE	9-12
3.0 FINDINGS: POLICIES, GUIDELINES AND STRATEGIES	13-17
3.1 STRUCTURE OF COMMUNITY HEALTH WORK IN ZIMBABWE	
3.2 COMMUNITY ENGAGEMENT AND PARTICIPATION	
4.0 ASSESSMENT SYNTHESIS	18-21
4.1 GENERAL BARRIERS TO FAMILY PLANNING	
4.2 BARRIERS TO EXPANDING ACCESS TO FP AT THE COMMUNITY LEVEL	
4.3 FACILITATING FACTORS AND OPPORTUNITIES	
5.0 VHWS SPEAK	21-22
6.0 RECOMMENDATIONS	23-24
Appendix 1. Key Informants and Focus Groups	26
Endnotes	27

ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
CBD	Community Based Distribution of contraceptives
CBFP	Community Based Family Planning
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
DHS	Demographic Health Survey
DFID	Department for International Development
DTTU	Delivery Team Topping-Up System
FP	Family Planning
IUCD	Intra-uterine Contraceptive Device
LAPM	Long-acting and Permanent Methods
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH&CH	Ministry of Health and Child Health
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHW	Village Health Worker
WHO	World Health Organization
ZNFPC	Zimbabwe National Family Planning Council

EXECUTIVE SUMMARY

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, universal access to reproductive health, including family planning (FP). Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa specifically, most recently in the March 2010 meeting among 12 African nations at Kigali. At the Kigali meeting, participating countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress toward the MDGs. This strategy resonates with earlier calls for action in the region, including the Maputo Plan of Action and the 2009 International Family Planning Conference held in Uganda.

The East, Central, and Southern African Health Community (ECSA-HC) has been working with its member states, including Zimbabwe, to address issues related to expanding access to family planning. ECSA led this assessment, using a desk review, key informant assessments, and focus group discussions. Similar assessments were conducted in four other ECSA member states (Kenya, Lesotho, Malawi, and Uganda).

In Zimbabwe, the key informant interviews were conducted in February 2011 with 11 individuals and eight focus groups (see Appendix 1). The interviews were conducted with Ministry of Health and Social Welfare (MOHSW) policy-makers and managers, professional health associations, regulatory boards and councils, community-based FP (CBFP) implementing agencies, donors, members of Parliament, district level providers, and community health workers.

About 60% of the population of Zimbabwe lives in rural areas. Compared to other countries in the region, unmet need for family planning is low, at about 13% nationwide and less than 16% even in rural areas. Even so, unintended pregnancy in Zimbabwe remains high at 33%, although it has decreased considerably over the past 15 years, with the well established family planning program contributing to this decline.

The National Health Strategy for Zimbabwe (2009 – 2013) acknowledges that one of the strategies to reducing maternal mortality is expanding community-based distribution systems and community mobilization to increase demand and use of sexual and reproductive health and family planning services. There is no specific strategy on community health work in Zimbabwe. However, there are various cadres of community health workers in Zimbabwe contributing to provision of FP information and services.

Section 3 of this report provides more information on policies, guidelines, and strategies about community-based FP services. Section 4 synthesizes findings from the key informants and focus groups. Section 5 includes comments from the focus group discussions with the community health workers themselves. All of this information combined with the desk review led to the seven recommendations discussed in Section 6 and listed below.

1. Expand community-based FP using existing CHW networks.
2. Advocate for policy changes and better guidelines on CHW provision of FP services.
3. Utilize a simple checklist to rule out pregnancy.
4. Harmonize the structure of CHWs.
5. Advocate for a budget line item in the national health budget for contraceptive commodities.
6. Develop a multi-pronged information, education and communication (IEC) approach.
7. Revitalize male involvement programs.

Both key informants and the CHWs themselves expressed concern about the issues listed here and had ideas about addressing them. This assessment shows that CBFP has clear benefits in improving access to family planning information and services. Therefore CBFP is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health.

1.0 INTRODUCTION

1.1 Background

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, which emphasizes the universal access to reproductive health (RH), including FP services. Most of the populations in sub-Saharan Africa (SSA) live in rural communities, where the demographic determinants including health infrastructure, human resource, and financial support for health are very poor. The achievement of universal access to FP and RH services remains a major challenge. Expanding access of FP to the community has gained recognition as a promising practice for the majority of the populations in SSA, who live in the rural areas.

Expanding access to FP at the community level has been emphasized by resolutions from the East, Central and South African (ECSA) Health Minister's Conference of 2008 and 2009; from the 2010 FP conference in Kigali, Rwanda; the 2009 International FP Conference held in Kampala, Uganda; and the Maputo Plan of Action of 2006. The 12 African nations attending the 2010 Kigali meeting built a consensus to prioritize expanded FP access at the community level as a strategy for addressing the unmet need for FP and accelerating progress toward the MDGs.

Women in rural areas have a particularly high unmet need for FP services, especially during the postpartum period. A review of data from 27 Demographic and Health Surveys (DHS) found that 67 percent of women who gave birth within the previous year had an unmet need for family planning. One way to address this is by strengthening systems that can make FP services more available to the communities. Some approaches have worked successfully to address the critical shortage of medical professionals and to expand access to a range of health services, such as empowering cadres of health workers who have not undergone the regular medical training programmes to provide FP services at the community level. In this concept of skills transfer (known as task sharing or task shifting), which has been endorsed by WHO, providers with less medical or paramedical training can deliver some of the same services with the same quality as providers with more training.

The ECSA-Health Community has addressed issues related to expanding access to FP services at the community level. In 2008, the 46th ECSA Health Ministers Conference (HMC) adopted resolution HMC46/R4, which urged member states to allocate/increase financial resources for FP and to reduce unmet needs by 10% by 2010. The resolution also urged member states to develop and implement policies, guidelines, and training curricula on task shifting among health care providers by 2011 that allow mid-level cadres to carry out specifically identified activities that shift non/less technical duties from mid-level to lower-level cadre staff, such as community based distributors of contraceptives. In the same resolution the ECSA secretariat was directed to support countries to develop and implement policies and guidelines on task shifting among health care providers by 2010.

In 2009, the HMC in ECSA/HMC 48/R5 urged member states by December 2011 to advocate for increased political and financial commitment to FP, ensure the full integration of FP into national development plans and poverty reduction strategies, and develop costed implementation plans for sexual and reproductive health (SRH) services informed by the Maputo Plan of Action. It also called on the member states to develop country-specific policies and guidelines on task shifting by December 2012 for the delivery of SRH and FP services to ensure access to FP services for the poor, marginalized, and underserved communities. The resolution also directed the secretariat to support member states to develop and/or adopt advocacy, costing, and modeling tools; document and disseminate promising and best practices in FP with links to proven effective change practices; and assist member states to implement various international instruments such as the Maputo Plan of Action and the African charter on the rights of the woman. All signature countries to such documents are required to report against the indicators and targets in these documents.

To address these resolutions, ECSA-HC has conducted an assessment on policies, guidelines, and financing of expanding access to FP services at the community level in five member states (Kenya, Lesotho, Malawi, Uganda, and Zimbabwe) to determine the current status of these three areas, and to recommend the best way to implement a strategy to expand services. The assessments took place between November 2010 and April 2011. The Zimbabwe assessment was conducted in February 2011.

1.2 Objectives

The objectives of the assessment were:

- To describe the degree to which national level policy and service delivery guidelines/standards facilitate the provision of quality FP at the community level.
- To determine the level and modalities of funding of FP services in the region.
- To describe the challenges and opportunities in current community-level FP service delivery systems and how they could be improved to better serve the FP needs of underserved populations.
- To synthesize commonalities with regional application and identify opportunities for improved approaches to FP services at the community level, in order to inform the development of recommendations on country and regional priorities for the improvement of expanded services to FP programs.

1.3 Methodology

The report of each country's assessment includes material from two primary sources:

- 1) Desk review of related literature, including DHS data, policy documents, national guidelines, research studies, and program reports; and
- 2) Qualitative input from key informant interviews and focus group discussions. The interviews and focus group discussions followed interview guides.

In Zimbabwe, the interviews and discussions were digitally recorded and notes taken by interviewers. Key informant interviews were conducted with 11 individuals in February 2011 and eight focus group discussions with some professional associations, provincial and district informants. The interviews were conducted with Ministry of Health staff, professional health associations, regulatory boards, a CBFP implementing agency, donors, a Member of Parliament (MP), and with district level providers (see Appendix 1).

2.0 RATIONALE

Why Expand Access to Family Planning at the Community Level

About 60% of Zimbabwe's 12 million people live in rural areas, where community-based services are needed. Compared to other countries in the region, unmet need for family planning is low, at about 13% nationwide and less than 16% even in rural areas.¹ Unintended pregnancy remains high in Zimbabwe at 33% of all pregnancies in Zimbabwe. Unintended pregnancy has decreased considerably over the past 15 years, with the well established family planning program contributing to this decline. However, the rate remains high at 33%. The rates are about the same in urban and rural rates (see Figure 2).² An unintended pregnancy is a pregnancy reported as either wanted later or not at all.

Figure 1: Trends in Unmet Need for Family Planning

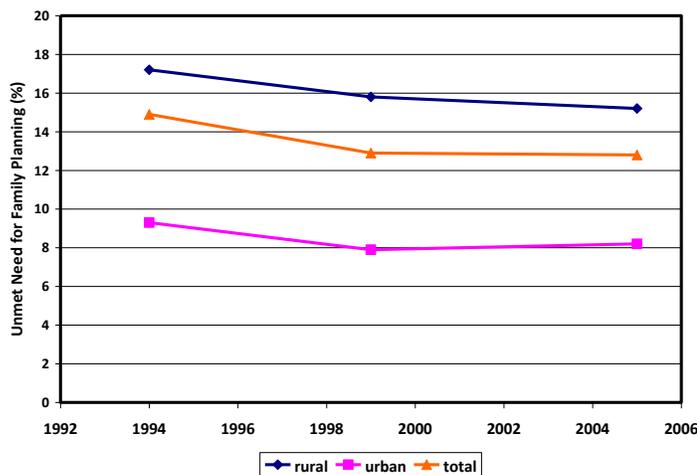
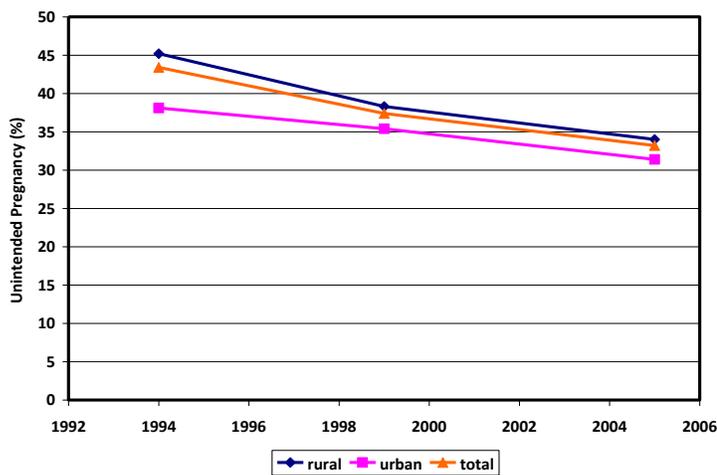


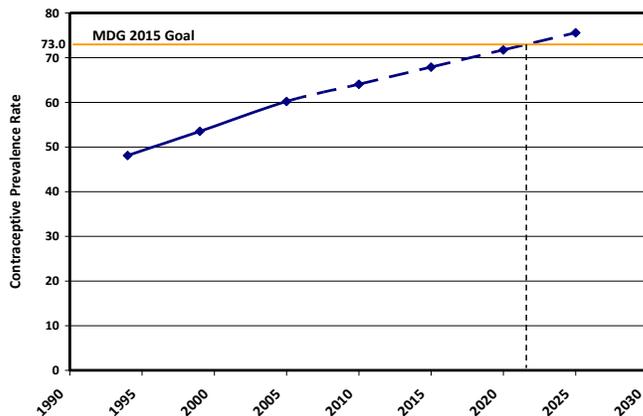
Figure 2: Unintended Pregnancy Trends in Zimbabwe



If women who desired to space or limit births had access to FP, 25 to 35% of maternal deaths could be avoided, including abortion-related mortality. Zimbabwe's maternal mortality rate (MMR) has significantly increased in recent years during the political unrest, growing more than 100% since 1990. The current rate at 790 deaths per 100,000 live births is high even compared to neighbors in the region.³ Increasing access to family planning services is a highly effective means of meeting the unmet need for family planning and thereby protecting the health and well-being of women and children.

The latest Zimbabwe DHS (2005/6) reports a 58% contraceptive prevalence rate (CPR) for modern methods among married women of reproductive age. The use of modern contraception by married women in Zimbabwe has more than doubled since the first DHS survey in 1984 and has consistently increased since then (see Figure 3).⁴

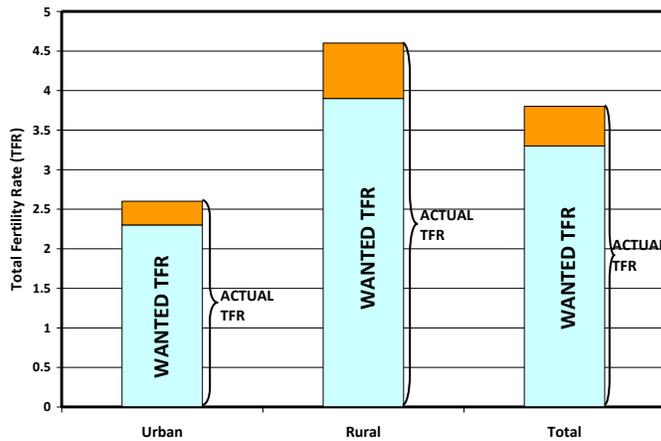
Figure 3: Trends in Contraceptive Prevalence Rate (Married Women, All Methods)⁵



To achieve the Millennium Development Goal (MDG) for family planning by 2015, Zimbabwe's CPR needs to rise to 73% percent (see Figure 3). The already high CPR (compared to its neighbors) would have to continue to rise at a rate similar to recent years to reach the MDG target, even by 2022, which is seven years after the target year. The data through 2006 come from the DHS; the dotted line for subsequent years comes from a recent modeling study.⁶

The latest DHS shows the total fertility rate (TFR) has decreased from 4.3 in 1994 to 3.8 in 2006. The TFR is close to twice as high in the rural areas (4.6) compared to urban areas (2.6), demonstrating both norms and inequities in services in rural areas (see Figure 4).⁷

Figure 4: Total Fertility Rate, Wanted versus Actual, Zimbabwe 2005/06

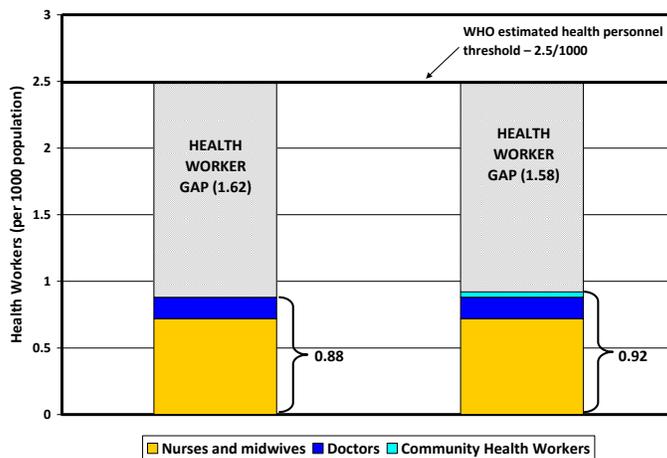


According to the latest DHS, about four of every five women (79%) in Zimbabwe report at least one problem accessing health care with the most commonly reported reason being lack of money for treatment and a concern no drug is available ranking second. The next two reasons cited were distance to a health facility and having to take transport, both key issues for community-based services. Not surprisingly, rural women are more likely to report problems in accessing health care, the distance to the health facility, and having to take transport as key issues.⁸ Most communities (60%) in Zimbabwe are within 5 km of a primary health care facility, except for the new settlement areas that have emerged in the so-called land reform process in the country.⁹

About two thirds of women (68%) in Zimbabwe access family planning from a public source. Also, two thirds of the people (63%) access family planning from hospitals, health centers, or clinics while 21% access family planning from a pharmacy or retail outlet. Only 6% of women access services from community based distributors.¹⁰

The WHO recommends that the health workforce (doctors, nurses, and midwives) ratio be at least 2.5 health workers per 1000 population to make progress on global health goals like the MDGs. The ratio in Zimbabwe is 0.88 health workers per 1000 population, (higher than Malawi but lower than Uganda), and well below the 2.5/1000 threshold. Adding in community health workers, the ratio increases to 0.92 health workers per 1000 population (see Figure 5).¹¹

Figure 5: Zimbabwe Health Work Force



The total health expenditure in Zimbabwe for 2007 (latest data available) is 304 million US dollars.¹² This amounts to approximately US \$7 per capita expenditures on health¹³, which is well below the WHO Commission on Macroeconomics and Health recommendation of US \$34 per capita.¹⁴

A declining international economy and political unrest has decreased donor funding available to the government of Zimbabwe for all sectors. Due to an unstable economy and severe inflation, the Government of Zimbabwe has been unable to provide much financial support to the health sector. These two factors together have caused a severe decline in the quality and availability of health services. The current health policy in Zimbabwe allows for a package of free primary care services, but user fees for certain services are being considered to make up for the financing gap. Despite the policy mandating free services, it is common for users to pay for the services.¹⁵

Historically, Zimbabwe has built an admirable system of primary health care services in the rural areas. Still, unintended pregnancies remain high, and the country needs to increase CPR. Zimbabwe needs to re-energize the community-based systems in the country, in both the quality and availability of services. This can help women achieve their own pregnancy goals and to help the country meet its MDG goals.

3.0 FINDINGS: POLICIES, GUIDELINES, STRATEGIES

The National Health Strategy for Zimbabwe (2009 – 2013) acknowledges that one of the strategies to reducing maternal mortality is expanding community-based distribution systems and community mobilization to increase demand and use of sexual and reproductive health and family planning services. The Zimbabwe Health Sector Investment Case (2010 – 2012) devotes a whole section to community health and the basis of primary level care. It reiterates that “community health workers (CHW) are not intended to be full-time health workers on salaries but receive variable monetary stipends and material incentives”. The document does not use family planning (FP) coverage as a measure of primary care coverage at the community level but includes it at the health centre level. The National Reproductive Health Policy and the Reproductive Health Service Delivery Guidelines are not explicit or are silent on the contribution of and utilization of CHWs to promote and provide FP services.

Zimbabwe has a government agency, the Zimbabwe National Family Planning Council (ZNFPC), which was set up by an Act of Parliament to pay specific attention to matters of family planning in the country. The mandate of ZNFPC is to facilitate the purchase and distribution of contraceptive commodities. They also run a network of 11 FP service delivery clinics and a nationwide community based distribution (CBD) program. It is the only organization providing CBD services in the country. ZNFPC works closely with the Department of Family and Child Health of the Ministry of Health and Child Health (MOH&CH) and the Director of the department is a member of the board of ZNFPC.

Some CHWs (see structure section below) are allowed (in practice) to provide FP information, distribute condoms and pills to community members, and refer clients to health facilities for other methods. However, this is not stipulated in any of the MOH&CH policies, strategies and guidelines. CBD agents can initiate and resupply pills while depot holders can only resupply. Both CBD agents and depot holders charge a fee of US \$1 for a six months supply of pills.

The service delivery guidelines do not allow most methods to be initiated if the client is not menstruating or is not within the first seven days of her menstrual cycle with the exception of the condom and other barrier methods. These can be given to a client at anytime in her menstrual cycle.

3.1 Structure of Community Health Work in Zimbabwe

There is no specific strategy on community health work in Zimbabwe. However, there are various cadres of CHWs in Zimbabwe contributing to provision of FP information and services. These include CBD agents, depot holders, youth peer educators and village health workers (VHW). All CHWs are selected by community members based on criteria set by either ZNFPC or the MOH&CH.

Community-based Distributors and Depot Holders. Zimbabwe has a long history of community based provision of FP through CBDs. The ZNFPC started the CBD program

in 1967 as a peer education and contraceptive referral program and expanded it in 1976 to allow CBD agents to dispense contraceptives at a fee. Currently there are about 336 CBD agents and 470 depot holders under ZNFPC.¹ About a quarter of the CBD agents and a tenth of depot holders are men. CBD agents are employees of ZNFPC. A CBD agent goes door-to-door providing services to clients. They are provided with a bicycle, a bag and uniform to facilitate their work. They are expected to distribute contraceptives, provide FP education and counseling, and provide STI and HIV/AIDS information and counseling. The criteria for selection provided by ZNFPC to the community to assist with identifying potential CBD agents include:

- 20-30 years of age
- Level of education: 5 'O' Level and above
- Health: able to cycle (medical examination)
- Married or single parent (will be revised in light of an adolescent emphasis)
- Good standing and respected in the community
- Should live and belong to the community
- Capable of cash handling and record keeping (trustworthy, honest)
- Good knowledge of the local language and community

The roles and responsibilities of a CBD agent include:

- Home visits
- Provision of FP information to community members
- Counseling on FP and provision of pills and condoms
- Referral of FP clients to health facilities for methods they cannot provide
- Creating awareness at public gatherings on FP

The CBD agent's area of operation is a ward with about 100 households (approximately 600 people). They work with a group of about six depot holders to be able to serve the households effectively. Depot holders are volunteers who are also selected by the community following a criteria provided by ZNFPC as listed below:

- 30-45 years
- Level of education Grade 8 (Junior Certificate)
- Should have a safe place to keep contraceptives-home
- A credible and respected person
- Should live and belong to the community
- Capable of cash handling and record keeping (trustworthy and honest)
- Good knowledge of local language and community

Roles and responsibilities of a depot holder include:

- Keeping and resupplying of contraceptives to users at depot holder's home at appointed times
- Providing information on FP methods

¹ Before the economic problems experienced by Zimbabwe, ZNFPC had over 1000 CBD agents countrywide, each working with about 6 depot holders.

Depot holders are home-based FP providers, and clients come to them at specified times for counseling services and resupply. Like the CBD agents, they are expected to distribute contraceptives, provide FP education and counseling, and provide STI and HIV/AIDS information and counseling.

A depot holder is provided with a bag, a T-shirt, a tin trunk for storing contraceptives and stationery for record keeping to facilitate their work. Both CBD agents and depot holders also get FP flip charts with messages, female and male reproductive organ models, pamphlets, cue cards and contraceptive samples for use during counseling and education of clients.

Village Health Workers. The MOH&CH has a network of volunteer village health workers (VHW) where there are no ZNFPC CBD agents. This is the most common type of community health worker in rural areas; they are equivalent to health promoters in urban centers. They serve as a link between health facilities and the community, especially between rural health centers and the community. Ideally, one VHW should serve 100 households or a village. VHWs are community members who are selected by the community based on the following criteria:

- Must be 25 years old and above
- Should be a permanent resident of the community
- Should be able to read and write
- Be a person respected and liked by the community

They provide a wide range of services to the community including:

- Treatment of minor ailments and disease surveillance.
- Health promotion, hygiene and water & sanitation
- Care of chronically ill patients in the village
- Ensure drug adherence
- Refer pregnant women and infants to seek services at health facilities (especially for antenatal care, delivery and immunization)
- Growth monitoring for infants
- Encourage communities to have kitchen gardens to improve on nutrition
- Record keeping

They are supposed to be paid an allowance of about US\$ 42 every three months. However, due to financial problems, very few have ever received this stipend. They are also provided with uniforms, bicycles and a VHW kit which includes pain killers, bandages, antiseptic fluid, eye ointment and cotton wool. Before the economic downturn in Zimbabwe they would also provide malaria drugs, but this has since been stopped. VHWs refer potential FP clients for services at the nearest health facility.

Training and Supervision. CBD agents undergo six weeks basic training (two weeks theory and four weeks practical field training) based on an MOH&CH approved curriculum. The training includes seven modules, namely: introduction to CBFP, human anatomy and physiology, human sexuality, contraceptive methods for distribution by CBDs, contraceptive methods for referral by a CBD, primary health care, and managing

CBD work. Group leaders, who are CBD agents themselves CBDs, undergo additional two-week training on supervision to equip them for their supervisory role.

Depot holders undergo two weeks of training (one week theory and the other practical in the field) and are supervised by CBD agents. They cover more or less the same training as the CBD agents including: introduction to depot holding, interpersonal communication, human anatomy and physiology, contraceptive methods for distribution by depot holders, contraceptive methods for referral, record keeping, and primary health care. Each CBD agent works with a maximum of six depot holders and collects service statistics from them and submits it as part of a monthly report to the Group Leader.

According to the ZNFPC organizational structure, 10-15 CBD agents are supervised by a ZNFPC group leader (also a CBD agent) at the district level. She/he holds monthly meetings with individual CBD agents. During the monthly visits to the Group Leader, a CBD agent brings the monthly report of activities and discusses any difficult issues she/he may have in serving clients. It is also a time to update and coach the CBD agent on new program requirements.

The CBD agents are re-supplied monthly or whenever necessary directly from the national level with pills and condoms. They never experience stock-outs as they are incorporated within the national Delivery Team Topping-Up (DTTU) System that seems to be working efficiently in ensuring distribution of commodities within Zimbabwe. The DTTU system is managed by ZNFPC in collaboration with MOH&CH and Crown Agents. The CBD agents then resupply the depot holders under their jurisdiction.

CBD agents in turn supervise about six depot holders working with them to serve the community. He/she visits the depot holders monthly to collect monthly service statistics and discuss issues a depot holder may be having with clients and top up the supply of pills and condoms.

In the ZNFPC system, Group Leaders are supervised by a Service Delivery Coordinator at the provincial level who in turn reports to the Provincial Manager. Provincial Managers report to the Director, Technical Services at the ZNFPC headquarters in Harare.

The MOH&CH trains village health workers for an initial six weeks and they are expected to undergo annual refresher courses but these have not been forthcoming because of lack of funds. Their initial training involves all aspects of primary health care at the community level with the exception of FP. They are trained to refer FP cases to a health facility.

According to the MOH&CH organizational structure, VHWs are supervised by a sister in-charge of community activities at the nearest hospital within the district who reports to the matron at the hospital. VHWs work closely with village health committees (set up in every village) who assist them with community mobilization and education.

3.2 Community Engagement and Participation

The community is engaged at several levels in the general health program and FP in particular. The CHWs work closely with village health committees to educate and mobilize community members to utilize health services. CHWs discuss with them health issues affecting the community and how they can be addressed. CHWs are also given opportunities at village meetings to create awareness on health issues facing the community including promotion of FP. The village health committees help with raising funds from the community to maintain facilities. The village health committee is composed of community members from the particular village.

At the rural health center level, members of the community form Ward health teams and at the district level members of the community are part of the community health council which supports the management of the hospital. The members are appointed by the MOH&CH.

4.0 ASSESSMENT SYNTHESIS

This section synthesizes information obtained during the key informant interviews and focus group discussions. The material is grouped according to general barriers to family planning that arose, barriers specific to CBFP programs, and facilitating factors and opportunities.

4.1 General Barriers to Family Planning

Economic Downturn. Almost all respondents interviewed were of the opinion that the main barrier to provision of FP was economic difficulties that the country is going through. This has affected both expendable supplies and equipment needed to provide contraceptive methods effectively especially at the facility level. Interestingly, in spite of the economic sanctions imposed on Zimbabwe by the international community, international and bilateral partners have continued to support contraceptive procurement and as such the country has not experienced any stock-outs.

Most facilities in the country have started charging service fees to enable them to maintain the facilities and purchase expendable supplies. In addition, some clients live far from the nearest health facility and as such incur transport costs to the facilities. This is usually a barrier to access of services to clients who cannot afford to pay. This problem is exacerbated in rural areas where land reforms have resulted in the emergence of new settlement schemes. Whenever possible the health facility staff take outreach services to these remote settlements. Some MOH&CH officials, however, felt that no client is turned away at the facility for FP services for lack of fees as there is a waiver system in place. This is only possible for clients who are able to go to the facility.

Due to lack of funding, training and updates for service providers are also hampered. Thus some facilities have providers who can only provide a limited range of contraceptive methods even though the facility infrastructure enables the provision of more methods. Grossly affected are long-acting and permanent (LAPM) methods especially IUCDs and implants which are mainly provided by nurses.

Policy. The Reproductive health service delivery policy and guidelines are silent on who can provide specific methods. Service providers are therefore dependent on verbal guidance from the MOH&CH on who can provide which FP methods. There seems to be an unwritten communiqué from the MOH&CH that VHWs can provide information only; CBDs can provide pills and condoms and can initiate the use of pills; nurses provide the above methods plus IUCDs and implants; and doctors can provide the whole range of methods including female sterilization and vasectomy.

Most respondents from the MOH&CH, professional associations, and regulatory bodies felt that CHWs should not provide other methods such as the injectables as it would lower the quality of services to FP clients. In addition, respondents from MOH&CH were emphatic that the country has enough service providers (nurses) to provide the

necessary services at health facilities and during outreach visits to remote areas of the country.

The use of checklists to reasonably rule out pregnancy is not in the service provision guidelines nor was it mentioned by any of the respondents. Women who are HIV positive are contraindicated to IUCD in the service delivery guidelines, and service provider interviewed believed HIV positive women should not use IUCDs. According to some respondents, most providers do not promote the use of IUCDs because of the high rates of HIV infection among their clients. Additionally, most of the providers lack the skills to provide the method as it is rarely promoted and provided.

Contraceptive Method Mix. Respondents were unanimous on the fact that long acting and permanent methods (LAPM) were not very popular with the exception of implants (Jadelle). It was felt that partly, due to the high HIV infection rates, the method mix is skewed towards pills and condoms. Condoms are actively promoted for dual protection. This is in line with one of the objectives and strategies in the National RH policy “to promote the use of barrier methods such as condoms, which protect both against pregnancy and STIs.” This policy has led to a push towards the use of condoms for dual protection, further resulting in a method mix skewed towards short-term methods.

In addition, IUCDs were reported to be bogged down for various reasons. Rumors related to their use among HIV positive women and the restrictive guidelines for HIV infected women limit the appeal for this method among providers. Most health workers are also not skilled in provision of IUCDs and other long-acting and permanent methods. Also, health facilities lack skilled human resources, equipment, and supplies to facilitate the provision of LAPMs. For some reason not fully established in this assessment, the permanent methods are not popular with clients. Vasectomy is practically unimaginable.

Contraceptive Security. Even though Zimbabwe has not experienced contraceptive stock-outs in the past several years, most stakeholders felt that complete dependence on donors for procurement of contraceptives is dangerous for a program as established as Zimbabwe’s. USAID has procured condoms for both HIV prevention and FP; DFID has procured the other contraceptives, and UNFPA often responds to emergency orders. This support is not given to the government directly but through an intermediary organization as humanitarian support. Respondents therefore suggested that the government needs to set aside funds in the national budget to procure contraceptives.

New Settlement Schemes. As mentioned above, a number of settlement schemes have sprung up since the initiation of land reforms in the country. The MOH&CH and other stakeholders have not been able to build facilities within these communities and set up necessary health programs. This means clients have to travel long distances to facilities in other areas and CHW programs have not been established in these areas. These also hamper access to FP services.

Socio-cultural and Religious. Almost all respondents were in agreement that the country does not have major socio-cultural barriers for FP. This literacy levels in the country are

high (98%) for both men and women. Families are also compelled to plan their families due to the harsh economic conditions they are going through. As a result, in some villages women have formed mother clubs to encourage each other to space their pregnancies. Members of the club who delivers two years or more after her last delivery is showered with presents for the baby while those who deliver in less than two years of last delivery miss out on the presents. This has encouraged healthy spacing of children.

Respondents also felt that men were generally left out of reproductive health services both on the program and the client side. They suggested greater involvement of men in delivery of services and as users. This is in line with the Reproductive Health Policy that spell-out male involvement in RH as one of the areas of program focus.

Some respondents felt that some religious sect especially the Apostolic Church is a barrier to utilization of FP in the country. They oppose the utilization of health services including FP for their members. Members are expected to rely on natural remedies and prayers for healing and couples are expected to deliver until they attain menopause. Most respondents especially from the MOH&CH felt this has contributed to the high unmet for FP.

4.2 Barriers to Community-based Family Planning

Limited CHW Coverage for FP. Currently there are very few CBD agents and depot holders for such a vast country. Given the difficult economic situation in the country, ZNFPC is experiencing financial problems and therefore not able to train new CBD agents and depot holders to replace those lost to natural attrition (death, migration). Sometimes the attrition rate is so high that the program cannot keep up with it. They are also not able to expand the program to cover areas in need of community-based FP. Other stakeholders are also not involved in community-based FP other than ZNFPC. This limits expansion of the program.

Policy-level Barriers. There seems to be an unwritten agreement among stakeholders that CHWs cannot provide any other contraceptive methods except pills and condoms. This limits the use of methods such as injectables to women who may not have access to facilities for either economic or distance reasons. WHO circulated a communiqué to countries providing evidence that community health workers can safely and effectively provide injectables with the same level of quality as clinic-based providers. However, the Nurses Council reviewed this communiqué and felt it was not for acceptable in Zimbabwe.

Resistance to Provision of Some FP methods by CHWs. Most respondents were supportive of distribution of limited FP methods by CBD agents. Representatives of regulatory bodies interviewed were in support of community health workers provision of FP information and limited services (pills and condoms). They were opposed to CHWs providing any other methods other than pills and condoms. The Nurses' Association and Council was particularly concerned about the quality of services CHWs would offer if they were allowed to provide other methods, especially injectables. Together with the

MOH&CH officials interviewed, they felt that the country had enough nurses in the country to serve every woman who needs a method. This was in spite of the fact that some regulatory bodies, MOH&CH and ZNFPC felt that there was high brain drain in the country affecting effective service delivery especially in rural facilities.

4.3 Facilitating Factors and Opportunities for Community-based Family Planning

Wide Network of CHWs. The country has a wide network of CHWs including CBDs, depot holders, village health workers and youth peer educators (who are currently limited to providing sexual and reproductive health information to youth and distributing condoms to their peers only). If all of them were trained to offer FP information and services even if limited just to condoms and pills, there would be an increase in access to FP services and an eventual reduction in unmet need for FP. It would also relieve ZNFPC from being the only organization responsible for CBD network expansion.

The findings from the interviews and focus groups suggest that many aspects of the FP program in Zimbabwe have been successful historically, leading to a higher CPR than many countries, with a thorough network of public health clinics. As economic hardship has come together with isolated groups in rural areas affected by the land reform, new issues regarding CBFP are arising. Many of the barriers to greater FP access involve general issues in the country. But greater attention to clarifying the roles of CHWs can also play an important role in the future.

5.0 In Their Own Words: VHWs Speak

As part of the assessment, a focus group was held in Seke District with seven VHWs and their supervisor (sister in-charge community) through the Kunaka Hospital. The matron in-charge of the hospital was also part of the discussion group. The group was mainly a female group as most VHWs in Zimbabwe are women. The summary below is based on their descriptions of their training, selection, and other aspects of their work. It is also as close as possible to their own words, given the fact that these responses were sometimes translated from the local language, and that the remarks by individuals have been merged into one response for each question. Unfortunately, we were not able to have a discussion with a CBDA group.

How much training did you receive and what do you think of the training?

We are trained for six weeks and the training is adequate. We also undergo annual update training for four weeks. We recently received refresher training after a long time. The initial training we receive is adequate but we need more refresher trainings to be well equipped to serve the communities.

What motivates you to perform your duties?

We are volunteers and are paid nothing to do this work but we are motivated by getting experience as health workers, the training we receive and the recognition by the villagers especially during public gatherings. In addition, we are able to provide first aid services during emergencies in the village. We used to get an allowance of Zimbabwe \$5 but with the economic downturn this has stopped. We are looking forward to getting some good things (allowance) in the near future.

How do you think the community can be more involved in delivering health services to women, men, and families?

We work closely with the village health committee that assists us in identifying cases needing health services in the village. They also assist us in reporting disease outbreaks, mobilize community for income generating and water and sanitation activities, and come up with ways of reaching hard-to-reach groups like religious groups opposed to health care services such as the Apostolic Church members.

What are some of the challenges of being a village health worker?

The work of a VHW is almost a full time job as the villagers come for services at any time of day or night. This leaves very little time for our personal and development activities. Community members need health education to adopt good health seeking behaviors as most of them are ignorant and we do not have the time to provide this education. We were given VHW kits but we have run out of supplies for dressing wounds including gloves, cotton wool, antiseptic and bandages. In some cases, we have to use polythene bags as a substitute for gloves. We can only give start doses but the villagers expect us to provide more doses because they sometimes delay to go to the health facility.

Being a volunteer in these difficult economic times is a challenge. We would therefore like to be compensated for the work we do even in a small way.

6.0 RECOMMENDATIONS

6.1 *Expand community-based FP using existing CHW networks.* The MOH&CH can enlist the support of ZNFPC to train VHWs in the provision of FP services to potential clients who may not have easy access to facilities and a CBD agent. This would increase access to women who would otherwise have an unmet need for FP.

6.2 *Advocate for policy changes and better guidelines on CHW provision of FP services.* The current RH policy and service delivery guidelines are silent on which providers are allowed to provide which services and types of contraceptive methods to clients. This should be spelt out clearly in the guidelines to leave no room to guess work. To facilitate this change, a policy change is needed to clearly allow lower cadre FP providers especially at the community level to offer services that available evidence show can be offered effectively and without any risk to clients. This will ease the burden at the facilities and give providers at the facilities more time to provide other contraceptive methods.

6.3 *Utilize a simple checklist to rule out pregnancy.* Simple checklists to rule out pregnancy have been used successfully in other countries to reasonably rule out pregnancy in non-menstruating women who want a method of contraception. Without the checklists a large proportion of women are denied the method of their choice because they are not menstruating. This affects both CHWs and clinic-based FP clients. This can be eliminated by introducing simple checklist to rule out pregnancy for both clinic- and community based providers. It would also enable depot holders and VHWs to initiate pill use among their clients.

6.4 *Harmonize the structure of CHWs.* Currently MOH&CH works with VHWs who are volunteers who receive a monthly stipend. On the other hand, ZNFPC has a network of CBDs who are her employees and depot holders who are volunteers and receive no stipend other than the tools to assist them with their depot holder work. The structure of CHWs in the country should be harmonized so that comparable cadres have comparable benefits.

6.5 *Advocate for a budget line item in the national health budget for contraceptive commodities.* The government is supportive of FP but due to a strained economy only donors have supported the procurement of contraceptives in many years. This puts the country in a precarious position in the event of donor withdrawal of funds in support of these essential commodities. It is therefore imperative that key persons in governments are sensitized on the contribution of FP to the economy and the health of women and children. The target audience for sensitization activities should include members of parliament, ministers, budget officers and economists in various ministries. This may compel the government to give some allocation to FP commodities in the national health budget.

6.6 *Develop a multi-pronged information, education and communication (IEC) approach.* The knowledge of contraception for both men and women continues to be

higher than the use level. This gap can be narrowed with continued and intense IEC activities utilizing all channels of communication. This could also educate the religious sects opposed to the use health services including FP on the importance of these services.

6.7 Revitalize male involvement programs. ZNFPC had a strong male involvement in FP project which ended with reduction in funding levels. This project needs to be revived as most stakeholders felt that male involvement as consumers and providers of FP and other reproductive health services was vital given that men are still the main decision makers in households.

Appendix 1

Key Informant Interviews

Group Type	Data Collection Method	Number conducted
Ministry of Health & Child Health	Interview	6
Donors	Interview	2
Local authority health services (Kampala City)	Interview	1
Members of Parliament	Interview	1
Regulatory Boards	Interview	1
Total		11

Focus Group Discussions

Group Type	Data Collection Method	Number conducted	Number of participants
Regulatory Boards	Group discussion/interview	2	
Professional Associations	Group discussion	2	
Implementing agencies	Group discussion	1	
Community Health Workers	Group discussion	1	
Mashonaland Provincial & Makonde District Health Management Teams	Group discussion	1	
Rural Health Centre	Group discussion	1	
Total		8	

Endnotes

¹ Zimbabwe DHS 2005-2006.

² MEASURE DHS. STAT Compiler. Available from: <http://www.statcompiler.com/>

³ WHO, UNICEF, UNFPA, The World Bank. *Trends in Maternal Mortality: 1990-2008*. (Geneva, Switzerland 2010). Available: http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

⁴ Zimbabwe DHS 2005-2006.

⁵ Zimbabwe 1994, 1999, 2005/06 data from: MEASURE DHS. STAT Compiler. Available from: <http://www.statcompiler.com/>; Projected data from: Moreland S, Smith E, Sharma S. *World Population Prospects and Unmet Need for Family Planning*. April 2010. Futures Group, Washington, D.C. Available from: <http://www.futuresgroup.com/wp-content/uploads/2010/04/World-Population-Prospects-and-Unmet-Need-for-Family-Planning.pdf>

⁶ Moreland, Smith, Sharma.

⁷ Zimbabwe DHS 2005/06

⁸ Zimbabwe DHS 2005-06.

⁹ The National Health Strategy for Zimbabwe, 2009-2013.

¹⁰ Zimbabwe DHS 2005-06.

¹¹ WHO. Global Atlas of the Health Workforce. Available from: <http://apps.who.int/globalatlas/dataQuery/default.asp>

¹² <http://data.worldbank.org/indicator/>

¹³ The National Health Strategy for Zimbabwe, 2009-2013.

¹⁴ http://www.who.int/macrohealth/events/en/cmh_rprt_overview_afro.pdf

¹⁵ The National Health Strategy for Zimbabwe, 2009-2013.

