



RESOURCE REQUIREMENTS FOR FAMILY PLANNING IN ZIMBABWE

Brief

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Although Zimbabwe's contraceptive prevalence rate (CPR) is one of the highest in sub-Saharan Africa, economic challenges in the last decade have led to a downward trend in some health indicators, including family planning (FP) use. Recognizing the right to high-quality reproductive healthcare and the links between population growth, health, and economic development, the Government of Zimbabwe made the following commitments (known as the FP2020 goals) at the 2012 London Summit on Family Planning:

- Increase the CPR to 68 percent by 2020
- Reduce unmet need¹ for family planning (FP) from 13 percent to 6.5 percent by 2020
- Increase access to a comprehensive range of FP methods, including long-acting and permanent methods (LAPMs)

Driven by the public sector and community-based distribution, the country's FP program is now largely donor-supported. Zimbabwe will have to step up the pace of its FP program significantly to achieve its FP2020 goals.

To give decisionmakers in Zimbabwe a picture of the additional investment in family planning that will be necessary between now and 2020, the United Nations Population Fund (UNFPA) Zimbabwe and the Health Policy Project (HPP), funded by the United States Agency for International Development (USAID), reviewed data on the country's demographic patterns and FP costs. Using the Gather, Analyze, and Plan (GAP) Tool,² the data was then analyzed to estimate the gap between resources available and those required for contraceptive commodities, FP service provision, and other programmatic needs.



Status of Family Planning

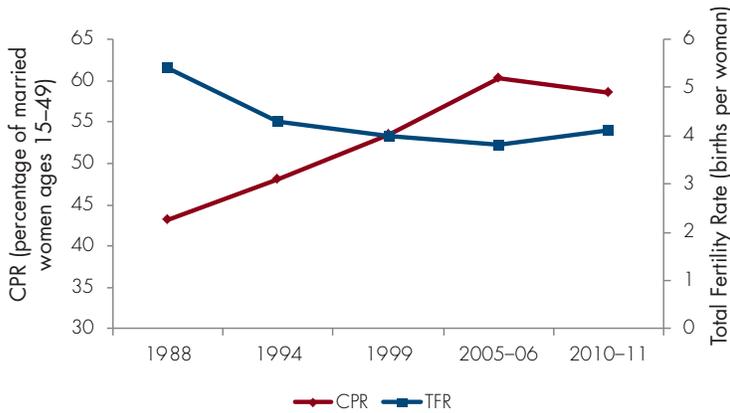
Contraceptive prevalence rose steadily in Zimbabwe's post-independence era, but progress has stagnated in recent years. According to the 2010–2011 Demographic Health Survey, 59 percent of currently married women use a contraceptive method, virtually unchanged from 60 percent in 2005–2006 (see Figure 1). Also since 2005–2006, the CPR in urban areas has dropped from 70 percent to 62 percent. Moreover, although the country's unmet need for family planning of 13 percent is the lowest in southern Africa, it is as high as 17 percent among youth and 26

percent in some sub-national populations. These factors likely contributed to the increase in the total fertility rate from 3.8 births per woman in 2005–2006 to 4.1 in 2010–2011. The country's economic crisis, ongoing since 2000, could worsen these trends.

Diversifying the contraceptive method mix in Zimbabwe could help to meet the needs of women and couples. Currently, of the women who use family planning, more than seven out of ten are using oral contraceptive pills. However, nearly one in five pill users discontinue use within the first year, and about one third of those who discontinued use cited side effects or method failure owing to incorrect use as the reason for abandoning the method. Few women in Zimbabwe use LAPMs: 5 percent of married women who use modern contraception have implants and 0.3 percent have intrauterine contraceptive devices (IUCDs).

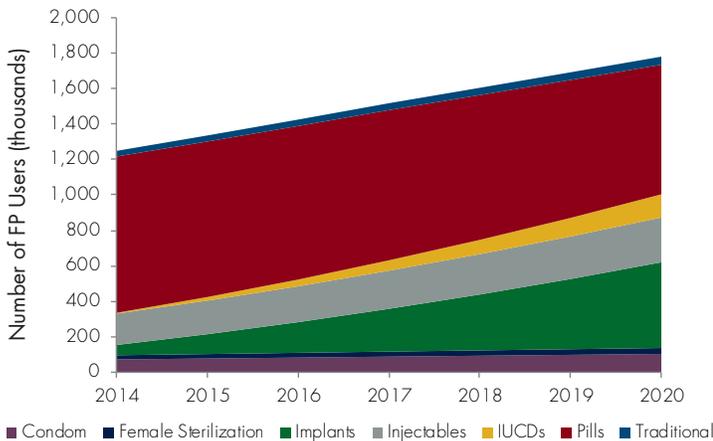
In Zimbabwe, as elsewhere, increased access to family planning, healthier birth spacing practices, and reduced unwanted fertility will be beneficial for women, families, and society. With family planning, women are better able to meet their reproductive health goals and achieve their desired fertility levels. This way, families are better able to feed, educate, and care for the children they do have. In turn, these children enjoy improved health and educational outcomes and have better chances of success in life, and parents have more time and household resources available to invest in the economy. At the national level, fewer births will result in savings in maternal and child healthcare. Slower, more sustainable population growth will reduce the burden on natural resources, the environment, and social services.

Figure 1. Trends in Zimbabwe's fertility and contraceptive prevalence rate



Source: Zimbabwe Demographic and Health Surveys

Figure 2: Estimated number of family planning users by type of method, 2014–2020



Estimated Resource Requirements

Zimbabwe can go a long way toward achieving these benefits by working now to fulfill its FP2020 commitments. The GAP analysis conducted by UNFPA and HPP, which also involved consultations with key governmental and nongovernmental FP stakeholders, estimates the funds needed to achieve these goals.

For Zimbabwe to succeed in lifting the CPR from 59 percent to 68 percent, the total number of FP users must increase from 1.2 million in 2014 to almost 1.8 million in 2020 (see Figure 2). To support this shift, FP stakeholders

anticipate an increase in the use of LAPMs in line with FP2020 commitments. They determined that an increase in the share of implants from 5 percent of FP users in 2014 to 27 percent in 2020 is achievable. Likewise, they expect an increase in the share of IUCDs from less than 1 percent of users in 2014 to 7 percent in 2020. These increases will be offset by a corresponding decrease in the percentage of women using oral contraceptive pills.

The GAP analysis excluded condoms because they are procured through the HIV program primarily for the prevention of HIV rather than as an FP commodity. A small number of women reported using condoms for family planning, but this is likely a significant underestimate of the total need for condoms for HIV prevention. Therefore, the GAP analysis assumed that funding for condoms is sufficient and did not consider either resource availability or need for condoms.

Results

The GAP analysis estimates the total cost of delivering family planning in Zimbabwe as of 2014 to be nearly US\$9.9 million. This figure includes both commodity and noncommodity spending. Costs are predicted to grow annually in order to reach the CPR goal of 68 percent. After accounting for population growth, increased prevalence, and changes in method mix, Zimbabwe will need an estimated US\$12.3 million for family planning in 2020 (see Figure 3). The FP cost under this scenario is only marginally higher than the cost for Zimbabwe to maintain its current CPR and method mix; the country would still need an estimated US\$11.4 million in 2020 to keep its CPR at 59 percent.

Regardless of the rate of scale-up, there are no current pledges to fund family planning beyond 2017, because donors in Zimbabwe commit resources only a few years in advance. However, even near-term planned funding for family planning is estimated to fall short: the funding gap in 2014 is about US\$1.2 million. Only two donors—the United Kingdom’s Department for International Development and USAID—have committed funding for family planning after 2014, leaving a gap of US\$23 million from 2015 to 2017.

The gap in near-term funding for commodities (see Figure 4) is also large. Donors have not yet pledged any funding beyond 2015. For 2014 and 2015, the funding gap for commodities (excluding condoms) is estimated

to be US\$2.7 million. (These figures are current as of June 2014.)

Although donor contributions have been crucial in closing funding gaps in the past, the government of Zimbabwe must increase its support of FP commodities to ensure contraceptive security. Without new sources of commodities, stockouts may affect the availability and quality of FP service delivery.

Diversifying the method mix will help to reduce long-term FP costs. Over time, LAPMs are more effective and cost-efficient in preventing pregnancy. Zimbabwe will spend less on FP commodities and wages for service providers in the long term if the share of LAPMs rises rapidly compared to a slower transition.

Figure 3: Overall family planning resource gap, 2014–2020, excluding condoms

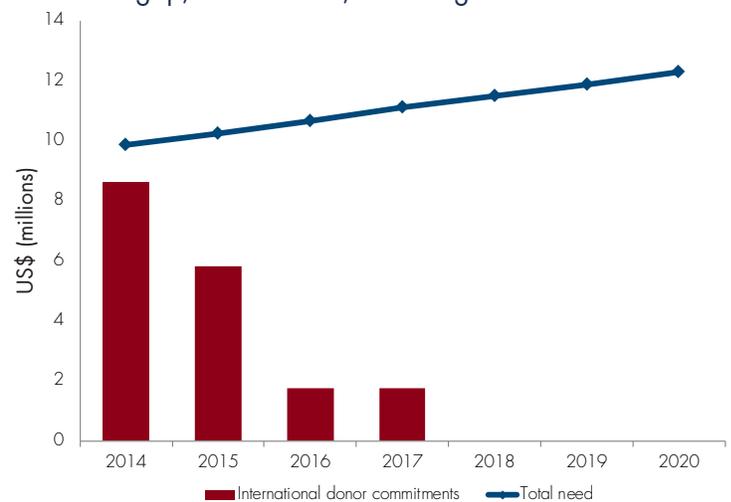
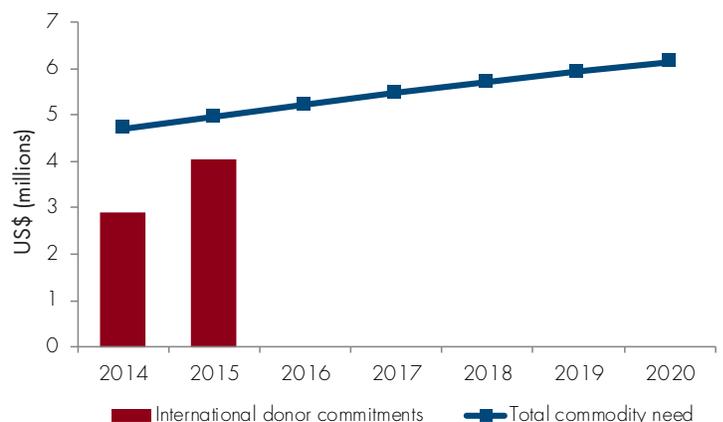


Figure 4: Family planning commodity resource gap, 2014–2020, excluding condoms



Recommendations

The GAP analysis shows that planned FP investments in Zimbabwe do not meet the financial resource requirements to achieve the FP2020 goal of a 68 percent CPR. The government and development partners should take action to increase investments in family planning and improve the quality of FP services. In particular, the Ministry of Health and Child Care must develop both a national FP strategy and a costed implementation plan that incorporate the country's FP2020 commitments:

- Commit resources and increase FP funding from 1.7 percent to at least 3 percent of the health budget
- Eliminate user fees for FP services
- Increase access to a full range of FP methods, including LAPMs
- Strengthen public-private partnerships in the provision of community-based and outreach services
- Strengthen the integration of family planning with reproductive and maternal health and HIV services
- Develop innovative service delivery models to meet the needs and fulfill the rights of adolescent girls, with the goal of reducing their unmet need for family planning from 16.9 percent to 8.5 percent

Drawing on the successes of other countries in increasing the use of LAPMs and allowing lower-level staff to provide these methods (“task sharing”), Zimbabwe should scale up training of health workers to insert and remove IUCDs and implants. These trainings should target health workers at all levels of the health system, including rural health centers.

In support of the government's efforts, development partners should

- Continue to contribute to the procurement of FP commodities, particularly LAPMs
- Support the training, logistics, and supervisory costs associated with the delivery of high-quality, integrated FP services

- Explore the use of innovative, private sector-based service delivery models, such as social franchising approaches
- Work with local leaders to address any cultural, traditional, or religious barriers to contraceptive use, including gender inequality or misconceptions about contraception
- Design social and behavior change communication strategies to address high wanted fertility and fertility among adolescent girls
- Continue to conduct in-depth research to generate evidence for programming

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Endnotes

¹ Defined as the percentage of married women who want to postpone their next birth by two or more years or stop childbearing, but are not using contraception.

² The GAP Tool, developed by the USAID | Health Policy Initiative and recently updated by HPP, is available at www.healthpolicyproject.com.

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