AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: PD-AAB-007

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: ZIMBABWE

3. PROJECT NUMBER: 613-0230 — 66476

4. BUREAU/OFFICE: AFRICA — 06

5. PROJECT TITLE (maximum 40 characters): Zimbabwe Family Planning

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 08 DD 31 YY 96

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 90 B. Quarter 3 C. Final FY 95

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 90 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	1,600	26	1,626	8,054	1,346	9,400
(Grant)	(1,600)	(26)	(1,626)	(8,054)	(1,346)	(9,400)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country	- 0 -	717	717	936	4,302	5,238
Other Donor(s)						
TOTALS	1,600	743	2,343	8,990	5,648	14,638

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) DFA	600	700				1,626		9,400	
(2)									
(3)									
(4)									
TOTALS						1,626		9,400	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 280, 580

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To support increased access to and use of a wider selection of family planning methods delivered through a sustainable system that includes an expanded role for the private sector and reduced costs per user borne by the Government of Zimbabwe.

14. SCHEDULED EVALUATIONS

Interim MM 08 YY 93 MM YY Final MM 06 YY 96

15. SOURCE/ORIGIN OF GOODS AND SERVICES

☒ 000 ☐ 941 ☐ Local ☒ Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

USAID/Zimbabwe Controller concurs with the proposed methods of implementation and financing.

Clearance: Controller, USAID/Zimbabwe:MLLewellen: Mary L Lewellen

17. APPROVED BY

Signature: ABHerrick

Title: Allison B. Herrick, Director

Date Signed: MM 08 DD 29 YY 90

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (8-79)

PDABB-007

PROJECT AUTHORIZATION

Country/Entity: Zimbabwe

Project Title: Zimbabwe Family Planning

Project Number: 613-0230

I. Pursuant to the Foreign Assistance Act of 1961, as amended; the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988; and Africa Bureau Delegation of Authority (DOA) 551, as amended, I hereby authorize the Zimbabwe Family Planning Project involving planned obligations of not to exceed Nine Million Four Hundred Thousand United States Dollars ($9,400,000) in grant funds over a six year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to assist in financing foreign exchange and local currency costs of the Project. The planned life of the Project is six years from the date of initial obligation.

II. The Project will provide assistance to achieve a sustainable reduction in the total fertility rate in Zimbabwe by 1995, and increase national self reliance in the provision of improved access to high quality family planning services. To achieve this goal, the Project will support increased access to and use of a wider selection of family planning methods delivered through a sustainable system that includes an expanded role for the private sector and reduced costs per user borne by the Government of Zimbabwe.

III. The Grant Agreement, which may be negotiated and executed by the officers to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

A. Source and Origin of Commodities, Nationality of Services

The source and origin of commodities and nationality of services (except ocean shipping) financed under the Grant with funds from the Development Fund for Africa (DFA) account shall be the United States and other countries included in A.I.D. Geographic Code 935 with respect to foreign exchange costs, and Zimbabwe with respect to local currency costs, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

B. Covenants

1. The Grantee agrees that any income accrued by the Zimbabwe National Family Planning Council (ZNFPC) from the sale of contraceptive commodities will be deposited in a separate account to be used for the purchase of ZNFPC's future contraceptive supplies.

2. The Grantee agrees to conduct a study to assess the advantages of modifying existing advertising restrictions on the sale of contraceptives while maintaining ZNFPC's role in quality control.

3. The Grantee agrees to develop a plan and initiate a process which would result in the elimination of import duties on all contraceptive commodities within two years after execution of the subject Grant Agreement.

4. The Grantee shall request and obtain from ZNFPC its written agreement to consider the addition of one new tutor position funded by its own budget each year, totalling six tutors for six project years ending in 1995.

5. The Grantee agrees to assume responsibility for the purchase of oral contraceptives, now funded from A.I.D. resources, on a phased basis before the end of the project.

6. The Grantee covenants that the Ministry of Health will make available medical staff, including hospital administrators, senior clinic staff, and other service delivery staff, for project-funded seminars on family planning policy and management to be held in the provinces.

7. The Grantee agrees to allow ZNFPC to refurbish the rooms allocated for Family Planning within Ministry of Health institutions in order to facilitate the implementation of clinical procedures.

8. The Grantee agrees that a designated amount of funds will be disbursed by USAID directly to ZNFPC who in turn will make the funds available to the Central Statistical Office to carry out the 1994 Demographic and Health Survey.

ABHerrick

Allison B. Herrick
Mission Director

29 August 1990
Date

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A. Technical Analysis
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D. Financial Analysis
E. Social and WID Analyses
F. Economic Analysis

LIST OF ACRONYMS

A.I.D.:	Agency for International Development
A.I.D./ Washigton:	Central A.I.D. offices and funds
AIDS:	Acquired Immuno-Deficiency Syndrome
AVSC:	Association for Voluntary Surgical Contraception
CA:	Cooperating Agency
CBD:	Community-based Distributor/ Distribution
CDSS:	Country Development Strategy Statement
CIMAS:	Commercial & Industrial Medical Aid Society (A.I.D. Contractor)
CSO:	Central Statistical Office, Ministry of Finance, Economic Planning and Development
ERU:	Evaluation and Research Unit (ZNFPC)
Enterprise:	The Family Planning Enterprise Project (A.I.D. Project)
EOPS:	End of Project Status
FHC	Family Health Care
FHP-I;II	Family Health Projects I and II (World Bank)
FPLM	Family Planning Logistics Management Project (A.I.D. project)
FPMT:	Family Planning Management Training (A.I.D. Project)
IEC:	Information, Education, and Communication
INTRAH:	Program for International Training in Health (A.I.D. Project)
IPPF:	International Planned Parenthood Federation
IUD:	Intra-uterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics (A.I.D. project)
IMPACT	Innovative Materials for Population Action (A.I.D. project)
MCH:	Maternal and Child Health
MIS:	Management Information System
MOH:	Ministry of Health
MLGRUD	Ministry of Local Government, Rural and Urban Development
MWRA:	Married women of reproductive age
NGO	Non-governmental Organization
NORPLANT$_R$	Hormonal implant (Brand Name)
PACD	Project Assistance Completion Date
PCS:	Population Communication Services (A.I.D. project)
POPTECH	Population Technical Assistance (A.I.D. project)
PSMAS:	Public Service Medical Aid Society
PVO:	Private voluntary organization
S&T/POP	Office of Population, Bureau for Science and Technology, AID
SEATS:	Service Expansion and Technical Support (A.I.D. project)
SOMARC:	Contraceptive Social Marketing Project (A.I.D. project)
STDs:	Sexually-transmitted diseases
TFR:	Total Fertility Rate
TIPPS:	Technical Information on Population for the Private Sector (A.I.D. project)
UNDP:	United Nations Development Program
UNFPA:	United Nations Population Fund
USAID/ Zimbabwe:	Bilateral A.I.D. funds
VSC:	Voluntary surgical contraception
WHO:	World Health Organization
YAS:	Youth Advisory Services (ZNFPC)
ZDHS:	Zimbabwe Demographic and Health Survey
ZNFPC:	Zimbabwe National Family Planning Council

1. Summary and Recommendations

1.1. Recommendations

The Project Development Committee recommends that the Director, USAID/Zimbabwe, approve and authorize the Zimbabwe Family Planning project (613-0230) at a level of $9.4 million in grant funds over a six year life of project (1990-1995). The total authorized amount of funds available from USAID/Zimbabwe will be implemented with funding in the amount of $6,312 million from A.I.D./Washington and a host country contribution of the equivalent of $5,238 million, bringing total program resources to be decided to achieving the project objectives stated herein to $20,950 million.

1.2. Summary Findings

The proposed Zimbabwe Family Planning project builds on previous A.I.D. population assistance to Zimbabwe, and addresses changes in user needs and program circumstances. The project will assist the Government of Zimbabwe, and specifically the Zimbabwe National Family Planning Council (ZNFPC), in achieving the goals of further reduction in fertility and increased national self reliance in the provision of high quality family planning services. The project is designed to complement other planned donor assistance, particularly from the World Bank and the United Nations Population Fund (UNFPA). The interdependence of the project and other donor assistance calls for careful project implementation, but promises a greater overall impact if all key components are carried out as envisioned.

Zimbabwe's family planning program is regarded as the most successful program in sub-Saharan Africa. Among married women of reproductive age, 36 percent in 1988 relied on modern contraceptive methods, a 33 percent increase over the 1984 figure of 27 percent. The rise in contraceptive use has contributed to a decline in fertility from 6.5 to 5.5 children per woman between 1984 and 1988.

Although the contraceptive prevalence rate is high by sub-Saharan Africa standards, there is evidence of a sizeable "unmet need" for family planning. Demographic surveys reveal that a significant portion of women who state that they want no more children or who want to space their next birth are not practicing family planning. It appears that a plateau has been reached in creating and meeting the demand for modern family planning methods using the current service delivery system, which is oriented primarily towards provision of oral contraceptives. Expanding access to unserved potential users requires diversification in available methods and an expansion of service delivery. There may be high recurrent costs associated with expansion of the current delivery system; thus, measures must be introduced to reduce costs and increase efficiency if high prevalence rates and quality services are to be sustained over the long term.

To promote a greater diversity of methods, the project will enhance the training capacity and role in clinical services of the ZNFPC. The project will support training of health personnel in effective, longer-term methods of contraception, including the IUD and sterilization. It will promote expanded use of the IUD and sterilization as well as of NORPLANT$_R$, the first effective new method of contraception developed in recent decades, by reorienting community-based distributors and preparing materials for information, communication and education (IEC) programs. The promotional component of the project will also strengthen evaluation and research activities leading to improved effectiveness. The project includes substantial financing for contraceptive commodities but also a plan for phasing out A.I.D. funding of this recurrent cost.

To promote more efficient and cost-effective service delivery, the project will continue and expand private sector initiatives in social marketing, employer-provided services, and insurance reimbursement schemes. A new initiative will promote corporate contributions to family planning. In addition, private physicians will be trained in service delivery.

It is expected that project-supported improvements in the expansion of available contraceptive methods and service delivery will result in an increase of 50 percent in the number of users of modern methods. The increased prevalence rate in contraceptive usage (expected to rise by 25 percent from the estimated current level of 40 percent) is expected to reduce the total fertility rate in Zimbabwe to 4.5 children by 1995.

Progress in project implementation will be assessed in relation to the following output targets: number of curricula adapted; numbers of tutors, ZNFPC staff, Ministry of Health personnel, and international participants trained and applying new service provision and counseling skills, especially those related to use of more effective, longer-term contraceptive methods; amounts of educational materials developed; number of clinics refurbished; number of employer-provided service programs operating; sales from the social marketing program; revenues generated from user and training fees and from corporate contributions; and studies completed.

The impact of the project will be measured in terms of the increase in contraceptive use (including number of new acceptors and rates of continuation); the degree of shift toward use of more effective, longer-term methods; and the increase in market share accounted for by private sector service providers. Also, the social impact of the project will be assessed to identify benefits acquired by families from adoption of longer term, clinical contraceptive methods.

The Zimbabwe Family Planning Project will be funded both bilaterally and centrally. Although funding sources are different, all elements are complementary and taken as a whole embody A.I.D.'s strategy in the family planning sector.

As shown in the Summary Financial Table below, USAID/Zimbabwe's $9.4 million will be complemented by an estimated $6.312 million in funds from A.I.D./Washington. The analyses and descriptions that follow encompass all planned activities but distinguish where necessary between the two funding sources.

Summary Financial Table

Zimbabwe Family Planning Project
Projection of Expenditures by Fiscal Year
($000's)

	A. I. D.			Host	
	Central	Bilat.	Total	Country	Total
FY 90	1,268	1,626	2,894	717	3,611
FY 91	1,685	1,654	3,339	717	4,056
FY 92	1,296	1,583	2,879	951	3,830
FY 93	639	1,445	2,084	951	3,035
FY 94	639	1,398	2,037	951	2,988
FY 95	394	648	1,042	951	1,993
Inflation	323	656	979		979
Contingency	68	390	458		458
Total	6,312	9,400	15,712	5,238	20,950

1.3. Conditions and Covenants

USAID proposes the following terms to be included in the agreement between the Government and the Agency for International Development:

1. Government agrees that any income accrued by ZNFPC from the sale of contraceptive commodities will be deposited in a separate account to be used for the purchase of ZNFPC's future contraceptive supplies.

2. Government agrees to carry out a study to assess the advantages of modifying existing advertising restrictions on the sale of contraceptives while maintaining ZNFPC's role in quality control.

3. Government agrees to initiate a process which would result in the elimination of import duties on all contraceptive commodities by June, 1992.

4. The ZNFPC Board agrees to advise Government of its intention to consider the addition of one new tutor position funded by its own budget each year, totalling six tutors for six project years ending 1995.

5. Government agrees to assume reponsibility for the purchase of oral contraceptives on a phased basis before the end of the project.

6. Government agrees that the Ministry of Health will make medical staff, including hospital administrators, senior clinic staff, and other service delivery staff, available for project-funded seminars on family planning policy and management to be held in the provinces.

7. Government agrees to allow ZNFPC to refurbish the rooms allocated for family planning within Ministry of Health institutions in order to facilitate the carrying out of clinical procedures.

8. Government agrees that funds will be disbursed by USAID/Zimbabwe to ZNFPC who in turn will make the funds available to the Central Statistical Office to carry out the 1994 Demographic and Health Survey.

2. Project Background

2.1. Trends and Accomplishments

Zimbabwe's total population of 10 million will double in 22 years if current rates of population growth continue. Given past high fertility and declining mortality, the current rate of population growth is high at about 3.2 percent. Fertility has been declining, but is still high. The national total fertility rate, which was close to eight in the late 1960's, had fallen to an average of 5.5 in 1988. The Zimbabwe Demographic and Health Survey estimates that the total fertility rate declined by over 20 percent between 1982-84 and 1985-88. The World Bank projects the average total fertility rate for the 1985-90 period to be 5.4.

Contraceptive use is increasing. Overall use of contraception at 43 percent is up from 36 percent in 1984, and includes both modern and traditional methods. Modern contraceptive prevalence has increased sharply from 14 percent in 1979, to 36 percent in 1988. The rate of contraceptive prevalence is the highest ever measured in sub-Saharan Africa and is approached (at 32 percent prevalence of modern methods) only in Botswana; rates elsewhere are usually less than ten percent. The pill is the primary method used.

The demand for family planning is still predominantly for child-spacing rather than limitation of family size, but shifts in attitudes are becoming apparent. The Zimbabwe Demographic and Health Survey analysis indicates that in 1988 compared with 1984, larger percentages of women wanted to stop childbearing (33 versus 25) and far fewer wanted another birth within the next two years (8 versus 28 percent). The statistics suggest that the normal African pattern of strong interest in spacing births but little interest in family limitation is breaking down in Zimbabwe, and that a smaller family norm may be taking hold.

The need for family planning services will increase even as AIDS mortality rises because of the age distribution of deaths and the need to discourage childbearing by HIV-positive women. While the impact of AIDS has been limited to date, mortality will almost certainly be greatest within the generation educated and nurtured since Independence to take over the country's economic and administrative leadership. Zimbabwe's ability to feed, care for, and educate economically unproductive infants will be even further constrained by the economic impact of AIDS. The popular perception that rising mortality will stop population growth is almost certainly incorrect judging by demographic projections from similarly hard hit Uganda. A.I.D. support for a project aimed at expanded contraceptive method mix is particularly appropriate because HIV-positive women need longer term birth prevention.

2.2. Government of Zimbabwe Policy

Although family planning was a controversial subject prior to Independence, the new government almost immediately recognized its importance as a maternal and child health intervention. Concern has focussed on the demographic situation since at least 1984, when the Government directed the ZNFPC to mount a child-spacing campaign to ensure a reduction in the population growth rate. A year later, Government directed the ZNFPC Board "to do more than confine itself to child spacing ... but also (to) alert the nation to the need for limiting family sizes . . ."

In 1985, the then Prime Minister (now president) Mugabe signed the World Leaders' Statement on Population Stabilization. The following year he made further supportive statements at two international conferences. Later, as an honoree at the International Forum on Population in the 21st Century (Amsterdam, 1989), President Mugabe declared that "we remain determined in our efforts to establish and maintain a population growth rate that correlates with our economic growth rate, within the shortest possible time."

A national population policy has not been promulgated; however, the lack of a published policy has not prevented the Government from pursuing an aggressive family planning program. The priority the Government places on the program is evident from the fact that government revenues covered over 75 percent of the costs of the public sector's family planning program and over 50 percent of ZNFPC's expenses between 1984 and 1988. No other African family planning program receives such a high proportion of its funding from government.

2.3. Operational Structure

Currently, family planning services are provided primarily through the ZNFPC, Community Based Distributors (CBDs) and clinics (25 and 13 percent of users rely on these sources, respectively); and through public sector facilities operated by the Ministry of Health, municipal governments, and district and rural councils (53 percent). The private sector plays a much smaller role in service provision through doctors, pharmacies and employer-provided services (6 percent).

The ZNFPC is a parastatal organization under the general direction of the Ministry of Health. ZNFPC is responsible for technical support and quality control for all public and private family planning services and has a major role in service delivery. The Council's mandate includes the following: training of family planning providers; promotion of private sector family planning activities; development of media campaigns and routine information, education, and communication (IEC) programs; procurement and storage of all contraceptives used in the country except for those sold through the private sector; and program evaluation and research.

ZNFPC provides three major services: (1) a network of 34 clinics serving mainly urban populations and used as back-up for CBD referrals; (2) 670 CBD's covering approximately 30 percent of the rural population; and (3) youth advisory services for nearly 850 schools around the country. In addition, ZNFPC assists private firms to provide contraceptives, IEC, and services.

Family planning services in Zimbabwe are also provided through health facilities or clinics run by the Ministry of Health (about 200), church groups, local authorities, industrial health care systems, and private health care providers. The Ministry and the other institutions are responsible for the management of family planning services delivered through their facilities, but personnel training and contraceptive supplies are managed by ZNFPC. Promotional activities are carried out by the Ministry of Health's outreach network of 7,000 village health workers, who refer acceptors to the Ministry of Health, ZNFPC, or other clinics for services.

2.4. Previous Family Planning Assistance

Shortly after Independence in 1980, ZNFPC, then known as the Child Spacing and Fertility Association and the principal family planning institution in Zimbabwe, was placed under government control. In 1982, A.I.D. and the Government signed an agreement for a five-year, $6.5 million Child Spacing and Fertility project. The purpose of the project was to extend the coverage of child-spacing information and services throughout the country. The expected outputs included improved management capacity, implementation of a comprehensive IEC program, expansion of training for family planning service providers, and development of a research and evaluation capacity.

An evaluation conducted in 1987 found that the project had greatly exceeded its original objectives. Principal achievements included improved execution and coordination of the overall ZNFPC program, design and operation of a computerized contraceptive inventory and distribution system, significant expansion of the CBD network (from 308 to 670 distributors), and the provision of family planning education and counseling to 1.5 million youths and 200,000 parents through the youth advisory services.

Since termination of the bilateral project in 1987, A.I.D. assistance, including the provision of contraceptive commodities, has been maintained through a number of separately managed, but programmatically interrelated, centrally-funded projects. Some 17 activities were initiated between 1987 and 1989, many dealing with concerns originally addressed in the bilateral project, such as IEC, youth advisory services, research and evaluation, and management services. In addition, new program initiatives were launched, including: development of private sector activities, promotion of new or under-utilized methods, and a demographic and health survey.

In 1989, all AID-supported projects expended a total of $2.1 million in Zimbabwe, with noteworthy successes: the private sector is now involved in family planning delivery, including social marketing; longer-term contraceptive methods have been taught to some clinic workers; and, a second comprehensive demographic survey has been conducted.

In addition to A.I.D., other donors, including the UNFPA Fund and the World Bank, have provided financial support. The World Bank funded Family Health Project (FHP-I) was authorized in 1987 for $52.6 million; about 20 percent of project funds were allocated for family planning. Funding for family planning is allocated for IEC activities and training (about one third and two thirds, respectively). The Project includes grant funds from the United Kingdom, the Netherlands, Norway, and the Federal Republic of Germany, plus concessional loans.

UNFPA began support of family planning in 1981, by assisting the Government with implementation of the 1982 census. The first five-year program for $3.4 million began in 1983. It focused on training of medical personnel, demographers, and community-based health workers. Other donors have included IPPF (technical assistance and contraceptive supplies), UNDP (ZNFPC support), Sweden (support to the census) and various non-government organizations (NGOs) that provide family planning services through their health facilities.

To date, it appears that donor assistance has been fairly specialized with A.I.D. concentrating on aid to ZNFPC and the private sector; UNFPA focusing on population data collection, research, awareness raising, and policy development; and the World Bank and its co-financers on strengthening the Ministry of Health's role in delivery of family planning IEC and services.

3. Project Strategy and Rationale

3.1. Problem Statement

Over the past decade, the Zimbabwe family planning program has made impressive progress. Awareness of family planning is widespread. Among married women of reproductive age (MWRA), 99 percent know at least one contraceptive method and 97 percent know a source. Contraceptive prevalence rates are among the highest in sub-Saharan Africa. Among MWRA, 43 percent are family planning users and 36 percent rely on modern methods, a 33 percent increase over the 1984 figure of 27 percent. This rise in contraceptive use has contributed to a decline in fertility from 6.5 to 5.5 children per woman between 1984 and 1988.

Despite these important achievements, significant areas of concern remain. First, over the next five years, the number of family planning users in Zimbabwe is expected to increase by nearly 300,000 (50 percent). These additional service costs must be borne primarily by the Government but with an expanded role for the private sector. Service expansion is constrained by high fixed and recurrent costs.

Second, although contraceptive prevalence is high by African standards, there is evidence of sizeable "unmet need." Among MWRA, just under one-third want no more children; fewer than half of these women are currently practicing family planning. Similarly, just over one-third of MWRA want to delay their next birth for two or more years; and only a little over half of these women are using family planning. Modern method prevalence in Zimbabwe should rise to 70 percent to meet the expressed needs of these non-users.

Third, the current family planning program in Zimbabwe is heavily reliant on the oral contraceptive. The 1988 ZDHS found that the pill accounted for 72 percent of all methods used and 86 percent of modern method use. It is remarkable that Zimbabwe has achieved a 43 percent rate of contraceptive use with a one-method program. Clearly, the CBD program has successfully promoted and supplied the oral contraceptive method to the exclusion of other methods. In fact, many of the areas where CBDs have been operating now have prevalence rates as high as 70 percent, and CBDs spend a large portion of their time on resupply. Furthermore, neither CBDs nor clinicians refer appropriate clients for more permanent clinical methods. The program's success to date strongly suggests that even greater levels of use can be realized with some programmatic modifications. Section 4.1 of Annex III.A contrasts present method mix in Zimbabwe with ideal method mix.

About one-third of pill users want no more children. For this group, the oral contraceptive is less than ideal due to (a) a lower rate of effectiveness than more permanent methods, (b) higher associated health risks among older women, (c) the requirement for continuous supply and use, and (d) high cost per couple year of protection.

Constraints to diversifying method mix are two-fold: (a) limited access to longer-term methods, and (b) limited awareness and knowledge. Among all married women of reproductive age, only 1.1 percent are using IUDs and 2.3 percent are using sterilization. While nearly all MWRA are aware of oral contraceptives and know a supply source, only 52 and 50 percent, respectively, are aware of IUDs and VSC (voluntary surgical contraception) and only 45 and 46 percent, respectively, are aware of supply sources.

The high prevalence rate and dependence on oral contraceptives has several implications for sustainability: (a) CBDs spend an inordinate amount of time on resupply and less than optimal amounts on new acceptor motivation; (b) the costs of resupply are higher than necessary and are borne by the government; and (c) a larger than necessary portion of the population is using shorter term methods which may not be optimum.

In summary, a sustainable increase in contraceptive prevalence is currently constrained by (a) an overdependence on short-term methods and consequent limitation on the number of users and continuation rates; and (b) high recurrent and fixed costs in service delivery. To shift users to methods that are more, effective and appropriate will require significant program modifications in the variety of contraceptives promoted and in the delivery system. The challenge this poses is further magnified by the large number of couples who will be seeking services in the future. Over the period 1990-1995, the number of married women of reproductive age (MWRA) will increase by 20 percent. To meet the needs of these additional women and the expected increases in demand for modern methods of contraception (about 2 percent per year), family planning services must support nearly 50 percent more users by 1995.

3.2. Project Response

Worldwide experience and research findings suggest that reduced fertility can be accomplished only by expanding the availability and use of a wider variety of contraceptive methods. The expanding number of potential contraceptive users will place additional demands on the delivery system, threatening sustainability in the long run. The high fixed and recurrent costs of current service delivery requires increased efficiencies, a partial shift of the cost burden from government to beneficiaries, specifically private employers, and the introduction of some cost recovery measures.

The project will address the system's constraints to higher, sustainable contraceptive prevalence rates by: (1) increasing the knowledge base of the provider as well as the potential user and the system's capacity to deliver a more diverse selection of contraceptive methods; and (2) expanding the sources of supply to reach increased numbers of potential users. The project will contribute to the sustainability of Zimbabwe's family planning system as a whole. With expanded access to more effective, longer-term methods (IUD, sterilization and NORPLANT$_R$), service delivery will be more cost-effective. Also, by increasing the role of the for-profit sector, the project will reduce the cost burden on the public sector budget, thus freeing up resources to allow the public sector to focus more on reaching the client population whose needs can best or only be met through free or partially subsidized services.

3.3. Project Rationale

3.3.1. Lessons Learned

Research over several decades has clearly demonstrated that the broader the range of methods, the higher the contraceptive prevalence and the more successful a program will be in satisfying the needs of users, achieving improved use-effectiveness, and increasing overall impact.

Two important things happen when a one or two method program (such as Zimbabwe's essentially one method program) introduces more methods. First, some current users switch to one of the newly introduced methods because their current method is not satisfactory (e.g., unpleasant side effects), is not ideal for their life style (e.g., the pill for couples who have only infrequent intercourse); or is inappropriate for the couple's reproductive life cycle (e.g. a 40 year old pill user who wants no more children). It is axiomatic that one family planning method cannot meet all the needs and desires of a population. The greater the choices, the more the needs and desires of couples can be satisfied.

Of course, if no more than a switch in method occurred with the introduction of new methods the overall level of use would remain static. But switching is not the only consequence of diversification.

Broadening choice also increases use by attracting (a) past users who stopped contracepting because of some problem or dissatisfaction, and (b) never-users who want to contracept but did not find acceptable any of the limited methods offered. Numerous studies have shown that overall prevalence increases, sometimes dramatically, when new methods are made available. In addition to increasing the level of use, a broad method mix also increases user satisfaction since more users can find a method suitable to their particular situation. This satisfaction translates into longer continuation rates which, in turn, mean improved use-effectiveness.

Two additional considerations underline the importance of a diverse range of methods. The first concerns reproductive risk. Research has documented factors associated with increased risk affecting the health and survival of both mothers and their children. Risk factors include: mother's age (under 18 or over 35); interval between births (intervals of less than two years are risky for both the newborn and the index child); and parity (4 or more). Increasingly, programs emphasize the need to educate providers as well as potential clients about reproductive risks. Also, programs stress the potential role of family planning for improving the health and survival of women by encouraging childbearing during the safest years and with good spacing and reduced parity. Thus, a key objective of family planning programs is to ensure that women who fall into one or more of the reproductive risk categories have good information and access to a range of appropriate contraceptive methods.

The second consideration involves reproductive intentions. Surveys worldwide have documented tremendous unmet need for contraceptives, based on women's stated desires either to limit the number of children or to space future births by two or more years. In many sub-Saharan Africa countries, very low proportions of these women are actually using contraception. Thus another objective is to help women who do not want any more children or who want to space subsequent births to achieve their reproductive intentions. One further benefit of family planning is to reduce unwanted pregnancies and abortions (legal or illegal) which occur more frequently with unwanted pregnancies. By ensuring access to a range of contraceptive methods, the unmet needs of these women can be addressed.

3.3.2. Conformance with A.I.D. Policy and Priorities

The Africa Bureau's "Population and Family Planning Strategy" (September 1988) states that "helping to reduce fertility ... has become a top priority for A.I.D. in sub-Saharan Africa and now plays a major role in the Agency's bilateral efforts to boost economic growth and improve human welfare in the region." The 1987 Zimbabwe CDSS calls for: (a) continued support for and expansion of the role of ZNFPC in national family planning; (b) contraceptive commodity supply on a cost sharing basis; and (c) integration of family planning into the Ministry's primary health care system.

The strategy of the Zimbabwe Family Planning project addresses both the Africa Bureau and USAID/Zimbabwe priorities for population assistance. The project will assist the ZNFPC to become an even more effective actor in Zimbabwe's national family planning program within the national primary health care system. Specifically, the project will strengthen the organization's training and service delivery capacities with particular emphasis on diversifying the contraceptive methods available. The project will also promote the role of the for-profit sector in the support and delivery of family planning, thereby widening the reach of the delivery system while reducing the cost burden on the public sector.

3.3.3. Complementarity with Other A.I.D. and Donor Assistance

A. A.I.D.

Though planned as a unified endeavor with a single set of goals, purposes and components, this project will be implemented jointly by A.I.D./Washington and USAID/Zimbabwe. The total amount of A.I.D. assistance for activities described in this paper is estimated at $15,712,000, of which A.I.D./Washington will cover $6,312,000 (40.2%) and bilateral funds $9,400,000 (59.8%).

Central funds will be used primarily for technical assistance, project management, and about 20% of contraceptive requirements. Bilateral sources will fund local costs, and the procurement of vehicles, equipment and contraceptives. Additional central funds (not discussed in this paper) may be used for activities addressing generic population issues, e.g., clinical field trials for new or modified contraceptives, operations research, and testing of training materials. Such efforts would benefit not only Zimbabwe, but the population field in general.

Because of their integration into the bilateral effort, each Cooperating Agency will have a clearly defined and, in most cases, a time-limited task. Table II.E.4 lists all Cooperating Agencies that will be involved and the purpose of their assistance.

B. Other Donors

The second phase of the World Bank's Family Health Project (FHP-II) is tentatively budgeted for $75-$100 million, approximately one-third to be provided from bilateral donors. Current plans for the World Bank FHP-II project are for design to be completed early in 1991 with approval scheduled for Spring, 1991 and project start up by Summer or Fall, 1991. FHP-II will focus on training and institutional support to the Ministry of Health (MOH), including construction, upgrading, and remodeling of Ministry and ZNFPC facilities. The World Bank also plans to finance: (1) decentralization of the ZNFPC Information, Education, and Communication (IEC) Unit and provision of materials, especially for service providers; (2) continued assistance in training especially of MOH personnel; (3) support to the Youth Advisory Services Unit; (4) management support especially strategic planning and human resource management; and (5) logistics back-up (e.g. vehicles) for the CBD system of ZNFPC.

The A.I.D. bilateral and FHP-II multilateral programs cover several areas of complementarity. These areas include: expansion of method mix (especially increased capacity for IUD insertion and sterilization); training of clinical personnel with emphasis on longer-term methods; Information, Education, and Communication (IEC); and strengthening the management of ZNFPC.

UNFPA has developed a $10 million project for five years (1990-1994). The major components are:

-- Data collection and analysis (primarily assistance for the 1992 Population and Housing Census);

-- Training in family planning for Ministry of Health personnel at ZNFPC facilities;

-- Provision of all Government requirements for foaming tablets, IUDs, Depo Provera and a major portion of condom requirements;

-- Support to decentralize IEC to the provincial level and for video production;

-- Training in demographic analysis and computers; and

-- Population policy development.

Several Government proposals are being reviewed by UNFPA headquarters and approval is expected in June, 1990. Three areas of activity for UNFPA are related to A.I.D.'s bilateral program: training of MOH personnel by ZNFPC staff; provision of contraceptive commodities; and support for IEC.

A chart summarizing the major areas of project assistance by A.I.D., UNFPA, and the World Bank is presented in Annex II.B. It is not certain, of course, to what degree the final project designs of the other donors will reflect the priorities and planned activities discussed with their representatives during design of the Project Paper. It is apparent, however, that the programs of these major donors will require extensive and continued coordination.

4. Project Description

4.1 Project Objectives

The project goal is to achieve a sustainable reduction in the total fertility rate in Zimbabwe by 1995, and to increase national self reliance in the provision of improved access to high quality family planning services. Achievement of this goal will be indicated by a reduction in the total fertility rate to 4.5 by 1995, and by a reduction in the portion of family planning contraceptive commodity and service costs funded from donor resources.

To achieve this goal and to serve the rapidly rising numbers of married women of reproductive age (a result of past high fertility), the number of family planning users will need to increase by 50 percent by 1995. Service provision must expand to meet the needs of approximately 300,000 additional users.

The project purpose is to increase access to and use of a wider selection of family planning methods delivered through a sustainable system that includes an expanded role for the private sector and reduced costs per user borne by government. If the purpose is achieved, at the end of the project there will be: (a) an increase in use of modern contraception from 36 to 50 percent of married women of reproductive age; (b) a wider variety of contraceptive methods available; (c) 15-20 percent of all family planning services will be financed or delivered by the private sector; and (d) net government costs of family planning services per user will be reduced.

Experience from other countries suggests that with expanded access to a wider variety of methods, user needs are more appropriately satisfied and overall use of contraception increases. Furthermore, increased use of the more effective, longer-term methods improves the effectiveness of contraceptive use. Hence, having a more diversified mix of methods will enhance the likelihood of an increase in overall contraceptive prevalence and a rise in the modern method prevalence.

Broader private sector participation will reach more users and increase government efficiencies in targetting the most difficult niches of the beneficiary population. The national delivery system as a whole will be more efficient and cost-effective, a key factor in enhancing system sustainability.

4.2. Project Components

Three project components will lead to achievement of the project purpose. The first will diversify the available mix of contraceptive methods. The second will promote the role of the for-profit sector in the delivery and financing of family planning services. These two components will both contribute to sustainability by reducing costs per contraceptive user as well as the government's burden in service provision. A third component will support private sector coordination activities and measures to enchance the total system's sustainability.

4.2.1 Component 1: Diversification of Methods

The project's strategy for achieving a more diversified method mix is to support: (A) promotional efforts to increase awareness and knowledge of both providers and potential users of longer-term methods; and (B) training, service delivery, evaluation and research, and provision of contraceptive commodities for the purpose of increasing access to longer-terms methods. Each assistance element is discussed below.

A. Promotion

Over the next five years, the project will develop promotional materials and processes directed towards specific service providers and methods. Promotional materials will help both counsellors and users in method selection. CBDs will be retrained to counsel and refer appropriate clients to clinics offering IUD insertion and sterilization; where these services are not available, retraining will be delayed until they are. Finally, staff in the Ministry of Health and other public sector facilities offering sterilization, NORPLANT$_R$, and IUDs will be offered orientation seminars to increase knowledge about and favorable attitudes towards these methods.

(1) Information, Education, and Communication (IEC)

Knowledge of family planning methods and service providers is a precondition to use of contraception. While knowledge about family planning is wide and attitudes are positive in Zimbabwe, there are critical gaps and problems which will be addressed through an information, education, and communications (IEC) effort.

Under the project, existing method-specific IEC material (flip-charts and handouts) will be adapted for Zimbabwe. Some materials will be specifically geared to male audiences and to those who consider that persons over age 35 are too old to be concerned about family planning. After pretesting among focus groups of providers and clients, a small number of materials will be locally printed using project-purchased ink and paper in year 2. After that, the World Bank will take over the support of production and distribution of these IEC materials. The Population Communications Services project of Johns Hopkins University will provide approximately 4 person-months of centrally-funded technical assistance for the adaptation and testing of prototype materials and will support limited production of these materials.

Materials will be used for the ZNFPC's own service delivery program, but will also be useful in promoting method choice in MOH facilities and among for-profit providers. The ZNFPC's Private Sector Coordinator will be responsible for distributing these and other available materials for employer-provided services, insurance reimbursement programs, and private physicians. The project will also use existing materials prepared under the office of population, bureau for science and technology innovative materials for population action (S&T/POP IMPACT) project to promote greater awareness of the benefits of family planning and contraceptive safety.

(2) CBD Reorientation

Gaps in knowledge and awareness will also be addressed by re-examining the role of the CBD. Central A.I.D. funds will be used to fund such a study. Guided by the results of this study, the project will support the retraining of CBDs in order to enhance their role as promoters of a wider range of methods.

Community-based distributors reach a vast number of rural women and are often the first point of information for potential sterilization, IUD, and NORPLANT$_R$ clients. As potential referral agents, they must be thoroughly familiar with the benefits and procedures of these newer methods and have the skills to identify, counsel, and refer appropriate clients. They must also have strong personal links with individual service providers to give referred women confidence that they will be treated respectfully. Reorientation of CBDs to these new roles, and development of supportive links with clinics will take time.

Training will prepare existing distributors for their new roles as family planning motivators and referral agents for expanded method mix. Included in the training will be the male motivators who work with the private sector program. The project will support this effort by developing a curriculum for CBD refresher training (central funds) and paying retraining costs for 80 percent of CBDs and their supervisors (bilateral funds). Assisted by the Pathfinder Fund, ZNFPC will develop a one-week course to inform CBDs of IUDs and sterilization and to strengthen their counselling skills. Simple reference materials will be prepared along the lines of those being developed for potential clients. Retraining will occur close to service delivery sites and strengthen individual referral relationships. In some cases, follow-up assistance may be needed to work out operational problems in local referral relationships.

(3) Clinical Service Provider Reorientation

The perception is widespread that the weak knowledge and attitudes of clinical service providers have been as much an obstacle to expansion of newer methods as has been the lack of user knowledge and the unavailability of services. Often, it is easier to hand a woman a packet of pills than to explain the advantages of sterilization and IUDs and then arrange a referral. Even trained personnel may delay starting new services because their supervisors do not appreciate the need or because they are given conflicting assignments.

Focusing on specific service delivery sites (including public sector clinics), the project will develop reorientation seminars for clinical personnel who come into contact with potential acceptors of longer term methods. Brief one-to-two day sessions will be developed in which participants will be informed of the advantages and disadvantages of longer term methods for specific types of client and given practical training in patient counselling and referral. With the approval of the Ministry of Health (see Section 1.3), hospital administrators, senior clinical staff, and Ministry of Health provincial health managers will be invited along with nurses and health educators. One topic to be addressed will be the importance of service statistics, the need for MOH staff to report to ZNFPC, and the benefits to MOH of cooperating with ZNFPC. To the extent possible, obstacles to referral within specific settings will be explored and resolved. The anticipated result will be more effective referral from general purpose MCH and family planning clinics to the more limited number of ZNFPC and public sector clinics capable of performing sterilization, NORPLANT$_R$ implants, and IUD insertion.

The centrally funded Population Communication Services project will provide three person-months of technical assistance. Local costs will be supported through bilateral funds.

B. Training

The project will support the ZNFPC Training Unit's key role in expanding family planning services. Training will be primarily in-service and designed for specific activities, especially sterilization, IUD insertion, and NORPLANT$_R$. Participants will include ZNFPC and private sector personnel, with some public sector staff included for sterilization training. Graduates will be monitored after training to ensure that they are properly conducting family planning services and to carry out refresher courses as needed. The project will also help develop ZNFPC into an international training resource for Anglophone Africa.

There are four major areas of project assistance for training: (1) development of a comprehensive training plan; (2) review and adaptation of the various course curricula; (3) expansion of ZNFPC training capacity and output; and (4) strengthening ZNFPC training follow-up.

(1) Comprehensive Training Plan Development

Central A.I.D. funds will support development of a comprehensive family planning training plan for Zimbabwe to be completed as part of a World Bank-funded strategic planning exercise during the quarter before this project begins. Once the training plan is completed, the project will support a ZNFPC-led workshop for principal cooperating agencies to delineate respective roles. Participants will include: AVSC, JHPIEGO, SEATS and Pathfinder.

(2) Curriculum Review and Development

Central A.I.D. funds will support revision of the Basic Course, completion of the IUD Course, and completion of the Sterilization Course. AVSC, JHPIEGO and SEATS agencies will be sourced to develop or adapt teacher and trainee course material as well as formal curricula. In each case, the state of current field practice will be assessed to guide the development of training content and to ensure that trained personnel are properly equipped and supervised to practice what they have been taught.

(a) Basic Course - The Basic Course will be revised: (i) to strengthen discussion of long-term methods, patient couselling and referral, and sexually-transmitted diseases (STDs) and acquired immuno-deficiency syndrome (AIDS); and (b) to encourage more supportive attitudes towards long-term methods on the part of public sector and other non-ZNFPC personnel. ZNFPC will be encouraged to give priority to employer-sponsored clinical staff in training. Course revision will involve assessment of the knowledge and skill requirements of typical participants and the relevance of the current curriculum to their needs.

(b) IUD Course - The project will fund technical assistance from JHPIEGO to adapt generic instructional material to include: (a) information specific to the Copper T-380A; (b) material on STDs and prevention of infection (including AIDS); and (c) guidance on client screening to identify those for whom the IUD is the most appropriate method.

(c) Sterilization Course - The project will support the costs associated with completion of the course and material production.

Centrally funded technical assistance will facilitate adaptation or development of courses for: private physician training (discussed in Section 4.2.2.C); improving CBD counselling and referral skills (Section 4.2.1.A); and NORPLANT$_R$ trials and expansion (Section 4.2.1.C).

(3) ZNFPC Training Expansion

The project will support ZNFPC efforts to significantly expand training of employer-sponsored personnel, as well as training of public sector and ZNFPC staff committed to performing sterilization and IUD insertion. Trainee selection criteria will be examined to reduce the intervals (presently up to 18 months) between application and enrollment. Criteria will be modified to give preference to female personnel and the following:

-- Sterilization training for committed public sector personnel (plus a few ZNFPC staff);

-- IUD training for staff of 34 ZNFPC clinics plus committed public sector personnel;

-- Basic and IUD training for employer-sponsored staff; and

-- Refresher training for CBDs and their supervisors.

To reduce staffing constraints, bilateral funds will finance the hiring and training of six additional tutors (three in year 1 and three in year 2), bringing the total to 19 (two of whom will be dedicated to trainee follow-up, as described below). Support for the tutors will be phased out as ZNFPC assumes responsibility (see Section 1.3) for their salaries: while ZNFPC holds the number at 19, the project will support six in years 2 through 4, three in year 5, and none in year 6. The nurse-tutors will be further assisted by approximately three physicians seconded from the University of Zimbabwe Medical School for clinical aspects of IUD and sterilization training. The project will provide limited technical assistance to train new ZNFPC tutors during year 2.

Bilateral funds will also support: purchase of training equipment (including stencil machines, photo copiers, overhead and film projectors, a typewriter, training models, etc.); a small renovation allowance; and other recurrent costs associated with high priority ZNFPC and private sector trainees (meals, lodging, transportation, and reproduction of materials).

With project assistance, ZNFPC will update its training cost schedule and develop cost recovery mechanisms for international trainees and those sponsored by the Ministry of Health through the Family Health Project. This activity is more fully discussed in the cost recovery section (section 1.6.B).

While lack of physical space is an important constraint in Bulawayo, considerably more can be done in Harare without further construction. Minimal funds have been budgeted for renovation of office and teaching space should it become possible for ZNFPC to locate additional space in Bulawayo.

(4) ZNFPC Trainee Follow-up

Project-supported ZNFPC follow-up activities will include monitoring (a) for quality control of courses offered by ZNFPC training graduates, particularly in the public sector; (b) to determine if ZNFPC personnel are providing the services for which they were trained; and (c) to determine needs for refresher training. Project asssistance will fund:

-- technical assistance to develop follow-up activities;
-- one vehicle dedicated to Training Unit follow-up activities;
-- salary support for two persons expected to spend full-time on trainee follow-up; and
-- assistance in developing a management information system for training follow-up (as described in Section 4.2.1.D).

C. Service Delivery

Given the importance of expanding method mix, this project emphasizes sterilization, IUDs, and NORPLANT$_R$ as the longer-term methods meriting the most attention in the next six years. The project will also continue to provide oral contraceptives (while gradually shifting the long-term financing burden to others) because oral contraceptives are and will remain the program's backbone for the foreseeable future.

For rural areas, ZNFPC has long relied on its network of community-based distributors (CBDs), achieving one of the most successful programs of this type in the world. Now, this program is severely constrained by cost and by its limited (though vitally important) role in expanding method mix. Only 26 percent of pill users get their services from CBDs, and clinics have already become the predominant source of supply for Zimbabwean users.

The project's service delivery strategy emphasizes private, public, and parastatal clinics for expansion of method mix, and private retailers for contraceptive distribution. Briefly, the stategy:

- Emphasizes sterilization as the long-term method with greatest potential but proceeds slowly to expanded service provision (initially through six public sector clinics and two ZNFPC facilities);

- Promotes full availability of IUDs through ZNFPC clinics, private physicians, and employer-sponsored clinics;

- Promotes the testing and expanded use of NORPLANT$_R$;

- Strengthens the motivation and ability of CBDs to refer sterilization and IUD clients; and

- Expands private sector contraceptive distribution through social marketing.

Expanding the service delivery capacity will involve five areas of project assistance: (a) assessment of ZNFPC and private sector clinic capabilities; (b) improved supervision systems; (c) expansion of ZNFPC sterilization facilities; (d) expansion in the number of ZNFPC clinics within public sector facilities; and (e) introduction of NORPLANT$_R$.

(1) Clinic Assessment

ZNFPC currently operates 34 clinics, including 20 free-standing ones, 9 located inside or on the grounds of public sector hospitals, and 5 mobile units. Surprisingly little is known about their capacity and output at the present time and thus a priority task is to assess their staffing, equipment, and performance. With centrally-funded technical assistance from SEATS and

JHPIEGO, the Evaluation and Research and Medical Units will conduct a systematic inventory of existing facilities, including their physical condition, the number, qualifications, and current skills levels of staff, and the status of essential equipment. Levels of activity and output will also be assessed. Analysts will also look at management information systems, supervision, and logistical support. The assessment will determine:

- Additional equipment and refurbishing needs to permit high quality IUD procedures;

- Which clinics, if any, might be candidates for upgrading as dedicated sterilization facilities;

- Required changes in clinic management and support systems; and

- Retraining requirements, including changes in curricula, to upgrade clinic management and service delivery.

This assessment is fundamental to the service delivery strategy and will occur in the first year of the new project.

(2) Clinic Strengthening

Following the above assessment, project assistance will be used to procure essential equipment, refurbish selected clinics, and train staff in IUD insertion (see training section). Bilateral funds will be used for some minor construction and refurbishing costs for ZNFPC's clinics. A.I.D./Washington will also support technical assistance to reinforce monitoring and supervision systems.

(a) Improve Supervision Systems - Strong clinic supervision is an important tool for quality control and improved service, but is often lacking because of inadequate transport, weak supervisory skills, and lack of clear performance standards. Management information systems also play a critical role. The clinic assessment referred to above may find supervision weaknesses, possibly necessitating follow-up assistance. Four person-months of centrally-funded technical assistance by SEATS have been allocated for supervision training for nursing officers, development of supervisory checklists, and other remedial measures as deemed appropriate.

(b) Sterilization Facilities Establishment - Female sterilization through "Mini-lap" under local anesthesia is likely to be the "new" method with greatest potential in Zimbabwe. High quality services are currently available at ZNFPC clinics in Harare and will shortly be offered though six public sector clinics being developed through the Ministry of Health's Family Health Project. Demand for sterilization will be rapidly fueled by service availability (especially for out-patient procedures) and focused promotion. Expansion beyond these sites will be needed within an estimated three years.

Most of the additional need will be met through Ministry of Health-financed public sector facilities and through a small number of private clinics, as described below. Demand will be inadequate to justify a physician's full time presence for sterilization at ZNFPC centers outside Harare and Bulawayo, but consideration will be given to establishing dedicated facilities in selected centers to be serviced by ZNFPC staff as need requires. ZNFPC clinics within district and provincial hospitals are the most likely candidates for this new service, scheduled to begin in year 3. To make it possible, the project will provide 4 person-months of SEATS technical assistance (central funds), equip and refurbish a small number of clinics (bilateral funds), and provide one vehicle (bilateral funds).

As noted elsewhere, project-supported promotion efforts will be particularly concentrated in areas where sterilization and IUD services have been fully developed. Community-based distributors will be an important link for referral to these clinic.

(c) Establishment of ZNFPC Clinics in Public Sector Facilities - Using mainly bilateral funds, the project will accelerate the strategy of co-locating ZNFPC service providers in public sector facilities. Locations will be chosen based upon the following criteria:

-- Geographical access;
-- Shortage of existing clinic-based services;
-- Suitability of the physical facility;
-- Adequacy of support services from public sector staff; and
-- Interest of associated public sector staff.

Implementation in each location will require:

-- ZNFPC service staff, usually two fully trained family planning nurses.

-- Equipment and supplies.

-- Orientation of existing facility personnel in family planning, including the benefits, indications, counselling for referral, and basic contraceptive technology.

-- Update training for nearby CBD workers, concentrating on the benefits of clinic-based methods and indications of the need to refer a client for additional follow-up or a method change.

-- Ongoing medical supervision and in-service training for ZNFPC service personnel.

To support this, central funds will support 4 person-months of SEATS technical assistance, while bilateral funds will provide an allowance for equipment and renovation.

As a condition for this grant, the Government will agree to allow ZNFPC to refurbish family planning rooms within Ministry of Health institutions (See Section 1.3).

(3) NORPLANT$_R$ Introduction

NORPLANT$_R$ is the first truly new contraceptive in several decades. As a subdermal implant, it requires minor surgery for insertion and removal. Because NORPLANT$_R$ is a new method, its introduction into Zimbabwe will be carried out in a careful, systematic manner. The Population Council, the developer of NORPLANT$_R$, has received UNFPA funds for the initial or pre-introduction phase of the method in Zimbabwe. The Population Council modifies its introduction protocol for different countries, but the following types of activities are part of the introductory process which is expected to take 1-2 years:

-- Explain NORPLANT$_R$ to policymakers, program administrators and regulatory officials.

-- Estimate the need for the method.

-- Provide model training and IEC material.

-- Train a select number of service personnel - clinicians and counselors.

-- Gain "hands-on" clinical experience in inserting and removing NORPLANT$_R$.

-- Assess the above experience to ensure high quality provision of NORPLANT$_R$.

-- Recommend action required for an appropriate and presumably expanded role for NORPLANT$_R$.

The Population Council is carrying out a study in Zambia which is comparing differences in physicians' vs. nurses' delivery of NORPLANT$_R$. If the study goes well, the government will be asked to approve nurses' role in delivery or to do a similar study. Otherwise, ZNFPC's role in deliverying NORPLANT$_R$ will be limited to its few physicians.

During the pre-introduction study, two physicians from the Department of Obstetrics and Gynecology of the University of Zimbabwe and the ZNFPC will receive training. About 200 subjects will be recruited during a 9-12 month period which could begin as early as October 1990. Subsequently, these subjects will be followed to assess the acceptability of the method and problems with its use. The results of this follow-up study will be reviewed by the Research and Ethics Committee of the MOH. Assuming GOZ's favorable review, wider-scale training and provision of NORPLANT$_R$ will proceed. A similar introductory study has recently and successfully been completed in

Kenya and plans are underway for wider distribution of NORPLANT$_R$. Based on GOZ's approval of the pre-introduction study in Zimbabwe and the Population Council's previous experience in other countries, it is not anticipated that there will be any obstacles to wider-scale distribution of NORPLANT$_R$ in Zimbabwe.

Starting in year three, central funds will support distribution of NORPLANT$_R$. The University of Zimbabwe will play the leadership role as a training center and ZNFPC will assist in providing clinic space and personnel. The project will support the training of gynecologists from the Department of Obstetrics and Gynecology at the University of Zimbabwe (1992), gynecologists working in Provincial Hospitals (1992-93), and physicians in Provincial Centers (1992-95). One counselor will be trained for each clinic where NORPLANT$_R$ will be available (1992-95). Physicians and counselors fro the private sector will also be trained. The project will also support the ongoing evaluation of the method and refresher training.

By the end of the project, it is anticipated that NORPLANT$_R$ will be an accepted method for contraception in Zimbabwe and will be used by about 15,000 women. The Population Council along with AVSC and JHPIEGO will provide technical assistance for the wider-scale distribution of NORPLANT$_R$.

D. Evaluation and Research

ZNFPC's Evaluation and Research Unit (ERU) monitors program implementation, identifies operational issues and problems, tests strategies for resolving problems, and evaluates program impact. A.I.D. has supported this Unit since its inception and will continue to do so through the new project.

There will be five specific areas of assistance: (a) general purpose technical support, (b) strengthening the collection and use of service statistics, (c) establishing a management information system for the Council's training program, (d) supporting various operations research studies, and (e) evaluating program impact.

(1) General Purpose Technical Assistance

The present Pathfinder resident advisor will leave the Evaluation and Research Unit (ERU) late in 1990, leaving technically competent but still somewhat insufficient Zimbabwean staff. To ease the transition, central and bilatral funds will support approximately three person-months per year of Pathfinder and/or Population Council technical assistance over the life of the project. Advisors will help determine study priorities, assist in review and revision of the service statistics system, and guide design of specific studies.

(2)) Service Statistics

ERU collects and maintains the Council's routine service statistics. Only a minority of public sector facilities regularly report on family planning activities, although the majority express willingness to do so if properly guided. At the present time, very little or no service statistics are made

available to provincial managers and senior educators, and they are not used as managerial tools. The project will help managers to fully benefit from ZNFPC's service statistics system. The sharing of service statistics with officials at the local level will not only serve to inform them about activities, but will also serve to compare clinics and services.

Central funds will help to strengthen the collection and use of program statistics by supporting 3 person-months of SEATS technical assistance to assess current ZNFPC and public sector reporting systems and the analysis and use of service statistics for program management.

(3) Training Information System

Another important role of the ERU is to develop and maintain the Council's management information systems (MIS). In light of the emphasis being placed on improving and expanding the training of clinicians (both medical doctors and nurses), counselors, and CBD promoters, the project will assist the ERU in developing an MIS to track all training participants.

The trainee monitoring system will record the names, locations, and institutional affiliations of all trainees to facilitate follow-up and supervision. The roster will then be used for periodic surveys to study graduates' current involvement in family planning service delivery and training. The MIS will be especially useful for assessing how well the ZNFPC is meeting its objectives in training both Council and MOH clinic staff, private providers, employer-based health personnel, and CBDs.

The MIS will be developed in close consultation with the Training Unit to ensure that it provides the most useful information. SEATS will provide one person-month of centrally-funded technical assistance.

(4) Operations Research

Operations research addresses programmatic issues and bottlenecks and tests alternative approaches to service delivery. The project will support various studies to improve the effectiveness and efficiency of the Council's program. The capabilities of the ERU will be enhanced through involving them as partners in the design and execution of research with the assistance of Cooperating Agencies. It will be the responsiblity of the A.I.D. project manager to make sure that planned formal training is provided by some of the Cooperating Agencies. Given that one of the overall objectives of the project is to expand method mix, one study will assess the acceptability of an expanded range of methods.

(a) Acceptability Study - As an essentially pill program, it is important that the ZNFPC quickly gain experience and knowledge about other methods. The Project will support an acceptability study of a broad method mix. The study will examine the acceptability of a wide range of methods among providers and users. Acceptors will be followed-up to assess

user-satisfaction, level of knowledge of other methods, side effects, and key socioeconomic characteristics which influence adoption. Providers will be interviewed to determine their attitudes about the different methods, the adequacy of their training, and their opinions about educational material on the various methods. The study will emphasize a quick turn-around time and will be carried out with centrally-funded technical assistance from the Population Council's Operations Research Project.

(b) Cost Recovery - The ERU will also conduct a major cost reduction and cost recovery study beginning in Year 3. This study is further described in Section 4.2.3B.

(c) Other Ongoing or Planned Studies - The Pathfinder Fund and the Population Council are currently preparing a proposal with ZNFPC to study alternative models for supply and resupply of pills in rural areas. It is likely that the results of this study will lead to changes in the ZNFPC's CBD program and possibly to further testing of alternative delivery models.

Other possible small studies aimed at resolving specific clinic management problems include: testing variation in clinic hours, and cost and benefit comparison of free-standing ZNFPC clinics vs. ZNFPC clinics within MOH facilities. To the extent that project funds are available, additional, yet-unidentified, studies related to the project objectives will be considered for support.

(5) Program Evaluation

The ERU will also be the locus for analyzing output measures by which the proposed project and ZNFPC's overall program will be assessed. The most important of these measures are: total fertility rate, contraceptive prevalence rate and method mix. Other measures are noted in the Log Frame. The ERU's ability to provide these output and impact measures will be greatly enhanced by another Demographic and Health Survey (DHS).

A combination of central and bilateral funds will support a third DHS in 1994. The survey will provide nationally representative data which in combination with data from the 1988 ZDHS will enable an assessment of changing knowledge, attitudes, and practices of family planning. It is anticipated that the survey will again be implemented by the Central Statistical Office (CSO) with technical assistance from ZNFPC and ERU staff in particular. The contractor for DHS III will provide 12.5 person-months of technical assistance to the CSO and ZNFPC to implement the survey.

E. Contraceptive Commodities

A.I.D. has supplied all contraceptives for organized family planning in Zimbabwe since 1982 and will continue to play a major role in commodity provision under the new project. As described in Section 4.2.3.C, however,

the project will also initiate processes to transfer this commodity procurement, management, and financing burden to the Government of Zimbabwe and to other donors. By year 6, this major recurrent cost burden will be fully borne by others, greatly enhancing substainability.

This section describes public sector commodity support, including both contraceptive supplies and assistance for logistics management. Section 4.2.2.A describes private sector commodity support, while 4.2.3.C discusses diversification in contraceptive sourcing.

(1) Public Sector Commodities

The project will provide only oral contraceptives and NORPLANT$_R$, while UNFPA assumes responsibility from the start for condoms, IUDs, foam tablets, and other vaginal methods. Pills will be provided during years 1-5 and NORPLANT$_R$ in years 3-6. Bilateral funds will cover 83.7% of contraceptive costs. Central funds will cover the remainder (including all funds for NORPLANT$_R$.

Based on the target setting model (Annex III.A, Appendix 1) and detailed calculations by the Family Planning Logistics Management Project, this project will provide the following:

13,090,948 cycles of Lo-Femenal Blue Lady
17,046,286 cycles of Ovrette
15,000 sets for NORPLANT$_R$

Projections by year are shown in Annex II.E.

(2) Logistics Management

The project aims to make ZNFPC self-sufficient in contraceptive need forecasting, procurement, and logistics management by the end of year 5. To achieve this, A.I.D./Washington will support 10 person-months of technical assistance through the Family Planning Logistics Management project plus $60,000 in computer hardware, software and training; while bilateral funds will cover the local costs of logistics management.

4.2.2. Component 2: Expansion of Private Sector Involvement

As its second component, the Zimbabwe Family Planning project seeks to broaden the role of the private sector in family planning service delivery and in financing. The basic principle of these initiatives is that there is usually a direct, even if medium- to long-term, financial benefit to the provider from making family planning available.

ZNFPC plays a vital role in coordinating and monitoring these expanded initiatives. It will also take the lead in managing the inter-face between private sector initiatives and its own activities as well as government programs and government agencies whose policies affect for-profit population activities.

The project will expand private sector involvement through program and staff support in five specific areas: (a) contraceptive social marketing, (b) employer-provided clinics and CBDs, (c) mobilization and training of private physicians, (d) increases insurance reimbursement, and (e) generation of corporate contributions. It will also increase ZNFPC coordination capabilities, as described in Section 4.2.3.A.

A. Contraceptive Social Marketing

A contraceptive social marketing program was initiated in 1987 through an agreement between the S&T/POP centrally-funded SOMARC project and Geddes, Ltd., a local pharmaceutical supplier. The SOMARC project provides technical assistance and contraceptives (orals, condoms, foaming tablets and IUDs) to Geddes for its Family Care Programme. Geddes, in turn, pays the import duties and takes responsibility for packaging, advertising and marketing the commodities through pharmacies and private doctors. Distribution of condoms is to be extended to cafes, hotels, bars, and supermarkets, if politically and socially acceptable. If AIDS prevention becomes a Government priority, this particular retail sales approach will become an especially effective services delivery strategy.
The project will support expansion of the social marketing program by providing 10 person-months of centrally-funded SOMARC technical assistance and $160,000 in bilaterally-funded contraceptives.

Following a cautious start, this program is poised for a period of rapid expansion. It currently has about one percent of the condom market but aims to grow to a significant market during the life time of the project. Growth in the distribution of pills, IUDs and other more permanent methods is projected, but will be constrained by supply and regulation issues. The project will contribute to the diversification of available methods, but its main contribution will be to help create a wider commercial contraceptive market. Its full marketing impact may not be felt until the regulatory environment for advertising is liberalized.

Private sector commodity requirements for years 1 and 2 are covered by existing contraceptive stocks at Geddes. Requirements for the remaining years assume a complete phase-out of USAID support by year 6. The requirements for years 2-5 are as follows:

Condoms: The social marketing program estimates that 968,000 condoms will be sold in 1990. As noted in the Technical Analysis, this is a 5-1/2 fold increase over 1989 actual sales of 173,000. The estimates in Annex II.E are based on a more conservative 30 percent annual increase in sales from the 1989 level.

Pills: The social marketing program projects 1992 sales of 67,000 cycles over the 1989 level of 47,702. This estimate is based on a 12 percent annual increase. This estimate is optimistic, but achievable.

IUD: This is a promising method for the social marketing program. In 1989 1,587 IUDs were sold. By 1992, 4,478 are expected to be sold. For subsequent years, a 20 percent annual increase is estimated.

At the end of 1991, contraceptive requirements for the social marketing program should be reassessed. A.I.D. will also work with the government to remove import duties on private sector contraceptive supplies and to reconsider restrictions on contraceptive advertising (see Section 1.3.)

B. Employer-Provided Services

With assistance from the S&T/POP centrally-funded Enterprise Project, the ZNFPC Private Sector Coordinator has created partnerships with five entities, including two large commercial farms (Triangle Ltd. and Hippo Valley), approximately 125 medium-scale commercial farms (members of the Commercial Farmers Union), a mining company (Lonrho Zimbabwe Ltd), and a large urban manufacturing company (British American Tobacco). The Enterprise Project has financed start-up costs (except for Hippo Valley), including service-provider training, IEC materials, equipment and planning. Most recurrent costs have been covered by the companies. Strong inquiries have also come from a major conglomerate (T.A. Holdings) and from two smaller companies. Through the four Enterprise supported partnerships, 37,000 couples now have access to family planning services.

The project expands employer-provided services in the following ways:

(1) By replicating successful projects in large estates and mines to similar public and parastatal enterprises.

(2) By working with the S&T/POP centrally-funded SEATS project to devise a strategy to expand provision through the Commercial Farmers Union, which employs 220,000 rural workers.

(3) By developing model projects and replicating them in the manufacturing sector: first, in factories where women workers predominate and the levels of maternity benefit paid give a strong incentive to provide family planning; and secondly, among receptive companies where male workers predominate.

(4) By developing demonstration projects in the service sector of the economy for both private sector, e.g. shops and large offices, and appropriate public sector entities such as civil service offices and major parastatals.

(5) By reducing training delays from an estimated 18 months at present to a target of three months.

To achieve these objectives, A.I.D./Washington funds will be used to develop presentations to gain the support of private sector managers and their public sector counterparts for the funding of employee family planning services. When appropriate, support will be available to help meet start up costs through existing ZNFPC programs including training, IEC, equipment, and analytical and planning expertise. Funds will also be used to support operations research.

It is expected that this effort will at least triple employer-provided services to cover 120,000 couples by 1995. In addition, contraceptive prevalance among covered employees is expected to rise to approximately 60 percent resulting in sustained services for 72,000 couples.

C. Mobilization of Private Physicians

There are 116 private clinics in Zimbabwe, and a total of 500 private physicians, over 200 of whom are authorized to dispense a full range of contraceptive products. In addition, general practitioners in the public health system, particularly in the outlying districts, provide some minor medical services on a fee basis. These resources are responsible for 17 percent of the "clinical" methods of contraception provided in Zimbabwe. It is expected that the proposed activity will result in the private sector's providing 25 percent of "clinic" methods. For women covered by medical aid schemes that offer a family planning benefit, "clinic" procedures are between 80 and 100 percent reimbursable.

The project will address an identified need to educate and inform private clinics and physicians about the advantages of family planning for their clients and explore with them the possibility of income generation from the sale of commodities. Central A.I.D. funds will be used to train private sector physicians for provision of clinical family planning methods. Priority will be given to training female physicians. The initial focus will be on practitioners in urban Harare, Chitungwiza, and Bulawayo. The doctors will receive a contraceptive technology update course and will all be trained to insert IUDs. The larger practices will have some of their nurses or assistants trained in counselling, especially for the more effective clinical methods. A special training module will be developed for male counselling since many of the private physicians see male patients and their families under the various medical aid societies. All participating clinics will be equipped for IUD insertions. In addition, a small number will be equipped to perform Mini-Lap sterilization procedures under local anesthesia.

The Pathfinder Fund will assist ZNFPC, the Zimbabwe Medical Association, and the College of Primary Care Physicians to implement this activity beginning in Year 1. It is expected that 200 physicians (40% of private practitioners) will be trained by the end of Year 3.

D. Insurance Reimbursement Programs

The S&T/POP centrally-funded TIPPS Project conducted a business analysis for CIMAS, Zimbabwe's largest private medical aid society. The analysis led to a decision by CIMAS to reimburse insured beneficiaries who use ZNFPC family planning services, and CIMAS and ZNFPC negotiated a fee schedule for these services. A more recent decision authorized service reimbursement for private physicians as well. These policy changes could result in sustained services for an estimated 30,000 family planning users.

The project will expand the reimbursement scheme to include other medical aid societies and -- following the CIMAS approach -- broaden reimbursement to include private providers. Using 2.75 person-months of centrally-funded SEATS technical assistance, ZNFPC will inform other medical aid societies of the CIMAS experience and assist them in instituting a fee structure and expense reporting system. The project will also support training of the Private Sector Coordinator in promotional and implementation aspects of this work.

It is expected that the reimbursement scheme will be adopted by two other major private medical aid societies (the Railways scheme and MASCA) and by the Public Service Medical Aid Society. There are also 27 small company-run "in-house" insurance schemes which will be targeted to support family planning. Successful implementation will result in coverage for about 100,000 couples. Assuming that contraceptive prevalence will increase to 50 percent, the effort should result in sustained family planning services for an additional 50,000 couples. Due to expanding medical aid society membership (CIMAS reports membership growth at about 13 percent), even higher levels of sustained services by 1995 may be obtained, particularly since the growth in membership is tending to come from groups of lower paid workers.

E. Corporate Contributions

The project will broaden its relations with the corporate community beyond the activities previously discussed. While benefiting acceptors, the sub-projects also include an element of financial incentives to the private sector provider. This new project element will appeal to the sense of "corporate citizenship" which motivates companies to become involved in social issues. There are "indirect" benefits to companies taking such initiatives, such as good public relations, but the main motive is to help resolve an important social and economic issue.

Corporate citizenship, expressed through community initiatives of various sorts, is an established but underdeveloped element of company policy in Zimbabwe. Companies already:

- Become involved in advocating development issues.
- Sponsor worthwhile "charitable" events and causes.
- Make local donations of cash and equipment.
- Provide substantial donations of "blocked" funds.

Using A.I.D./Washington funds, the project will mobilize such resources to support ZNFPC private sector coordination and the wider campaign to promote family planning. The measures of success for these activities will be very specific: for example, the amount of funds donated or air time given to discussing the issue of population growth, national development, and family planning. While none of these ideas has been tested in Zimbabwe and the whole field is very experimental, it ought to be possible to raise Z$10,000 in cash or kind to support the ZNFPC private sector coordinating office in the first year and double that amount in the second and subsequent years. As to resource mobilization and fund raising for the family planning cause as a whole, the ZNFPC private sector coordinating office will seek to use its scarce resources in a classic "venture capitalist" mode; investing small amounts in activities such as seeking blocked funds, which can give a high yield return of cash or other resources to the cause.

4.2.3. Component 3: Coordination and Sustainability Enhancement

Expected increases in demand for family planning over the next five years have serious financial implications for the present service delivery system. To effectively respond to this demand requires increased private sector delivery of services, reliance on existing public sector health facilities, cost-recovery from user fees and tuition fees, and efficiency of service delivery systems.

Currently, ZNFPC directly serves 38 percent of modern method users. ZNFPC receives a significant portion of its funding through the Government. It is unlikely, however, that Government funding for ZNFPC will expand commensurately with demand for services. The problem can be addressed through more effective use of public sector facilities, through expanded use of private sector facilities, and through organizational and functional modifications in ZNFPC. The project supports the following activities to increase sustainability:

-- Adding family planning services to existing Ministry facilities to achieve a more cost-effective use of existing infrastructure (discussed in Section 4.2.1.C).

-- The ZNFPC will work to promote program sustainability by facilitating service delivery through private as well as public channels.

-- ZNFPC will improve its own sustainability by examining the potential for increased user fees, service fees charged to insurance providers, and fees charged to other agencies for clinical training.

-- ZNFPC will examine alternative service delivery models to augment its own efficiency in delivery services, thus reducing recurrent costs.

A. ZNFPC Private Sector Coordination Support

The ZNFPC Private Sector Coordination effort is a rare example of a national agency which tries to stimulate contributions from the for-profit sector and coordinate them with public sector policy and initiatives. Much can be learned from the office's activities over the next few years which may have valuable applications in other countries. Furthermore, the introduction of the two areas of corporate involvement to this project ensures that it fully covers all aspects of potential private sector involvement except for local contraceptive manufacture, which has been dealt with in separate studies. In this respect, the work of the project is unique; it is trying to ensure that a national private (for-profit) sector makes a full contribution to family planning development. It is an ambitious strategy to fully mobilize the latent power of the sector to address population issues.

A considerably expanded role for the ZNFPC Private Sector Coordinator is envisioned. Consequently, the project will support the creation of the for-profit sector or external affairs unit within the ZNFPC. The existing ZNFPC Private Sector Coordinator will be actively involved in implementing aspects of the expanded private program, including such promotional activities as meetings and presentations. Since the coordinator's work load will expand significantly, bilateral funds will support two local consultants to assist the coordinator in developing new for-profit involvement in the first five years of the project.

One of these local consultants, preferably with some experience in the for-profit sector, will develop a broad network of contacts in the business community and expand "demand" for more subprojects. The second consultant will ensure that companies offering family planning obtain timely information and support services. The for-profit staff will draw on other ZNFPC units for technical support in training and IEC.

In order to be effective in this expanded and much more high profile role, the ZNFPC private sector coordination staff will be provided the tools to do their job with great efficiency. Its style of operation will mirror that of the for-profit sector. To support its success, the project will provide the unit with a vehicle and such office equipment as a fax, phone answering machine and photocopying equipment.

B. Cost Recovery

Cost recovery and cost reduction will be strengthened in ZNFPC to increase available resources and to make better use of existing ones. In considering cost recovery, it is important to keep in mind that family planning is a service that the Government of Zimbabwe is interested in providing to all the people at the lowest possible cost. The ZNFPC currently has a two-tiered pricing structure. Fees are charged for clients with a monthly income over Z$150 (U.S. $62.50); but, with the exception of sterilization, all methods are free to clients with incomes below that level.

The project will support a major effort to reduce costs, improve revenue collection, and revise fee levels. This effort will have four parts:

1. Operations research to strengthen fee collection and management.

2. Method-specific cost analysis of current services.

3. Price elasticity study for contraceptive services.

4. Cost analysis and fee setting for training programs.

These sub-studies may be conducted together or in sequence and will begin by Year 3. A.I.D./Washington will fund 10 person-months of Population Council technical assistance for this activity, while bilateral funds will cover local costs.

(1) Fee Collection

Studies have shown that improved fee collection and strengthened revenue management can double or even triple cost recovery, even without price increases. Changes that frequently improve collection include: (a) verification of income or other eligibility criteria for fee exemption, (b) modification of eligibility criteria for exemptions, (c) use of receipt books for all payments, (d) secure depositing of all receipts, and (e) periodic audit. Underlying success in many cases has been the creation of managment incentives for local staff, usually in the form of partial retention of revenues for improvements in service quality. An important cost recovery sub-study will therefore create incentives and procedures for improved revenue collection and management.

(2) Cost Analysis of Contraceptive Services

A thorough cost analysis of current services is also necessary for two reasons: (a) to guide cost reduction efforts, and (b) to enable managers to set realistic prices. This analysis will be specific to individual contraceptive methods and reflect differences in usual service delivery sites. Even if policy rules out major price changes, this sub-study will increase the ratio of costs covered by improving operating efficiencies.

(3) Price-Elasticity

At the present time, ZNFPC's fee schedule is very low, in part due to inflation and the lack of regular, periodic adjustments. The ZNFPC's current pricing structure is as follows:

Orals	Z$0.20 per cycle
Condoms	Free
Foaming Tablets	Z$1.00 for 12
IUD	Z$2.00
Depo Provera	Z$0.25 per vial for three months
Sterilization	Z$10.00

(U.S. $1.00=Z$2.40). These fees have not been adjusted since 1985. The project will support regular fee adjustment for inflation, in order to avoid the present situation where fees bear no relation to actual costs, and to avoid the need to make large adjustments that can make services inaccessible to some users.

Operation research will examine the price elasticity of contraceptive services rto assess potential for generating revenue in the public and parastatal sectors. Using a quasi-experimental design, the study will test the impact of increasing fees for various services. Results will guide adjustments in the prices charged for service delivery and commodities for the entire program and lead to a plan for market segmentation. Ultimately, the Council's user-fee structure will enable the collection of reasonable fees from those who can pay and the collection of minimal or no fees from the poorest segments of the population. Further, by increasing user fees for public and parastatal sector services, there will be some incentive for some clients to switch to the private sector.

(4) Training Cost Analysis

ZNFPC currently charges minimal fees for international trainees and trainees sponsored by the Family Health Project. Charges are believed to be below actual costs due to inflation and inadequate analysis of fixed costs. Fees for international trainees in particular, could be significantly increased because of the wide interest in Zimbabwe and the lack of competing courses at lower prices.

The project will increase training cost recovery by providing technical assistance to analyze costs and by promoting international participation.

C. Diversification in Contraceptive Sourcing

As noted in Section 4.2.1E, contraceptives are a major part of the proposed project's budget. Having such a large percent of the budget devoted to contraceptives is typical of successful programs as they supply more and more users. This success does lead to a number of problems, however, which the project will begin to address. These problems, it should be emphasized, are not unique to Zimbabwe, and their resolution will be influenced by factors external to this project.

The principal problem with an increasing proportion of the program's budget paying for contraceptives is that fewer funds are available for other activities, unless of course, the program's overall budget increases each year to compensate for the growing contraceptive burden. A.I.D.'s overall contraceptive budget has recently been increasing by over 20 percent each year while its total budget has remained essentially static. As a result, A.I.D. has less money for areas where it has a clear comparative advantage such as sterilization training, survey research, management, I.E.C., and operations research.

Simply shifting the burden of contraceptive supply to host-country programs is not a realistic solution in the intermediate future, although this should be a long term goal. Some of the problems facing host-countries are: lack of both funds and foreign exchange; the need to continue, at least for a transitional period, the donor-supplied formulations (of oral contraceptives) and brands; and, limited or no experience in procurement of contraceptives. Consequently, donors and host-countries need to work together to find ways to manage contraceptive requirements in ways that are optimal for the overall family planning effort.

(1) Diversification of Donor Support

A.I.D. finances 75 percent of donor contributed contraceptives worldwide. Other donors recently have stepped up their global contraceptive procurement efforts, especially UNFPA and the World Bank.

Sharing the contraceptive burden not only allows the respective donors to maintain adequate levels of support in other areas, but also means that each donor can emphasize its comparative advantage. For instance, UNFPA can purchase condoms at half the price that A.I.D. must pay. If A.I.D. bought the contraceptives to be supplied by UNFPA and WHO, it would have to pay $6.5 million, not the $2.95 million that these other donors are paying. This would raise A.I.D.'s total contraceptive donation to $12 million, making the project no more than a contraceptive commodity procurement transaction. An efficient use of donor funds is for A.I.D. to purchase all pills (since A.I.D. can purchase pills at competitive world prices) and for other donors to buy other methods.

During the identification stage of this project, agreement was reached with the Government, the AIDs Control Programme, and UNFPA, to reapportion donor support for the 1990-91 period as follows:

Donor Funding for Contraceptive Commodities in Zimbabwe
1990-1994

	US Dollars (000)	Percent
A.I.D.	5,431	65
UNFPA	1,599	19
WHO/GPA*	1,352	16
Total	$8,382	100

* Funds from the WHO/Global Programme for AIDS for condoms. They are included here since some will undoubtedly be used for family planning and - if not supplied by WHO - would be supplied by another donor, such as A.I.D.

Tables in Annex III.A, provide details. USAID will encourage creation of a donor coordination committee, particularly focussed on contraceptives, and will actively participate in meetings.

(2) Increased Government of Zimbabwe Financing

Other donor support will not be sought for oral contraceptives because experience worlwide shows that users are very sensitive to particular pill formulations and brands. Other donors would not be able to continue purchase of the brands now provided by A.I.D. because of restrictions on their procurement processes. Discontinuities in pill supply would be particularly serious for Zimbabwe because of its dependence on this single method and must be avoided if at all possible.

A.I.D. is encouraging some host-countries to assume part or all of their contraceptive requirements. Zimbabwe already pays for 50 percent of its family planning program. Projections for this project estimate requirements for oral contraceptives, over five years, of U.S.$8.3 million. The present plan calls for U.S.$5 million worth of oral contraceptives over six years, assuming that the Government will assume responsibility for increasing portions of the total annual requirement and 100 percent of the need beginning in year 6. It is now planned that the GOZ will begin to purchase about 21 percent of the pill requirements in the 3rd year of the project, 25 percent in the 4th year, 50 percent in the 5th, and a 100 percent in the 6th.

GOZ financial requirements for supply of pills in the later years of the project cannot be determined precisely at this time but can be estimated. While pills may represent a less important method in the future as a wider range of methods become available, the quantity of pills needed may not decline much if at all. There may be an absolute increase in the number of women using pills due to the 20 percent increase in the total number of married women of reproductive age between 1990 and 1995. It is safe to assume, however, that the total amount for project years 4,5, and 6 will be well over U.S.$3 million.

As one of the conditions for this project the Government will agree to assume responsibility for the purchase of oral contraceptives on a phased basis before year 6. (See Section 1.3.)

Shortly after year 2 of the project, interested parties will review contraceptive use data and re-assess earlier projections. Based on these new estimates, a more accurate estimate of pill requirements can be made. At that time, the plan to have the Government of Zimbabwe begin to assume responsibility for the purchase of oral contraceptives will also be examined. If the Government is able to purchase pills with foreign currency, USAID and S&T/POP will assist their GOZ counterparts in the procurement process. If, however, the Government is unable to meet any on all of the foreign currency contraceptive requirements, other options will be considered, especially in

light of external circumstances that might affect the choices for Zimbabwe. Options may include:

a. Vehicle Funds: Funds currently allocated to vehicles could be used instead for contraceptive purchases.

b. Contingency Funds. The project has a contingency fund, which could be partially used to meet contraceptive requirements.

c. NORPLANT$_R$: There is $345,000 budgeted for NORPLANT$_R$. Discussions are being held among donors to determine if one of them would become the primary source of funds for NORPLANT$_R$. If this were to happen, it would 'free-up" these funds for other uses.

d. Local Production and Consortium Buying: As noted earler, international donors and other interested parties are discussing ways to deal with the huge, global increase in demand for contraceptives. These discussions may well increase the options for funding contraceptives by the end of 1992. Local production of pills in Zimbabwe has been actively considered by a European firm and consortium purchasing by donors and host-country governments is a serious possibility.

e. Transfer of local costs to the Government: Perhaps the simplest alternative would have the GOZ fund local costs that USAID now plans to cover. USAID, in turn, would purchase pills for the GOZ using its "savings."

There are major changes that are taking place in the contraceptive procurement field, both within and outside A.I.D. It is appropriate, therefore, that USAID and ZNFPC wait two years before mapping out a plan for the GOZ to take on more of the burden for funding contraceptives.

4.3 Project Management and Administration

Zimbabwe's family planning program will undergo major strategic restructuring in the next five years, and A.I.D. should contribute its decades long experience and in-depth knowledge of international programs. ZNFPC's ability to influence Ministry of Health and private sector activities must be greatly strengthened. Program emphasis must be shifted from pills to sterilization, IUDs, and NORPLANT$_R$. Lengthy and complex negotiations will be required to shift contraceptive financing to the Government and to other donors. Long-term sustainability of all project activities will be a major concern.

The successful implementation of this design requires full-time technical monitoring by a dedicated staff person in the USAID/Zimbabwe. Hired using central funds under the SEATS project, this person will be located in the USAID/Zimbabwe offices. He or she will liaise on a regular basis with his/her counterparts in the ZNFPC, Ministry, UNFPA, WHO/AIDS Office, and others as deemed appropriate by USAID/Zimbabwe Mission management. The

Administrator will have a vehicle and access to secretarial support. Selection criteria and a scope of work are included in Annex II.D.

4.4. Cost Estimate and Financial Plan

A. A.I.D. Contribution

Over the six year life of this project, A.I.D./Washington and USAID/Zimbabwe expect to provide resources totaling $15,712,000 for activities described in this Paper. Roughly 40% ($6,312,000) will derive from central funds and 60% ($9,400,000) from bilateral funds.

The major budget elements are presented in Table A. The A.I.D. budget will cover short term technical assistance, training, training supplies and materials, evaluation and research, staff support, equipment, commodities, and project management. Reasonable allowances have been provided for contingency and inflation.

Planned A.I.D. obligations by fiscal year are shown in Table B. The obligation plan is based on the implementation plan. Project grant funds to finance local currency expenses will be disbursed to and managed by the implementing agency, ZNFPC. Accounting and financial reports will be prepared by ZNFPC. The principal local currency expenses will be limited duration contracts of locally recruited people to supplement existing ZNFPC staff, materials printing costs, and training support costs. To ensure the best use of resources, the project includes the contract cost for a project manager.

Under the above scenario of bilateral and central funding, combined A.I.D. assistance devoted to Zimbabwe will increase slightly over past years. In 1989, $2.1 million was expended on Zimbabwe population activities. In contrast, the proposed project's average annual budget is $2.6 million. The project has a very favorable in-country to Cooperating Agency expenditure ratio. For every three dollars spent in Zimbabwe (including vehicles and commodities) one dollar will fund technical assistance of Cooperating Agencies. The project design shifts resources and expertise to where it counts -- to Zimbabwe - and in so doing improves efficiency by expending fewer resources on the overhead costs of technical assistance derived from cooperating agencies.

B. Host Country Contribution

The Government of Zimbabwe contribution to the project budget, primarily for staff salaries and operating cost, are shown in Table C. The high level of Government contributions to ZNFPC family planning activities (78% of total ZNFPC budget) assures that adequate host country funding will be available to finance proposed activities and to meet the host country contribution requirement of at least 25 percent of the total project cost. Other donor contributions will consist of UNFPA-donated contraceptive commodities, technical assistance and other support.

C. Recurrent Cost Analysis

The proposed project attempts to minimize expansion of recurrent cost requirements which would have to be assumed by Government when project assistance ends. In those areas in which new recurrent cost obligations are created, the project phases out A.I.D. assistance and phases in Government assistance over the life of the project.

Table A. Zimbabwe Family Planning Project
Projected A.I.D. Expenditures by
Source of Funds
(U.S. $000's)

	Central Funds	Bilateral Funds	Total
Method Diversification	$3,471	$6,478	$ 9,949
Private Sector	745	166	911
Coordination/Sustainability	205	300	505
Project Administration	1,500	-	1,500
Vehicles	-	1,200	1,200
Evaluation/Audit		210	210
Contingencies/Inflation	391	1,046	1,437
Total	$6,312	$9,400	$15,712

Table B: Zimbabwe Family Planning Project
Projection of Expenditures by Fiscal Year
(U.S. $000's)

	A. I. D. Central	A. I. D. Bilateral	Total	Host Country	Total
FY 90	1,268	1,626	2,894	717	3,611
FY 91	1,685	1,654	3,339	717	4,056
FY 92	1,296	1,583	2,879	951	3,830
FY 93	639	1,445	2,084	951	3,035
FY 94	639	1,398	2,037	951	2,988
FY 95	394	648	1,042	951	1,993
Inflation	323	656	979		979
Contingency	68	390	458		458
Total	6,312	9,400	15,712	5,238	20,950

Table C: Zimbabwe Family Planning Project
Summary Cost Estimate and Financial Plan
(U.S. $000's)

Item	TOTAL A. I. D. Fx	TOTAL A. I. D. Local	Host Country Fx	Host Country Local	Total
Diversification	$ 8,009	$1,940	$	$4,667	$14,616
Private Sector	911				911
Coordination/Sustainability	205	300			505
Project Administration	1,500				1,500
Vehicles	1,200				1,200
Evaluation/Audit	210		571		781
Contingencies/Inflation	1,437				1,437
Total	$13,472	$2,240	$ 571	$4,667	$20,950

ZIMBABWE FAMILY PLANNING PROJECT
NO. 613-0230

ILLUSTRATIVE FINANCIAL PLAN

(US$ 000's)

PROJECT ELEMENT	PLANNED FY 1991 OBLIGATIONS				PLANNED FY 1992 OBLIGATIONS				PLANNED FY 1993 OBLIGATIONS			
	A.I.D.	Grantee	Other (A.I.D/W)	Total	A.I.D.	Grantee	Other (A.I.D/W)	Total	A.I.D.	Grantee	Other (A.I.D/W)	Total
I Method Diversification	1,274	717	1,040	3,031	858	717	901	2,476	1,297	717	344	2,358
II Private Sector	-	-	320	320	45	-	70	115	54	-	20	74
III Coordination/Sustainability	80	-	75	155	80	234	75	389	50	234	25	309
IV Project Administration	-	-	250	250	-	-	250	250	-	-	250	250
V Vehicles	300	-	-	300	600	-	-	600	-	-	-	-
VI Evaluation/Audit	-	-	-	-	-	-	-	-	44	-	-	44
VII Contingency/Inflation	46	-	22	68	117	-	126	243	255	-	71	326
TOTAL	1,700	717	1,707	4,124	1,700	951	1,422	4,073	1,700	915	710	3,361

ZIMBABWE FAMILY PLANNING PROJECT
NO. 613-0230
ILLUSTRATIVE FINANCIAL PLAN

(US$ 000's)

PROJECT ELEMENT	PLANNED FY 1994 OBLIGATIONS				PLANNED FY 1995 OBLIGATIONS				T O T A L			
	A.I.D.	Grantee	Other (A.I.D/W)	Total	A.I.D.	Grantee	Other (A.I.D/W)	Total	A.I.D.	Grantee	Other (A.I.D/W)	Total
I Method Diversification	1,215	717	344	2,276	689	812	172	1,673	6,478	4,302	3,471	14,251
II Private Sector	67	-	20	87	-	-	35	35	166	-	745	911
III Coordination/Sustainability	50	234	25	309	50	139	5	184	300	936	205	1,441
IV Project Administration	-	-	250	250	-	-	250	250	-	-	1,500	1,500
V Vehicles	-	-	-	-	-	-	-	-	1,200	-	-	1,200
VI Evaluation/Audit	66	-	-	66	100	95	-	195	210	-	-	210
VII Contingency/Inflation	302	-	91	393	321	-	13	334	1,046	-	391	1,437
TOTAL	1,700	915	730	3,381	1,150	1,046	475	2,671	9,400	5,238	6,312	20,950

ZIMBABWE FAMILY PLANNING PROJECT

BUDGET JUSTIFICATION

	Centrally Funded	Bilateral Fx	Local	Total
1. DIVERSIFICATION OF METHODS				
A. Promotion				
Technical assistance: 8 person-months	160			160
4 person-months to adapt method-specific patient counselling materials				
1 person-month to design curriculum for CBD refresher training				
3 person-months for MOH seminars and related activities				
Commodities	75			75
Ink and paper for motivational materials			75	75
Printing costs for the above			385	385
CBD refresher training (80% of estimated costs) assumes 30 CBDs in Year 1, 60 in Year 2, 150 in Year 3, 160 in Year 4, and 170 each in Years 5 and 6. Estimate based on double current ZNFPC fees for a two week course, i.e. U.S.$650 per trainee				
Public sector workshops two day seminars for MOH and other public sector clinical personnel to improve their knowledge of, and attitudes towards, longer term methods seminars may be held for higher level managers as well assumes 50 seminars at $2,000 each			100	100
B. Training				
Technical assistance: 32 person-months	640			640
3 person-months to develop comprehensive project training plan				
3 person-months to revise Basic Course				
3 person-month to complete IUD course design and conduct initial courses				
2 person months for VSC training design				
4 person-months to develop training materials				
2 person-months to train ZNFPC trainers				
2 person-months to support trainee followup activities				
7 person-months for NORPLANT$_R$ training				
6 person-months for unforeseen needs				
Note: training CAs will meet early in Year 1 to review training priorities and establish a more complete plan of action				

ZIMBABWE FAMILY PLANNING PROJECT

BUDGET JUSTIFICATION

	Centrally Funded	Bilateral Fx	Bilateral Local	Total
Teaching equipment		20		20
Salaries for ZNFPC tutors Year 1, 36 person-months; Years 2-4, 72 person-months each; Year 5, 36 person-months; Year 6, none. Salaries figured at Z$1,800 per month.			224	224
Remodelling a small renovation allowance for training facilities, especially in Bulawayo; not to be used for significant new construction.			50	50
Other local costs $20,000 each for Years 2-6 for reproduction of course syllabi and take-home reference materials, preparation of slides and other graphics $18,000 each for Years 2-6 for trainee support (meals, lodging, transportation)			190	190
C. Service Delivery				
Technical assistance: 17 person-months 2 person-months to assess problems in clinic services and develop remedial strategy 4 person-months to strengthen supervision systems 4 person-months to establish ZNFPC clinics in MOH hospitals 4 person-months for sterilization services 3 person-months for IUD support	340			340
Support for NORPLANT$_R$ expansion $34,000 each for Years 3-6	136			136
VSC clinic equipment $15,000 each to upgrade 6 ZNFPC clinics for VSC	90			90
Clinic support funds for minor renovation and equipment purchase also, possible use for new ZNFPC clinics to be established within public sector hospitals	90		220	310

ZIMBABWE FAMILY PLANNING PROJECT

BUDGET JUSTIFICATION

	Centrally Funded	Bilateral Fx	Bilateral Local	Total
D. Evaluation and Research				
Technical assistance: 34.5 person-months	580	110		690
3 person-months to assess and recommend improvements in service statistics system				
1 person-month to develop training information system				
18 person-months (3 per year) for general purposes				
12.5 person-months for DHS (5 each in Years 4-5 and 2.5 in Year 6)				
Local consultants			90	90
12 person-months per year for individual studies				
costs estimated at U.S.$1,250 per month				
Acceptability study	225			225
Demographic and Health Survey			500	500
$100,000 in Years 4 and 6 and $300,000 in Year 5				
Miscellaneous study costs	18		36	54
$18,000 each in Years 1-3				
E. Contraceptives				
Oral contraceptives	512	4,408		4,920
see explanation in Technical Analysis				
NORPLANT$_R$	345			345
see explanation in Technical Analysis				
Technical assistance for logistics mananagement: 10 person-months	200			200
Family Planning Logistics Management Project to develop ZNFPC's capacity to make its own projections and procure its own commodities				
Computer support for logistics management	60			60
$15,000 for computer				
$10,000 for software				
$ 5,000 for maintenance				
$20,000 for staff training				
$10,000 for materials				
Other logistical support			70	70

ZIMBABWE FAMILY PLANNING PROJECT
BUDGET JUSTIFICATION

	Centrally Funded	Bilateral Fx	Bilateral Local	Total
II. PRIVATE SECTOR				
A. Social Marketing				
Technical assistance: 5 person-months	100			100
Contraceptives		166		166
See explanation in Technical Analysis				
Research and evaluation	20			20
B. Employer-provided Services				
Technical assistance: 2.75 person-months	55			55
Equipment	15			15
bicycles, blood pressure kits, and other standard paraphernalia for 50 privately-sponsored CBDs				
Research and evaluation	40			40
C. Private Physicians				
Pathfinder/Population Council sub-project, described in Section	400			400
D. Insurance				
Technical assistance: 2.75 person-months	55			55
Research and evaluation	20			20
E. Corporate Contributions				
Technical assistance: 2 person-months	40			40
III. COORDINATION/SUSTAINABILITY				
A. ZNFPC Coordination				
Equipment for private sector activities	5			5
fax and answering machine for the private sector coordinator				
ZNFPC private sector coordination staff			120	120
24 person-months each for Years 1-5				
salary estimated at U.S. $1,000 per month				

ZIMBABWE FAMILY PLANNING PROJECT

BUDGET JUSTIFICATION

	Centrally Funded	Bilateral Fx	Local	Total
Seminars and workshops an attempt to sell businesses on family planning and seek additional participation			80	80
B. Cost recovery studies costing of method-specific service delivery improved revenue management price elasticity analysis of training costs	200		100	300
C. Diversification of Contraceptive Sources				
V. OTHER				
A. Project Management budgeted at $250,000 per year	1,500			1,500
B. Evaluation and Audit includes $30,000 for special impact assessment described in Social Soundness Analysis		210		210
C. Vehicles 48 at an average cost of $25,000 estimate includes about $5,000 for spare parts for each vehicle at current prices, some but not all of these vehicles can be 4x4 the remainder one vehicle each for training followup, VSC services, private sector activities, and project management contribute to ZNFPC's much larger needs and are likely to be used both centrally and in provincial offices		1,200		1,200
D. Contingency calculated as 5% of all identified costs (before inflation) in Years 3-6	68	390		458
E. Inflation assumes 5% annual inflation on all items except contraceptives and contingencies	323	656		979
	6,312	7,160	2,240	15,712

The main recurrent cost supported by the project is the cost of contraceptive commodities. In the past, virtually all commodities have been provided by A.I.D. The project will support only oral contraceptives, as UNFPA and other donors will provide the balance of contraceptive requirements, as explained in Section 4.2.3.C of this document.

The promotion of longer term methods, the reduced reliance on pills, expansion of the role of the private sector, and application of user charges and other cost recovery measures are all measures which should over time reduce the government's per user cost of service delivery.

5. Project Implementation

5.1. Implementation Plan and Monitoring Responsibilities

A. Implementation and Monitoring

The key implementation activities for the life of the project are presented in Appendix II.C. Key areas of involvement of S&T/POP Cooperating Agencies in project implementation for the life of the project are set forth in Table II.E.4. An annual implementation plan will be developed by the project manager with the implementing agencies and principal cooperating agencies. The plan will be approved by USAID.

Project monitoring for bilateral activities and complementary centrally funded activities will be the responsibility of the project administrator under A.I.D. oversight. The project manager will monitor implementation progress against output targets, . ing quarterly reports, from the implementing agencies and cooperating agencies. The project administrator will also be expected to keep abreast of other donor activities and maintain a close liaison to ensure that all donors are cognizant of any problems that could jeopardize the achievement of project objectives.

B. Role of S&T/POP Cooperating Agencies

Table II.E.4 lists all Cooperating Agencies that will be involved in providing technical assistance. Since the proposed project will draw on the Cooperating Agencies, attention has been given to the planned project assistance completion dates of the respective cooperating agency projects. A review of the Cooperating Agency projects shows no problem in this area because:

- S&T/POP plans to continue these types of activities into the indefinite future.

- Six of the ten Cooperating Agencies are non-competitive procurements (POPTECH, Pathfinder, AVSC, JHPIEGO, JHU-PCS, and Population Council).

- For remaining activities, only the demographic and health survey (DHS) will require a buy-in extending past the PACD (1994) of the current contractor (Macro Systems). S&T/POP will have a follow-on DHS III project, and Zimbabwe's DHS would be completed by whatever organization has the follow-on DHS project. It is likely that the same contractor will carry out the follow-on project since no one competed for DHS II except the present incumbent.

As with other countries with bilateral population programs, S&T/POP may occasionally request approval for projects that are not directly related to the bilateral program and which address generic population issues, e.g. clinical field trials for new or modified contraceptives.

5.2. Methods of Implementation and Financing

This grant will be implemented using the standard operating procedures which have been established between the Government of Zimbabwe and the USAID for bilateral grant agreements. Specifically, the project will be obligated by a grant agreement signed by the Government of Zimbabwe and USAID. The grant agreement will authorize the USAID to negotiate and sign a specific support agreement with ZNFPC who will administer and implement the project. The balance of funds ($7.16 million) will remain under the control of the Government and will be committed and disbursed upon the mutual concurrence of USAID and the Government.

The grant will contain in Annex 1 a detailed project description which will provide 1) a comprehensive project narrative, 2) an overall project budget, 3) a project budget by implementing agent and 4) a project budget reflecting estimated expenditures by project year by implementing agency. Annex 1 will describe the responsibilities of all parties under the grant and will be supplemented by a project implementation letter which will amplify specifically how the project will be administered and implemented.

Project oversight will be provided by an implementing committee composed of participants from the Ministry of Health, ZNFPC, and USAID. This committee will be responsible for reviewing the grantee's (ZNFPC) annual workplan and budget and will provide policy guidance, as required, to the grantee. The committee will be responsible for establishing with the grantee and USAID, annual goals and objectives. The grant to ZNFPC will require that the grantee submit quarterly operational and financial status reports to the Government of Zimbabwe and USAID/Zimbabwe. In addition, an annual workplan will be submitted to all parties to the agreement at least 60 days prior to the end of each operating year. This workplan and budget will be reviewed by the implementing committee to ensure its consistency with the goals and objectives of this project as well as the policy guidance provided by the implementing committee.

The sub-grantee, using the approved workplan as amended by the quarterly reviews, will have complete authority and responsibility for implementing the project. Day to day operational decisions and implementation will be administered by the sub-grantee without further review by either USAID or the Government of Zimbabwe.

USAID/Zimbabwe will have responsibility for project management and financial accountability. Payments to the grantee and sub-grantee (ZNFPC and GOZ) will be by direct payment or reimbursement. These procedures are approved methods of financing. To the extent required, periodic advances will be provided to the grantee and sub-grantee in order to facilitate commodity procurement, training, or resource projects. Advances will be limited to the amount required for immediate disbursing needs in accordance with U.S. Treasury cash management guidelines.

USAID/Zimbabwe will be responsible for procurement of vehicles under the project using the RPSO/Tokyo. The Project officer will prepare the PIO/Cs with assistance as required from the Regional Commodity Management Officer to ensure that all specifications are in compliance with A.I.D. regulations and the grantees' needs. The PIO/Cs, after completion, will be forwarded to USAID/Zimbabwe EXO for contracting action.

The sub-grantee will be responsible for procuring all necessary locally available supplies and for leasing of all necessary equipment through competitive procurement procedures.

Funds for contraceptive procurement will be transferred from USAID/Zimbabwe to A.I.D./Washington for purchases made through A.I.D.'s central procurement contract.

Project management will be the responsibility of the grantee for the funds budgeted for ZNFPC. Project funds have been budgeted for remodelling of family planning facilities and clinics and for workshops. ZNFPC will arrange for bids to be obtained for all construction work and necessary procurement of supplies. All construction and procurement will be competed using approved A.I.D. procedures.

Funds budgeted for seminars/workshops and training will be sub-granted to ZNFPC who will handle all the logistical arrangement for such. Funds have also been budgeted for a demographic survey. These funds will be administered by ZNFPC under their sub-grant. The survey itself will be carried out by the CSO. ZNFPC will reimburse the CSO for all necessary costs of the survey.

5.3. Procurement Plan

5.3.1. Procurement Entities

Offshore procurement for the project will be undertaken by a variety of entities.

All of the vehicles will be purchased by the USAID Zimbabwe Executive Office through the U.S. Embassy Regional Procurement Services Office in Tokyo during the first three years of the project. PIO/C's for each year's vehicle requirements will be drafted by the assigned project Officer in the first quarter of each fiscal year. The Contraceptives and clinical equipment will be purchased by AID/W S&T/POP under centrally negotiated contracts. Drafting PIO/C's for these purchases will also be the responsibility of the assigned project officer. The data processing equipment, printer's ink and paper, the blood pressure apparatuses, the bicycles, some of the audio visual equipment and some of the training aids will be purchased by AID/W SER/OP utilizing GSA schedules. In addition, $100,000 will be made available to reimburse ZNFPC for small value purchases of commodities including some of the audio visual equipment and some of the training aids which are undertaken on the local market for direct support of Project activities.

5.3.2. Sources of Funding for Commodity Inputs

Centrally provided funds from S&T POP will be used to finance the purchase of equipment for six clinics to perform voluntary surgical contraception. An undetermined but smaller amount will be used to re-equip the general purpose ZNFPC clinics. Centrally provided funds have also been budgeted to equip new private sector CBD's and for data processing, audio visual and associated training equipment. Centrally provided funds will also finance 16.3% or $857,000 of the costs of contraceptives including all of the costs for NORPLANT. The remainder of the commodity inputs, including $4,408,000 worth of contraceptives will be funded by bilateral resources made available under the Project.

5.3.3 Commodity List/Budget

The Project will finance the importation of the below listed commodities. In addition $100,000 will be made available to reimburse ZNFPC for the purchase of various small value items on the local market. The following list is broken down by commodities which are planned for purchase in each year of Project implementation:

YEAR I

Item	Procurement entity	Prob source/origin	Budget
Vehicles:			
5 each 4X4 Utility Vehicles	USAID Thru RPSO Tokyo	Japan	$ 90,000
5 each 2X4 Pick Up trucks	USAID Thru RPSO Tokyo	Japan	$ 60,000
13 each 2X4 Sedans	USAID Thru RPSO Tokyo	Japan	$ 150,000
Contraceptives	AID/W S&T	U.S.	$1,145,000 *
Clinical Equipment	AID/W S&T	U.S.	$ 143,000
Blood Pressure Kits	AID/W SER/OP	U.S.	$ 5,000
Bicycles	AID/W SER/OP	U.S.	$ 16,000
Audio/visual Equipment	AID/W SER/OP	U.S.	$ 20,000
Ink and Paper	AID/W SER/OP	U.S.	$ 20,000
Local Purchases	ZNFPC	Zimbabwe	$ 50,000
Year 1 Commodity Budget.....			$1,699,000

YEAR II

Vehicles:			
6 each 4X4 Utility Vehicles	USAID Thru RPSO Tokyo	Japan	$ 120,000
12 each 2X4 Pick Up trucks	USAID Thru RPSO Tokyo	Japan	$ 180,000
4 each 2X4 Sedans	USAID Thru RPSO Tokyo	Japan	$ 105,000
Contraceptives	AID/W	U.S.	$1,255,000 *
Clinical Equipment	AID/W S&T	U.S.	$ 37,000
Data Processing Equipment	AID/W SER/OP	U.S.	30,000
Local Purchases	ZNFPC	Zimbabwe	$ 50,000
Year 2 Commodity Budget.....			$1,777,000

YEAR III

Item Budget	Procurement entity		Prob source/origin
Vehicles:			
4 each 4X4 Utility Vehicles	USAID Thru RPSO Tokyo	Japan	$ 80,000
5 each 2X4 Pick Up trucks	USAID Thru RPSO Tokyo	Japan	$ 70,000
12 each 2X4 Sedans	USAID Thru RPSO Tokyo	Japan	$ 150,000
Contraceptives	AID/W S&T	U.S.	$1,165,000 *
Audio/visual Equipment	AID/W SER/OP	U.S.	$ 20,000
Data Processing Equipment	AID/W SER/OP	U.S.	$ 20,000
Ink and Paper	AID/W SER/OP	U.S.	$ 20,000
Local Purchases	ZNFPC	Zimbabwe	$ 10,000
Year 3 Commodity Budget.....			$1,535,000

YEAR IV

Contraceptives	AID/W S&T	U.S.	$ 904,000 *
Local Purchases	ZNFPC	Zimbabwe	$ 10,000
Year 4 Commodity Budget			$ 914,000

YEAR V

Contraceptives	AID/W S&T	U.S.	$ 700,000 *
Year 5 Commodity Budget			$ 700,000

YEAR VI

Contraceptives	AID/W S&T	U.S.	$ 1,000 *
Year 6 Commodity Budget			$ 1,000

Total Estimated Cost of Commodities	$6,626,000
Contingency	$ 374,000
Total Commodity Budget for Project	$7,000,000

*For a detailed list of the types of contraceptives to be financed see Annex II.E - Tables II.E.1 and II.E.2. Over the life of the Project, A.I.D. will provide 30,137,234 cycles of oral contraceptives and 15,000 NORPLANT sets for use in the public and parastatal sectors.

5.3.4. Technical Assistance

Projected buy-ins to centrally contracted A.I.D. projects are listed in Appendix II.E These activities are described more fully in Section 4.2. The commodity and technical assistance inputs to be provided under the project, the project elements in which the inputs will be used, the probable source of each input and the entity responsible for purchasing the input are listed in Table D below:

TABLE D: ZIMBABWE FAMILY PLANNING PROJECT
PROCUREMENT REQUIREMENTS

Item	Purpose	Probable Source	Purchasing Entity
A. Commodities			
Oral Contraceptives	Public Sector Services	U.S.A.	A.I.D./W S&T
NORPLANT$_R$	Service Delivery	POP/Council	A.I.D./W S&T
Various Contraceptives	Social Marketing	SOMARC	
Paper and Ink	Promotional materials	U.S.A.	A.I.D./W SER/OP
B. Equipment			
48 vehicles	Service delivery; Private Sector; Training Followup; VSC; Project Management	U.S.A.	USAID/Z
Audio-visual and related equipment	Training	U.S.A./Local	A.I.D./W SER/OP
Clinical equipment	Sterilization and other services	U.S.A.	A.I.D./W S&T
Computer ment	Logistics Manage-	U.S.A.	A.I.D./W SER/OP
Blood pressure kits, bicycles	Private Sector CBDs	U.S.A.	A.I.D./W SER/OP
C. International Technical Services			
8 person-months	Promotion	PCS, Pathfinder	A.I.D./W
32 person-months	Training	AVSC, JHPIEGO,SEATS	A.I.D./W
17 person-months	Service Delivery	JHPIEGO, AVSC, SEATS	A.I.D./W
Technical support	NORPLANT$_R$ expansion	POP/Council	A.I.D./W
34.5 person months	Evaluation and research	SEATS, POP/ Council, Pathfinder Fund, Macro Systems	A.I.D./W USAID/Z
10 person-months	Logistics management	FPLM Project	A.I.D./W
6 person-months	Contraceptive social marketing	SOMARC	A.I.D./W
2.75 person-months	Insurance reim-bursement	SEATS	A.I.D./W

TABLE D: ZIMBABWE FAMILY PLANNING PROJECT
PROCUREMENT REQUIREMENTS
(continued)

Item	Purpose	Probable Source	Purchasing Entity
2 person-months	Corporate Contributions	POPTECH	A.I.D./W
5 person-months	Cost recovery studies	POP/Council	A.I.D./W
66 person-months	Project management	SEATS	A.I.D./W
Technical assistance	Evaluation	POPTECH	A.I.D./W
D. Other Services			
Printing	Promotional materials	Local	ZNFPC
Renovation	Training facilities	Local	ZNFPC
Renovation and other clinic development	Service delivery	Local	ZNFPC
Audit	Audit	Local	USAID/Z

5.3.5. Source/Origin

All bilateral funds made available under the project will come from the Development Fund for Africa (DFA). Therefore, the authorized source/origin for commodities and commodity related services is AID Geographic Code 935. However, in keeping with Africa Bureau guidelines regarding the implementation of projects funded under the DFA, all reasonable efforts will be made to source procurement from the United States. However, since no right hand drive U.S. made passenger vehicles can be services in Zimbabwe, the project vehicles will be purchased in AID Geographic Code 935 (Japan) under the world wide right hand vehicle waiver. All other commodities with the exception of approximately $100,000 in local cost financing, and all expatriate technical services funded by the project will be of U.S. source/origin.

5.4. Evaluation and Audit Plan

In addition to continuous monitoring of key indicators, two evaluations of the project are planned: a mid-term assessment in the second quarter of Fiscal Year 1993, and a final evaluation in the first quarter of Fiscal Year 1996.

The evaluations will assess progress in implementing the three project components and their impact on family planning use in Zimbabwe. The evaluations will draw upon service statistics collected by ZNFPC, ZNFPC reporting documents, the private sector, participating Cooperating Agencies, and interviews with representatives and field staff from ZNFPC, the Ministry of Health, and private sector organizations.

The final evaluation will also draw upon a third national demographic survey to be carried out in 1994. The survey will provide nationally representative data and, in combination with data from the 1988 ZDHS, will enable an assessment of changing knowledge, attitudes, and practices with regard to family planning. Of particular interest will be assessing the impact of the project on: (a) fertility levels; (b) overall contraceptive prevalence as well as use of long-term methods; and (c) increasing the role of the for-profit sector as a source of family planning services. The evaluations are in addition to monitoring of project implementation.

Implementation progress will be assessed in relation to output targets: number of personnel trained to deliver longer-term methods and applying new service provision and counseling skills; number of CBDs (both public and private) trained and applying skills to motivate demand for a wider range of contraceptive methods; distribution and use of IEC materials; number of clients served by ZNFPC clinics; number of employer-provided service programs operating; number of private physicians providing a wide range of family planning services; and number of beneficiaries reimbursed for family planning services by medical aid societies.

While the project's progress will be assessed each year, the first management review by USAID staff (to be scheduled at the end of Year 1) will be especially important. The management review will use the Logical Framework in Annex II.A to determine if the implementation of the project is on track. The results of the management review will then be used to determine if modifications in the design or implementation plans are warranted.

Non-federal audits (NFAs) will be provided under the regional indefinite quantity contracts managed by RIG/Nairobi or under a direct contract awarded by REDSO/ESA.

In Year 6 of the project, a Social Impact Evaluation will be undertaken. (See Annex III.E).

6. Project Analyses Summaries

6.1. Technical Analysis

Despite the achievements of the Zimbabwe Family Planning Program, significant constraints exist to further expanding access and increasing prevalence rates to a higher, sustainable level.

First, there is evidence of sizeable "unmet need" for family planning. Second, the current family planning program in Zimbabwe is heavily dependent on the oral contraceptive. Research over several decades has clearly demonstrated that the broader the range of methods that a program offers the more successful it will be in satisfying the needs of users, improving use-effectiveness, and increasing overall impact.

Shifting users to methods that are safer, more effective, and more appropriate will require significant program modifications. The challenge this shift poses is magnified by the large number of couples who will be seeking family planning services in the future. Over the period 1990-1995, the number of married women of reproductive age (MWRA) will increase by 20 percent. To meet the needs of these additional women and the expected increases in demand for modern methods of contraception (about 2 percent per year), family planning services must reach nearly 50 percent more users by 1995.

To achieve the project's target rate of 50 percent of MWRA using modern methods of family planning will require that the number of users increase by about 50 percent from an estimated 575,000 in 1990 to 880,000 by 1995. (See Annex III.A, Appendix 1, for Zimbabwe National Target-setting Model.) Is it feasible to expect such a dramatic expansion in only five years?

The results of the technical analysis indicate that it is feasible. The basic program infrastructure exists, but needs to be modified. The project must continue support to the ZNFPC and assist the organization in shifting its role towards technical support of other service delivery systems -- both private and public. The ZNFPC's own service delivery operations will continue, but will become a less important organizational function and will diminish with respect to other private and public sector sources for family planning services.

The private sector has a critical service provision which has only begun to be tapped. If the private sector increases its share of the total market from roughly 6 percent in 1990 (41,000 users) to 15-20 percent by 1985 (146,000 to 195,000), then the public and parastatal sectors need to expand their capacity to serve clients from about 648,000 in 1990 to somewhere between 781,000 and 830,000 by 1990. This represents an increased capacity to serve between 132,000 and 181,000 more clients by 1995 adding 22,000 to 30,000 per year. Assuming use of more effective, longer-term methods, the additional burden

would be partially offset by a changed, and presumably more cost-effective use of the public and parastatal sectors' resources. In sum, it is technically feasibly to achieve the purposes of the project, although doing so will require expert management of USAID's project resources and close collaboration with other population donors in Zimbabwe.

6.2. Administrative Analysis

The administrative analysis examined the Zimbabwean family planning system in terms of structure and process to identify how the proposed project would interact with the whole. A summary of the analysis is presented below. Charts E and F illustrate the discussion.

A. Family Planning Organizations

The top portion of chart E shows four major organizations, or groups of organizations, that support family planning in Zimbabwe. Two of these are governmental ministries, for Health (MOH), and for Local Government, Rural and Urban Development (MLGRUD). Under the umbrella of the Ministry of Health is the Zimbabwe National Family Planning Council (ZNFPC), the country's lead technical agency for family planning and, since 1982, the main recipient of USAID grant assistance. Finally, the private sector supports family planning through industrial employers, commercial farmers, medical aid societies (only CIMAS at the present time), and a social marketing program operated by Geddes Ltd.

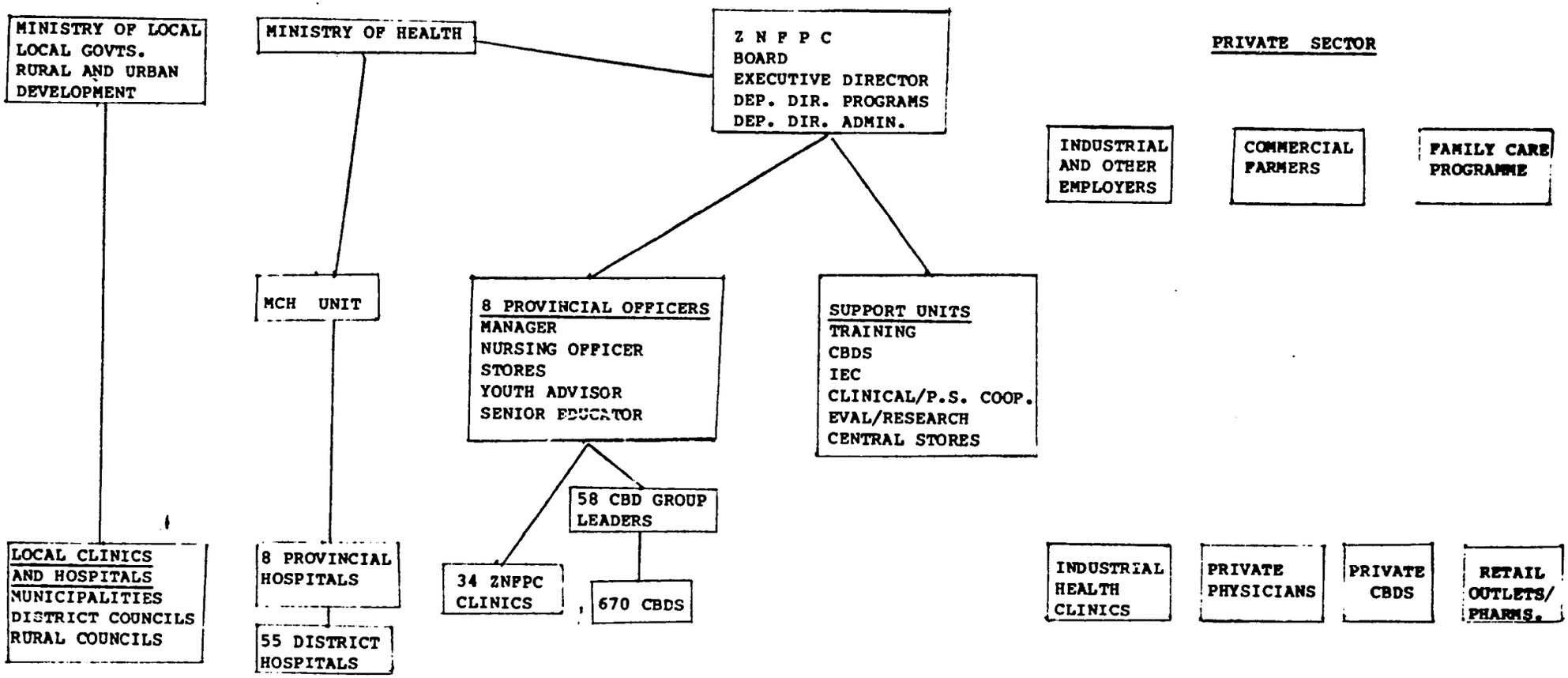
B. Family Planning Service Providers

All four of these groups provide family planning services, though the two public sector agencies account for the majority of users. (See bottom portion of chart E.) The Ministry of Health operates 8 provincial and 55 district hospitals, which together served 18.8% (111,000) of the user population in 1988. Most or all of these facilities provide family planning within the context of integrated maternal and child health care. The Ministry of Health's network also includes a number of church-sponsored facilities designated as district hospitals.

The Ministry of Local Government Rural and Urban Development oversees and partially finances municipal governments in Harare, Chitungwiza, and Bulawayo, as well as District and Rural Councils in more outlying areas. These local governments operate approximately 1100 health facilities, ranging from large hospitals to small one-person clinics, and approximately 150 of these provide a limited range of family planning services. In 1988, 18.0% (106,000) of users were served by Municipal and District clinics and 16.1% (95,000) by Rural Councils.

CHART E: ZIMBABWE FAMILY PLANNING PROGRAM

ORGANIZATIONS AND SERVICE PROVIDERS



The private sector provides health services through 161 industrial clinics, about 500 private physicians, and 22 employer-financed (but ZNFPC-supervised) CBDs. There are also a small number of church-affiliated health care providers outside the MOH network. In 1988, 3.7% of family planning users (22,000) relied on private physicians or pharmacies, 1.8% on missions or churches (11,000), and 0.5% (3,000) on industrial clinics (total 6.0%; 35,000).

C. Training

ZNFPC's main instrument for quality control is training, but it is not known how effective this is once trainees leave their courses. Almost all of those currently providing services in Zimbabwe were initially trained at one of the ZNFPC's two facilities (in Harare and Bulawayo), though recent years have seen a start to "second tier" training by MOH, municipal, and University of Zimbabwe tutors (also ZNFPC-trained). There should be greater efforts to expand both pre-service and in-service training (perhaps using ZNFPC clinic patients for practical work), but at the moment Training Unit staff have little information about whether the tutors they have trained are still using appropriate curricula or, indeed, whether they are teaching family planning at all. A better followup system is clearly needed. Chart F shows both the direct and indirect training services that ZNFPC provides to other agencies.

D. Referral Systems

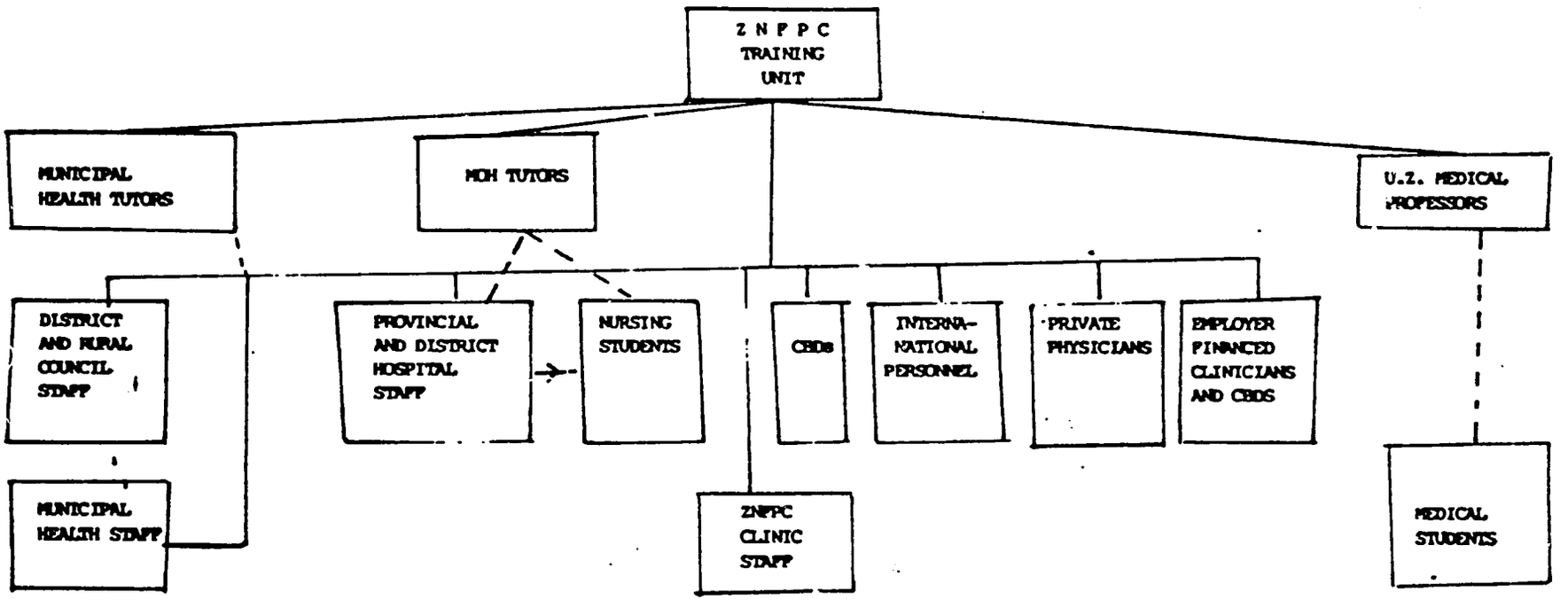
Given the limited number of sources for longer term methods in Zimbabwe, referral relationships among various providers are critical to expanded acceptance and use. Neither IUDs nor sterilization will be widely available for the foreseeable future, heightening the need for conscientious counselling and referral of appropriate clients to places where they are available. Provider knowledge and attitudes require strengthening in many cases, and those who are referred will require followup to ensure that they actually reach a service delivery point.

This project will help by reorienting CBDs and a limited number of public sector personnel and by giving them specific patient counselling skills.

6.3. Institutional Analysis

The institutional analysis examined the project's principal implementing agency, ZNFPC, to define its role and organizational capacity to implement project activities. The analysis also examined the sustainability of project-supported activities and ZNFPC's ability to properly manage A.I.D. funds. A summary of major findings follows.

Chart F: ZIMBABWE FAMILY PLANNING PROGRAM
TRAINING RELATIONS



DIRECT TRAINING

SECOND-TIER TRAINING

A. Role

Since its inception in 1957, the ZNFPC and its predecessors (the Family Planning Association of Rhodesia and the Zimbabwe Child Spacing and Fertility Association) have been the main inspiration and technical resource for Zimbabwean family planning as well (until the mid-1980s) as the major source of services and supplies. They have also played major roles in initiating and guiding public and private sector activities, initially through Ministry of Health facilities and more recently through private pharmacists, employers, and medical aid societies.

Widely recognized as one of the most effective organizations of its type in Africa, ZNFPC trains most family planning providers, promotes private sector activities, conducts media campaigns and routine IEC, and procures and stores virtually all contraceptives used in the country except for those sold through the private sector.

Serving 30 percent of the rural population, ZNFPC Community-Based Distributors (CBDs) motivate clients and supply pills and condoms. ZNFPC also operates 34 clinics, including nine clinics located within public sector facilities and five mobile units.

As a parastatal organization, ZNFPC collaborates closely with the Ministry of Health and with private employers and insurers. ZNFPC is a mature organization, with an over thirty year history of survival and growth under stress, and there can be little question of its ability to implement the broad lines of the proposed project.

B. ZNFPC Institutional Capacity

An important objective of the proposed project is to enhance ZNFPC's institutional capacity in the areas of training, clinic management, private sector support, and evaluation and research. This will be done by providing technical assistance, vehicles and equipment, and in several cases, by increasing staff. Although these measures are constrained by budget limitations and sustainability concerns, the analysis suggests that they are adequate for the purposes outlined. ZNFPC may, nevertheless, have difficulty in accommodating the 8 new staff envisioned both because of hiring freezes and because of scarce accommodation. This problem will need to be addressed in ongoing discussions with ZNFPC management.

C. Sustainability

There are a number of serious threats to the viability of family planning activities in Zimbabwe, and not all could be addressed in the project design. Concerted efforts, jointly planned with the Ministry of Health, ZNFPC, and other donors will need to continue throughout the life of the

project to ensure that USAID-supported activities continue after project termination. Sustainability concerns and the project design responses are briefly summarized below:

(1) The significant recurrent cost implications of the multiple donor-financed activities now planned: The private sector initiative will be critical to reducing the government cost burden for family planning financing and service delivery over time. Also, the project supports operations research to identify the most cost-effective means to deliver program services. In addition, studies planned for the introduction of cost recovery measures will assist in mitigating costs over time. Finally, the project encourages local contraceptive production, which if successful will reduce demands on scarce foreign exchange and dependence on external sources.

(2) The possibility of stagnant or declining government financing (in real terms) at a time when family planning acceptance rates must rise: Government support has not proven to be a concern in Zimbabwe to date. Continued dialogue with government to reinforce the benefits of a sustainable family planning program to the economy as a whole should be continued by the project manager. Also, the project will stimulate and support the coordination of corporate contributions to family planning.

(3) The relatively high costs of certain core ZNFPC activities not included in the project design: The project supports initial efforts to increase cost recovery through improved collection of user charges, a price elasticity study, and above-cost fees for international trainees. The studies will contribute to a better understanding of costs and their rationalization.

(4) The possible loss of political support if decision-makers mistakenly think that AIDS reduces the need for family planning: The project includes AIDS awareness and referral in new and refresher training for all cadres.

(5) Government restrictions on cost recovery in the public sector: The policies are flexible and project studies and analysis will assist with further clarification of appropriate procedures and their understanding at all levels.

(6) The program's dependence on a single contraceptive method at a time when user needs are changing: Project resources will be directed towards diversifying family planning methods and reducing dependence on the pill, further strengthening the project should support for pills weaken.

(7) Possible disruptions caused by changes in contraceptive suppliers: The project requires only gradual changes in contraceptive sourcing to minimize complications from brand changes. Project monitoring will be particularly sensitive to this concern and should identify early in the program if contraceptive changes are occuring and their impact. The project has the resources to respond appropriately.

The best response to all of the potential problems cited above is strong project management and monitoring and attention to sustainability as an important project objective. Recognition of sustainability factors was pervasive in the thinking of project planners and in their strong efforts to coordinate with the World Bank, the UNFPA, the GTZ and other donors.

The project design has budgeted resources for technical assistance on sustainability-related problems wherever they could be identified and addressed at the time of project development.

6.4. Financial Analysis

The financial analysis examined projected expenditures by A.I.D./Washington, USAID/Zimbabwe, and the Government of Zimbabwe and found all to be reasonable. Particular attention was given to the recurrent costs of contraceptive supplies and ZNFPC salaries and provision made for government assumptions of these costs by year 6. The government's contribution to total costs over the life of the project has been conservatively estimated at 25%.

To further promote financial sustainability, the project funds detailed cost analyses and several studies to set service prices and enhance cost recovery. The project also transfers significant recurrent costs to private individuals and employers, through both direct service provision and third part insurance.

6.5. Social Soundness and WID Analyses

The project design was reviewed and found to be socially sound and responsive to gender concerns. A summary of major findings and their influence on project design is presented below.

A. Sociocultural Context

A family planning intervention is socially and culturally acceptable. Approximately 36 percent of married Zimbabwean women already use a modern contraceptive method, indicating high acceptbility. Economic constraints for vast majority of households encourage receptivity to space and limit the number of children. The relatively low infant and child mortality rates have a reinforcing influence on acceptability.

B. Sociocultural Feasibility

The analysis examined gender "norms" or ideals, which define social expectations and values related to being male or female. It was found that such norms still favor relatively large families, virginity at the time of marriage, male control over decisions affecting the family, taboos on

associated discussion about sex between husbands and wives, and proof of virility and fertility. A number of gender concerns have been considered in project design and implementation plans:

(1) Men play a critical role in deciding whether or not a woman uses contraception, particularly a clinical method such as IUD and sterilization. Therefore, some of the IEC materials on method mix will be geared particularly for men. The materials will provide adequate information about the probability of side effects and reliability. In addition, under private sector activities, men will be reached through male motivators.

(2) Because of women's preference for treatment by female nurses and doctors, female doctors will be given preference for training in female sterilization. All of the ZNFPC tutors and clinical staff who will receive training are female.

(3) Discussion of sex is not socially condoned, since it is considered a private matter. This coupled with the fact that interviewees are likely to give responses which they think the interviewer wants limits the reliability of data collected in one-time surveys through structured questionnaires. To address these considerations, the project will use interview guides and probe questions in all of its studies.

(4) The project will improve the mix of contraceptives used and focus on longer term methods. Since the longer term methods are suitable for women who want to cease childbearing, special attention will be given in CBD training and IEC materials to the common concept that women over age 35 are too old to be concerned about family planning.

(5) Since longer term methods are particularly desirable for many women, in cost recovery studies will be given attention to: (a) the client's total financial cost associated with receipt of services, (b) the effect of having to pay a relatively large sum at one point in time in comparison to the small amounts spent periodically on pills, and (c) the appropriateness of basing the fee structure upon whether the woman or the husband receives the minimum wage, on the assumption that the woman has access to the man's income or has her own independent funds.

C. Participation

The project development effort involved the managers of the ZNFPC at both the identification and intensive review stages. Their suggestions and recommendations are reflected in project design. In addition, key persons in the for-profit sector were consulted. Finally, the project includes support for strengthening ZNFPC Private Sector Coordination activities to further involve employers, health insurance schemes, and doctors in family planning.

Available studies have documented the views of potential family planning users and have been factored into project design. In regard to implementation, the project includes operations research, monitoring, and a midterm evaluation which will provide feedback from potential users or their partners. This information will be used to guide implementation.

D. Beneficiaries and Social Consequences

Approximately 930 family planning-related service personnel, of whom at least 85 percent will be women, will receive training. One category will be the 737 Community Based Distributors and male motivators, who work at the local level. Second, private sector employer-based health personnel will receive training in counseling and provision of family planning services. Third, training in clinical family planning methods will be given to approximately 19 ZNFPC tutors who will then train Ministry of Health tutors and 127 ZNFPC clinic staff.

Thousands of women and men reached by those trained under the project, by project-funded commodities, and by other project activities will derive benefits from the project. People within all sections of the country and both urban and rural dwellers are expected to benefit from improved availability and access to family planning services.

E. Impact

The project is expected to have a positive impact on a large number of Zimbabwe families, but especially women. By enabling couples to have the number of children they desire and to space children as they desire, the activities should result in healthier childbearing and healthier children. Second, the quality of childrearing should be enhanced as mothers devote more resources to nurturing and educating each child. Third, control over their fertility will enable women to pursue educational and non-household work opportunities. As part of the project final evaluation, a special study will assess the extent to which this impact is occurring.

6.6. Economic Analysis

Numerous economic benefits are associated with averting unwanted births and postponing mistimed births. Some, such as recurrent education costs, are more easily measured; others, such as reduced medical costs attributed to high-risk births (e.g., high-parity and closely-spaced births) are more difficult to quantify. Some, such as school fees, are measured at the family level; others, such as recurrent health care costs, are measured at the national level.

The cost-benefit analysis undertaken for this paper compares the costs of expanding Zimbabwe's family planning program with the savings associated with reduced government expenditures in the education (owing to reduced numbers of school-age children) and health (owing to reduced numbers of maternal and child clients) sectors. The analysis begins in 1985. The marginal program costs of a moderate decline are $4 million in 1990, increase to $15 million by 1995 and to $23 million by 2000. Combined savings from the education and health sectors are $2 million in 1990, increase to $18 million by 1995 and to $74 million by 2000. Thus, the "break-even" point, where annual savings equal annual costs, occurs in 1991 and the "pay-back" point, where cumulative savings begin to exceed cumulative costs, occurs in 1993. The internal rate of return on the investment in family planning considered here is 56 percent. This means that one would have to discount future benefits by well over 50 percent annually for the investment in family planning programs not to be cost-beneficial. Hence, the benefit-to-cost ratio for family planning in Zimbabwe is extremely favorable.

ANNEX I.A

Telegrams: "MINFIN", HARARE
Telex: 2141
Telephone: 722181/794571

Private Bag 7705, Causeway
Zimbabwe

ZIMBABWE

Reference: A/28/75
9AE 337

MINISTRY OF FINANCE, ECONOMIC
PLANNING AND DEVELOPMENT
Munhumutapa Building
Samora Machel Avenue
Harare

27 August 1990

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Mrs A.B. Herrick
The Director
USAID/Zimbabwe
1 Pascoe Avenue
Belgravia
Harare

AUG 28 1990

Dear Mrs Herrick

RE: REQUEST FOR SUPPORT TO ZIMBABWE FAMILY PLANNING PROJECT

The Ministry of Health has been receiving USAID support for Family Planning Programmes under Zimbabwe National Family Planning Council (ZNFPC) since 1982. The grant which amounted to US$6,5 million played a vital role by providing important resources to the programme during its early stage.

The purpose of this second phase is to expand access to and use of a wider selection of Family Planning methods delivery in an efficient and cost-effective manner that includes an expanded role for the private sector. The project is estimated at US$15 million over a period of five years (1990 - 1995).

I hereby, on behalf of the Government of Zimbabwe, formally request the Government of the United States of America, through you, to support this project.

I hope this request will meet your favourable consideration.

Yours sincerely

O.M. Matshalaga
for: SENIOR SECRETARY FOR FINANCE
ECONOMIC PLANNING AND DEVELOPMENT

11

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E.O. 12356: N/A
TAGS:
SUBJECT: ZIMBABWE FAMILY PLANNING (613-0230)

ECPR CHAIRED BY AFR/PD DIRECTOR TIMOTHY J. BORK, MET ON APRIL 20, 1990 TO REVIEW THE PID FOR SUBJECT PROJECT. REPRESENTATIVES OF AFR/PD/SA, AFR/TR/HPN, S AND T/POP, PPC/PDPR. GC/AFR, AND AFR/SA ATTENDED. THE PID WAS APPROVED FOR FURTHER DEVELOPMENT SUBJECT TO GUIDANCE TO FOLLOW SEPTEL. AFR/PD CONGRATULATES MISSION ON EXCELLENT PID. MISSION DIRECTOR AUTHORITY TO APPROVE THE PROJECT PAPER AND AUTHORIZE LOF FUNDING UP TO DOLS 20 MILLION PER DOA 551 IS CONFIRMED. KIMMIT
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AAPF-01 SEOP-01 SEOS-02 FMAD-02 FM-01 SERP-01 SECS-02
MHS-09 AMAD-01 SEPS-03 FMAD-01 /071 A0 17/1558Z

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APPROVED BY: AID/AFR/PD:TBORK
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AID/ST/POP:DGILLESPIE (DRAFT) AID/GC/AFR:MAKLEINJAN
AID/AFR/TR/HPN:JCOURY (DRAFT) AID/PPC/PDPR/SP:THORRIS (DRAFT)
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AIDAC NAIROBI FOR REDSO/ESA; MBABANE FOR RLA

E.O. 12356: N/A
TAGS:
SUBJECT: ZIMBABWE FAMILY PLANNING (613-0238): PID ECPR GUIDANCE CABLE

1. AN EXECUTIVE COMMITTEE PROJECT REVIEW OF THE SUBJECT PID WAS HELD ON FRIDAY 20 APRIL. THE REVIEW WAS CHAIRED BY THE DIRECTOR, AFR/PD, AND WAS ATTENDED BY REPRESENTATIVES OF S AND T/POP, AFR/TR/HPN, AFR/SA, PPC/PDPR/SP, AFR/PD/SA AND GC/AFR. THE PID WAS APPROVED FOR FURTHER DEVELOPMENT, SUBJECT TO THE GUIDANCE BELOW.

2. GENERAL: THE PROJECT COMMITTEE WAS PLEASED WITH THE PID'S OPEN AND FORTHRIGHT TREATMENT OF THE CONSTRAINTS WHICH EXIST TO ACHIEVING THE PROJECT OBJECTIVES. THE ECPR UNDERSCORED THREE INTER-RELATED. DESIGN CONCERNS, WHICH THE PID TEAM FORMULATED. BRIEFLY, THESE CONCERNS ARE: A) WHETHER ADEQUATE FUNDING IS AVAILABLE TO ACHIEVE THE PROJECT OBJECTIVES, GIVEN THE HEAVY DEMAND FOR CONTRACEPTIVE COMMODITIES; B) WHETHER OTHER DONORS WILL COMMIT FROM THEIR FUNDS A SUFFICIENT PERCENTAGE OF THE COSTS OF CONTRACEPTIVE COMMODITIES; C) WHETHER THE REQUIREMENTS FOR PROJECT MANAGEMENT ARE ADEQUATE, GIVEN THE PLANNED NEW DIRECTIONS AND THE ADMITTED COMPLEXITY OF THE PROJECT.

3. ISSUE ONE: CAN THE PROPOSED PROJECT'S LDP BE ABSORBED WITHIN THE MISSION.S APPROVED OYB LEVEL?

DISCUSSION: WITH REGARD TO THE A.I.D. BILATERAL PROGRAM IN ZIMBABWE, THE OPERATING ASSUMPTION, BASED ON CONSULTATIONS BETWEEN MISSION DIRECTOR HERRICK AND DAA/AFR SAIERS IN OCTOBER 1989 AND CONFIRMED WITH THE PID SUBMISSION, IS THAT A REORIENTATION OF THAT PROGRAM HAS BEGUN. EVEN BEFORE THE PRESENT PROPOSAL WAS CONCEIVED, ALL PARTIES WERE IN AGREEMENT THAT ABOUT $2.5 MILLION ANNUALLY OF THE OYB WOULD BE PROGRAMMED FOR FAMILY PLANNING ACTIVITIES.

GUIDANCE: AID/W CONFIRMS AND ENDORSES THE MISSION DECISION TO FOCUS ON THE POPULATION SECTOR. IN THIS SENSE, OBLIGATING MUCH OF THE OYB TO THIS SECTOR, AS

PROPOSED, IS APPROPRIATE. THE PROJECT COMMITTEE FOUND THE PROPOSAL WELL REASONED AND TECHNICALLY FEASIBLE. AS PRESENTED IN THE PID, THE PROPOSED ACTIVITIES CAN BE ABSORBED WITHIN THE FINANCIAL LIMITATIONS OF THE MISSION'S OYB. ON THE OTHER HAND, IF FINANCING BECOMES CONSTRAINED BECAUSE OF THE NEED TO FUND A LARGER PORTION OF REQUIRED COMMODITIES, THE MISSION SHOULD EXPLORE OPPORTUNITIES DURING THE DESIGN PHASE TO FOCUS THE PROJECT ACTIVITIES; I.E., SOME SCALING BACK MAY BE NECESSARY. AT A MINIMUM, THE PP SHOULD PRIORITIZE ACTIVITIES AND IDENTIFY THOSE WHICH WOULD BECOME OF LESS STRATEGIC IMPORTANCE SHOULD FUNDING BECOME CONSTRAINED.

IN CONJUNCTION WITH THE POINT ABOUT THE ADEQUACY OF FUNDING RESOURCES, THE PID CORRECTLY DRAWS ATTENTION TO THE IMPORTANCE OF OBTAINING FIRM ASSURANCES OF FINANCING OF CONTRACEPTIVE COMMODITIES FROM OTHER DONORS. IN ORDER TO ACHIEVE A BROADER BASE OF SOURCES FOR COMMODITY SUPPLY, AND ALSO TO ENSURE THAT ESSENTIAL COMMODITIES WILL BE AVAILABLE ON A TIMELY BASIS, THE MISSION SHOULD REQUIRE THAT WRITTEN, MULTI-YEAR COMMITMENTS FOR CONTRACEPTIVE SUPPLY WITH COLLABORATING DONORS BE IN PLACE PRIOR TO PROJECT OBLIGATION.

4. ISSUE TWO: APROPOS PROJECT MANAGEMENT, WHAT ARRANGEMENTS MAKE THE MOST SENSE TO HELP ACHIEVE PROJECT OBJECTIVES?

DISCUSSION: THE ECPR TOOK NOTE OF THE FACT THAT ACCORDING TO BUREAU MANAGEMENT DECISIONS THERE ARE NO NEW POSITIONS APPROVED AT PRESENT FOR THE MISSION IN ZIMBABWE. NOR ARE THERE LIKELY TO BE ANY IN THE FORESEEABLE FUTURE. IF THE ISSUE IS ONE OF TECHNICAL COMPETENCE AND EXPERIENCE IN FAMILY PLANNING, AND IT APPEARS FROM THE PID THIS IT IS, THEN THE PROJECT COULD PROBABLY DO WELL BY A CONTRACTOR. IF THE ISSUE IS BROADER AND INCLUDES A ROLE OF DONOR COORDINATION AND REPRESENTING A.I.D. POLICY IN CONTACTS AND NEGOTIATIONS WITH OTHER DONORS, THE PRIVATE SECTOR AND THE GOVERNMENT, THEN CLEARLY A USDH OR SOMEONE WITH SIGNIFICANT USDH EXPERIENCE IS PREFERABLE.

GUIDANCE: -IT IS THE SENSE OF THE ECPR THAT IF A POSITION FOR A USDH IS NOT AVAILABLE IN THE SHORT RUN, THEN A FORMER A.I.D. POPULATION OFFICER HIRED AS A PSC IS SUFFICIENT PROVIDED THE OFFICER HAS A STRONG RECORD OF RELEVENT EXPERIENCE, TECHNICAL SKILLS AND FAMILIARIZATION WITH A.I.D. POLICY. OVER THE LONGER TERM, AND REFLECTIVE OF THE OVERALL SHIFT IN THE PORTFOLIO TO THE POPULATION SECTOR, MISSION SHOULD CONSIDER CONVERTING A USDH POSITION TO SUPERVISE THIS IMPORTANT PROGRAM.

UNDER HANDBOOK 14 (AIDAR), APPENDIX D, SECTION 4 (2) (I), PSC'S MAY NOT NEGOTIATE ON BEHALF OF THE USG WITH FOREIGN GOVERNMENTS OR INTERNATIONAL ORGANIZATIONS. DEPENDING UPON THE NATURE OF POLICY-RELATED WORK, THIS COULD POSSIBLY AFFECT A SMALL PART OF WHAT A PSC COULD DO. HOWEVER, IF THIS BECAME A CONCERN, THE MISSION SHOULD BE AWARE THAT A FEW DEVIATIONS HAVE BEEN APPROVED RECENTLY, WAIVING ONE OR MORE OF THE SECTION 4 (3) (I) RESTRICTIONS ON PSC ACTIVITIES.

5. ISSUE THREE: WHAT, IF ANY, SHOULD BE THE ROLE OF THIS FAMILY PLANNING PROJECT IN HELPING TO MEET AIDS PREVENTION NEEDS IN ZIMBABWE

GUIDANCE: AS PART OF ITS NORMAL PROGRAM PLANNING PROCESS, THE MISSION SHOULD SEEK TO FURTHER THE DATA COLLECTION AND ANALYSIS ACTIVITIES ON AIDS AS

SB

APPROPRIATE. IN THE MEANTIME, A HEIGHTENED RECOGNITION OF THE ISSUE OF AIDS PREVENTION COULD BE INCLUDED IN CERTAIN PROJECT ACTIVITIES WHERE IT CAN BE DONE WITHIN PROPOSED LEVELS OF EFFORT. FOR EXAMPLE, FAMILY PLANNING

WORKERS DUE TO BE PERFORMING SERVICES UNDER A.I.D. PROJECT FINANCING, COULD RECEIVE INFORMATION ABOUT AIDS AND OTHER STD IN CONJUNCTION WITH REGULARLY SCHEDULED PROJECT TRAINING ACTIVITIES.

6. ISSUE FOUR: WHAT CAN THE PROJECT REALISTICALLY EXPECT TO ACCOMPLISH IN THE AREA OF COST RECOVERY

GUIDANCE: AS PART OF THE EFFORT TO GET A BETTER HANDLE ON COST RECOVERY, THE PROJECT SHOULD INCLUDE AN OPERATIONS RESEARCH ACTIVITY, TO BE INITIATED EARLY ON IN THE LIFE-OF-THE-PROJECT. ACTIVITIES TO INITIATE AND TEST COST RECOVERY SCHEMES SHOULD BE INTRODUCED AND SUPPORTED.

7. CONCERNS:

A. ARRANGEMENTS FOR TECHNICAL ASSISTANCE: IF BUY-INS TO EXISTING CENTRALLY-LOCATED COOPERATIVE AGREEMENTS OR CONTRACTS IS ENVISAGED, PROJECT DESIGN MUST TAKE INTO CONSIDERATION BOTH (1) THE PACD OF THAT SOURCE OF SERVICES AND (2) THE EXISTING BUY-IN/CONTRACT CEILING. AND OBTAIN A WRITTEN COMMITMENT FROM S AND T/POP TO RESERVE CEILING FOR THIS PROJECT'S BUY-INS. ON THE OTHER HAND, GIVEN THE LEVEL OF RESOURCES AND EFFORT THAT THE MISSION IS PLANNING TO DEVOTE TO THIS PROJECT, IT MAY WANT TO HAVE A DIRECT RELATIONSHIP WITH CONTRACTORS OVER THE LIFE OF THE PROJECT. IT MAY BE PREFERABLE FOR THE MISSION TO CARRY OUT ITS OWN CONTRACTING. CONTRACT MANAGEMENT WOULD BE ALOT MORE DIRECT. MORE ZIMBABWE INVOLVEMENT WOULD BE POSSIBLE, AND COSTS COULD/WOULD BE LESS PER UNIT OF ASSISTANCE.

B. TECHNICAL ASSISTANCE: FOR REASONS OF PROGRAM DEVELOPMENT AND SUSTAINABILITY AS WELL AS FOR PRACTICAL CONSIDERATIONS OF COST, THE AFRICA BUREAU IS CONCERNED ABOUT THE PROPORTION OF A.I.D. RESOURCES WHICH IN A PROJECT ARE DIRECTED TOWARDS LONG-TERM, RESIDENT TECHNICAL ASSISTANCE. THE BUREAU IS CONCERNED ABOUT PUTTING AN EVENTUAL MANAGEMENT AND COST BURDEN ON THE HOST GOVERNMENT DUE TO A.I.D.'S ASSUMPTION THAT THE PROJECT.S ACTIVITIES WILL BE INTEGRATED INTO THE NATIONAL PROGRAM. THE MISSION SHOULD LOOK FOR AND SEIZE OPPORTUNITIES FOR THE HOST GOVERNMENT TO ABSORB THE COSTS OF TECHNICAL ASSISTANCE.

C. PARTICIPATION OF WOMEN IN THE PLANNING/DESIGN PHASE OF THE PROPOSED PROJECT, IN THE IMPLEMENTATION PHASE, AND AS BENEFICIARIES: THE AFRICA BUREAU WOULD LIKE TO SEE POSITIVE INITIATIVES TAKEN TO INCLUDE QUALIFIED WOMEN AT EVERY LEVEL OF THE PROJECT. PARTICULAR ATTENTION SHOULD BE GIVEN TO WOMEN MANAGERS.

D. GRAY AMENDMENT: BASED ON CONTRACT ACTIONS WHICH ARE IDENTIFIED IN THE DEVELOPMENT OF THE PROJECT PAPER, THE MISSION SHOULD LOOK FOR OPPORTUNITIES TO CONTRACT WITH WOMEN AND MINORITY-OWNED FIRMS. THIS APPLIES TO DIRECT CONTRACTING AS WELL AS TO THE BUY-IN OPTION. ADDITIONALLY, THE REQUIREMENTS OF AIDAR NOTICE 90-2, IMPLEMENTING SECTION 579 OF THE FOREIGN ASSISTANCE APPROPRIATIONS ACT, REQUIRING THAT 10 PERCENT OF THE DOLLAR VALUE OF ALL A.I.D. DIRECT T.A. CONTRACTS BE SUBCONTRACTED TO GRAY AMENDMENT ENTITIES, UNLESS THE CONTRACTING OFFICER CERTIFIES THAT THERE IS NO REALISTIC EXPECTATION OF U.S. SUBCONTRACTING OPPORTUNITIES. OR

UNLESS THE ADMINISTRATOR APPROVES AN EXCEPTION, APPLIES TO BUY-INS AS WELL AS PROJECT SPECIFIC CONTRACTS.

8. UPON AUTHORIZATION OF THE PROJECT, AFR/PD REMINDS THE MISSION OF THE REQUIREMENT THAT A DULY EXECUTED COPY OF THE PP BE FORWARDED TO AID/W WITHIN 2 WEEKS OF THAT ACTION. THAT PACKAGE MUST INCLUDE (1) THE ISSUES PAPER OF THE ECPR LEVEL REVIEW, (2) THE ACTION MEMORANDUM. (3) THE AUTHORIZATION AND (4) THE COMPLETE PROJECT PAPER (INCLUDING ALL ANNEXES).

9. IEE. THE BUREAU ENVIRONMENTAL OFFICER HAS CONCURRED WITH AND GC/AFR HAS CLEARED THE RECOMMENDATION OF THE IEE. EAGLEBURGER

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5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1990 Appropriations Act Sec. 569(b). Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? — No.

2. FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b). (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs — N/A.

are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government): (a) Does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? and (b) Has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (2) the vital national interests of the United States require the provision of such assistance?

3. 1986 Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to N/A.

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Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. FAA Sec. 620(c). If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity? No.

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No.

6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

No.

7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?

No.

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC?

Yes.
N

Negotiation underway.

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

No.

10. FAA Sec. 620(q); FY 1990 Appropriations Act Sec. 513 (Brooke Amendment). (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

No.

No.

11. FAA Sec. 620(s). If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

N/A.

12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

Zimbabwe's UN obligations are fully paid

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? No.

15. FY 1990 Appropriations Act Sec. 564. Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? No.

16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? No.

17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? No.

18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) No. No.

19.	FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device?	No.
20.	ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)	N/A. While reported to haee failed to to disassociate itself from the communique, this was taken into consideration by the Administrator at the time of approval of the Agency OYB.
21.	FY 1990 Appropriations Act Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?	No.
22.	FY 1990 Appropriations Act Sec. 539. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?	No.

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B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? — No.

b. FY 1990 Appropriations Act Sec. 535. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? — No.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest? — No.

b. FY 1990 Appropriations Act Sec. 569(d). Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking? — Yes.

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5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? — Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? — Yes. Congress has been properly notifie

2. FAA Sec. 611(a). Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? — Yes.

3. FAA Sec. 611(a)(2). If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? — N/A.

4. FAA Sec. 611(b); FY 1990 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	N/A.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?	
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	No. The project will support some regional training.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	The project will encourage greater efficiency through increased private sector responsibility for delivery of family planning services.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	U.S. firms will be providing oral contraceptives.

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	The Financial Tables indicate Host country contribution and will form part of the agreement
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	N/A.
11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	N/A.
12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?	No.
13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other	N/A.

wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A.

15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A.

16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? N/A.

17. FY 1990 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? N/A.

18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

This requirement will be met.

19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate?

N/A.

20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Yes.

21. FY 1990 Appropriations Act Sec. 592(a). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

N/A.

Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? N/A.

Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes? N/A.

If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1980 Appropriations Act Sec. 546 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers? — N/A.

b. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? — N/A.

c. FAA Sec. 281(b). Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government. — The project will strengthen national capacity to deliver family planning services through local institutions.

d. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes.

e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries.

The project will directly benefit women and improve their economic potial.

f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used?

Yes.

g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for

N/A.

use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?

h. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? — N/A.

i. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? — Yes.

j. FAA Sec. 123(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? — Yes.

k. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. — The project will support institutional development of the Zimbabwe National Family Planning Counci

l. FY 1990 Appropriations Act, under heading "Population, DA," and Sec. 535. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? — No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	No.
Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	No.
Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?	Yes.
In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?	No
Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No.
m. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes.
n. FY 1990 Appropriations Act Sec. 579. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and	No.

private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

o. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a

Yes.

condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; and (11)/utilize the resources and abilities of all relevant U.S. government agencies?

p. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project: (1) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (2)/take full account of the environmental impacts of the proposed activities on biological diversity? N/A.

q. FAA Sec. 118(c)(14). Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? No.

r. FAA Sec. 118(c)(15). Will assistance be used for: (1) activities which would result in the conversion of forest lands to the rearing of livestock; (2) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (3) the No.(1)(2)(3)(4)

colonization of forest lands; or (4) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

s. FY 1990 Appropriations Act Sec. 534(a). If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? N/A.

t. FY 1990 Appropriations Act Sec. 534(b). If assistance relates to energy, will such assistance focus on improved energy efficiency, increased use of renewable energy resources, and national energy plans (such as least-cost energy plans) which include investment in end-use efficiency and renewable energy resources? N/A.

Describe and give conclusions as to how such assistance will: (1) increase the energy expertise of A.I.D. staff, (2) help to develop analyses of energy-sector actions to minimize emissions of greenhouse gases at least cost, (3) develop energy-sector plans that employ end-use analysis and other techniques to identify cost-effective actions to minimize reliance on fossil fuels, (4) help to analyze fully environmental impacts (including impact on global warming), (5) improve efficiency in production, transmission, distribution, and use of energy, (6) assist in exploiting nunconventional renewable energy resources, including wind, solar, small-hydro, geo-thermal, and advanced N/A.

biomass systems, (7) expand efforts to meet the energy needs of the rural poor, (8) encourage host countries to sponsor meetings with United States energy efficiency experts to discuss the use of least-cost planning techniques, (9) help to develop a cadre of United States experts capable of providing technical assistance to developing countries on energy issues, and (10) strengthen cooperation on energy issues with the Department of Energy, EPA, World Bank, and Development Assistance Committee of the OECD.

u. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA" (as interpreted by conference report upon original enactment). If assistance will come from the Sub-Saharan Africa DA account, is it: (1) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (2) being provided in accordance with the policies contained in section 102 of the FAA; (3) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (4) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take

Yes. (1)(2)(3)(4) (5)

into account, in assisted policy reforms, the need to protect vulnerable groups; (5) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

v. International Development Act Sec. 711, FAA Sec. 463. If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (1) the world's oceans and atmosphere, (2) animal and plant species, and (3) parks and reserves; or describe how the exchange will promote: (4) natural resource management, (5) local conservation programs, (6) conservation training programs, (7) public commitment to conservation, (8) land and ecosystem management, and (9) regenerative approaches in farming, forestry, fishing, and watershed management. N/A.

w. FY 1990 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? N/A.

ANNEX D.

INITIAL ENVIRONMENTAL EXAMINATION

Project Country: Zimbabwe

Project Title: Zimbabwe Family Planning Project

Funding: FY (s) 90-95 $ 15,000,000

Environmental Action Recommended:

Positive Determination _____
Categorical Exclusion X
Negative Determination _____

Discussion:

As a "program involving ... population and family planning", the Project meets the criteria for Categorical Exclusion in accordance with Section 216.2(viii) of the Code of Federal Regulations. The Project does not include activities directly affecting the environment.

Concurrence:
Bureau Environmental Officer

Approved: _____
Disapproved: _____
Date: _____

Gray Amendment Considerations

The Gray Amendment (Section 579 of P.L. 101-167, the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1990) requires A.I.D. to ensure participation in A.I.D. projects by business concerns which are owned and controlled by socially and economically disadvantaged individuals, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic American, and private voluntary organizations which are controlled by individuals who are socially and economically disadvantaged, including women, (referred to herein as Gray Amendment entities).

The requirements of AIDAR Notice 90-2, implementing section 579 of the Foreign Assistance Appropriations Act requires that for any contract in excess of $500,000 (except for a contract with a disadvantaged enterprise)not less than 10 percent of the dollar value of the contract must be subcontracted to Gray Amendment entities, unless the contracting officer certifies that there is no realistic expectation of U.S. subcontracting opportunities or unless the Administrator approves an exception. This provision applies to "buy-ins" as well as project specific contracts.

Certification

Elements of the project are appropriate for minority or Gray Amendment organization contracting. The procurement plan of this project has been developed with full consideration of maximally involving Gray Amendment organizations in the provision of required goods and services. The Mission will make every effort to identify disadvantaged enterprises, particularly women and minority-owned firms, which can handle studies and analyses planned in the project. Where possible, qualified Gray Amendment firms will be given consideration for direct contracting as well as in consideration of the buy-in option for services required.

Furthermore, the Mission will in the case of any contract in excess of $500,000 funded from amounts covered by the Gray Amendment include a provision requiring that no less than ten percent of the dollar value of the contract be subcontracted to Gray Amendment entities unless the Contracting Officer certifies that there is no realistic expectation of U.S. subcontracting opportunities, or unless the prime contractor is a Gray Amendment entity.

Allison B. Herrick, Director

Date: 22 August 1990

ZIMBABWE FAMILY PLANNING PROJECT: PROJECT NUMBER 613-0230

LOGICAL FRAMEWORK

Narrative Summary	Objective Verifiable Indicators	Means of Verification	Assumptions
Goal: To reduce the total fertility rate (TFR) in Zimbabwe and to increase national self-reliance for improved access to high quality family planning services.	Reduction in TFR from 5.5 in 1988 to 4.5 Government and private sector assumption of most recurrent service delivery costs by 1995.	National DHS scheduled for 1994-1995. Government budget private sector records.	Continued political support for safe, effective family planning. Political and economic stability will permit national family planning coverage.
Purpose: To expand access to and use of wider selection of family planning methods delivered in cost-effective and sustainable manner that includes an expanded role for the private sector.	Increase in use of modern contraception from 36 to 50 percent of MWRA. Greater proportion of longer-term methods being used; Increased proportion of service delivery by private sector.from 6 percent to 15-20 percent.	National DHS. o National DHS o Service statistics of ZNFPC/MOH/private providers. o Contraceptive commodity distribution statistics. o Sales records from social marketing program. o Financial records of all providers.	Continued adequate budgetary support of ZNFPC by Government. Cooperation and coordination by ZNFPC and MOH & Univ. of Z. and CSO. Unmet demand for longer-term, more effective methods. Provision of technical assistance financial support and commodities from other donors (esp.World Bank & UNFPA). Private sector understanding of firancial and corporate benefits from sponsoring family planning. Availability of complementary A.I.D./W funding.
Outputs: Component 1: Diversification of Methods			
A. Promotion CBDs trained in Patient Counselling/Referral	536 CBDs rrtrained as promoters	Training Unit Records	Clinical services available for CBD referrals. A.I.D./W funding for technical assistance.

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Narrative Summary	Objective Verifiable Indicators	Means of Verification	Assumptions
Public Sector personnel reoriented to long-term methods	50 seminars conducted	ZNFPC quarterly reports	Public Sector staff participate in ZNFPC seminars.
IEC materials developed and printed	20,000-25,000 copiess of IEC materials developed.	Use of IEC materials in training courses, clinics, and by CBDs.	Availability of A.I.D./W funding for technical assistance. Availability of A.I.D./W funding for technical assistance.
B. Training			
Curricula for training are reviewed and adapted.	Revised curricula available on: a) IUDs & STDs b) sterilization c) NORPLANT$_R$ d) CBD retraining e) private physicians	Training materials for tutors and trainees are being used.	A.I.D./W support for technical assistance.
Training is provided for: - ZNFPC tutors - MOH tutors- - ZNFPC clinic staff - MOH clinic staff - Employer-based health personnel (docs., nurses & CBDs)	 19 ZNFPC tutors trained. MOH tutors trained (World Bank). 127 ZNFPC clinic staff retrained. MOH clinic staff trained (World Bank). Health personnel from 35-50 employer-based companies.	Semi-annual training progress reports.	Tutors released for training. Private Sector health personnel released for training. World Bank funds transport and expenses for MOH trainees.
Trainee performance evaluated	All categories of trainees evaluated.	Training Unit's progress reports.	
Assessment of training fee rates and collection procedures	Study complete		
Increased number of fee paying trainees	150-200 international trainees	Training progress reports Financial reports.	

Narrative Summary	Objective Verifiable Indicators	Means of Verification	Assumptions
C. Service Delivery			
Clinic facilities and output assessed & strategic plan developed	34 ZNFPC clinics assessed, strategic plan available.	Semi-annual progress reports.	A.I.D./W central support of outside technical assistance.
Sterilization facilities equipped	6 additional clinics equipped for sterilization.	ZNFPC Quarterly reports	A.I.D./W support for equipment.
Strengthen existing ZNFPC clinics	34 ZNFPC provided improved IUDs & other services.	ZNFPC Quarterly reports	A.I.D./W support for equipment.
Increased number of ZNFPC clinics established in public facilities	6 additional ZNFPC clinics in public sector facilities.	ZNFPC Quarterly reports	MOH and MOLGRUD approve allocation of space for ZNFPC's family planning services.
Introduce NORPLANT$_R$	NORPLANT$_R$ available at limited number of ZNFPC, public sector and private sector clinics.	ZNFPC Quarterly reports	NORPLANT$_R$ use approved by Government A.I.D./W support for technical assistance.
D. Evaluation and Research			
- Assessment and revision of service statistics system	Increased proportion of ZNFPC and Public Sector clinics reporting within 15 days of month's end. Increased use of service statistics by managers.	Use of quarterly service statistics report to monitor output.	Public Sector staff will report to ZNFPC. A.I.D./W support for technical assistance.
- M.I.S. for tracking trainees developed.	M.I.S. training system functioning	Semi-annual training progress reports.	A.I.D./W support for technical assistance.
- Operations research and other studies conducted.	Studies completed.	Study reports used in improving ZNFPC program.	A.I.D./W central support of outside technical assistance.
- DHS conducted	Report published.	DHS report	Compliance of all parties (ZNFPC, CSO and interviewees) for the national survey.
E. Contraceptives			
- Continued maintenance of logistics management system	Self-sufficient commodity procurement management system.	Logistics report	A.I.D./W central support of outside technical assistance.

Narrative Summary	Objective Verifiable Indicators	Means of Verification	Assumptions
Component 2: Private Sector			
A. Social Marketing			
- Increased distribution of contraceptives by Social Marketing System	Increase contraceptive sales.	Financial reports	A.I.D./W support for technical assistance.
B. Employer-provided Services			
- Increased number of employer-based clinics providing family planning services	35-50 employer-based companies providing family planning services.	Company records	Employers upgrade and equip clinics. A.I.D./W support for technical assistance.
C. Mobilization of Private Physicians			
- Increased No. of private doctors offering family planning	200 private doctors trained and providing family planning.		Private Physicians willing to be trained; A.I.D./W Central funding for technical assistance.
D. Insurance-Reimbursement Programs			
- More Medical Aid societies cover family planning as benefit	15 additional medical aid societies cover family planning and 100,000 additional couples covered by family planning benefits and increased revenues.	Financial Reports	A.I.D./W central support of technical assistance.
E. Corporate Contributions			
- Corporate contributions for for family planning made	Z$110,000 contributed for family planning	Financial reports	A.I.D./W support for technical assistance.
Component 3: Coordination and Sustainability Enhancement			
A. ZNFPC Private Sector Coordination			
- Expanded staff with improved outreach capacity	Number of ZNFPC P.S. Coordination staff	ZNFPC Quarterly reports	

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Narrative Summary	Objective Verifiable Indicators	Means of Verification	Assumptions
B. Cost Recovery			
- Private Sector operations research studies.	Number of studies completed.	ZNFPC Quarterly reports	A.I.D./W support for technical assistance.
- Revenue management study	Completed study.	ZNFPC Quarterly reports	Government will permit revenue enhancement effort.
- Method Cost analysis	Completed study.	ZNFPC Quarterly reports	Government will permit ZNFPC to retain revenue.
- Training cost analysis	Completed study.	ZNFPC Quarterly reports	Government will permit ZNFPC to retain revenue.
- Price Elasticity study	Completed study.	ZNFPC Quarterly reports	Government will permit ZNFPC to retain revenue.
C. Diversification in Contraceptive Sourcing			
- Government or other donors take over contraceptive financing	Adequate contraceptive supplies as USAID financing phases out.	ZNFPC reports	Government willing and able to allocate funds.

Project Inputs

	Centrally Funded	Bilateral
1. Diversification of Methods		
A. Promotion		
Technical assistance: 8 person-months	160	
Commodities	75	
Printing costs		75
CBD refresher training		385
Public sector workshops		100
B. Training		
Technical assistance: 32 person-months	640	
Equipment		20
Salaries for ZNFPC tutors		224
Remodelling		50
Other training costs		190
C. Service Delivery		
Technical assistance: 17 person-months	340	
Support for NORPLANT$_R$ expansion	136	
VSC clinic equipment	90	
Clinic support	90	220
D. Evaluation and Research		
Technical assistance: 34.5 person-months	580	110
Local consultants		90
Acceptability study	225	
Demographic and Health Survey		500
Miscellaneous study costs	18	36
E. Contraceptives		
Oral contraceptives	512	4,408
NORPLANT$_R$	345	
Technical assistance for logistics mananagement: 10 person-months	200	
Computer support for logistics management	60	
Other logistical support		70
II. Private Sector		
A. Social Marketing		
Technical assistance: 5 person-months	100	
Contraceptives		166
Research and evaluation	20	
B. Employer-provided Services		
Technical assistance: 2.75 person-months	55	
Equipment	15	
Research and evaluation	40	
C. Private Physicians		
Pathfinder/Population Council sub-project	400	

	Centrally Funded	Bilateral
II. Private Sector		
D. Insurance		
Technical assistance: 2.75 person-months	55	
Research and evaluation	20	
E. Corporate Contributions		
Technical assistance: 2 person-months	40	
III. Coordination/Sustainability		
A. ZNFPC Coordination		
Equipment for private sector activities	5	
ZNFPC private sector coordination staff		120
Seminars and workshops		80
B. Cost Recovery		
Technical assistance: 10 person-months	200	100
C. Diversification of Contraceptive Sources		
V. OTHER		
A. Project Management	1,500	
B. Evaluation and Audit		210
C. Vehicles		1,200
D. Contingency	68	390
E. Inflation	323	656
	$6,312	$9,400

Table II.B.1 Planned Donor Assistance
in Population and Family Planning for 1990-1995
by Project Component

	Source of Funding			
	A. I. D. Bilat.	A.I.D./W	UNFPA	FHP-II
I. Diversification of Methods				
A. Promotion/IEC				
- Decentralization of ZNFPC IEC Unit			x	x
- Develop, test and print prototype materials on method mix for providers, users, and males	x	x		x
- IEC support			x	
- Leadership seminars/workshops (senior MOH personnel, private sector)	x	x		x
- Population IEC thru Min. Info. Youth Ed.			x	
- Retrain CBDs to promote method mix	x	x		
- Youth Advisor Services			x	x
B. Training				
- Core support for ZNFPC training unit	x			
- Training of ZNFPC tutors and clinicians		x		
- Training of Ministry staff			x	x
- Training of TMs, VCWs			x	
- Evaulate impact of training	x	x		
C. Service Delivery				
- Upgrade and equip ZNFPC clinics		x		x
- Transport for CBD's & supervisors	x			x
- Upgrading of static clinics	x			x
- NORPLANT$_R$ introduction/expansion	x		x	
D. Evaluation and Research				
- Strategic planning for ZNFPC		x		x
- O.R. study of CBDs' role[1]		x		
- Assessment of service statistics		x		
- Acceptability study		x		

Footnote

1. Study being funded by Population Council's O.R. project.

	Source of Funding			
	A. I. D.			
	Bilat.	A.I.D./W	UNFPA	FHP-II
E. Contraceptive Commodities				
- Orals	x	x		
- Condoms			x[2]	
- Injectables			x	
- IUDs			x	
- NORPLANT$_R$		x	x[3]	
- Logistics management	x	x		
II. Private Sector				
A. Social marketing		x		
B. Employer Service		x		
C. Private Physicians		x		
D. Insurance & Reimbursement		x		
E. Corporate Contributions		x		
III. Coordination/Sustainability				
A. ZNFPC Coordination	x			
B. Cost recovery	x	x		
C. Diversification of Contraceptive Sourcing		x	x	x
IV Project Management		x		

Footnotes

2. Some support for condoms will be provided by WHO/GPA.
3. UNFPA funds cover NORPLANT$_R$ in years 1&2, thereafter USAID.

Implementation Plan

Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
I. Diversification of Methods						
A. Promotion						
IEC	x	x	*	*	*	*
CBD reorientation		x	x	x	x	x
Clinical reorientation		x	x			
B. Training						
Strategic planning for CA participation	x	x				
Curriculum review and adaptation	x	x				
Expanded training output	x	x	x	x	x	x
Trainee followup	x	x	x	x	x	x
C. Service Delivery						
Assess clinic facilities and service delivery	x	x				
Strengthen existing ZNFPC clinics						
- Procure equipment		x	x			
- Establish mgt and supervision system		x	x			
Expand sterilization clinic facilities			x	x	x	x
Set up additional ZNFPC clinics within public sector hospitals				x	x	x
			x	x	x	x
NORPLANT$_R$ expansion			x	x	x	x
D. Research and Evaluation						
Assess service statistics	x	x				
Set up and maintain MIS to track clinical and CBD training	x	x	x	x	x	x
Design and implement acceptability study	x	x				

* In Years 4-6, materials will be produced and distributed with support from the FHP-II project of the MOH.

Implementation Plan

Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Demographic and Health Survey				x	x	x
E. Contraceptive Commodities						
Procure pills	x	x	x	x	x	
NORPLANT$_R$			x	x	x	x
Logistics Management	x	x	x	x	x	x
II. Expansion of Private Sector						
A. Social Marketing						
Technical assistance	x	x	x	x	x	x
Provide commodities			x	x	x	
B. Employer-Provided Services						
Develop awareness presentation on C/B of family planning	x					
Develop action plan expand No. of companies	x					
Implement Action Plan		x	x	x	x	x
Sponsor meetings, seminars, workshops to present C/B analysis		x	x	x	x	x
Provide training, IEC, other follow-up assistance to businesses		x	x	x	x	x
C. Private Physicians						
Mobilize and train	x	x				
Provide services		x	x	x	x	x
D. Insurance reimbursement						
Provide IEC assistance/ materials to market benefits	x	x	x	x	x	
Follow-up/track revenues from beneficiaries	x	x	x	x	x	
E. Promote corporate support	x	x	x	x	x	x

Implementation Plan

Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
III. Coordination and Sustainability						
A. ZNFPC Coordination	x	x	x	x	x	
B. Research and analysis						
Fee collection			x			
Cost Analysis			x			
Price elasticity				x		
Training analysis			x			
C. Diversify Contraceptive Sourcing						
Other donors	x	x	x	x	x	x
Govt. of Zimbabwe			x	x	x	x
IV. Other						
Project Management	x	x	x	x	x	x
Provide Vehicles	x	x	x	x	x	x
Evaluation and Audit			x	x	x	x

First-Year Implementation Plan and key issues for Management of Project

Year 1

1. Hire project manager

2. Procure initial group of vehicles for ZNFPC

3. Assist in World Bank's strategic planning exercise with ZNFPC (especially ensure participation of training/manpower analyst)

4. Confirm participation of following 8 CAs/consultants in first two years of project's implementation:

Training:	AVSC, JHPIEGO, SEATS
Promotion:	JHU-PCS
Service Delivery:	SEATS
Evaluation & Research:	SEATS, Population Council
Contraceptive Logistics	Family Planning Logistics Management
Social Marketing:	SOMARC
Employer Services:	SEATS
Private Physicians:	Pathfinder Fund, Population Council
Insurance Reimbursement:	SEATS
Coporate Contributions:	POPTECH

No buy-ins to central projects are needed in first year.

5. Set up local family planning donor coordinating group (World Bank, UNFPA and USAID, etc.) and schedule regular consultation meetings.

6. Set up first meeting of training CAs (AVSC, JHPIEGO, Pathfinder, SEATS) to define specific roles vis-a-vis USAID's Zimbabwe Family planning project and ZNFPC's new strategic plan (see 2 above.) Include in agenda, a plan for reviewing and completing all curricula relevant to ZNFPC's training program and project.

7. Ensure that study on role of CBDs under the operations research project (not funded under the bilateral) of Population Council gets off to timely start in September 1990. Results are key to redefining CBDs role as promoters.

8. Assist ZNFPC to assess clinic facilities and output with technical assistance from AVSC, JHPIEGO and SEATS (1st October FY 91).

9. Following above assessment, assist ZNFPC to refurbish and equip limited number of clinincs.

10. Monitor progress of NORPLANT$_R$ pre-introduction study.

11. Assist ZNFPC to assess service statistics and clinical reporting system including analysis and use of statistics for program management at Headquarters and at provincial centers.

12. With SEATS t.a., ensure that ERU and Training Units develop a management information system to track trainees.

13. Ensure that Population Council assists ERU in design of acceptability study with quick turnaround.

14. Plan for procurement of FY 91 and 92 (?) commodities for public program. No commodities will need to be procurred in year 1 for social marketing.

15. Arrange for consultant to work with ZNFPC's private sector coordinator and SEATS on an action plan and implementation schedule for activities in the private sector.

16. Arrange for Pathfinder and Population Council to set up project to train private physicians.

Year 2

1. Procure second year vehicles and commodities.

2. Assess government's position on partial funding of commodities (pills) in year 3 and review options described in PP as needed.

4. Review results on NORPLANT$_R$ pre-introduction study with government, and if acceptable, plan for wider training and distribution.

Position Description for Project Administrator

Article I - Title

Zimbabwe Family Planning Project (613-0230) - Project Administrator

Article II - Objectives

The Project Administrator will be responsible for all aspects of A.I.D. monitoring and administration of the Zimbabwe Family Planning Project. He or she will serve as the principal advisor to the USAID/Zimbabwe mission on all family planning matters related to the proposed FY 1990 Zimbabwe Family Planning Project. The Administrator will also serve as a technical resource person on family planning activities and experience in similar programs in other countries.

Article III - Statement of Work

A. Background

Zimbabwe's family planning program is regarded as one of the most successful programs in the developing world. Among married women of reproductive age, 36 percent rely on modern contraceptive methods. The 33 percent rise in contraceptive use since 1984 has contributed to a decline in fertility from 6.5 to 5.5 childern per woman between 1984 and 1988.

Although the contraceptive prevalence rate is high by sub-Saharan Afica standards, there is evidence of a sizeable "unmet demand" for family planning. Expanding access requires improvements in service delivery and diversification of available methods.

Since 1982, A.I.D. has provided administrative support, commodities, training, and technical assistance to the Government of Zimbabwe to increase the technical and managerial capacity of the Zimbabwe National Family Planning Council (ZNFPC) to expand its provision of family planning services and commodities in rural and semi-urban Zimbabwe. Since termination of the bilateral project in 1987, A.I.D. family planning assistance, including the provision of contraceptive commodities, has been maintained through a number of separately managed, but programmatically interrelated, centrally-funded population projects.

Some 17 project activities were initiated between 1987 and 1989. Many of them dealt with concerns originally addressed in the bilateral project, such as information, education, and communications; youth advisory services; research and evaluation; and management services for decision making.

In addition, new program initiatives were launched, including development of private sector activities, promotion of new or under used methods, and a demographic and health survey.

To promote more efficient and cost-effective service delivery, the Fiscal Year 1990-95 Zimbabwe Family Planning Project will support the continuation and expansion of private sector initiatives in social marketing, employer-provided services, and insurance reimbursement schemes. Also, new initiatives in training private physicians in service delivery will be supported. In addition, the project will fund experimentation with alternative models of Community Based Delivery. Finally, the project will examine means of expanding the role of public clinics in service delivery with special attention given to the development of specialized centers with increased capacity to provide long term methods.

The bilateral project is part of an overall effort that includes the World Bank, UNFPA, and USAID. There is a great deal of interdependence among these three separate efforts, e.g., UNFPA is supplying all contraceptives except pills and NORPLANT$_R$ which USAID will provide. In addition, the bilateral effort will be complemented by Cooperating Agencies (CAs), whose core funding is from the Office of Population in A.I.D./Washington. The bilateral project will "buy-in" to these CAs. There is a strong coordination component to this job.

To diversify the selection of contraceptive methods, the project will enhance the training capacity of the Zimbabwe National Family Planning Council and improve clinic management and organization. Complementary activities include: a survey and analysis of method preferences, development of a strategy for the media promotion of longer term contraceptive methods, and the provision of re-orientation training to community based distributors. In addition, the project will fund new initiatives to involve private physicians and private health centers, which will improve the method mix by expanding the base of service delivery points providing clinical methods.

B. Specific Tasks

(1) Programmatic Duties and Responsibilities

a. Become thoroughly informed about the project: its antecedents; its goal, purpose, and objectives; its design, structure, and relationship to other family planning initiatives in Zimbabwe and Africa; its target areas and participating partners; and its operational procedures and methodologies.

b. Assist USAID/Zimbabwe in all aspects of oversight, management, administration, monitoring, and evaluation, including oversight on: timeliness in meeting commitments and scheduled completion dates; contractor performance; quality , adequacy, and condition of equipment; and other related management objectives.

c. Maintain Mission project support files, records, and management tools; monitor and review financial disbursement requests by the Ministry of Health and the ZNFPC and advise responsible mission offices of any need for Mission action.

d. Assist counterpart agencies in: (i) definition of their specialized technical assistance and training needs; (ii) preparation of scopes of work for technical assistance services to be provided under the Zimbabwe Family Planning Project; and (iii) monitoring and reporting on the adequacy and accomplishments of technical assistance, training, and other project inputs.

e. Liaise between USAID/Zimbabwe and (1) designated agencies and officials of Zimbabwe; (2) designated officials of participating non-governmental organizations, and (3) private sector entities involved in project-supported activities to enhance coordination and avoid duplication of activities..

f. Travel extensively and frequently to project sites: to keep abreast of project activities and developments, to establish and maintain effective communication and coordination between the parties of the project, to troubleshoot problems, and to collect technical and administrative information needed for project monitoring and reporting purposes.

g. Provide technical contributions to family planning sector components of USAID Mission program documents, including country or Regional Development Strategy Statements, Action Plans, Annual Budget Submissions, and other documents, as requested.

(2) <u>Administrative Duties and Responsibilities</u>

a. Advise counterpart agencies on the proper administration of A.I.D. funds in accordance with A.I.D. regulations.

b. Provide technical input to project implementation documents, including: Project Implementation Orders (PIOs), Project Implementation Letters (PILs), Project Implementation Reports (PIRs), and Project Evaluation Summaries (PESs), as well as feasibility studies, Environmental Impact Assessments, procurement waivers, and other related project documentation requirments.

c. Collect, collate, and analyse data needed for project management, administration, monitoring, and evaluation.

d. Prepare reports on project activities and actions undertaken by or for the project, on field trips, meetings, and other events of significance to the project and its participating partners, and on opportunities and problems encountered by the project.

e. Prepare drafts of official correspondence related to the administration of the project.

f. Perform such other duties and responsibilities as may be assigned from time to time.

g. The contractor will not perform functions that are reserved for U.S. direct hire employees, including: supervisory, internal management, or administrative functions, voucher approval, and final decisions regarding the expenditure of U.S. Government funds and final review or approval of internal Agency documents.

Article IV - Administrative Relationship

The Zimbabwe Family Planning Project Administrator will be supervised by and report directly to the USAID/Zimbabwe Program Officer who has overall responsibility for the family planning portfolio. He or she will work closely with the project coordinator based at the ZNFPC, and the Project Assistant based at USAID. In addition, the Project Administrator will receive guidance from the USAID/Zimbabwe Mission Director regarding Mission policies, development strategies, and development objectives that pertain to the Zimbabwe Family Planning Project.

Article V - Work Plans and Reports

A. The Contractor will be required to develop with his or her supervisor an Annual Work Plan. The Work Plan will lay out specific activities and schedules. Copies of the approved Annual Work Plans and any substantive revisions will be forwarded to designated project liaison officers in the USAID Mission, the ZNFPC, and to any other offices designated by the USAID Mission Director.

B. The Contractor will prepare and submit to his or her supervisor quarterly progress reports. The reports will be a key input for monitoring and evaluating project implementation progress measured by outputs and impact in achieving the project purpose. The reports will describe in detail achievements during the reporting period, particularly as related to the project logical framework and related Annual Work Plan.

Article VI - Terms of Performance

The contract will be for five and half years, subject to review of performance after the first year. The contract may be extended beyond five years, subject to continuing need for the contractor's services and availability of funds. The services provided under the contract should begin on or about _____ and be completed on or about _____.

Article VII - Qualifications and Experience

In order to accomplish this objective, the proposed Project Administrator should have the following qualifications and experience:

a. Formal training in family planning and/or public health is highly desirable. A combination of training in management or social science plus practical overseas work experience is a minimum requirement for this position.

b. Thorough knowledge of contemporary effective contraceptive methods.

c. At least six years of experience in administering/monitoring family planning programs.

d. Thorough knowledge of modern contraceptive delivery systems, e.g., clinics, social marketing, CBD, etc.

e. At least four years of experience with family planning programs in the developing world, preferably sub-Saharan Africa.

f. Knowledge and experience in general management/administration principles.

g. Experience with A.I.D. requirements and procedures.

h. Experience working with other population donors.

TABLE II.E.1: PUBLIC SECTOR CONTRACEPTIVES

Quantities

	1990	1991	1992	1993	1994	1995	TOTAL
LO-Femenal Blue Lady	3,604,595	4,395,136	2,385,136	1,672,297	1,033,784	0	13,090,948
Ovrette	3,490,000	3,444,800	4,371,622	3,395,270	2,344,594	0	17,046,286
	7,094,595	7,839,936	6,756,758	5,067,567	3,378,378	0	30,137,234
$NORPLANT_R$	0	0	2,500	3,000	4,000	5,500	15,000

Costs (U.S.$)

LO-Femenal &	533,480	650,480	353,000	247,500	153,000	0	1,937,460
Ovrette	610,750	602,840	765,034	594,172	410,304	0	2,983,100
$NORPLANT_R$	0	0	58	69	92	126	345

Cost Per Unit U.S.$
Lo-Femenal = 0.148
Ovrette = 0.175
$NORPLANT_R$ = 18.00 per sets plus $5.00 per insertion for equipment

TABLE II.E.2: USAID CONTRACEPTIVE REQUIREMENT FOR SOCIAL MARKETING

	1990	1991	1992	1993	1994	1995	Total
Quantities							
CONDOMS (000)	0	0	371	482	626	0	1,479
NORQUEST (000)	0	0	67	75	84	0	226
IUD	0	0	4,478	5,374	6,449	0	16,301
Costs (U.S.$)							
CONDOMS	0	0	$22,260	28,920	37,560	0	$ 88,740
NORQUEST	0	0	17,420	19,500	23,140	0	60,560
IUD	0	0	4,521	5,427	6,513	0	15,461
TOTAL	0	0	$44,701	53,847	67,213	0	$165,761

Cost per Unit
CONDOMS = U.S.$0.06
NORQUEST = U.S.$0.26
IUD = U.S.$1.01

TABLE II.E.3: OTHER COMMODITIES AND EQUIPMENT ($000's)

	1990	1991	1992	1993	1994	1995	Total
Vehicles	300	300	600				1,200
Training equipment		20					20
Clinical equipment	143	37					180
Computer		30	20				50
Private Sector equipment	20						20
Other		75					75
Total	463	462	620				1,545

Table II.4: INTERNATIONAL TECHNICAL SERVICES, BY CONTRACTOR

Project Component	S&T/POP Cooperating Agency	Period	Estimated Amount
I. Diversification of Methods			
A. Promotion			
IEC materials	PCS	4 PM	
CBD refresher training	SEATS or Pathfinder	1 PM	
MOH Seminars	PCS	3 PM	
B. Training	AVSC, JHPIEGO, SEATS	32 PM	
C. Service Delivery			
Clinic Assessment	JHPIEGO, SEATS*	2 PM	
Supervision Systems	SEATS	4 PM	
Clinics in MOH hospitals	SEATS	4 PM	
Sterilization Services	AVSC and JHPIEGO	4 PM	
IUD Support	JHPIEGO	3 PM	
NORPLANT$_R$ expansion	Population Council/AVSC/ JHPIEGO		$136,000
D. Evaluation and Research			
Assess Service Statistics	SEATS	3 PM	
Training Information	SEATS	1 PM	
General Purposes	Population Council, Pathfinder	18 PM	
Demog/Health Survey	Macro Systems	12.5 PM	
Acceptability Study	Population Council		$225,000
E. Contraceptive Logistics Management	FP Logistics Management	10 PM	
II. Private Sector			
A. Social Marketing	SOMARC	10 PM	
B. Employer Services	SEATS	2.75 PM	
C. Private Physicians	Pathfinder, POP. Council		$400,000
D. Insurance Reimbursement	SEATS	2.75 PM	
E. Corporate Contributions	POPTECH	2 PM	
III. Coordination/Sustainability			
B. Cost recovery studies	Population Council	10 PM	$100,000
IV. Other			
A. Project Management	SEATS	66 PM	
B. Evaluation	POPTECH		$300,000

* Roles to be determined through strategic Planning exercise

TABLE II.E.5: INTERNATIONAL TECHNICAL SERVICES, BY YEAR ($000'S)

	1990	1991	1992	1993	1994	1995	Total
I Diversification							
Promotion	120	40					160
Training	190	170	70	70	70	70	640
Service Delivery	110	100	104	54	54	54	476
Evaluation/Res	210	2150	60	160	160	110	915
Contraceptives	40	40	40	40	40		200
II Private Sector							
Social Marketing	20	20	20	20	20	20	120
Emp. Services	20			35			55
Private Phys.	200	200					400
Insurance	20	20	15				55
Corp.Contributions	20	20					40
III Coordination							
Cost recovery		75	75	25	25		200
IV Other							
Management	250	250	250	250	250	250	1,500
Evaluation							
	1,200	1,150	669	619	619	504	4,761

TABLE II.E.6: OTHER SERVICES, BY YEAR ($000'S)

	1990	1991	1992	1993	1994	1995	Total
Printing		75					75
Training Renov'n		30					30
Clinic Renov'n			55	55	55	55	220
ERU consultants	15	15	15	15	15	15	90
Audit/Evaluation			44		66		110
	15	120	114	70	136	70	525

TECHNICAL ANALYSIS

1. Trends and Accomplishments

Over the past decade, the Zimbabwe family planning program has made impressive progress and is regarded as among the most successful programs in Sub-Saharan Africa. Awareness of family planning is widespread: among married women of reproductive age (MWRA), 99 percent know at least one contraceptive method and 97 percent know a source for family planning services. Contraceptive prevalence rates are also among the highest: among MWRA, 43 percent are family planning users and 36 percent rely on modern methods, a 33 percent increase over the 1984 figure of 27 percent. This rise in contraceptive use has contributed to a decline in fertility from 6.5 to 5.5 children per woman between 1984 and 1988.

2. Constraints Analylsis

Despite the important achievements of the Zimbabwe Family Planning Program, significant constraints exist to further expanding access and increasing prevalence rates.

First, although the contraceptive prevalence rate is relatively high, there is evidence of sizeable "unmet need." Among MWRA, just under one-third want no more children and fewer than half of these women are currently practicing family planning. Similarly, just over one-third of MWRA want to delay their next birth two or more years, and only a A little over half of these women are using family planning. Modern method prevalence in Zimbabwe would rise to 70 percent if this "unmet need" were satisfied.

Second, the current family planning program in Zimbabwe depends heavily on the oral contraceptive. Of all modern method users, 86 percent use pills. About one-third of pill users want no more children. For this group, the oral contraceptive is less than ideal due to (a) a lower rate of effectiveness than more permanent methods, (b) higher associated health risks among older women, (c) the requirement for continuous supply and use, and (d) high cost per couple-year of protection.

The CBD program has successfully promoted and supplied the oral contraceptives to the exclusion of other methods. In fact, many of the areas where CBDs have been operating now have prevalence rates as high as 70 percent, and CBDs spend a large part of their time on resupply. Furthermore, there is very little referral for more permanent clinical methods. Consequently, levels of awareness of longer-term methods of family planning are relatively low.

Research over several decades has clearly demonstrated that the broader the range of methods offered, the higher the contraceptive prevalence and the more successful a program will be in satisfying the needs of users, achieving improved use-effectiveness, and increasing overall impact. Important things happen when a one or two method program (such as Zimbabwe's essentially one method program) introduces more methods. Some current users switch to one of the newly introduced methods because of dissatisfaction with their current method (e.g., unpleasant side effects), because their current method is not ideal for their life style (e.g., the pill for couples who have only infrequent intercourse), or because it is inappropriate for the couple's reproductive life cycle (e.g. a 40 year old pill user who wants no more children). It is axiomatic that one family planning method cannot meet all the needs and desires of a population. The greater the choices, the more the needs and desires of couples can be satisfied.

Of course, if only method switching occurred with the introduction of new methods, the overall level of use would remain static. But switching is not the only consequence of diversifying the mix of methods.

Broadening the choice of methods also increases use by attracting (a) past users who stopped contracepting altogether because of some problem or dissatisfaction and (b) never-users who want to contracept but did not find acceptable any of the limited methods offered. Numerous studies have shown that overall prevalence increases, sometimes dramatically, when new methods are made available. In addition to increasing the level of use, a broad method mix also increases user satisfaction since more users can find a method suitable to their particular situation. This satisfaction translates into longer continuation rates which, in turn, mean improved use-effectiveness.

Two additional considerations underline the importance of a diverse range of methods. The first concerns reproductive risk. Studies have documented factors associated with increased risk affecting the health and survival of both mothers and their children. Risk factors include: mother's age (under 18 and over 35); interval between births (intervals of less than two years are risky for both the new born and the index child); and parity (4 or more). Increasingly family planning programs emphasize the need to educate providers as well as potential clients about these reproductive risks also programs increasingly emphasize the potential role of family planning for improving the health and survival of women by encouraging childbearing during the safest years and with good spacing and reduced parity. Thus a key objective of family planning programs is to ensure that women who fall into one or more of the reproductive riskscategories have good information and access to a range appropriate contraceptive methods.

The second consideration involves reproductive intentions. Surveys worldwide have documented tremendous unmet need for contraception, based on women's stated desires either to limit their number of children or to space future births by two or more years. In many sub-Saharan Africa countries, very low proportions of these women are actually using contraception. Thus another objective of family planning is to help women who do not want any more children or who want to space subsequent births to achieve their reproduction intentions. One further benefit of family planning is to reduce unwanted pregnancies and abortions (legal or illegal) which frequently result from unwanted pregnancies. By ensuring access to a range of contraceptive methods, the unmet needs of these women can be addressed.

Shifting users to methods that are safer, more effective, and appropriate will require significant program modifications. The challenge this shift poses is further magnified by the large number of couples who will be seeking family planning services in the future. Over the period 1990-1995, the number of MWRA will increase by 20 percent. To meet the needs of these additional women and the expected increases in demand for modern methods of contraception (about 2 percent per year), family planning services must support nearly 50 percent more users by 1995.

Clearly, the objective of reduced fertility in Zimbabwe can be accomplished only by expanding the availability and use of a variety of contraceptive methods. However, the broadening of the contraceptive method mix is limited by constraints on both the supply and demand for more effective, longer-term methods. What are the constraints to each of these methods?

2.1. Sterilization

From the 1988 ZDHS, only 1.7 percent of all married women of reproductive age (MWRA) or 2.3 percent of currently married women had been sterilized (about 32,000 women in all of Zimbabwe.) The principal constraint to access is that few physicians have been trained to provide voluntary surgical contraception (VSC) and few facilities are equipped. There may also be limitations due to unofficial guidelines concerning who can receive the procedure. While there are no official or published criteria for eligibility, informal guidelines cover parity, age and informed consent. For example, these informal guidelines for the ZNFPC are:

a) minimum parity of 2-3 children
b) minimum age of 30
c) written informed consent of the woman, her spouse and a physician.

There may be other constraints related to the demand for sterilization. Based on 1988 ZDHS, for example, only 50 percent of married women of reproductive

age know about sterilization (55 percent of currently married women know of the method.) In addition, only 46 percent know a source for information or services (51 percent of currently married women). Of those women who know of this method, over 90 percent know a source - a very encouraging finding. Demand may also be constrained by perceived problems in using a given method. Among women who know about sterilization, 25 percent have no problem with the method. However, 75 percent cited one of the following problems:

Main Problem	Percent
Permanent nature of method	31
Don't know	24
Health concerns	15
Inconvenient to use	2
Husband disapproves	1
Other	2
	75

To increase prevalence of sterilization from 2.3 in 1988 to 6 percent by 1995, the total using this method would need to increase from about 32,000 to nearly 110,000, or triple use in 1988. The number of sterilization procedures needed to achieve the target is estimated (from the target setting model) to be:

	Annual number of procedures
1989	5,200
1990	8,500
1991	13,000
1992	14,700
1993	16,500
1994	18,500
Future users	76,400
Current users	32,000
TOTAL	108,400

In sum, there appear to be no constraints to increased use of sterilization in Zimbabwe that cannot be overcome by a well planned and implemented strategy which combines increasing access to services and improved IEC and promotion activities.

2.2. IUD

From the 1988 ZDHS, use of IUDs was only 0.7 percent of all MWRA (or 1.1 percent of currently married women). Thus only about 14,000 women were using IUDs in 1988. Constraints to increased access to IUDs concern several issues directly related to service delivery. First, is simply the limited number of health personnel who have been trained to perform IUD insertion. Second,

among those who have been trained there is no guarantee that they will be assigned to positions which allow them to provide IUD services. Third, because of the prevalence of sexually-transmitted dieseases and the problem of pelvic inflamatory disease, a critical constraint to expanded use is proper screening and counseling of potential users. There are no regulatory constraints on IUD use.

Looking at the demand side, IUDs are about as well-known as sterilization. From the 1988 ZDHS, 52 percent of MWRA (59 percent of currently married women) know about IUDs as a method of contraception. Fewer know of a source: 45 percent of MWRA and 53 percent of currently married women. As with sterilization, knowledge of a source is very high (86 percent) for those women who have some knowledge of IUDs.

Perceived problems are slightly higher with IUDs (80 percent) than with sterilization. The problems and frequency of citation are given below:

Main Problem	Percent
Health concerns	25
Inconvenient to use	9
Not effective	6
Method permanent	1
Husband disapproves	< 1
Dont know	38
	80

Expanding use of IUDs should involve a two-pronged strategy similar to that for sterilization. First, increased access to services will depend on training more health personnel to insert IUDs and managing the assignments of trained personnel to ensure that they are placed in appropriate positions and have the necessary mandate to spend time delivering IUDs. Training and service delivery on IUDs must also give the highest priority to screening and counseling prospective users. Second, increasing the demand for IUDs will require a careful IEC and promotion strategy to increase awareness of the method and to allay fears and misceptions.

Projections of the future number of users suggest that there should be an increased level of use from 0.7 in 1988 to about 2.3 percent by 1995. This means that about 39,000 women would be using IUDs in 1995 compared to only 14,000 in 1988 - almost a three-fold increase. This level of increase should be feasible since there are no insurmountable obstacles on either the supply or demand equation which would inhibit expansion of IUD use.

2.3. NORPLANT$_R$

Since NORPLANT$_R$ will be a new method in Zimbabwe, there is no direct experience on which to assess constraints to its introduction and expanded use. However, information is available to assess indirectly possible constraints. The information comes from past experience in Zimbabwe with a long-acting method and research on NORPLANT$_R$ from other countries.

There are no official constraints to the introduction of NORPLANT$_R$. The government of Zimbabwe has already approved a pre-introduction study to be conducted at the University of Zimbabwé. After the two-year study is completed and assuming no problems with pre-introduction phase, it can safely be assumed that the government will approve expanded use of the method. (The recent experience in Kenya with a successful pre-introduction study and government approval for expanded use is the basis for this optimism.)

Constraints to supply will be: (a) the speed with which health personnel can be trained in the actual procedure and related counseling; and (b) whether nurses as well as physicians will be able to perform the surgical procedure. A study currently underway in Zambia is comparing differences between physicians and nurses in the provision of NORPLANT$_R$. If this study finds no differences, it bodes well for including nurses as well as physicians in the cadre of health personnel who would be providing the method.

Constraints to the demand for NORPLANT$_R$ can be examined in light of the experience with another long-term method, an injectable. Current use of injectables is insignificant because of a virtual prohibition of its use in Zimbabwe. Of women who know about injectables (62 percent of all MWRA), 30 percent cite no problem with its use. The percentage citing no problem with the method is higher than for any method except for the condom (35 percent). Of the remaining 70 percent who did cite a problem in the 1988 ZDHS, the distribution of concerns is as follows:

Main Problem	Percent
Don't know	28
Health concerns	19
Method permanent	17
Inconvenient to use	3
No effective	1
Husband disapproves	< 1
Other	1
TOTAL	70

Given the types of problems cited, a good IEC and promotion program will be essential to increasing demand for an implants.

The major concern for IEC will be to carefully coordinate plans to promote the method with actual availability so that a demand is not created prematurely which could lead to dissatisfied potential users.

Projections of the use of NORPLANT$_R$ obviously start at zero users in 1990. Estimates of potential users by 1995 range from about 8,000 to 15,000. There is no way of determining in advance exactly how acceptable the method will be in Zimbabwe and how quickly it will become accessible to the population at large. It is a clinic-based method and thus its ultimate use will be constrained only by its availability in clinics.

3. Feasibility Analysis

To achieve the project's purpose of 50 percent use of modern methods of family planning will require that the number of users increase by about 50 percent from an estimated 575,000 in 1990 to 880,000 by 1995. (See Appendix 1 for Zimbabwe National Target-setting Model.) Is it feasible to expect such a dramatic expansion of the service delivery program in only five years?

The results of this technical analysis indicate that it is feasible. The basic program infrastructure exists, but needs to be strengthened and expanded. Similarly, acceptance and use of family planning is well established in Zimbabwe and needs only to be strengthened and expanded.

The private sector has a critical role which has only begun to be tapped. If the private sector can increase its share of the total market from roughly 6 percent in 1990 (41,000 users) to 15-20 percent by 1995 (146,000 to 195,000), then the public sector needs to expand its capacity to serve clients from about 648,000 in 1990 to somewhere between 781,000 and 830,000 by 1990. This represents an increased capacity to serve between 132,000 and 181,000 more clients by 1995 (or 22,000 to 30,000 per year) than it is now doing. Assuming use of more effective, longer-term methods, the additional burden from the increase in overall numbers of clients would be offset partially by a changed, and presumably more cost-effective use of the public sector's resources. In sum, it is technically feasible to achieve the purposes of this project, although doing so will require careful and expert management of USAID's project resources and close collaboration with other major population donors in Zimbabwe.

4. Recommended Interventions

Overcoming the identified constraints to increased contraceptive prevalence will require: (1) expanding the variety of contraceptive methods available and (2) an increased role for the private sector in provision of planning

services. Specific project interventions must be designed to address the needs of Zimbabwe's family planning delivery system discussed below:

4.1. Component 1: Diversification of Method Mix

As has been noted, Zimbabwe essentially has a one method program. The 1988 ZDHS found that the pill accounted for 72 percent of all methods used and 86 percent of modern method use. It is remarkable that Zimbabwe has achieved a 43 percent rate of contraceptive use among married couples with a one method program. This success strongly suggests that even greater levels of use can be realized with some programmatic modifications.

The table below shows the relative effectiveness of methods in contrast to Zimbabwe's present method mix. Measures of effectiveness reflects each method's relative failure and continuation rates.

	Relative Effectiveness	Zimbabwe Method Mix	Percent of Users of Contraception
Most Effective	Sterilization	Pill	72.0 most popular
	NORPLANT$_R$	Withdrawal/Trad	15.3
	IUD	Sterilization	5.8
	Injection	Condoms	2.9
	Pill	IUD	2.5
	Condom	Injection	0.01
	Other Barrier	Natural Fam Plan.	0.01
	Nat.Family .Plan.	Other Barrier	0
Least Effective	Withdrawal & Trad.	NORPLANT$_R$	0 least popular
			98.82*

* less than 100% due to rounding errors.

Constraints to diversifying the method mix are two-fold: (i) limited access to longer-term methods, and (ii) limited awareness and knowledge. Among all married women of reproductive age, only 1.1 percent are using IUDs and 2.3 percent are using sterilization. While knowledge of at least one method of family planning is almost universal in Zimbabwe, awareness of more effective, longer-term methods is more limited.

To achieve a more diversified method mix, the project should fund new initiatives in: Information, Education, and Communications (IEC), training, service delivery, evaluation and research, and provision of contraceptive commodities. Suggested interventions in each area are discussed below.

4.1.1. Promotion

Knowledge of family planning methods and of service providers is a precondition to use of contraception. Zimbabwean women are very knowledgeable about family planning. For example, over 95 percent know at least one modern method, not surprising since 79 percent have practiced family planning. While knowledge about family planning is widespread and attitudes toward family planning are positive, there are critical gaps and problems which can be addressed through effective IEC.

What are the gaps in knowledge and needs which can be addressed by an IEC program? As mentioned above, the 1988 ZDHS found that while most women know something about family planning, their knowledge is not very comprehensive. Only half of all women know about IUDs and female sterilization, though this is remarkably high considering that neither method is readily available in Zimbabwe. There is a further gap in knowledge of a source of services for IUDs and female sterlization: only 45 percent know a source for IUDs and similarly, only 46 percent know a source for sterilization.

While lack of information about a specific method or about a service provider is an obvious barrier to use, there are other factors. For example, concerns about side effects or effectivenss might keep a woman from adopting a method which might otherwise be preferrable given her age or reproductive intentions. In the ZDHS, health concerns were cited as the main problem for use of the pill (40 percent); IUD (25 percent) and sterlization (15 percent). In addition, sizeable proportions of women said they did not know if there were problems with a method (IUD - 38 percent, sterilization - 24 percent, pill - 19 percent). This finding also suggests a lack of knowledge about various methods. A good IEC program can provide information on the advantages and disadvantages of methods and go a long way toward correcting misinformation about methods or allaying fears.

General attitudes toward family planning are very positive in Zimbabwe. Still, 15 percent of non-users gave as a reason for not using contraceptives as being personally opposed to family planning, husband's opposition, or same other person's opposition. An I.E.C. effort could help lessen this disapproval of family planning among those whose stance is based on misconceptions or ignorance.

The overall level of awareness is also remarkable given that information and materials on family planning are very scarce. Based on the 1988 ZDHS, only about one in two women were regularly exposed to messages about family planning through radio, television, or the print media. A 1987 evaluation of the ZNFPC's program found an almost total lack of even the most basic material at the clinic and fieldworker levels. There is an obvious need for I.E.C. activities in family planning which becomes even more important when new methods are introduced.

A recent World Bank assessment confirms the need for ZNFPC to emphasize basic print and audiovisual materials to support the service delivery network (Lynn, 1989). Materials and IEC activities need to be developed to support service provider needs (training and in clinics) at all levels as well as those of clients. The World Bank's current Family Health I project is on strengthening IEC activities of both the ZNFPC and the Ministry of Health. The Bank's Family Health II project will make I.E.C. one of its major components and therefore will support much of the I.E.C. activities. The UNFPA will also be supporting decentralization of IEC activities at ZNFPC. Therefore, a small, well-targetted, intervention rather than a comprehensive I.E.C. effort is recommended for inclusion in the planned A.I.D. assistance.

To be effective, methods have to be acceptable not only to potential users, but also to providers. Providers must be able and willing to inform clients about the advantages and disadvantages of different methods. It is well known that visual material coupled with a verbal message can be extremely useful in conveying knowledge. Moreover, giving clients printed material to take with them is known to reinforce the communication process. One cannot have informed choice without sufficient information and understanding of various alternatives.

The underlying principle for the I.E.C. component should be that, at a minimum, information on contraceptives should be as available as the actual contraceptives. After having methods explained to them with the aid of sturdy flipcharts, providers should have a generous supply of inexpensive handouts for clients who want more information. There are many existing and widely used examples of such materials.

4.1.2. Training

ZNFPC's Training Unit has played a key role in expanding family planning services through both the public and private sectors in Zimbabwe and, more recently, internationally as well. Virtually all domestic personnel involved in family planning have either been trained there themselves or have been trained by ZNFPC graduates. The Unit should play a key role in expanding both service accessbility and method mix during the coming period.

There are four suggested areas for project assistance in training: (a) development of a comprehensive training plan; (b) review and adaptation of the various course curricula; (c) expansion of the ZNFPC training capacity and output; and (d) strengthening ZNFPC trainee follow-up.

(a) Comprehensive Training Plan

A prerequisite for project training assistance is the development of a comprehensive family planning training plan for Zimbabwe, currently scheduled as part of a World Bank-funded strategic planning exercise.

The project should assist the Bank team to ensure that issues relevant to this training design are addressed. Following strategy development, USAID and ZNFPC should convene a meeting of the principal cooperating agencies to more clearly delineate respective roles. This meeting would involve AVSC, JHPIEGO, SEATS, and Pathfinder.

(b) Curriculum Review and Development

Courses offered: The Training Unit currently offers a variety of two to four week courses, but spends a third to a half of available time on its Basic Clinical Course for nurses and doctors. Lasting four weeks, the course orients new personnel to family planning problems and methods and gives them about two and half weeks of supervised practise in patient management. It does not, however, teach IUD insertion or sterilization, reserving these for subsequent courses. The majority of participants are now public sector staff, though trainees also come from private employers and programs in other countries. The course is taught three times per year in Harare and three times in Bulawayo.

Other courses include the IUD course (taught six times a year until recently, but now "on hold"), the Basic CBD course (also largely stopped because of lack of new ZNFPC hiring of CBD workers), and periodic refresher training for CBD staff (Senior Health Educators, Group Leaders, and distributors). Plans are also well underway for sterilization training, and, at an appropriate time, for the introduction of NORPLANT$_R$ (see Service Delivery Section). To date, two courses have been held for CBD program managers from the African region.

Considerable AVSC and JHPIEGO work has gone into curriculum development, but both the IUD and sterilization courses need to be finalized, and the Basic Course needs to be fully reviewed and updated. New courses will need to be adapted or devised for training private sector practitioners, for NORPLANT$_R$ trials and expansion, and for improving CBD counselling/referral skills. In each case, the state of current field practice will need to be assessed to guide determination of training content and to ensure that trained personnel are properly equipped and supervised to practice what they have been taught.

The curriculum for the Basic Course was developed in 1984, and staff have identified shortcomings regarding long-term methods, patient counselling and referral, and Sexually transmitted diseases (STD) and AIDS. Revision of this course is a particular priority because of its high output and to ensure that public sector and other non-ZNFPC personnel develop more supportive attitudes than they now exhibit towards long-term methods. Employer-sponsored clinical staff should be given priority in the crowded training queue.

ZNFPC's current curriculum for IUD training is not specific to the Copper T-380A and lacks sufficient material on STD and prevention of infection (including AIDS). Clinicians and counselling personnel particularly need

guidance on client screening to identify those for whom the IUD is the most appropriate method. JHPIEGO has developed generic instructional materials which need only to be adapted to the Zimbabwean context. This material includes one week of instruction (during the three week course) on treatment of sexually transmitted genito-urinary tract infections. The sterilization curriculum is now complete. New course materials will also be required for the introduction of NORPLANT$_R$ into the Zimbabwe family planning program.

(c) Expanded Training Output

To fulfill the proposed project objectives, ZNFPC needs to significantly expand training of private practitioners and employer-sponsored personnel, as well as training of public sector and ZNFPC staff committed to performing sterilization and IUD insertion. Intervals between application for training and enrollment run up to 18 months at present, leading to lengthy delays in starting innovative services. Some improvements may be possible by changing trainee selection criteria, but in the long run overall output will have to be increased as well.

The project should encourage ZNFPC to modify trainee selection criteria to give preference to:

- Sterilization training for dedicated public sector personnel (plus a few ZNFPC staff);
- IUD training for staff of 34 ZNFPC clinics plus committed public sector personnel;
- Basic and IUD training for private practitioners and employer-sponsored staff; and
- Refresher training for CBDs and their supervisors.

Even with modified selection criteria, significant training backlogs will remain. There are a number of constraints to expanded output, not all of which the project can resolve. These include:

- shortage of qualified training staff,
- inadequate physical space,
- inadequate recurrent cost financing, and
- lack of access to IUD and sterilization clients for practical training.

Training capacity can only be expanded slowly because of these constraints (particularly the lack of IUD and sterilization clients) but should be fully developed by the end of year 3.

The ZNFPC Training Unit currently has an authorized staff of 13 nurse-tutors, four based in Bulawyo and nine in Harare. Two vacancies currently exist in Harare. To reduce staffing constraints, the project should finance the hiring and training of six additional tutors (three in year 1 and three in year 2), bringing the total to 19 (two of whom, though, will be dedicated to trainee

follow-up, as described below). These nurse-tutors should be further assisted by approximately three physicians seconded from the University of Zimababwe Medical Shcool for clinical aspects of IUD and sterilization training. ZNFPC will need to re-estimate its training costs and develop cost recovery mechanisms for international trainees and those sponsored by the Ministry of Health through the Family Health Project.

While lack of physical space is an important constraint in Bulawyo, considerably more can be done in Harare without further construction. Minimal funds should be budgeted for renovation of office and teaching space should it become possible for ZNFPC to locate additional space.

(d) Training Follow-up

To reduce the load on ZNFPC staff, much of the family planning training of public sector personnel is provided elsewhere, by Ministry of Health tutors originally trained at ZNFPC. Though technically responsible for quality control even at this level, ZNFPC, in fact, has little direct knowledge of the number of courses provided or of their quality. Additional second tier training will occur through the Family Health Project II and may eventually reach more family planning personnel than ZNFPC itself.

The Training Unit is currently staffed and equipped to do little more than train personnel and send them into the field, yet training follow-up remains an important part of their responsibility. Follow-up is also needed to determine if ZNFPC personnel are providing the services for which they were trained and to determine needs for refresher training. Follow-up and supervision are important activities which should be included for support under the project.

4.1.3. Service Delivery

Family planning service provision in Zimbabwe is increasingly complex, leading to greater difficulty in programming but greatly enhanced prospects for sustainability. Originally dependent in large measure on ZNFPC's community-based distributors supported by a few clinics, family planning is now available through approximately 200 public sector facilities, an increasing range of private sector providers and distributors, and 34 ZNFPC clinics. Given the importance of expanding method mix, the program needs to emphasize sterilization, IUDs, and NORPLANT$_R$ as the longer-term methods meriting the most attention in the next six years. Oral contraceptives will remain the program's backbone for the foreseeable future. There will, however, be less need for training and technical support for pills in the coming years because both supply systems and demand are better established than for the new methods.

Another element of strategic design concerns the choice of providers. For rural areas, ZNFPC has long relied on its network of community-based distributors (CBDs), achieving one of the most successful programs of this type in the world. Now, this program is severely constrained by cost and by its limited (though vitally important) role in expanding method mix. Only 25 percent of pill users obtain their services from CBDs, and clinics have already become the predominant source of supply for Zimbabwean users.

Clinics are critical to increasing access to a diversified method mix because only they can provide sterilization and IUD services and because they increase acceptance and proper method use by providing medical backup to CBDs. By far, the greatest number of clinics are in the public sector but within a diverse network comprising the Ministry of Health proper, municipal health authorities (Harare, Chitungwiza, and Bulawayo), and district and rural council clinics. The Ministry of Health portion of this sector also includes hospitals and clinics operated by religious missions but with Ministry policy guidance and financing. The Ministry's hope is that all 1231 public sector facilities will eventually provide family planning services.

There are clearly multiple avenues for expansion, not all of which can be supported. The strategy for the coming period should emphasize private, public, and parastatal clinics for expansion of method mix, and private retailers for contraceptive distribution. The strategy should:

- Emphasize sterilization as the long-term method with greatest potential but proceed slowly to expanded service provision (initially through 6 public sector clinics and two ZNFPC facilities);

- Promote full availability of IUDs through ZNFPC clinics, private physicians, and employer-sponsored clinics;

- Promote the use of NORPLANT$_R$;

- Strengthen the motivation and ability of ZNFPC's CBDs to refer sterilization and IUD clients; and

- Expand private sector contraceptive distribution through social marketing.

Expanding service delivery capacity should involve four areas of project assistance: (a) assessment of the ZNFPC and private sector clinic capabilities; (b) expansion of ZNFPC sterilization facilities; (c) expansion of the number of ZNFPC clinics within public sector facilities; and (d) NORPLANT$_R$ introduction.

(a) Assessment of Clinic Capabilities

ZNFPC currently operates 34 clinics, including 20 free-standing ones, 9 located inside or on the grounds of public sector hospitals, and 5 mobile units. Surprisingly little is known about their capacity and output at the present time and thus a priority task is to assess their staffing, equipment, and performance. There should be a systematic inventory of existing facilities, including: physical condition; the number, qualifications, and current skill levels of staff; and the status of essential equipment. Levels of activity and output should also be assessed. Other areas which should be examined are management information systems, supervision, and logistical support. Answers should be sought to the following questions:

- What additional equipment and refurbishing is needed to permit high quality IUD procedures?

- Which clinics, if any, might be candidates to be upgraded for sterilization?

- What changes might be required in clinic management and support systems?

- What retraining, including changes in curricula, is required to upgrade clinic management and service delivery?

This assessment is fundamental to the service delivery strategy and should occur in the first year of the new project.

(b) Development of Sterilization Facilities

Female sterilization through use of the mini-laparoscope under local anesthesia is likely to be the "new" method with greatest potential in Zimbabwe. High quality services are currently available at ZNFPC clinics in Harare and Bulawayo and will shortly be offered though six public sector clinics being developed through the Ministry of Health's Family Health Project II. Demand for sterilization will be rapidly fueled by service availability (especially for out-patient procedures) and focused promotion. Expansion beyond these eight sites will be needed within an estimated three years.

Most of the additional need will be met through Ministry of Health-financed public sector facilities and through a small number of private clinics, as described below. Demand will be inadequate to justify a physician's full time presence for sterilization at ZNFPC centers outside Harare and Bulawayo, but consideration should be given to establishing dedicated facilities in selected centers to be serviced by ZNFPC staff as need requires. ZNFPC clinics within district and provincial hospitals are the most likely candidates for this new service. To make it possible, the project should equip and refurbish a small number of clinics and provide one vehicle.

As noted elsewhere, project-supported promotion efforts must be particularly concentrated in areas where sterilization and IUD services have been fully developed. Community-based distributors will be an important link for referral to these clinic sites.

(c) Establishment of ZNFPC Clinics in Public Sector Facilities

ZNFPC has had substantial success in placing personnel directly into public sector clinics for the provision of family planning in an integrated MOH context. This strategy has several advantages:

- The use of existing facilities eliminates construction costs and delays.
- The clinics have an existing client population.
- Referral mechnisms are simple.
- Support services are available.
- The concept of family planning as a method of improving the health of women is fostered.

Suggested criteria for selection of location are:

- Geographical access;
- Shortage of existing clinic-based services;
- Suitability of the physical facility;
- Adequacy of support services from public sector staff; and
- Interest of associated public sector staff.

Implementation in each location should entail the following activities:

- Provision of ZNFPC service staff, usually two fully trained family planning nurses.
- Provision of necessary equipment and supplies.
- Orientation of the existing public sector personnel in family planning, including the benefits, indications, counselling for referral, and basic contraceptive technology.
- Training update for existing CBD workers in the area, concentrating on the technology of clinic-based methods and indications of the need to refer a client to the clinic for additional follow-up or a method change.
- Ongoing medical supervision and in-service training for the ZNFPC service personnel.

(d) Introduction of NORPLANT$_R$

NORPLANT$_R$ is the first truly new contraceptive in several decades. As a subdermal implant, it requires minor surgery for insertion and removal. It should be introduced in Zimbabwe as part of the program to diversify the available contraceptive methods. Because NORPLANT$_R$ is a new method, its introduction must be carried out in a careful, systematic manner.

The Population Council, the developer of NORPLANT$_R$, has received UNFPA funds for the initial or pre-introduction phase of the method in Zimbabwe. The Council is the most experienced organization in this area and has successfully introduced it into a number of countries. While the Population Council may modify its introduction protocol for different countries, the following types of activities are part of the introductory process which is expected to take one to two years:

- Explain NORPLANT$_R$ to policymakers, program administrators and regulatory officials.
- Estimate the need for the method.
- Provide model training and IEC material.
- Train a select number of service personnel - clinicians and counselors.
- Gain "hands-on" clinical experience in inserting and removing NORPLANT$_R$.
- Assess the above experience to ensure high quality provision of NORPLANT$_R$.
- Recommend action required for an appropriate and presumably expanded role for NORPLANT$_R$.

Specific plans for Zimbabwe should include the following: During the pre-introduction study, two physicians from the Department of Obstetrics and Gynecology of the University of Zimbabwe and the ZNFPC should receive training. About 200 subjects should be recruited during a 9-12 month period which could begin as early as October 1990. Subsequently, these subjects should be followed to assess the acceptability of the method and problems with its use. The results of this follow-up study should be reviewed by the Research and Ethics Committee of the Ministry of Health. Assuming Government's favorable review of the results, wider-scale training for and provision of NORPLANT$_R$ should proceed.

A similar introductory study has recently and successfully been completed in Kenya and plans are underway for wider distribution of NORPLANT$_R$. Based on Government's approval of the pre-introduction study in Zimbabwe and the Population Council's previous experience in other countries, it is not anticipated that there will be any obstacles to wider-scale distribution of NORPLANT$_R$ in Zimbabwe.

It is suggested that the University of Zimbabwe play the leadership role as a training center and that the ZNFPC assist in providing clinic space and personnel for the expansion program. The training should include gynecologists from the Department of Obstetrics and Gynecology (OB/Gyn) at the University of Zimbabwe; gynecologists working in Provincial Hospitals; physicians in Provincial Centers; and counselors for each clinic where NORPLANT$_R$ will be available. Nurse training should be added at a later date if a study currently underway

in Zambia is successful and if Zimbabwean authorities consider it appropriate. Physicians and counselors from the private sector should also be trained.

4.1.4. Evaluation and Research

Evaluation and research are key functions of a successful family planning program. The Evaluation and Research Unit (ERU) of the ZNFPC is responsible for providing ongoing information on program implementation, identifying operational issues or problems, testing strategies for resolving these problems, and evaluating the impact of the Council's program. ERU activities in four areas need to be strengthened: (a) service statistics; (b) information management, (c) operations research, and (d) program evaluation.

(a) Service Statistics

A major responsibility of the Evaluation and Research Unit (ERU) is the collection and maintenance of the Council's routine service statistics. ZNFPC's service statistics system is one of the better in the developing world, yet managers do not fully benefit from either its routine analyses or from the potential richness of its contents. At the present time, very little or no service statistics are made available to Clinic Directors, and they are not used as managerial tools. The sharing of service statistics with officials at the local level will not only serve to inform them about local activities, but also serve to compare clinics and services. The project should strengthen the collection and use of program statistics by providing technical assistance to assess current ZNFPC and public sector reporting system and the analysis and use of service statistics for program management.

(b) Training Information System

Another important role of the ERU is the development and maintenance of management information systems (MIS) which can improve the efficiency and effectivness of the Council's programs. In light of the considerable emphasis being placed on improving and expanding the training of clinicians (both medical doctors and nurses), counselors, and CBD promoters, the ERU should develop an MIS to track all training participants. The trainee monitoring system should record the names, locations, and institutional affiliations of all trainees to facilitate follow-up and supervision. This roster could then be used for periodic surveys to study graduates' current involvement in family planning service delivery and training.

An MIS would be especially useful for assessing how well the ZNFPC is meeting its objectives in training both Council and Ministry of Health clinic staff, private providers, employer-based health personnel, and CBDs. The system should also be designed to enable follow-up of trainees and thereby ensure that the expanded number of contraceptive methods are actually available.

(c) Operations Research

Operations research addresses programmatic issues and bottlenecks and tests alternative approaches to improved service delivery. Operations research can also improve the effectiveness and efficiency of the Council's program. Given that one of the overall objectives of the project is to expand method mix, one key research area is the need to assess the acceptability of an expanded range of methods.

Acceptability Study - As an essentially pill program, it is important that the ZNFPC quickly gain experience and knowledge about other methods. An acceptability study of a broad method mix would provide valuable experience and information to the ZNFPC. Such a study should examine the acceptability of a wide range of methods among providers and users.

Other Ongoing or Planned Studies - The Pathfinder Fund and the Population Council are currently preparing a proposal with the ZNFPC to study alternative models for supply and resupply of pills in rural areas. It is likely that the results of this study will lead to changes in the ZNFPC's CBD program and possibly to further testing of alternative delivery models. Other possible small studies aimed at resolving specific clinic management problems might include: testing variation in clinic hours and cost and benefit comparison of free-standing ZNFPC clinics vs. ZNFPC clinics within Ministry of Health facilities.

(d) Program Evaluation

ERU should be the locus for analyzing output measures by which this project and ZNFPC's overall program will be assessed. The most important of these measures are: total fertility rate, contraceptive prevalence rate, and method mix.

The family planning program in Zimbabwe has benefitted from good information on attitudes and practices on family planning as well as on fertility levels. Two national surveys have been carried out during the 1980s. The first was the Zimbabwe Reproductive Health Survey in 1984. More recently, the Zimbabwe Demographic and Health Survey (ZDHS) was carried out in 1988. The ZNFPC provided key assistance for the 1988 ZDHS on questionnaire content, sampling, analysis, and preparation of the final report.

A third DHS in 1994 is recommended to provide nationally representative data which in combination with data from the 1988 ZDHS will enable an assessment of changing knowledge, attitudes and practices on family planning.

4.1.5. Commodities

A.I.D. is the principal source of donor-contributed contraceptives, accounting for around 75 percent of all contraceptives donated worldwide. Other donors recently have stepped up their global contraceptive procurement efforts, especially UNFPA and the World Bank. Sharing the contraceptive burden among donor organizations not only allows the respective donors to maintain adequate levels of support in other areas, but also means that each donor can emphasize its comparative advantage. For instance, UNFPA can purchase condoms at half the price that A.I.D. must pay.

Although A.I.D. is still, by far, the largest contributor of contraceptive supplies, the support of other donors is critical. If A.I.D. bought the contraceptives to be supplied by UNFPA and WHO, it would have to pay $6.5 million, not the $2..95 million that these other donors are paying. This would raise A.I.D.'s total contraceptive donation to $12 million, making the project no more than a contraceptive commodity procurement transaction. An efficient use of donor funds is for A.I.D. to purchase all pills (since A.I.D. can purchase pills at competitive world prices) and for other donors to buy other methods. The attached tables 1-4 provide details of the commodity inputs of each donor.

A.I.D. is encouraging some host-countries to assume part or all of their contraceptive requirements. Zimbabwe already pays for 50 percent of its family planning program. Projections for this project estimate requirements for oral contraceptives, over five years of U.S.$8.3. The present plan calls for U.S.$5 million worth of oral contraceptives over six years. This plan presents a real challenge to the Government and to A.I.D.

The private sector commodity requirements for years 1 and 2 are covered by existing contraceptives stocks at held by the firm of Geddes Ltd. Requirements for the remaining years of the project assume a complete phase out of USAID support by year 6. The requirements for years 2-5 are as follows:

Condoms: The social marketing program estimates that 968,000 condoms will be sold in 1990. As noted in the technical analysis section, this is a 5 1/2 fold increase over of 1989 actual sales of 173,000. The estimates in Table 5 are based on a 30 percent annual increase in sales from the 1989 level.

Pills: The social marketing program projects 1992 sales of 67,000 cycles o r the 1989 level of 47,702. This estimate is based on a 12 percent annual increase. While the estimate may be somewhat optimitstic, it is certainly possible.

IUD: This is a promising method for the social marketing program. In 1989 1,587 IUDs were sold. By 1992, 4,478 are expected to be sold. For subsequent years, a 20 percent increase is estimated. Contraceptive requirements for the social marketing program should be reassessed at the end of 1991.

Given the incresed complexity of sources of support for commodities and the likely involvement of the Government of Zimbabwe's by year 3, technical assistance should be provided for logistics management for commodities during the first five years of the project by John Snow Inc.

4.2. Component 2: Expansion of Private Sector Involvement

The private for-profit sector could play an increasingly important role in providing and generally supporting the expansion of family planning services in Zimbabwe. The 1988 ZDHS estimates that private hospitals, clinics and pharmacies currently supply about six percent of all users of modern contraception. It is not possible to assess with any accuracy what proportion of the total "market" for contraception the private sector could be responsible for by the end of the project (much depends on the relative growth of the public sector). However, given the need to expand total availability of services, the for-profit sector will have to play an increasingly important role in service provision and financing.

4.2.1. Expand Contraceptive Social Marketing

A contraceptive social marketing program was initiated in 1987 through an agreement between the S&T/POP centrally-funded SOMARC project and Geddes, Ltd., a local pharmaceutical supplier. The SOMARC project provides technical assistance and contraceptives (orals, condoms, foaming tablets and IUDs) to Geddes for its Health Family Care Program. Geddes, in turn, pays the import duties and takes responsibility for packaging, advertising and marketing the commodities through pharmacies and private doctors.

Following a cautious start, this program is poised for a period of rapid expansion. It currently has about one percent of the condom market but aims to grow to a significant share of an expanded total market during the life time of the project. Growth in the distribution of pills, IUDs and other more permanent methods is projected, but will be constrained by supply and regulation issues. The project should contribute in the short term to

TABLE III.A.1 UNFPA COMMODITY ESTIMATES FOR ZIMBABWE

Quantities

	1990	1991	1992	1993	1994	1995	TOTAL
Foam Tables (VFT)	97,800	103,500	109,400	115,636	122,228	0	548,564
IUD	14,800	19,700	26,200	34,900	46,460	0	142,060
Condoms (000)	17,930	7,170	8,270	9,010	9,820	0	52,200
Depo Provera	13,040	14,590	15,410	16,000	17,000	0	76,040
Other Vaginal (Delfen & Ramses)	918	1,096	1,310	1,565	1,865	0	6,754

Costs (U.S.$ 000)

Foam Tables (VFT)	$ 8,802	9,315	9,846	10,407	11,000	0	$ 49,370
IUD	10,656	14,184	18,864	25,128	33,451	0	102,283
Condoms	466,180	186,420	215,020	234,260	255,320	0	1,357,200
Depo Provera	12,388	14,444	16,026	17,440	19,380	0	79,678
Other Vaginal	1,377	1,644	1,965	2,348	2,798	0	10,132
	$499,403	226,007	261,721	289,583	321,949	0	$1,598,663

Cost per unit: U.S.$

VFT = 0.09

IUD = 0.72

Condom = 0.026

Depo = 1990= 0.95

1991= 0.99

1992= 1.04

1993= 1.09

1994= 1.14

Other Vag.= 1.50

(Delfen & Ramses)

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TABLE III.A.2 WHO/GPA CONDOM ESTIMATE FOR AIDS/STD USE

Quantities

	1990	1991	1992	1993	1994	1995	TOTAL
CONDOMS (000)	0	11,360	12,410	13,520	14,720	0	52,010

Cost (U.S.$ 000)

	0	$295,360	322,660	351,520	382,720	0	$1,352,260

Cost per Condom = U.S.$0.026

TABLE III.A.3 USAID PILL ESTIMATES FOR ZNFPC

Quantities

	1990	1991	1992	1993	1994	1995	TOTAL
LO-Femenal Blue Lady	3,604,595	4,395,136	2,385,136	1,672,297	1,033,784	0	13,090,948
Ovrette	3,490,000	3,444,800	4,371,622	3,395,270	2,344,594	0	17,046,286
	7,094,595	7,839,936	6,756,758	5,067,567	3,378,378	0	30,137,234

TABLE III.A.4 USAID NORPLANT ESTIMATES FOR ZNFPC

Quantities

1990	1991	1992	1993	1994	1995	TOTAL
0	0	2,500	3,000	4,000	5,500	15,000

Cost (U.S.$ 000)

$ 0	0	58	69	92	126	345

Cost Per Unit U.S.$
$NORPLANT_R$ = 18.00 per sets plus $5.00 per insertion for equipment

TABLE III.A.5 USAID CONTRACEPTIVE REQUIREMENT FOR SOCIAL MARKETING

Quantities

	1990	1991	1992	1993	1994	1995	Total
CONDOMS (000)	0	0	371	482	626	0	1,479
NORQUEST(000)	0	0	67	75	84	0	226
IUD	0	0	4,478	5,374	6,449	0	16,301

Costs (U.S.$ 000)

CONDOMS	0	0	$22,260	28,920	37,560	0	$ 88,740
NORQUEST	0	0	17,420	19,500	23,140	0	60,560
IUD	0	0	4,521	5,427	6,513	0	16,461
TOTAL	0	0	$44,701	53,847	67,213	0	$165,761

Cost per Unit
CONDOMS = U.S.$0.06
NORQUEST = U.S.$0.26
IUD = U.S.$1.01

creation of a wider commercial market for contraception with all of the cost and benefits that that implies. Its full marketing impact may not be felt until the regulatory environment for advertising is liberalized.

Despite receiving a subsidy from foreign donors, the social marketing project in Zimbabwe operates as a market-led commercial enterprise. The "Family Care Program" as it is called, uses traditional mass marketing techniques to create a demand for contraception and responds to it by primarily using commercial outlets. Consequently its success is affected by the economic and regulatory environments which govern the economy and the sale of pharmaceuticals in particular. Matters such as foreign exchange regulations, import duties, constraints on advertising and the supply of contraceptive products are critical to the growth and success of this project, and most of these factors are beyond its immediate control.

(a) Condom Distribution

The program estimates that the total demand for condoms in Zimbabwe may be as high as 7 million a year. At this time it distributes just over 60,000 per year or about 1 percent of the total market. It currently uses 200 outlets of all sorts but estimates there exists a potential 3,000 nationwide. At this time 80 percent of these outlets are in and around Harare and Bulawayo. As the program grows, it intends to make greater use of such outlets as beer halls, petrol stations, and supermarkets. It is thought likely that growing public awareness of AIDS will be an important factor in stimulating the demand for condoms and that the government will support an extensive advertising campaign to promote their use on family planning and public health grounds. The Family Care Program is also seeking to extend consumer choice by offering an extra thin variety at Z$1.50 per package of 3 as opposed to Z$1.00 per package of 3 for the standard product. The program's growth plan for condom sales is as follows:

Table III.A.6 Condom Sales Future Projections

Year	90	91	92	% growth 1992 over 1990
Thousand sales	968	1250	1510	56

There are two major constraints on the performance of this program and they both originate in GOZ policy.

(i) The program is required to pay 25 percent duty on its imported commodities.

(ii) There are undefined but very real constraints felt by the program on the vigor and scope that a private company can apply to its advertising campaigns for condoms.

Both these problems need to be addressed if the full effectiveness of the program is to be achieved.

A restructuring of the Geddes Company has occurred, which means a wider range of company representatives will now carry the full line of contraceptive products, especially condoms. This development should overcome some internal constraints on the amount of sales activity the company has been able to get. In 1989 its total sales of condoms was only 172,778. Thus, projected figures for 1990 represent a massive marketing and sales effort to increase sales by five and a-half times, and this may not be a realistic target.

(b) The Pill

The pill can only be sold commercially with a prescription from a physician. While this situation remains in force distribution will be primarily limited to commercial pharmacies. There are only 82 such outlets nation-wide, most of which are in the "low density" (i.e. middle to upper income) neighborhoods. However, some distribution is possible through the 116 private clinics that exist in Zimbabwe. In 1989 a total of 27,702 cycles of "Norquest" pills were sold.

The program assesses the total market for the pill to be in the range of 7 million cycles, of which ZNFPC provides 2.7 million. However, even given critical constraints, the program might have a reasonable chance of capturing a large proportion of the urban and suburban market, which is approximately 20 percent of Zimbabwe's total population. The program's growth plan for sales of the pill is as follows:

Table III.A.7 Pills Future Projections

Year	1990	1991	1992	% growth 1992 over 1990
Thousands	46,800	56,160	67,390	44

The pill is classified as an ethical pharmaceutical and as a result it cannot be advertised outside of medical journals. Consequently, the mass marketing strengths of the Family Care Program cannot be used. Furthermore, as long as the existing program is limited to a prescription basis using pharmacies and

clinics, this element of private sector distribution will never grow significantly. Government will need to change its policy about allowing the purchase of Norquest without prescription and permit large-scale advertising of the product before the commercial sector can play a major role in distribution of the pill.

However, some changes seem possible in the liberalization of pill sales. It may soon be possible for acceptors holding a clinic card to purchase new supplies at the pharmacy on presentation of the card. This development ought -- in time -- to help: (i) acceptors obtain speedy resupply; (ii) acceptors have a broader choice in pill selected for use; and (iii) achieve some cost transfers from the public to commercial sectors.

(c) I.U.D.'s

The program offers copper T IUD's at a price of $15 to the patient, the market price being $40. In 1989, it sold 1,587 IUD's, and Geddes believes that there is considerable unmet demand for the product. At this time, Geddes is servicing about 40 percent of the existing market. The program's future projections for the sale of IUD's is as follows:

Table III.A.8 IUDs Future Projections

Year	1990	1991	1992	% growth 1992 over 1990
	2,985	3,582	4,478	50

There are constraints to demand creation for IUD's. However, the program is not in a position to mount a separate IEC campaign to help create demand. It could give prominence to IUDs and indeed other more permanent methods if restrictions on advertising were eased or clarified. The demand for IUDs will in the main be created through the general IEC work of ZNFPC.

There are also significant constraints on the supply of the product to acceptors because there are not enough physicians trained to insert the copper T. Such training has to be a high priority if this method is to be more widely used and should include not only most private physicians (see following section) but ZNFPC personnel and those in the public sector as well. At the moment, private physicians play an important role in providing this method and could be responsible for a significant growth in its availability.

Table III.A.9 Percentage Distribution of Users of "Clinic"* Methods of Contraception by Source

Family Planning Source	"Clinic" Method
ZNFPC CBD	0.0
ZNFPC Clinic	7.5
Government Hospital/Clinic	65.0
Private Sector**	21.0
Other	6.5
TOTAL	100.0

* "Clinic" methods includes IUD, injectables, and sterilization.
** Includes doctors/pharmacy/industry owned facilities.

Source: 1988 ZDHS.

The program leadership has also suggested that private midwives be included in the IUD training program and this matter should be explored further with ZNFPC.

Over time, one of the major outcomes of a social marketing program is the creation of a commercial market for contraceptive products and services. It can thus have a vital role to play in shifting acceptors from dependence on free public sector provision to fully financing their contraceptive needs from their own family budget. Critical to providing commodities on the commercial market at a low unit cost is the volume of sales that can be generated. Zimbabwe alone is a relatively small market. Consequently the program is looking to extend its activities into Lesotho and Botswana, thus extending, somewhat, the total market it can expect to serve. This is a positive development and should be encouraged; such developments on an even wider scale are essential if local production of contraceptive products is ever to become a viable possibility.

4.2.2. Expand Employer-provided Services

Over the last three years, five private sector entities have begun providing family planning services. These are: two large commercial farms (Triangle Ltd. and Hippo Valley), approximately 125 medium-scale commercial farms (members of the Commercial Farmers Union), a mining company (Lonrho Zimbabwe Ltd), and a large urban manufacturing company (British American Tobacco). The Enterprise Project has financed start-up costs (except for Hippo Valley), including provider training, IEC materials, equipment and planning. Most recurrent costs implementation have been covered by the companies. Through the four partnerships, 37,000 couples now have access to family planning services.

Table III.A.10 Distribution of employees by Industrial Sector

Employees ('000, annual average)	1981	1988
Agriculture & forestry	294.3	258.0
Mining & quarrying	68.2	
Manufacturing	173.2	187.3
Construction	47.1	58.6
Electricity & Water	6.6	8.6
Transport & Communications	49.1	51.2
Distribution, Hotels, etc.	75.0	87.2
Finance & Real Estate	13.8	17.2
Public Administration	83.2	92.4
Education	59.1	100.3
Health Services	16.3	22.8
Private Domestic Service	104.6	102.0
Other Services	47.3	68.8
Total	1,037.7	1,112.1

Sources: Quarterly Digest of Statistics; First National Development Plan (for agriculture and Forestry in 1985); Confederation of Zimbabwe Industry.

The work of the Enterprise project has demonstrated the cost effectiveness of employer-provided services in large agricultural plantations and mining camps. The projects currently running are effective in family planning terms; raising the prevalence levels in these closed population groups from 22 percent to 65 percent in two years. They also work economically as some cost savings accrue to the employer in terms of reduced medical and educational costs for the spouses and offspring of the predominant male employees.

(a) Mining and Agriculture

Despite a steady decline in the numbers employed in the mining and agriculture sub-sectors of the economy, there is considerable scope for replicating these projects in other comparable plantations and mines. A priority for the project must be to carefully analyze the pattern of employment in these two sub-sectors identifying all major employers and using the experience gained to

encourage them to provide services to employees and their spouses. No developmental or analytical work should be necessary for the rapid expansion of services to comparable enterprises; it will be largely a matter of "selling" the concept and showing the existing successes.

The important exception is the commercial farmers who provide the large bulk of agricultural employment. They operate relatively small agricultural units (50-300 employees) and do not have clear financial incentives to provide family planning. Unlike the large plantations, they only provide their employees with limited benefits. However, the commercial farmers have extensive communication networks in the rural areas, and they can organize effective contraceptive distribution systems and might make a small contribution to the costs involved if a partnership can be negotiated with ZNFPC.

The centrally-funded SEATS project will continue to build on Enterprise's work with the commercial farmers to try to promote their greater involvement in family planning provision. This is critical because they employ 220,000 workers who have up to 1.2 million dependents. The Commercial Farmers Union (CFU) is represented on the ZNFPC for-profit sector coordination committee, and there are reasonable expectations that the project can help develop arrangements with the CFU for the delivery of family planning to their employees and spouses. While these arrangements may not achieve significant cost transfers from the public to the private sector, they made lead to valuable cost savings in terms of a very effective supplement to ZNFPC's community distribution network. Even if ZNFPC has to offer a small subsidy to the commercial farmers to have them become involved in contraceptive distribution, the costs involved ought to be well below the real costs of meeting that need.

(b) Other sub-sectors of the Formal Economy

The challenge to the project over the next six years will be to develop family planning activities in new sub-sectors of the economy. Manufacturing, distribution and finance employ nearly 300,000 workers and offer significant prospects. Office workers/Public administration (92,400 employees) might also offer good opportunities to develop contraceptive distribution schemes. Less attractive because of a lack of a clear infrastructure are the domestic services and informal sectors of the economy. The overhead cost of developing projects in these sectors will probably be very high unless effective models have been developed in other parts of the world. (Enterprise has developed some micro-businesses specializing in contraceptive sales in Latin America for example.) The major motive for trying to enter these "market segments" is that they are very largely dominated by female workers.

(c) Women Workers as Primary Targets

Within the formal sector of the economy the next most significant targets for the project to address are businesses that employ a large percentage of women workers. The reason is that there is a clear financial incentive to those

businesses to provide family planning because they will make savings on the maternity and other benefits which they are obliged to pay; as well as all the other costs associated with absence from work due to pregnancy such as absenteeism, lost production, and the costs of replacement workers.

In Zimbabwe, labor law requires employees to grant a woman employee up to ninety days maternity leave. The relevant act states:

> "She shall, in addition to receiving all her normal benefits payable by the employer, be entitled to not less than seventy-five percent of her normal pay which shall be payable as and when it would have been regularly payable, had she not gone on such maternity leave."

Furthermore the "Labor Relations Act" states that:

> "The frequency of paid maternity leave that a female employee may take - - - shall not exceed once every twenty-four months and a total of three times with respect to her total service to any one employer."

Under the terms of this act the cost saving to employers of reduced pregnancy rates ought to be significant. The distribution of women workers in the formal sector of the economy is as follows:

Table III.A.11 Distribution of Female Employment by Industry
(Percentage of Total Female Labor Force)

Year	Agric.	Mine and Quarry	Mfg.	Elect. Gas and Water	Constr.	Trade Rest. and Hotels	Trans Stor Comm.	Finance Insur. Busin.	Pers. Srvc.	Other
Zimbabwe 1984	20	5	16	1	4	8	5	2	33	5

Note: Sectors may not sum to 100% due to rounding

Source: Based on information provided in 1988 International Yearbook, International Labor Office, Geneva, 1988.

These figures mean that there are real opportunities to develop projects with employers that have a significant number of women employees. The World Bank Industrial Sector Memorandum (page 84) shows that Textiles and Ginning, for example, employs approximately 16,600 workers many of whom are women. At this time, seven companies account for 80 percent of the country's capacity, and once one company has been convinced of the value of providing family planning services it ought to be relatively easy to spread an appreciation of the benefits to other companies in the sub-sector. The same analysis may well apply in Foodstuffs, clothing, and footwear. The remaining sectors are dominated by male employees.

(d) Male-dominated Industry

By working with the male-dominated B.A.T. plant in Harare, the Enterprise project has demonstrated some modest but encouraging success in educating male workers about the benefits of family planning and raising the prevalence of use among their wives by 15 percent over an eighteen month period. With this experience as a basis, ZNFPC may find it worthwhile to deploy some resources to persuade other major employers of male labor to promote family planning among their workers. There is also a case that can be made to trade unions (which claim to represent 17% of the employed work force) to support family planning. However, it is unlikely that such projects will contribute to self-sufficiency objectives since employers may well be reluctant to incur costs with no clear savings (unless they pay medical benefits) for spouses not covered by medical aid schemes. However, they can help with the distribution and cost recovery through the sale of commodities while providing captive audiences for IEC work.

(e) Employment in the Wider Economy

While the project will of necessity focus on the formal economy; it should, particularly in years 3 to 6, explore opportunities to reach potential acceptors in the self-employed, farming, and informal sectors because all these groups are in the wider economy and potentially have personal financial incentives to use family planning.

Some work with these groups has been pioneered by centrally-funded projects such as Enterprise, but it is very intensive and is not likely to have a rapid or significant effect on prevalence. However, these groups and their associations, which represent the more marginal investment of resources for the project, cannot be ignored completely, especially if an opportunity arises for a useful experimental or demonstration project.

The pioneering work done by the centrally-funded Enterprise project in the agricultural and mining sectors means that there is no need to initiate demonstration projects in these sectors. All the information exists that is

Table III.A.12 Employment by Sector

	Men	Women
Formal Sector	47%	8%
Informal Sector	0.7%	5%
Unemployed	9%	5%
Farmers	24%	29%
Economically Inactive 1/	20%	53%
	100%	100%

1/ The economically inactive covers homemakers, students, income recipients and others that are not working or seeking for work in the labor market.

Source: UNIFEM, Report on Women in Zimbabwe

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needed to "sell" the concept to other employers in the same industry and existing projects are running successfully. This is not the case in other sectors of the economy. The work done with male employees in the B.A.T. factory needs further refinement and case studies do not exist in Zimbabwe for plants, shops, or offices employing women workers.

One of the best tools for selling family planning to employers is a successful case studies within the given industry, particularly one which can be recommended by a member of the owner's managers peer group. Consequently, the development of some case study material may be necessary as part of an initial approach to new sectors of the economy. However this requirement does not imply the need for full-scale demonstration projects in each new employment area. However, some analytical work will be necessary to accuratly assess the costs and benefits that might accrue to an employer establishing a scheme. Initial information for a presentation might come from projects in similar industries in other developing countries with similar population and benefits structures. But, to be credible it must be customized to the circumstances in Zimbabwe, and this could be a role for the project's external consultant in support of the "demand creation" side of the project's activities.

In summary, employer-provider services could be expanded in the following ways:

(1) By replicating successful projects in large estates and mines to all similar enterprises in Zimbabwe; private, public and parastatal.

(2) By working with the S&T/POP centrally-funded SEATS project to devise a strategy to expand provision through the Commercial Farmers Union which employees 220,000 rural workers.

(3) By developing initial example projects and replicating them in the manufacturing sector; firstly in factories where women workers predominate and secondly among receptive companies where male workers predominate where the levels of maternity benefit paid give a strong incentive to provide family planning.

(4) By developing demonstration projects in the service sector of the economy for both private sector, e.g. shops and large offices, and, if appropriate, public sector entities such as civil service offices and major parastatals.

To achieve these objectives the project should develop presentations to gain the support of private sector managers and their public sector counterparts for the funding of family planning services to their employees. When appropriate, support should be available to help meet start-up costs through existing ZNFPC programs, including: training, IEC, equipment, and analytical and planning expertise. This effort could triple employer-provided services to cover 120,000 couples by 1995. In addition, contraceptive prevalance among covered employees could be expected to rise to approximately 60 percent, resulting in sustained services for 72,000 couples.

4.2.3. Expand Insurance-reimbursement Programs

The S&T/POP centrally-funded TIPPS Project conducted a business analysis for CIMAS, Zimbabwe's largest private medical aid society. TIPPS demonstrated that there is a clear medium- to long-term financial benefit to reimbursing insured beneficiaries who use ZNFPC family planning services. CIMAS and ZNFPC negotiated a fee schedule for these services. This policy change could result in sustained services for an estimated 30,000 family planning users.

All the component parts of the scheme are in place, and members are reimbursed 80 percent of the cost of contraceptive products and any related medical expenses. The reimbursement covers services given in both the public and private clinics which provide the service. Consequently the program has the potential to promote cost transfers from the public to the for-profit sectors and assisting in revenue generation for the ZNFPC. It also assists with increasing prevalence within the closed populations which are its beneficiaries. Since the beneficiaries for all such schemes nation-wide total about 465,000, a take up of provision by all such schemes can make a contribution to reducing the public sector's cost if it now provides subsidized services to these people.

While the principle of reimbursement has been established and basic systems recently put into place (October 1989), the take up by members is slow. It is mainly in the Harare area, and work needs to be done to promote the take up of the scheme generally and throughout the country. CIMAS is aware of this issue and the technical problems - such as getting the information into the hands of the wives of male members - and will be seeking help from the TIPPS project and ZNFPC to address them. When fully effective, CIMAS can provide coverage for 46,000 women of childbearing age and also assist them to obtain longer-term, more effective methods of contraception at very economical prices under medical supervision; thus helping achieve a major project objective of a diversified method mix.

The first priority for the project must be to help ensure that the CIMAS scheme is consolidated and fully implemented and effective. Some assistance with IEC and promotional work will be necessary to create demand as well as training for clinic doctors wanting to insert IUDs. Such assistance will come through the ZNFPC Private Sector Coordinating Committee. ZNFPC has a strong incentive to help as it is being reimbursed by CIMAS for those of its members who use its facilities. In the Lister Clinic in Harare, this transaction is generating Z$2,000 per month of revenues for ZNFPC. At this time, CIMAS membership is growing by 13 percent a year, and much of that growth comes in the expansion of a limited coverage package for lower paid urban workers; a prime target group for the project.

The second priority must be to extend the provision of family planning as a benefit in the other medical aid schemes of Zimbabwe. There are two routes to achieve this:

1. Through work with the Public Sector Medical Aid Society (PSMAS) which is directly comparable with CIMAS but is restricted to services in the public sector; consequently the two schemes are not in competition. PSMAS has a total of 154,000 beneficiaries of whom approximately 35,400 women are of childbearing age.

2. Through work with the National Association of Medical Aid Societies (NAMAS) or singularly with its smaller sized, constituent members which number 27. These are mainly "in-house" company medical schemes, although one is formal classed as workers compensation insurance. NAMAS has a total of 111,000 beneficiaries of whom about 23 percent or 25,000 are estimated to be of childbearing age.

The total number of women of childbearing age in all medical aid schemes is currently about 100,000, and these numbers are growing rapidly and could soon be as high as 115,000. The women tend to be concentrated in the urban and suburban areas and could more easily gain access to the IUD which is now between 100% and 80% cost reimbursable from both public and private physicians.

The basic tools to "sell" the idea of family planning as a benefit were created by the TIPPS project for CIMAS. It should be a straight-forward matter to convince other societies to follow suit. No further demonstration projects are needed, but the ZNFPC coordinator may wish to work jointly with, or delegate to, the demand creation consultant the task of re-shaping the presentation and delivering it to the leadership of other societies.

This could be accomplished very quickly if ZNFPC also trained their staff to use reimbursement forms and supported some IEC work with society beneficiaries. The societies themselves should be responsible for communicating the availability of the benefit to their members but some joint effort may need to be worked out.

The proposed project should support training of the Private Sector Coordinator in promotional and implementation aspects of this work.

Successful implementation could result in coverage for about 100,000 couples. Assuming that contraceptive prevalence will increase to 50 percent, the effort should result in sustained family planning services for 50,000 couples. Due to expanding medical aid society membership (CIMAS reports membership growth at about 13 percent), even higher levels of sustained services by 1995 may be obtained, particularly since the growth in membership is tending to come from groups of lower paid workers.

4.2.4. Mobilize Private Physicians

So far in Zimbabwe no initiative has been taken to promote the role of private physicians in providing family planning. At this time there are a total of 116 private clinics in Zimbabwe and approximately 500 private doctors, of whom 250 are "dispensing doctors" with authority to dispense the full range of ethical drugs. Some of this group may be specialists, but it is understood that public sector general practitioners do provide a limited range of private services particularly in the rural areas. The potential of working with private midwives has not yet been assessed but should be considered under this project.

The main intervention the project can make in this field is in providing training in the use of modern contraceptive methods, including IUD insertionl. ZNFPC can conduct the training, which would also include training on STDs, the problem of pelvic inflamatory disease, and AIDS in relation to contraceptive practice.

ZNFPC, with the project's support, is well equipped to provide all the training necessary on clinical matters. However, not enough is known on the financial benefits that might accrue to private doctors involved in providing family planning either in terms of providing commodities or the insertion of IUDs. It is suggested that a small analysis of the economic aspects of such work be undertaken so that its results can be integrated into the clinic training that the doctors are given. It would serve to inform them about the wider economic and health benefits that can accrue to their practice through the provision of family planning care.

The proposed intervention could result in the private sector's providing 25 percent of "clinic" methods given a significantly expanded emphasis on this initiative.

4.2.5. Promote Corporate Contributions

The previously discussed initiatives with the for-profit sector assume that there are potential direct financial benefits to the private organizations or individuals stimulating them to become involved in the provision of family planning. Some corporations may be willing to assist with the development of family planning services because of a broad sense of social responsibility. If they can be brought to understand the vital role population policy plays in laying a foundation for economic growth and social development at the national level, they might be persuaded to give it priority in their community involvement policies. There is evidence that a number of companies have such policies; so far the population community has not derived any benefit from them in Zimbabwe.

Corporate citizenship, expressed through community involvement initiatives of various sorts, is an established but underdeveloped element of company policy in Zimbabwe. Companies do:

- Become involved in advocating development issues.
- Sponsor worthwhile "charitable" events and causes.
- Make local donations of cash and equipment.
- Provide substantial donations of "blocked" funds.

While community involvement policies are developed in large part as an aspect of being a good "corporate citizen" or "social partner", companies do derive some indirect benefits from such initiatives in the case of Zimbabwe. The public and government are likely to be more supporting and accepting of private companies that are perceived to be taking positive steps to assist the social as well as the economic development of the nation. The population issue neatly links the two concerns, but few in the business community, as in the society at large, understand the relationship. The project should seek to overcome that lack of understanding and mobilize a broad range of corporate resources to support the overall objectives of Zimbabwe's activities in family planning.

(a) Public Advocacy of Public Family Support Policy

ZNFPC has developed an effective program to educate parliamentarians about family planning and population issues. A similar campaign with the leadership of the business community could be of great value because:

(1) Business leaders have considerable influence on Government and society in general; their support for family planning could increase its prestige and profile in society.

(2) The support of business leaders at the national level will make it much easier for ZNFPC to work with individual firms within the business community.

A strong motive for private business to be interested in the population issue is the extremely rapid growth of the numbers of young people entering the labor market with no comparable growth in private sector jobs. Zimbabwe has the highest average annual growth rate of the labor force in Africa. About 300,000 young people are going to be leaving secondary school each year while the formal sector is only creating around 10,000 jobs a year, of which approximately 50 percent are currently in the public service sector. Under such circumstances, attempts to stimulate job creation will be swamped by the rise in population and because growth in government spending and job creation has plateaued. Zimbabwe is looking to its business community to provide new jobs.

(b) Commercial Sponsorships

Companies in Zimbabwe already engage in commercial sponsorships for sports events. ZNFPC may be an attractive partner for a company to support a "Family Health" campaign or event. The experience of the Johns Hopkins University's PCS project in promoting such sponsorships in the Philippines and Mexico may be replicable in Zimbabwe. The project should assess the possibilities of finding some commercial sponsorship for aspects of its program. Companies will make their commitment on the basis of the "fit" between ZNFPC's interests and their own marketing or public affairs interests. As the ZNFPC's coordinating committee becomes more integrated into the for-profit sector, it will be more able to assess where such arrangements are possible. Should they be available, some technical assistance may be necessary to assist in crafting the agreement.

(c) Donations

Most major companies in Zimbabwe make "charitable" donations of one kind or another. B.A.T., Rothmans, Unilever and locally-owned companies are constantly responding to appeals for support from charitable organizations. The Rio Tinto Zinc Company maintains a major foundation which gives up to $1 million at a time for development projects. I.B.M. has made equipment donations to St. Lucy's College near Bulawayo. Family planning, particularly in the context of "family health" is clearly a charitable cause.

The ZNFPC coordinating committee needs to test the possibility of obtaining cash and equipment donations to support its own work or the wider work of the Council. To assist in making such donations possible and clearly tax deductable, the coordinating committee may need to create a special charitable fund, with a separate identity and registration. The board of the fund could be drawn from the Council and business community, and its work should be distinctive, including using resources to promote even greater corporate involvement in family planning issues by, for example, the creation of special campaign and promotional materials.

The for-profit sector also has a large reservoir of managerial and marketing skill. The coordinating committee may be able to have a donation of expert help employed to assist with problems facing the ZNFPC. For example an advertising agency might be persuaded to assist in the development of an IEC compaign or an accounting firm give advice on cost-control systems.

(d) Blocked Funds

Zimbabwe retains approximately Z$600 million worth of multinational profits, which under current law, cannot be repatriated without punitive charges. These funds can be used in many ways to the advantage of a company, as permitted by the government, for example, investing in land or a new business. However, from time to time some companies wish to dispose of

such funds by donation and count them against their tax liability in the U.S.A. or Europe. The use of these funds for donations is rare but occur in Zimbabwe. Zimbabwe Leaf Tobacco Comapny, for example, has given substantial sums to the World Wildlife Fund and property to Africare. The financial regulations for such donations have worsened since that time, but companies such as Smith Kline Beecham and Coca-Cola have explored possibilities very recently. The appeal of such donations is that they are usually very large ($1 million is a usual unit) because the technical complexities of tranferring such funds are significant and lawyers' bills can be large. Consequently companies only tend to make such donations when the sums involved are substantial.

The ZNFPC might well be designated an eligible recipient for such a donation; a separate charitable fund would certainly be so. The project should explore the possibilities of obtaining such donations from multi-national companies (the largest group is British and they can claim tax benefits on a similar basis to U.S. companies). Some external technical assistance will be needed to explore this possibility, but it would be a reasonable investment of resources since a breakthrough could lead to similar donations to family planning groups in other less developed countries. The use of donated debt should also be explored at that time since it is basically the same issue and to some extent the same process is required. Zimbabwe's debt is discounted on the secondary debt market and may be available for donation. A related area involves some $400 million of "surplus" funds (i.e. undeclared dividends in the bank accounts of multinationals in Zimbabwe). The project will also explore the availability of surplus funds for donation to family planning activities.

The project should seek to mobilize a range of resources in support of the ZNFPC private sector coordination office and the wider compaign to promote family planning in Zimbabwe. The measures of success for these activities could be very specific, e.g., the amount of funds donated or air time given to discussing the issue of population growth, national development and family planning. While none of the these ideas has been tested in Zimbabwe and the whole field is very experimental, it ought to be possible to raise Z$10,000 in cash or kind to support the ZNFPC private sector coordinating office in the first year and double that amount in the second year and subsequent years. As to resource mobilization and fund raising for the family planning cause as a whole, the ZNFPC should seek to use its scarce resources in a classic "venture capitalist" mode: investing small amounts in activities, such as seeking blocked funds, which can give a high yield return of cash or other resources to the cause.

The ZNFPC private sector coordinating effort is a rare example of a national agency which tries to stimulate contributions from the private for-profit sector and coordinate them with public sector policy and initiatives. Much can be learned from its activities over the next few years which may have

valuable applications in other countries. Furthermore, the introduction of the two new areas of corporate involvement to this project ensure that it fully covers all aspects of potential for-profit sector involvement except for the single issue of the local manufacture of contraceptive supplies which has been dealt with in separate studies. In this respect, the work of the project is unique in the family planning field; it is trying to ensure that a national for-profit sector makes a full contribution to family planning development in a single country. It is an ambitious strategy to fully mobilize the latent power of the sector to address population issues.

4.3. Component 3: Enhancement of Sustainability

4.3.1. Cost Recovery and Cost Reduction

The concepts of cost recovery and cost reduction should be applied to family planning activities of the ZNFPC in order to increase the available resources and to have a better use of the existing ones. In considering cost recovery, it is important to keep in mind that family planning is a service that the Government of Zimbabwe is interested in providing to all the people at the lowest possible cost. The Council currently has a two-tiered pricing structure. Fees are charged for clients with a monthly income over Z$150 (U.S. $62.50); but, with the exception of sterilization, all methods are free to clients with incomes below that level.

The project should support a major study to reduce costs, improve revenue collection, and revise fee levels. It should have four parts:

1. Operations research to strengthen fee collection and management.

2. Method-specific cost analysis of current services.

3. Price elasticity study for contraceptive services.

4. Cost analysis and fee setting for training programs.

These sub-studies may be conducted together or in sequence and will begin by Year 3.

(1) Fee Collection

Studies have shown that improved fee collection and strengthened revenue management can double or even tripple cost recovery, even without price increases. changes that frequently improve collection include: (a) verification of income or other eligibility criteria for fee exemption, (b) modification of eligibility criteria for exemptions, (c) use of receipt books for all payments, (d) secure depositing of all receipts, (e) periodic audit. Uderlying success in many cases has been the creation of management incentives for local staff, usually in the form of partial retention of revenues for improvements in service quality. An important cost recovery sub-study should therefore attempt to create incentives and procedures for improved revenue collection and management.

(2) Cost Analysis of Contraceptive Services

A thorough cost analysis of current services is also necessary for two reasons: (a) to guide cost reduction efforts, and (b) to enable managers to set realistic prices. This analysis will be specific to individual contraceptive methods and reflect differences in usual service delivery sites. Even if policy rules out major prices changes, this sub-study will increase the ratio of costs covered by improving operating efficiencies.

(3) Price-Elasticity Sub-Study

At the present time, ZNFPC's fee schedule is very low, in part due to inflation and the lack of regular, periodic adjustments. ZNFPC's current pricing structure is as follows:

Orals	Z$ 0.20 per cycle
Condoms	Free
Foaming Tablets	Z$ 1.00 for 12
IUD	Z$ 2.00
Depo Provera	Z$ 0.25 per vial for three months
Sterilization	Z$10.00

(U.S. $1.00 = Z$2.00). These fees have not been adjusted since 1985 regular fee. The project should support adjustment for inflation, in order to avoid the present situation where fees bear no relation to actual costs, and to avoid the need to make large adjustments that can make services inaccessible to some users.

Operations research should examine the price elasticity of contraceptive services to assess potential for generating revenue in the public and parastatal sectors. The study should quasi-experimental design, using test the impact of increasing fees for various services. Results should guide adjustments in the prices charged for service delivery and commodities for the entire program and lead to a plan for market segmentation. Ultimately, the Council's user fee structure will enable the collection of reasonable fees from those who can pay and the collection of minimal or no fees for public and parastatal sector services, there will be some incentive for a certain category of clients to switch to the private sector for family planning.

(4) Training Cost Analysis

ZNFPC currently charges minimal fees for international trainees and trainees sponsored by the Family Health Project. Charges are believed to be below actual costs due to inflation and inadequate analysis of fixed costs. Fees for international trainees in particular, could be significantly increased because of the wide interest in Zimbabwe and the lack of competing courses at lower prices.

The project should increase training cost recovery by providing technical assistance to analyze costs and by promoting international participation.

Zimbabwe National

Target - Setting Model

Prepared by
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May 1990

Appendix A
to Technical Analysis

Zimbabwe National

Target - Setting Model

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May 1990

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Target Setting Model
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Title = ZIMBABWE 85-95A

First year = 1985
Last year = 1995

	1985	1990	1995
TFR	6.00	5.25	4.50
Women aged 15-49 (Thousands)	1884.0	2295.0	2739.0

METHODS

Method	Effectiveness	Discontinuation	Consumpt
Pill	0.90	0.35	13.0
IUD	0.95	0.15	
Female sterilization	1.00	0.01	
Male sterilization	1.00	0.01	
Injectables	0.99	0.35	0.0
Other	0.70	0.50	100.0
Traditional	0.70	0.50	0.0
Implants	0.99	0.15	1.0

METHOD MIX

	1985	1990	1995
Pill	63.90	72.60	68.00
IUD	2.00	2.60	4.00
Female sterilization	4.80	5.80	11.00
Male sterilization	0.00	0.00	0.00
Injectables	0.00	0.00	0.00
Other	2.20	2.80	6.00
Traditional	27.10	16.20	10.00
Implants	0.00	0.00	1.00

PROXIMATE DETERMINANTS

	1985	1990	1995
Prevalence (%)	39.3		
Percent WRA married	62.0	62.5	63.0
Duration of postpartum infecundability (months)	12.6	12.3	12.1
Induced abortion rates per 1000 women 15-49	0.00	0.00	0.00
Pathological sterility rates (% childless at age 49)	3.40	3.17	2.93

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Target Setting Model
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Title = ZIMBABWE 85-95A

DISTRIBUTION BY SOURCE IN 1985

	Pill	IUD	Female ster	Male ster
CBD/CBEW	25.7	0.0	0.0	0.0
ZNFPC Clinic	13.9	6.9	1.4	0.0
MOH Hospital/Clinic	14.8	58.6	74.6	0.0
Municipal/Local Clin	19.2	6.9	4.2	0.0
Rural Council Clinic	18.1	0.0	0.0	0.0
Other/Private	5.5	20.7	15.5	0.0
Private Dr. / Pharma	2.9	3.4	1.4	0.0
Don't Know/Missing	0.0	3.4	2.8	0.0

	Injectables	Other	Traditional	Implants
CBD/CBEW	0.0	21.1	0.0	0.0
ZNFPC Clinic	0.0	10.5	0.0	6.9
MOH Hospital/Clinic	0.0	10.5	0.0	58.6
Municipal/Local Clin	0.0	18.4	0.0	6.9
Rural Council Clinic	0.0	13.2	0.0	0.0
Other/Private	0.0	23.7	100.0	20.7
Private Dr. / Pharma	0.0	0.0	0.0	3.4
Don't Know/Missing	0.0	2.6	0.0	3.4

DISTRIBUTION BY SOURCE IN 1995

	Pill	IUD	Female ster	Male ster
CBD/CBEW	25.7	0.0	0.0	0.0
ZNFPC Clinic	13.9	6.9	1.4	0.0
MOH Hospital/Clinic	14.8	58.6	74.6	0.0
Municipal/Local Clin	19.2	6.9	4.2	0.0
Rural Council Clinic	18.1	0.0	0.0	0.0
Other/Private	5.5	20.7	15.5	0.0
Private Dr. / Pharma	2.9	3.4	1.4	0.0
Don't Know/Missing	0.0	3.4	2.8	0.0

	Injectables	Other	Traditional	Implants
CBD/CBEW	0.0	21.1	0.0	0.0
ZNFPC Clinic	0.0	10.5	0.0	6.9
MOH Hospital/Clinic	0.0	10.5	0.0	58.6
Municipal/Local Clin	0.0	18.4	0.0	6.9
Rural Council Clinic	0.0	13.2	0.0	0.0
Other/Private	0.0	23.7	100.0	20.7
Private Dr. / Pharma	0.0	0.0	0.0	3.4
Don't Know/Missing	0.0	2.6	0.0	3.4

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Target Setting Model
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ZIMBABWE 85-95A

Output Table for All methods from All sources

Year	Percent MWRA Using	Number Using (Thousands)
1985	39.3	459.1
1986	41.1	500.4
1987	42.9	543.9
1988	44.6	589.8
1989	46.3	638.1
1990	48.0	688.9
1991	49.8	741.0
1992	51.5	795.6
1993	53.2	852.9
1994	54.9	913.0
1995	56.6	975.9

Output Table for Pill from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Cycles (Thousands)
1985	25.1	293.3		
1986	27.0	328.4	154.5	4269.7
1987	28.9	366.5	171.1	4764.2
1988	30.9	407.6	189.1	5299.4
1989	32.8	452.1	208.6	5877.8
1990	34.9	500.2	219.4	6502.2
1991	35.7	531.1	222.1	6904.9
1992	36.5	563.0	234.4	7318.6
1993	37.2	595.7	247.0	7743.6
1994	37.8	629.2	259.9	8179.8
1995	38.5	663.6		

Output Table for IUD from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Insertions (Thousands)
1985	0.8	9.2		
1986	0.9	10.6	3.3	3.3
1987	1.0	12.2	3.7	3.7
1988	1.1	13.9	4.1	4.1
1989	1.1	15.8	4.6	4.6
1990	1.2	17.9	5.7	5.7
1991	1.4	21.3	7.2	7.2
1992	1.6	25.1	8.2	8.2
1993	1.8	29.3	9.3	9.3
1994	2.0	34.0	10.5	10.5
1995	2.3	39.0		

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ZIMBABWE 85-95A

Output Table for Female sterilization from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Procedures (Thousands)
1985	1.9	22.0		
1986	2.1	25.0	3.9	3.9
1987	2.2	28.3	4.3	4.3
1988	2.4	31.8	4.7	4.7
1989	2.6	35.7	5.2	5.2
1990	2.8	40.0	8.5	8.5
1991	3.4	50.7	13.0	13.0
1992	4.1	62.7	14.7	14.7
1993	4.7	76.1	16.5	16.5
1994	5.5	90.9	18.5	18.5
1995	6.2	107.4		

Output Table for Other from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	0.9	10.1		
1986	1.0	11.6	7.5	1160.8
1987	1.0	13.3	8.5	1327.1
1988	1.1	15.1	9.6	1509.8
1989	1.2	17.1	10.8	1710.0
1990	1.3	19.3	13.9	1929.0
1991	1.7	25.5	19.6	2549.0
1992	2.1	32.5	24.0	3246.1
1993	2.5	40.3	28.8	4025.6
1994	2.9	48.9	34.2	4893.5
1995	3.4	58.6		

Output Table for Traditional from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	10.7	124.4		
1986	10.2	124.7	63.4	0.0
1987	9.8	123.7	61.5	0.0
1988	9.2	121.3	58.7	0.0
1989	8.5	117.3	55.1	0.0
1990	7.8	111.6	53.9	0.0
1991	7.4	110.9	55.4	0.0
1992	7.1	109.2	53.6	0.0
1993	6.6	106.4	51.1	0.0
1994	6.2	102.6	48.0	0.0
1995	5.7	97.6		

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Target Setting Model
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ZIMBABWE 85-95A

Output Table for Implants from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	0.0	0.0		
1986	0.0	0.0	0.0	0.0
1987	0.0	0.0	0.0	0.0
1988	0.0	0.0	0.0	0.0
1989	0.0	0.0	0.0	0.0
1990	0.0	0.0	0.7	0.0
1991	0.1	1.5	1.7	1.5
1992	0.2	3.2	2.4	3.2
1993	0.3	5.1	2.9	5.1
1994	0.4	7.3	3.5	7.3
1995	0.6	9.8		

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ADMINISTRATIVE ANALYSIS

As shown in Charts III.B.1 to III.B.6, the Zimbabwean family planning program is complex and involves multiple agencies. USAID will work directly with many of these groups but only indirectly (if at all) with others.

I. Family Planning Organizations

The top portion of Chart III.B.1 shows four major organizations, or groups of organizations, that support family planning in Zimbabwe. Two of these are governmental ministries, for Health (MOH), and for Local Government, Rural and Urban Development (MLGRUD). Under the umbrella of the Ministry of Health is the Zimbabwe National Family Planning Council (ZNFPC), the country's lead technical agency for family planning and, since 1982, the main recipient of USAID grant assistance. Finally, the private sector supports family planning through industrial employers, commercial farmers, medical aid societies (only CIMAS at the present time), and a social marketing program operated by Geddes Ltd.

II. Family Planning Service Providers

All four of these groups provide family planning services, though the two public sector agencies account for the majority of users. (See bottom portion of Chart III.B.1.) The Ministry of Health operates 8 provincial and 55 district hospitals, which together served 18.8% (111,000) of the user population in 1988. Most or all of these facilities provide family planning within the context of integrated Maternal and Child Health care. MOH's network also includes a number of church-sponsored facilities designated as district hospitals.

The Ministry of Local Government Rural and Urban Development oversees and partially finances municipal governments in Harare, Chitungwiza, and Bulawayo, as well as District and Rural Councils in more outlying areas. These local governments operate approximately 1100 health facilities, ranging from large hospitals to small one-person clinics, and approximately 150 of these provide a limited range of family planning services. In 1988, 18.0% (106,000) of users were served by Municipal and District clinics and 16.1% (95,000) by Rural Councils.

Totalling these three figures, the public (but non-parastatal) sector served 52.9% (312,000) of users in 1988. For the clinical methods that this project emphasizes, the proportion was 65.0%. The number of public sector sterilization acceptors is likely to increase significantly in the coming months as six clinics equipped and staffed though the Family Health Project come into full operation. Efforts to increase IUD acceptance through public clinics have languished, for reasons that are currently under investigation.

The Zimbabwe National Family Planning Council (ZNFPC) operates 34 clinics, including twenty free-standing, nine located on the grounds or within the structures of district and provincial hospitals, and five in mobile vans. While the majority of ZNFPC clinics "offer" IUD services, only six performed more than 9 in the most recent quarter and only Sphilhaus did more than 100. Only Spilhaus at present performs sterilizations. In 1988, ZNFPC clinics served 13.1% (77,000) of Zimbabwean family planning users.

Working mainly in densely populated communal farming areas, ZNFPC's 670 Community-based Distributors (CBDs) recruit clients and supply oral contraceptives and condoms. CBDs were largely responsible for the remarkable expansion of Zimbabwean family planning in the early to mid-1980s, but with increasing success, they have had to devote increasing time to resupply of existing users rather than to new recruitment. Estimated to reach 30% of the rural population, CBDs served 36.1% of rural users and 24.5% of all users (145,000) in 1988. CBDs at present have few links with either ZNFPC or public sector clinics, a problem that will clearly have to be addressed if they are to become effective referral agents for sterilization, IUDs, and NORPLANT$_R$.

The private sector provides health services through 161 industrial clinics, about 500 private physicians and 22 employer-financed (but ZNFPC-supervised) CBDs. There are also a small number of church-affiliated health care providers outside the MOH network. In 1988, 3.7% of family planning users (22,000) relied on private physicians or pharmacies, 1.8% on missions or churches (11,000) , and 0.5% (3,000) on industrial clinics (total 6.0%; 35,000).

III. Quality control and Technical Support

The government and the public reportedly consider ZNFPC responsible for the quality of family planning services, regardless of provider, yet the Council's supervisory relationships are limited to its own clinics and CBDs. In practice, quality control for non-ZNFPC providers occurs only through training, periodic technical assistance, and occasional observational visits.

Chart III.B.2 shows both formal and informal supervisory relationships. Within ZNFPC, services are primarily supervised by provincial offices, under the direction of non-technical Provincial Managers. Each manager in turn delegates clinic supervision to the Provincial Nursing Officer and CBD supervision to the Senior Educator. (Senior Educators supervise CBD Group Leaders at the district level.) Provincial Managers report to the Deputy Director for Programmes but maintain advisory relationships with technical unit heads.

Relationships with non-ZNFPC providers are less direct. Most Provincial Managers attempt to monitor and guide all family planning activities within their areas, but their effectiveness depends on personalities and circumstances. Provincial Nursing Officers regularly visit public sector facilities, where they generally find providers polite and interested but restricted in their ability to make changes. (Decentralization of decision-making authority has proceeded to lower levels within ZNFPC than in other public sector .) Issues considered serious enough may be discussed at monthly meetings of health care groups at the provincial level. The fundamental problem of considerable significance for family planning in Zimbabwe is that public sector institutions that provide integrated health services can devote only limited time to family planning.

ZNFPC would like to delegate responsibility for private sector activities to provincial offices as well, but this has occurred only partially to date. ZNFPC Group Leaders supervise employer-sponsored CBDs within their areas, but ZNFPC provides only technical support (not supervision) to employer-sponsored clinics. Other private sector providers reportedly turn frequently to ZNFPC for technical advice but are in no way supervised by the Council.

An important (potential) supervisory tool is management information and service statistics. Only ZNFPC clinics and CBDs are obliged to report service statistics to the Evaluation and Research Unit, through reports are also received from CIMAS and most employer-sponsored facilities. MOH facilities are not obliged to report but apparently do so anyway in certain areas where they have been given the appropriate forms. The project needs to deal with the problem of non-ZNFPC reporting to strengthen ZNFPC's monitoring capabilities.

IV. Training

ZNFPC's main instrument for quality control is training, but it is not known how effective this is once trainees leave their courses. Almost all of those currently providing services in Zimbabwe were initially trained at one of the Council's two facilities (in Harare and Bulawayo), though recent years have seen a start to "second tier" training by MOH, municipal, and University of Zimbabwe tutors (also ZNFPC-trained). There should be greater efforts to expand both preservice and inservice training (perhaps using ZNFPC clinic patients for practical work), but at the moment Training Unit staff have little information about whether the tutors they have trained are still using appropriate curricula or, indeed, whether they are teaching family planning at all. A better followup system is clearly needed. Chart III.B.3 shows both the direct and indirect training services that ZNFPC provides to other agencies.

V. Financing and Commodities

The various family planning groups in Zimbabwe are also closely linked through financial and commodity flows, again with the Ministry of Health and ZNFPC as key actors.

At the present time, ZNFPC imports and distributes all contraceptives used in the public and parastatal sectors, a role that has made considerable sense because ZNFPC's benefactor, USAID, has been the sole external supplier. (This relationship may change as other donors and the government itself assume greater responsibility.) Private sector family planning providers (including employer-sponsored clinics and private retailers) obtain supplies from Geddes Ltd., which in turn receives them as a grant from the SOMARC program. (Geddes must, however, pay a 25% duty on all of its imports.)

One issue that has arisen concerns responsibility for distribution of condoms to be used for STD and AIDS prevention rather than family planning. ZNFPC currently imports these but have wisely not taken an active role in the controversial area of condom distribution for non-family planning purposes. Agreement was reached during the Project Identification stage that the AIDS programme should pay for 70% of condom imports after 1991, but the question of distribution responsibilities has not yet been addressed.

Chart III.B.4 shows financing relationships among the various family planning organizations, further illustrating the complexity of program structures. The majority of funding derives from general taxation and international donations, passed through the Ministry of Health or (in the case of USAID) given directly to ZNFPC. The MOH, in turn, subsidizes, ZNFPC and supports its own hospitals and clinics. ZNFPC uses all of its money internally, though it does give other agencies commodities and in-kind services, as noted above. The Ministry of Local Government's Rural and Urban Development (MOLGRUD), like the MOH, is supported by general tax revenues but also benefits from local tax sources.

As noted in the Financial Analysis (Annex III.D) user payments to the public and parastatal sectors are limited at present. Both groups sell USAID-provided commodities at minimal cost, but MOH revenue is sent to the Ministry of Finance rather than to ZNFPC.

Funding for the private sector in Zimbabwe mainly derives from the formal employment sector, including both industrial enterprises and commercial farms. Some funds go into direct service provision through employer-sponsored clinics and CBDs. Another major portion takes the form of out-of-pocket payments by individual users to private physicians and retail contraceptive distributors. A third portion, hopefully increasing in the future, passes through medical aid societies (only CIMAS at present). Growth in the private sector over the next few years depends significantly on continued growth in the formal economy.

VI. Referral Systems

Given the limited number of sources for longer term methods in Zimbabwe, referral relationships among various providers are critical to expanded acceptance and use. Neither IUDs nor sterilization will be widely available for the foreseeable future, heightening the need for conscientious counselling and referral of appropriate clients to places where they are available. Provider knowledge and attitudes require strengthening in many cases, and those who are referred will require followup to ensure that they actually reach a service delivery point. Charts III.B.5 and III.B.6 show how referral links should work for IUD and sterilization services respectively, but it should be noted that few of these relationships are currently in place.

This project should help by reorienting CBDs and a limited number of public sector personnel and by giving them specific patient counselling skills.

CHART III.B.1: ZIMBABWE FAMILY PLANNING PROGRAM

ORGANIZATIONS AND SERVICE PROVIDERS

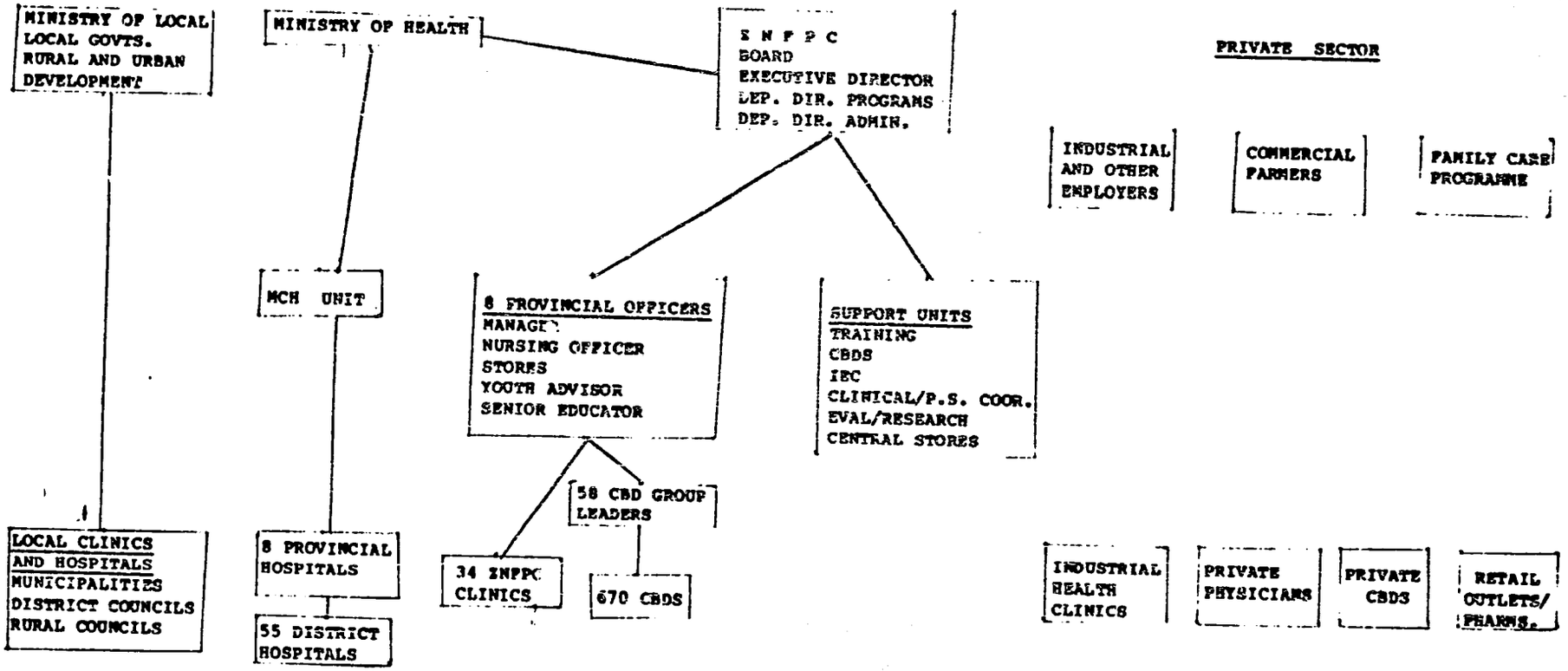


CHART III.B.2: ZIMBABWE FAMILY PLANNING PROGRAM

QUALITY CONTROL AND TECHNICAL SUPPORT

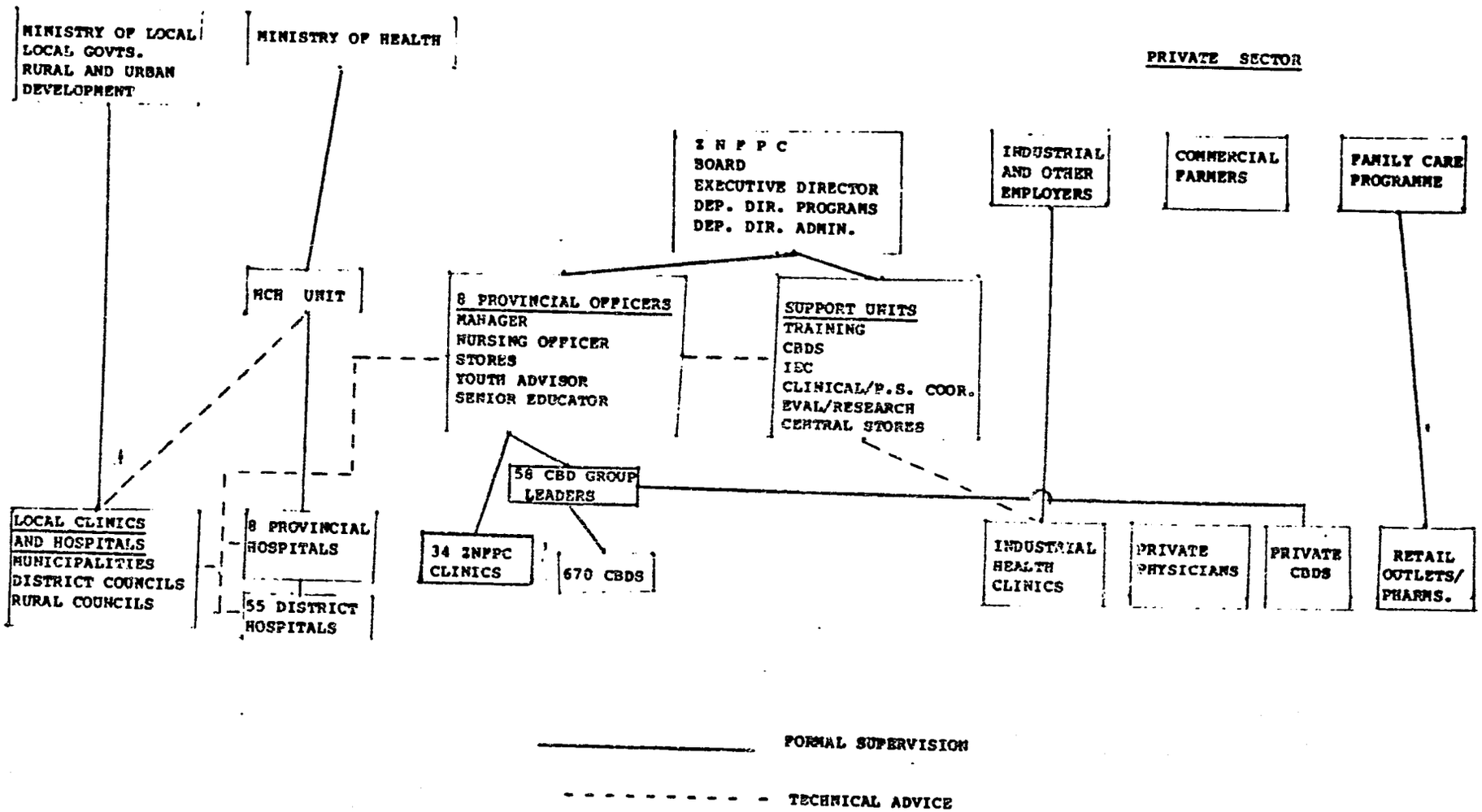
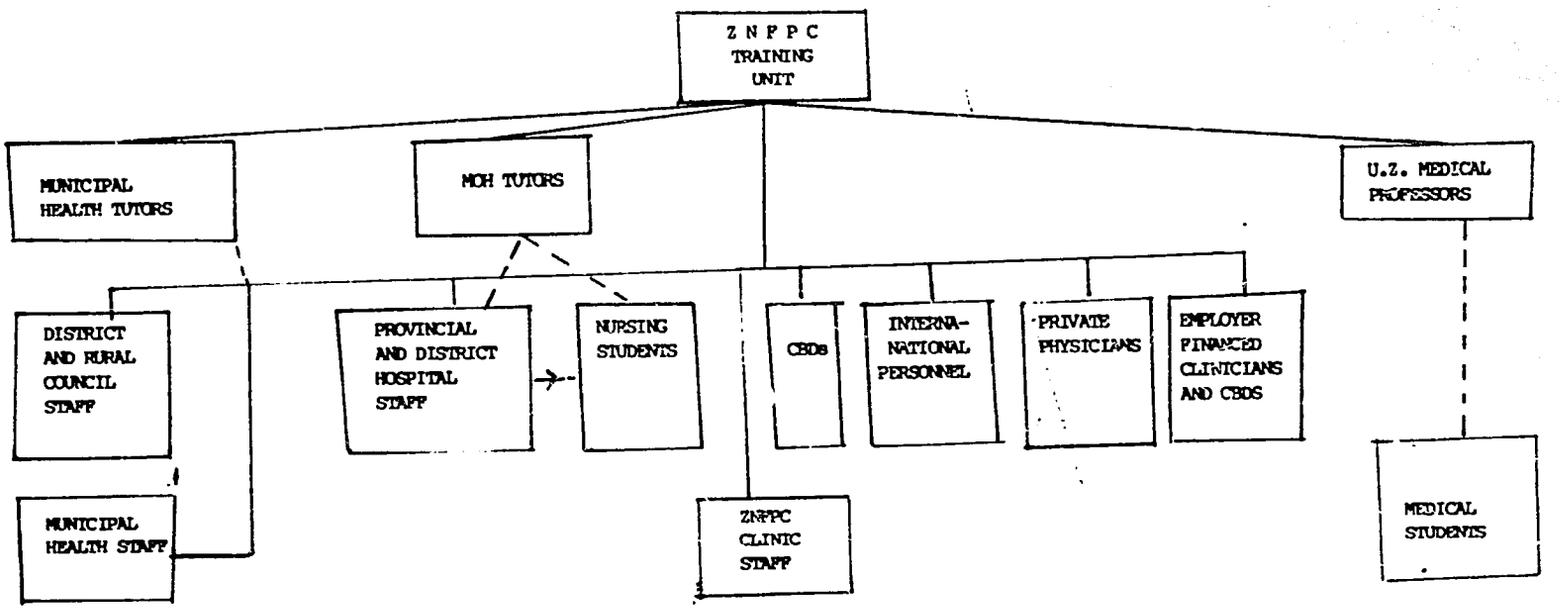


CHART III.B.3: ZIMBABWE FAMILY PLANNING PROGRAM
TRAINING RELATIONS



DIRECT TRAINING

SECOND-TIER TRAINING

CHART III.B.4: ZIMBABWE FAMILY PLANNING PROGRAM

FINANCING

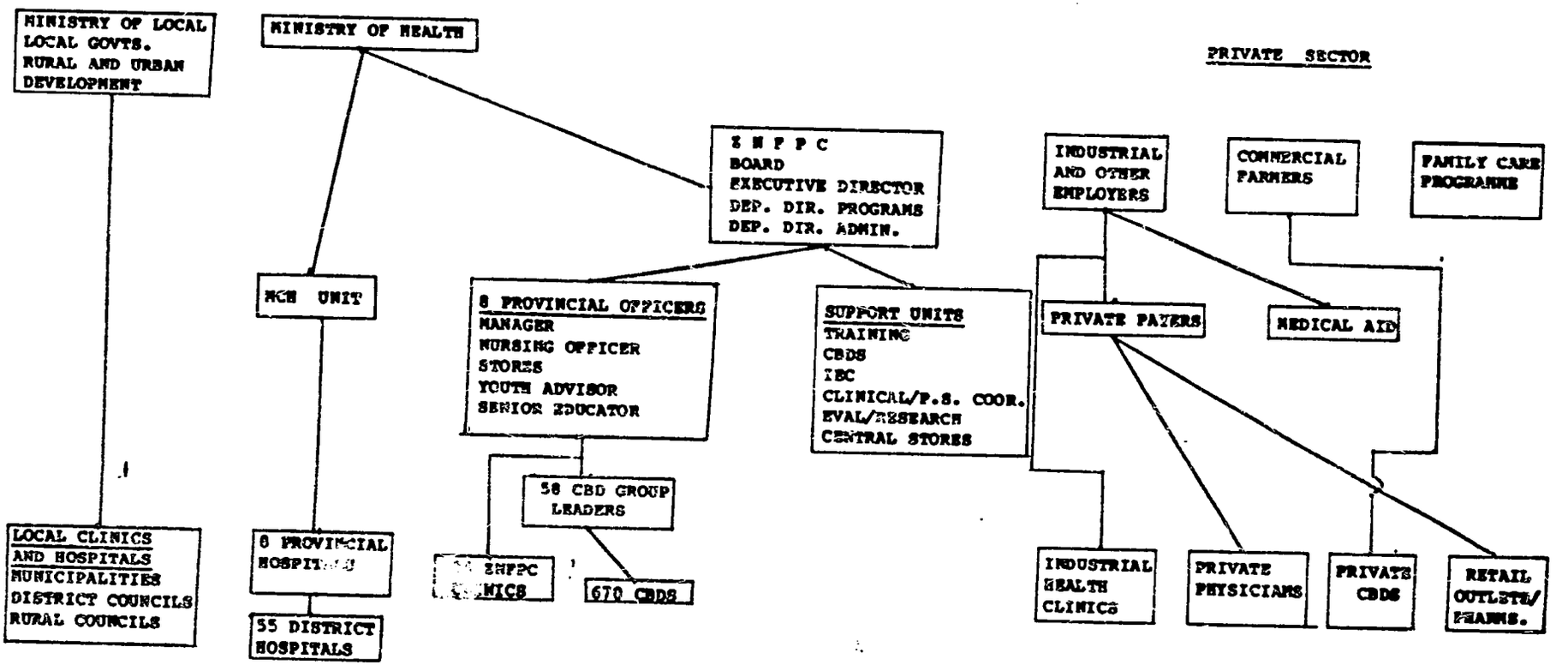


CHART III.B.5: COUNSELLING, REFERRAL, SERVICE DELIVERY

IUD INSERTION

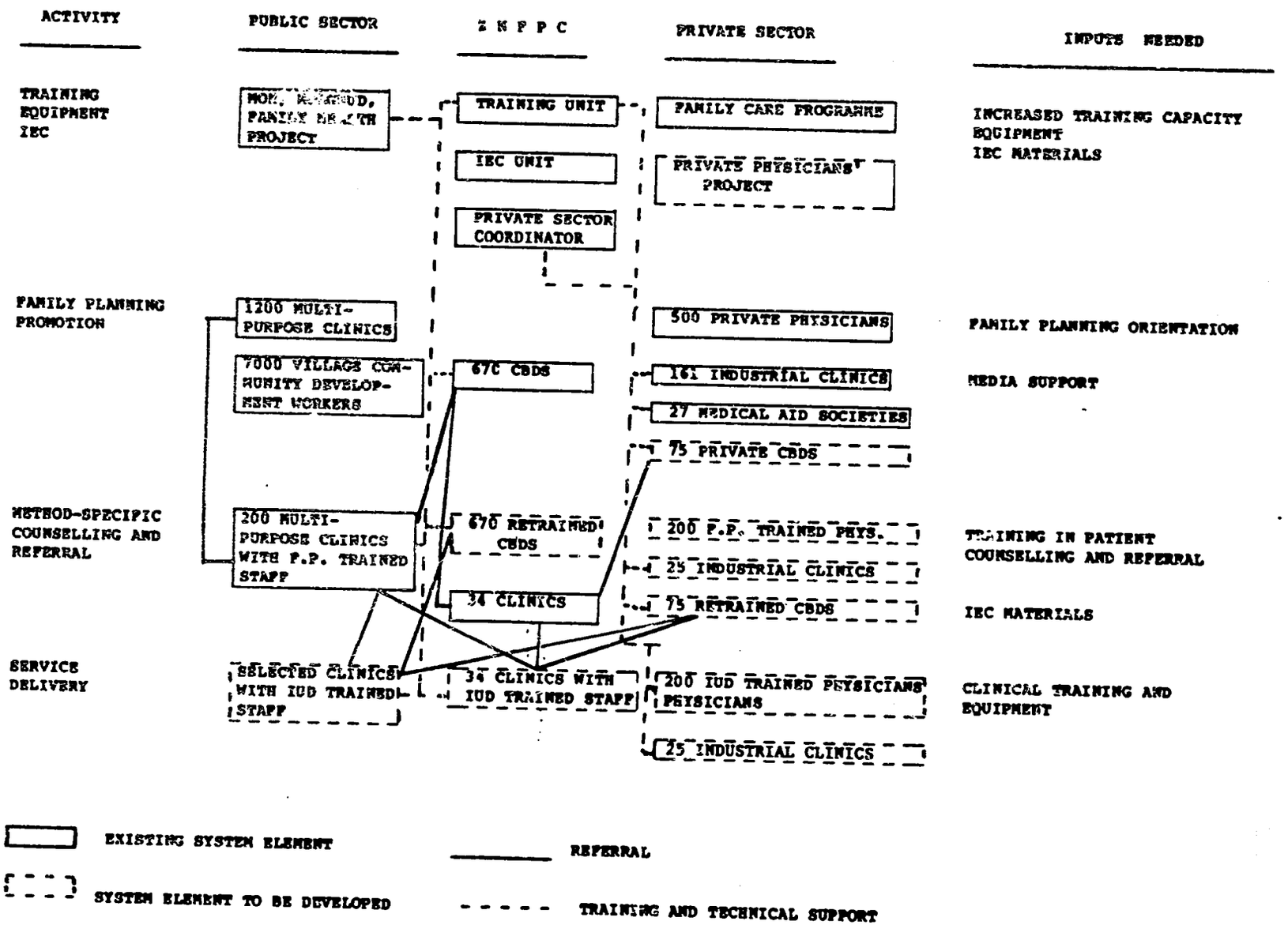


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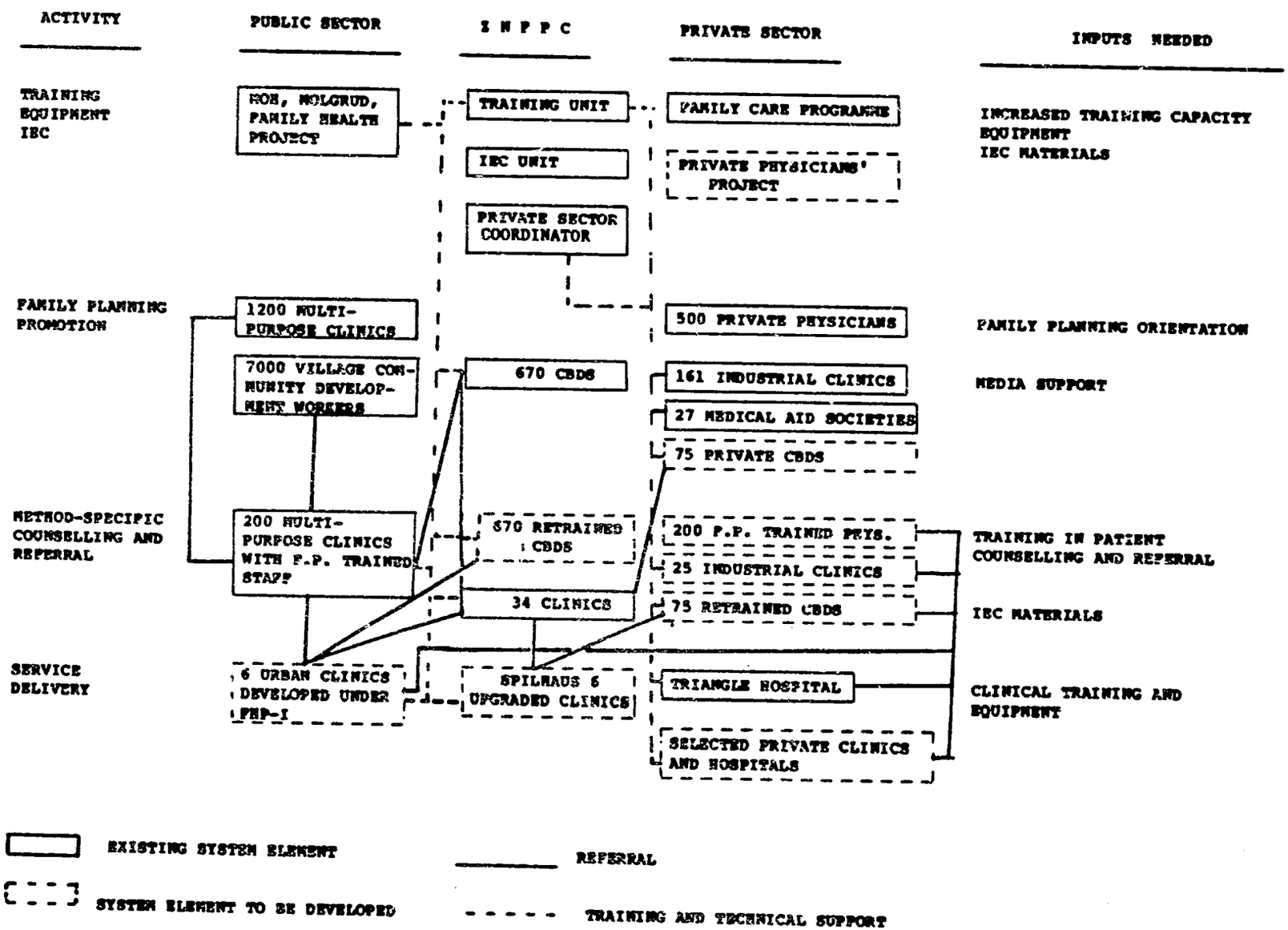
CHART III.B.6: COUNSELLING, REFERRAL, SERVICE DELIVERY

VOLUNTARY SURGICAL CONTRACEPTION



INSTITUTIONAL ANALYSIS

I The Zimbabwe National Family Planning Council

Since its inception in 1957, the Zimbabwe National Family Planning Council and its predecessor agencies (the Family Planning Association of Rhodesia and the Zimbabwe Child Spacing and Fertility Association) have been the main inspiration and technical resource for Zimbabwean family planning as well as (until the mid-1980s) the major source of services and supplies. They have also played major roles in initiating and guiding public and private sector activities, initially through Ministry of Health (MOH) facilities and more recently through private pharmacists, employers, and medical aid societies.

Widely recognized as one of the most effective organizations of its type in Africa, ZNFPC trains most family planning providers, promotes private sector activities, conducts media campaigns and routine IEC, and procures, stores, and distributes virtually all contraceptives used in the country except for those sold though the private sector. As a parastatal organization, ZNFPC collaborates closely with the Ministry of Health and with private employers and insurers.

ZNFPC is a mature organization with functioning (though still problematic) personnel, financial, and information systems. Considerable decentralization has already occurred but may progress further in coming years.

A. Legal Status

ZNFPC is a parastatal organization, supervised and significantly funded by the Ministry of Health. As a parastatal, it hires and manages its own staff, sets its own personnel policies, obtains at least a portion of its funding independently of the Ministry, and manages and accounts for these funds according to its own procedures. The relationship between the government and parastatals has been changing in recent months, but these adjustments appear unlikely to affect the ZNFPC or specific project activities.

ZNFPC is governed by an 18-member Board, chaired by the Permanent Secretary of Health, assisted by the Permanent Secretary for Community Development, Cooperatives, and Women's Affairs. Board members are nominated by participating groups and approved by the Ministry of Health. According to its Enabling Act, the ZNFPC Board is to:

- ensure the involvement of all relevant sectors in family planning and the application of a multisectoral approach to implementation
- ensure that family planning is an integral part of the overall national development program
- provide effective liaison between the public and the agencies involved in the family planning program

- furnish advice and recommendations to other government agencies, and
- give direction to the Executive Committee.

The latter group, a seven-member body, oversees implementation of ZNFPC directives.

The Enabling Act further specifies that ZNFPC is to:
- promote and provide adequate facilities for family planning services
- treat infertility
- participate in the primary health care program
- conduct research on reproductive health
- diagnose and treat sexually-transmitted diseases (STDs) and cervical cancer
- stimulate family planning awareness among medical students and service delivery personnel
- provide facilities for infertility, sterilization, and cytology services.

As a parastatal organization, ZNFPC is also authorized to collect and keep its own revenue.

ZNFPC's recently acquired role in stimulating private sector family planning is not specified in the Act, nor is the Council given formal responsibility for quality control in this sector.

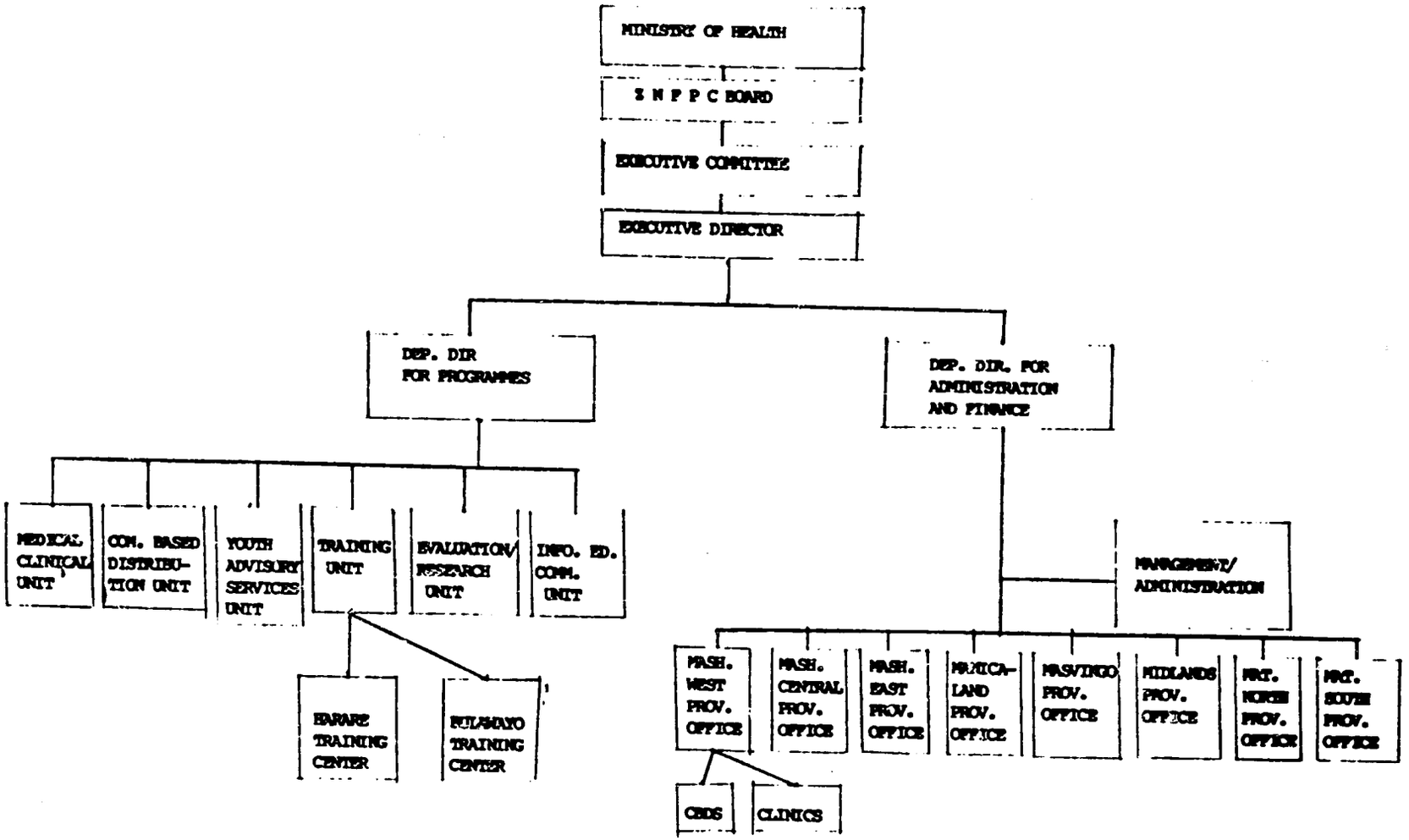
B. Organizational structure, brief description of units

ZNFPC's organizational chart (Chart III.C.1) shows its leadership structure and main operational units. Key management staff include the Executive Director and Deputy Directors for Programmes and Administration and Finance. Six operating units and eight provincial offices have also been established.

This analysis focuses particularly on the Training, Clinical, CBD, and Evaluation/Research Units, since these are the units most likely to be involved in new project activities.

1. Evaluation and Research Unit: The Evaluation and Research Unit is responsible for ZNFPC's service statistics, management information system, and most of its computer systems, and has also played significant roles in financial and commodity management. Headed by expatriate advisors since its inception in 1984, ERU has, nevertheless, suffered from frequent staff turnover and other management problems. It is now fully staffed for the first time: members include a masters'level economist trained at Cornell and four bachelors' level research officers. There is also at present an American graduate student intern, scheduled to remain in country until September 1990. The current expatriate advisor will leave in November 1990 and will not be replaced. His Zimbabwean successor has not been identified but may be a rotating committee rather than an individual.

CHART III.C.1: ZNFPC ORGANIZATION



The ERU produces a number of routine reports and conducts (or, in one case, contracts for) operations research studies or other special analyses as required (and funded). Maintenance of the service statistics system requires the full-time attention of one researcher. ERU staff computerize monthly CBD and clinic reports and calculate (every three months) the numbers of new acceptors and revisits and the estimated couple-years of protection (CYP). These data are then reported in the quarterly program summary prepared by the Deputy Director for Programmes. Considered unreliable, service statistics submitted by non-ZNFPC facilities in Masvingo, Midlands, and Mashonaland East are not tabulated; other public sector clinics report infrequently or not at all. ERU also prepares annual analyses of family planning trends in Zimbabwe.

ZNFPC's family planning service statistics are among the better in Africa but suffer from irregular or non-existant clinical reporting and from inadequate presentation of results. Forms for public sector reporting were developed several years ago but have not been widely used because of excessive MOH workloads. ZNFPC, thus, has very limited (and non-quantitative) information on public sector activity levels and types of acceptors. Even reports from ZNFPC clinics are said to be delayed or missing, with particular problems reported regarding sterilization. Quarterly summaries are of little use to Provincial Managers or Nursing Officers and do not highlight either successes or problems. Additional work is clearly needed on both data collection and analysis, with attention to both ZNFPC activities and those of other providers.

Of the five Zimbabwean staff members, one will always be fully occupied with the service statistics system, while others are available for operations research and special studies. Three major and a number of minor studies are currently underway or planned for the near future. These include:

- a Male Motivation study (to be completed in September 1990)
- a multifaceted study to analyze operational problems in IUD services (sub-contracted to the University of Zimbabwe and scheduled to end in October 1990)
- an operations research study to restructure the CBD program (two years, beginning in late 1990)
- a small study to validate CBD reporting system, and a separate but also small study of clinical reporting
- an analysis of the characteristics of (the so far few) sterilization acceptors
- a client satisfaction study to understand and hopefully resolve reported difficulties in patient-client interactions.

The sum of these efforts will fully occupy existing staff through 1990, but only the major CBD study and maintenance of the service statistics system will continue thereafter. There should, therefore, be two to three individuals available for new studies in 1991 and thereafter.

The Evaluation and Research Unit played a significant advisory role for the 1988 ZDHS vis-a-vis the Central Statistical Office although it did not participate directly in data collection. ERU would not be prepared to take the lead role in any future survey but could repeat its advisory relationship. Funds should be passed through ZNFPC, rather than directly to the CSO, to encourage better control over the results.

ERU appears to suffer from excessive preoccupation with big multi-year and multi thousand dollar studies and to participate infrequently in routine observational diagnoses of operational trouble spots. Other groups have found that simple systems analyses and quick turnaround studies may be of greater use to routine decisionmaking than the complex studies usually favored by devotees of "hard" data. There will be great need for simple problem-solving studies as ZNFPC moves from a pill-based to a more clinical program, and ERU should play a lead role in this evolution.

ERU may also have difficulties after the expatriate advisor leaves and will need ongoing assistance for study design and, perhaps, the conduct of routine analyses and studies. Full access to shortterm technical assistance, both local and international, is highly desirable. There should also be provision for brief staff development courses in neighboring countries.

ERU appears to be amply supplied with computers, including three laptops, 3 IBM PS/2s, and several old PCs.

2. Training Unit: ZNFPC's Training Unit has played a key role in expanding family planning services through both the public and private sectors throughout Zimbabwe and, more recently, internationally as well. Virtually all domestic personnel involved in family planning have either been trained there themselves or trained by a ZNFPC graduate. The Unit will play a key role in expanding both service accessibility and method mix during the coming period.

Responsibilities: The Training Unit both provides training itself and assists family planning training by the Ministry of Health and the University of Zimbabwe. The first role takes most of the Unit's time, but in the long run its greater impact may be through second tier training by these other groups.

Facilities: The Training Unit operates from a relatively spacious and well-equipped facility in Harare and from a cramped and underdeveloped facility in Bulawayo. The Harare facility, located at ZNFPC headquarters, includes numerous lecture halls, staff offices, a student dormitory and mess, and easy access to Spilhaus Clinic. It could easily handle double the current course load, though office space for additional tutors would be a serious problem. The Bulawayo facility includes only a single small lecture hall and one tutor office plus makeshift accommodation for only some students offsite. (A new vehicle is needed to bring students to daily sessions.) Bulawayo courseloads can almost certainly not be increased without facility expansion.

Course Offered: The Training Unit currently spends 24 of approximately 66 annual training weeks on its Basic Family Planning Clinical Course, intended for nurses and physicians already in service. The course is offered six times per year (three times each in Harare and Bulawayo), lasts four weeks, and takes 20 students at a time. The total output per year is thus 120 students, against a backlog that ZNFPC estimates at about 8,500. (This number represents the total number of medical personnel registered by the Health Professions Council, 11,000, less the number believed to have been trained, 24,000.) Trainees are nominated by the 8 Provincial Nursing Officers, and demand vastly exceeds course availability; indeed, training delays are reported to be the greatest obstacle to expansion of private sector family planning services.

Other ZNFPC courses are briefly described in Chart III.C.2. Two previously important courses now occur less frequently or are "on hold": the IUD clinical course because of its so far limited impact on service provision, and the basic CBD course because only replacement and private sector CBDs are currently being added to the workforce. Special courses are also arranged from time to time for sterilization and other technical topics. To date, two courses have been held for CBD program managers from the Africa region.

Curricula: As noted in the chart, most of the curricula used in these courses are five or more years old and in need of updating. The Basic Course and CBD Course will need to be modified to reinforce patient counselling skills and longterm methods, and to add vital new material on AIDS. New course material must be developed for IUD insertion and sterilization. Refresher courses must also be strengthened.

Constraints to Expansion: Expansion of training output requires (a) the hiring and training of additional tutors, (b) possible facility construction in Bulawayo, and (c) recurrent cost financing (for tutor salaries, student transport and maintenance, and facility maintenance).

Staffing: The Training Unit currently has an authorized staff of 13 tutors, four to be based in Bulawayo and nine in Harare. Two vacancies currently exist in Harare. Turnover has been limited to date but may become more serious as ZNFPC salary scales diverge from those of the Ministry of Health and other potential employers.

Tutor training is available in Zimbabwe, but graduates are not generally attracted by ZNFPC salary scales and the relatively limited job description (compared with competing Ministry of Health openings). Graduates come from two degree programs: the diploma in Nursing and Adult Education (requiring two years full-time study), and the Diploma in Adult Education (also two years, but only parttime). For reasons noted above, though, ZNFPC more frequently hires graduates of its own Basic Clinical and IUD courses and then trains them, either by closely supervising their initial efforts, or, preferably, by arranging for an INTRAH training of trainers course.

Training of MOH tutors: To reduce the load on ZNFPC staff, much of the family planning training of MOH personnel is provided elsewhere, by MOH tutors originally trained at ZNFPC. Though technically responsible for quality control even at this level, ZNFPC, in fact, has little direct knowledge of the number of courses provided or of their quality. Additional second tier training will occur through the Family Health Project II and may eventually reach more family planning personnel than ZNFPC itself. Obstacles to ZNFPC quality control at this level include lack of staff time and vehicles, but a more fundamental problem may be ZNFPC's apparently limited influence over MOH family planning activities.

Preservice Training: MOH's goal is to ensure that all physicians and nurses in Zimbabwe have clinical family planning skills, yet even newly educated personnel require ZNFPC to bring them up to appropriate standards. The time devoted to family planning during regular coursework appears to be minimal, and curricula developed through ZNFPC in 1985 (with USAID technical assistance) appear not be applied.

Cost recovery: The potential for ZNFPC cost recovery for family planning courses will be further discussed in the Financial Analysis.

3. The Clinical Unit and the Private Sector Coordinator: This section discusses both the Clinical Unit as a whole and the activities of the Private Sector Coordinator within it.

ZNFPC clinics: As noted in Section I above, ZNFPC currently operates 34 clinics (plus one new clinic recently opened in Kariba). The distribution of these clinics by province is as follows:

Mashonaland West: 3 clinics, including one within a MOH hospital
Mashonaland Central: 1 clinic in a MOH hospital
Mashonaland East: 3 clinics (including Spilhaus and a Youth Advisory Service clinic in Harare)

Manicaland: 7 clinics, including 1 in a MOH hospital and 2 mobile units
Masvingo: 6 clinics, 1 in a hospital and 2 mobile units
Midlands: 8 clinics, including 3 in hospitals and 1 mobile unit
Matebeleland North: 5 clinics
Matebeleland South: 2 clinics, both in hospitals

The condition of these clinics and their equipment and staffing needs are not well known at present and will require further analysis.

Private Sector Coordinator: The Private Sector Coordinator is a single overworked individual housed within the clinical Unit but responsible for all relevant activities including those of other units. She is currently involved most heavily in maintaining and expanding employment-based family planning services, including those initiated or stimulated by the highly successful Enterprise project, plus recruitment of potential new employer participants. She works closely with the TIPPS coordinator to manage payment of Medical Aid Societies for ZNFPC services but has not so far helped to recruit new service providers or insurers; she has also been only marginally involved in the social marketing program.

Maintenance and replication of TIPPS and ENTERPRISE-type activities will require extensive work by the ZNFPC Private Sector Coordinator. The feasibility of phasing out external technical assistance depends greatly on early identification, training, and hiring of supplemental assistance.

C. Personnel and Staffing: ZNFPC has a permanent staff of 1056, distributed by unit as follows:

Administrative/Finance	139
Medical/Clinical	124
Youth Advisory Services	33
CBD Unit	736
Training Unit	12
IEC	6
Evaluation and Research Unit	6

Approximately 70 percent of staff are associated with the CBD program, including 670 distributors, 58 Group Leaders, and 8 Senior Educators. Eight percent are either clinic nurses (79 persons) or doctors (4). An additional 4 percent are engaged in delivering other services: 33 in Youth Advisory Services and 13 in training.

ZNFPC's Harare office employs 77 in Finance and Administration, while 62 serve these functions in provincial offices. Finance and Administration thus employ 13 percent of ZNFPC staff.

Even with donor funding, creation of new staff positions is difficult at ZNFPC and must be approved by the Board. The hiring freeze may be temporarily bypassed through use of consultants, but ZNFPC cannot increase the staff establishment without guaranteed longterm funding for the particular position.

D. Sources of ZNFPC Financing: This subject is discussed in the Financial Analysis and will not be further discussed here.

II. THE PUBLIC SECTOR

The Government of Zimbabwe has supported family planning service delivery since at least 1966 when the Ministry of Health authorized widespread contraceptive distribution through health facilities and began administrative and technical support to the Family Planning Association. The Permanent Secretary of Health became an ex-officio member of FPA's Executive Committee.

Faced with the potential dissolution of organized family planning in 1980-81, the new government's Ministry of Health took an active role in reorganizing the old Family Planning Association into the Zimbabwe Child Spacing and Fertility Association (CSFA). The newly created Maternal and Child Health Department was assigned responsibility for the central direction of MOH family planning activities and for coordination with the CSFA. Government financial assistance continued, with the Ministry of Health matching USAID funds 2 for 1 when the new project began in 1982.

The 1982 Health for All Action Plan directed the Ministry of Health to integrate family planning into primary health care services nationwide, and in 1987, the Ministry, with World Bank support, initiated the five year Family Health Project to make this possible. Working in eight demonstration zones (one per province), the Family Health Project is training all service delivery personnel and equipping clinics to offer family planning. The World Bank and Ministry of Health continue to pursue this goal through a major new Family Health Project being currently discussed for initiation in 1992.

Though working under the single umbrella of the Ministry of Health, public sector clinics belong to a diverse network of 1231 health facilities, including 4 central hospitals, 12 general hospitals, 6 maternity hospitals, 28 district hospitals, and 56 rural hospitals. The majority of these units are managed and directed on a day to day basis by non-MOH bodies, including religious missions, district and rural councils, and municipal governments. Religious missions, though technically run by PVOs, are generally considered within the public sector because most are incorporated into the MOH network, follow MOH policies, and receive substantial recurrent funding from the government.

The exact number of public sector facilities providing family planning is not fully known and merits further analysis. ZNFPC provincial offices reported that their staff visited 403 non-ZNFPC facilities in the first quarter of 1990 but did not indicate how many of these were repeat visits. The World Bank estimates that 200 public facilities are active. The type and volume of services offered obviously varies by the facility's size and organizational placement, as well as by the degree to which staff are trained, motivated and equipped: while hospitals are generally able to provide the full service range, including female sterilization and IUD insertion, smaller facilities offer little more than resupplies. Public sector clinics are reported to be crowded and understaffed, with women and men often waiting hours simply to obtain pills and condoms. The Ministry of Health and ZNFPC hope that all health care providers in Zimbabwe will eventually offer family planning services, an aspiration that USAID shares but cannot help finance.

III. THE PRIVATE SECTOR

A wide variety of private groups support family planning in one way or another, as further described in the Technical Analysis. To summarize, these groups include:

1. the Geddes company, for direct marketing of contraceptive supplies through the Family Care Programme and for wholesale contraceptive sales to employer-sponsored clinics

2. perhaps up to 20 private employers for service delivery through company-operated clinics

3 private physicians

4. at least one private voluntary organization (the Marie Stopes clinic in Chitungwiza)

5. the Commercial and Industrial Medical Aid Society (CIMAS) and other insurance agencies for financing of service delivery

6. private market research groups, contracting to the social marketing (Family Care) program.

IV. THE CENTRAL STATISTICAL OFFICE OF THE MINISTRY OF FINANCE, ECONOMIC PLANNING AND DEVELOPMENT

The Central Statistical Office (CSO) was largely responsible for data collection and analysis for the 1988 Zimbabwe Demographic and Health Survey and should play the lead role in any future demographic survey.

Located within the Ministry of Finance, Economic Planning and Development, the CSO is the national center for generating and processing statistical information on all aspects of Zimbabwean development. Its Population Statistics Division which managed the ZDHS, is chiefly responsible for the national census and for the Zimbabwe National Household Survey Capability Programme. It also provides educational and employment statistics. The Division only recently completed analysis of 1982 census data and is already engaged in planning for the next round in 1992.

The Economic Statistics Division is responsible for industrial matters, national accounts, finance, consumer prices, training, research, and information.

Studies based on household interviews have included the 1983/84 Demographic Socio-Economic Survey, 1983/84 and 1984/85 Nutrition Surveys; the 1984/85 Income, Consumption, and Expenditure Survey; the 1985/86 Labour Force Survey, and the 1987/88 Inter-Censal Demographic Survey.

The CSO has offices in all 8 provinces and trains many enumerators. It is assisted by the UNFPA and other donors.

V. INTER-ORGANIZATIONAL RELATIONSHIPS

Organizational capacity for project activities will be affected not only by internal structures and processes but also by inter-organizational relationships. Two sets of problems may affect the implementation of the new USAID project:

- the private sector's relationship to the government, and
- ZNFPC's ability to influence the quality of care in public institutions.

A. Private Sector/government relationships

Government and business are not used to collaborating for social purposes in Zimbabwe and often see each other as mutually antagonistic. Profit motivations, and the desire to avoid unnecessary personnel costs (for undesired pregnancies, for example) may be suspect. Almost every significant private (and public) sector initiative in Zimbabwe requires government approval, and this may take anywhere upwards to two years. While Zimbabwe has one of the most developed private sector in Africa, its entrepreneurial instincts are blunted by general uncertainty about governmental attitudes and be decades-old sheltering from foreign competition.

Three issues affect implementation of the Family Care Programme in particular. The first is the government's insistence that Geddes pay a 25% duty on all imported commodities, even though USAID donates these without charge through the SOAMRC social marketing program. The government's position is that these are sold at a profit and that the national treasury should benefit from a portion of the receipts. The argument that the contraceptives themselves are a public good appears not to have been accepted. USAID should challenge this unfortunate practice as diplomatically as it can.

The second issue concerns requirements that socially marketed pills be sold on a doctor's prescription only. While this is a common stipulation in Europe and America, it is generally not applied in high birth rate countries where the risks of closely spaced and too numerous pregnancies vastly exceed the minimal medical risks associated with pills. Zimbabwe itself reached this judgment a number of years ago when it authorized CBDs to distribute pills without prescription, and continued adherence to the requirement for pharmacies may ironically force CBDs to continue resupply functions that might more cost-effectively be handed over to retail outlets.

A third issue concerns restrictions on the advertising of socially marketed contraceptives. For condoms, this is currently permitted but only under closely regulated conditions because of concerns about public propriety. For oral contraceptives, on the other hand, it is not permitted at all because of the prescription requirement described above. Lack of aggressive advertising may seriously inhibit the potential growth of the Family Care Programme.

B. <u>ZNFPC influence on the quality and volume of family planning services in the public sector</u>

ZNFPC has long been the lead family planning institution in Zimbabwe but is rapidly losing its role as the main service delivery agent and provider of supplies. This diversification of providers can only be welcomed, yet questions must be raised about ZNFPC's continued ability to lead when most of those providing service are outside its direct control. This problem is particularly evident with regard to Ministry of Health and other public sector clinics.

ZNFPC provincial offices have regular programs for visiting non-ZNFPC family planning providers, but their influence, at best, appears to be limited to technical issues. Little appears to be known about the quality and volume of family planning services in public sector facilities, or even about the total number of active facilities. Only in three provinces do public sector clinics regularly report their family planning activities to ZNFPC. MOH tutors trained at ZNFPC may or may not be passing their knowledge and skills to other MOH personnel. The public sector integrates family planning and MOH services, an arrangement that theoretically encourages acceptance but in practice makes it unlikely

that staff will have sufficient time. Lack of time is a particularly critical obstacle to sterilization and IUD insertion, since many clinicians reportedly find it much easier to give a woman another brief pill supply than to counsel and refer for, or to perform, longer lasting procedures.

The Ministry of Health's approach is to attempt to train every MCH provider in at least the basics of family planning, with an eventual goal to have someone at every clinic able to counsel potential users and provide pills, condoms, and IUDs. A more cost-effective alternative might be to install dedicated family planning personnel (presumably employed by ZNFPC) at high volume general purpose clinics to take advantage of the easy recruitment/referral possibilities while nevertheless ensuring adequate staff time and quality control. ZNFPC is already doing this to good effect in nine district and provincial hospitals, and should consider expanding this option in the future.

Three particular problems should be addressed in the forthcoming project. The first is the need to institute regular reporting from public sector clinics to ZNFPC, particularly for new sterilization, IUD, and NORPLANT$_R$ services. The second is the need to track ZNFPC-trained MOH tutors to ensure that they continue to provide high quality family planning training. A third need is to correct the inadequate knowledge and unfavourable attitudes that many public sector personnel currently exhibit towards the longer term clinical methods that require greater effort on their part.

VI SUSTAINABILITY ANALYSIS

There are a number of serious threats to the viability of family planning activities in Zimbabwe, not all of which can be addressed in project design. Concerted efforts, jointly planned with the Ministry of Health, ZNFPC, and other donors, will need to continue throughout the life of this project to ensure that USAID-supported activities continue after project termination.

Briefly summarized, threats to sustainability include:

- the significant recurrent cost implications of the multiple donor-financed activities now planned.
- the possibility of stagnant or declining government financing (in real terms) at a time when family planning acceptance rates must rise
- the relatively high costs of certain core ZNFPC activities.
- possible loss of political support if decision-makers mistakingly think that AIDS reduces the need for family planning
- government restrictions on cost recovery in the public sector
- the program's dependence on a single contraceptive method at a time when user need are changing
- possible disruptions caused by changes in contraceptive suppliers.

The greatest hope for overcoming these threats is that those involved in project design and management are aware of them and committed to continued growth and sustainability. The project should also enhance sustainability by:

- greatly increasing reliance on private sector financing and service provision
- taking steps to increase cost recovery through improved collection of user charges, a price elasticity study, and above-cost fees for international trainees
- diversifying family planning methods, to reduce dependence on the pill
- requiring only the most gradual changes in contraceptive sourcing
- encouraging local contraceptive production
- supporting operations research to identify the most cost-effective ways to deliver program services
- including AIDS awareness and referral in new and refresher training for all cadres
- providing a rationale for corporate contributions to family planning
- only gradually phasing out the USAID central funding which ZNFPC has used to such good effect over the last three years.

Firmness will be needed to control costs during project implementation but also flexibility to ensure that technical assistance is provided or project elements modified when this becomes necessary to increase the likelihood of continuity when funding ends.

CHART III.C.2 ZNFPC COURSES CURRENTLY OFFERED

1. Basic family planning clinical course
   duration: 4 weeks
   number per year: 6
   types of participants: nurses and physicians nominated by provincial nursing officers; international personnel
   participants per course: 20
   estimated need: vast
   status of curriculum: developed in 1984, needs updating for (a) AIDS, (b) patient counselling, (c) method mix
   comments: for USAID, mainly a priority for training of private sector personnel.

2. IUD course
   duration: 3 weeks (2 weeks for international personnel)
   number per year: 6 (currently suspended pending outcome of operations research study)
   types of participants: graduates of basic course
   participants per course: 10
   estimated need: uncertain till OR study is completed
   status of curriculum: JHPIEGO has refined curriculum to include one week on genito-urinary tract infections and prevention of infections (including AIDS)
   comments: a high priority for USAID

3. Basic CBD course
   duration: 4 weeks
   number per year: currently held only for replacement and private sector CBDs; 1 or 2 per year
   types of participants: community personnel
   participants per course: 25
   estimated need: mainly needed now for CBDs sponsored by the Commercial Farmers Union, since ZNFPC is not hiring new CBDs
   status of curriculum: designed in 1984; will need to be revised to reflect modified CBD job description and method mix
   comments: only refresher training is a USAID priority

4. Sterilization course: conducted periodically by AVSC

5. Senior educators' refresher course
   duration: 2 weeks
   number per year: 1
   types of participants: provincial CBD managers (i.e., senior educators)
   participants per course: 8
   estimated need: currently met
   status of curriculum: none
   comments: mainly important for project in connection with CDB refresher training

6. Group leaders' refresher course
   duration: 2 weeks
   number per year: 4
   types of participants: CBD supervisors
   participants per course: 15
   estimated need: as is
   status of curriculum: none
   comments: mainly important for project in connection with CDB refresher training

7. CBD refresher course
   duration: 1 to 2 weeks
   number per year: few recently
   types of participants: CBDs
   participants per course: variable
   estimated need: annual refreshing for every CBD
   status of curriculum: must be developed
   comments: high priority to train all CBDs near service delivery sites in patient counselling and referral for expanded method mix

FINANCIAL ANALYSIS

I. Cost Estimate and Financial Plan

Over the six year life of this project, A.I.D./Washington and USAID/Zimbabwe expect to provide resources totaling $15,712,000 for activities described in this Paper. Roughly 40% ($6,312,000) will derive from central funds and 60% ($9,400,000) from bilateral funds.

The major budget elements are presented in Table A. III.D.1.

The A.I.D. budget will cover short term technical assistance, training, training supplies and materials, evaluation and research, staff support, promotion, service delivery, commodities, seminars and workshops, equipment (vehicles, office and clinic equipment), evaluation and project management. In addition, reasonable allowances have been provided for contingency and inflation.

This is a prominent project that will support family planning activities of the GOZ, and will supplement and coordinate with the efforts of other donors, in order to have the best possible relation between cost and results. A.I.D. support is basic to ensure the continuity of the program, and its strengthening in order to offer better and more family planning services to the people of Zimbabwe, through the ZNFPC, the parastatal institution that carries out the family planning programs of the GOZ.

ZNFPC will face a tremendous financial challenge during the next six years, not only because of the number of users, but also because of the method mix that should be offered. The increased demand will come not only because of population growth but because of the increase acceptance of family planning services, as a result of ZNFPC promotion activities, and all this will translate into increased expenses.

Other interesting aspects of the project, because of its financial implications, are related to the promotion of the private sector as a family planning services provider. This new source of services to users will also result in the reduction of the load on governmental programs and resources.

Table III.D.1: Zimbabwe Family Planning Project
Projected A.I.D. Expenditures, by Source of Funds
(U.S. $000's)

	Central Funds	Bilateral Funds	Total
I. Method Diversification			
A. Promotion	235	560	795
B. Training	640	484	1,124
C. Service Delivery	656	220	876
D. Evaluation/Research	823	736	1,559
E. Contraceptives	1,117	4,478	5,595
II. Private Sector			
A. Social Marketing	120	166	286
B. Employer Services	110		110
C. Physicians	400		400
D. Insurance	75		75
E. Contributions	40		40
III. Coordination/Sustainability			
A. ZNFPC Coordination	5	200	205
B. Cost Recovery	200	100	300
C. Source Diversification			
IV. Project Administration	1,500		1,500
V. Vehicles		1,200	1,200
VI. Evaluation/Audit		210	210
VII. Contingencies/Inflation	391	1,046	1,437
TOTALS	$6,312	$9,400	$15,712

Table III.D.2: Zimbabwe Family Planning Project
Projection of Expenditures by Fiscal Year

	A. I. D.			Host	
	Central	Bilat.	Total	Country	Total
FY 90	1,268	1,626	2,894	717	3,611
FY 91	1,685	1,654	3,339	717	4,056
FY 92	1,296	1,583	2,879	951	3,830
FY 93	639	1,445	2,084	951	3,035
FY 94	639	1,398	2,037	951	2,988
FY 95	394	648	1,042	951	1,993
Inflation	323	656	979		979
Contingency	68	390	458		458
Total	6,312	9,400	15,712	5,238	20,950

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The project grant funds to finance local currency expenses will be disbursed to and managed by the implementing agency, ZNFPC. Accounting and financial reports will be prepared by ZNFPC. The principal local currency expenses will be limited to contracts with locally recruited assistance to supplement existing ZNFPC staff, IEC campaigns, and program marketing costs. To ensure a better use of these resources, the project includes the contract cost for a project manager.

Host Country Contribution

The contribution of the GOZ to family planning activities, and in particular to the ZNFPC has been signficant since the Independence of the country. If we analyse the budget of ZNFPC, for the FY (July 1st to June 30th) 1989-1990, the GOZ contribution of Z$10,300,000 when compared to the total budget of Z$13,250,000, is 77%. When we compare the total expenditure for previous years, as shown in the following table, during the five year period analyzed, the minimal percentage of GOZ contribution was 73% in 1986/87. A large percentage of the ZNFPC budget is expected from the GOZ during the life of the project, but for all practical purposes, the contribution to the Project by the GOZ (Host Country contribution) was budgeted on the assumption that such contribution will remain constant in U.S. dollar terms, during the life of the project.

ZNFPC Expenditure and GOZ Contribution from 1984/85 to 1988/89
Z$, 000

Fiscal Year	ZNFPC Expenditure	GOZ Contribution	Percent
1988/89	10,011	9,300	93
1987/88	8,504	10,400	122
1986/87	6,816	5,042	74
1985/86	5,454	5,004	92
1984/85	2,569	4,594	179

For the FY 1990/91, the total Government contribution to the project activities is estimated at Z$1,791,659 (US$716,664 with an expected 1990/91 exchange rate of US$1=Z$2.5). This figure was caculated based on the following data from the 1990/91 budget:

Training	Z$ 133,440
Promotion, IEC	442,300
CBD	215,629
Medical Clinic Unit	762,427
ERU	237,863
Total	$1,791,659

A total Host Country Contribution of US$5,238,000 is estimated for the six year (life of the project), which is 25% of total project costs. It should be taken into account that these figures do not include salaries and fringe benefits for the people related to the project, and if such figures were included, a larger percentage would result.

Salaries, fringe benefits and other direct and indirect host country contributions could be assigned to this project, but information will only be available after the cost recovery program.

In addition, the Government of Zimbabwe is expected to assume 21% of the costs of oral contraceptives in year 3, 25% in year 4, 50% in year 5, and 100% in year 6. These contributions are conservatively projected to total $936,000. Using only the direct contribution figures presented in US$, the following figures permitted us to determine a Host Country Contribution of US$5,238,000 over the life of the project.

The figures for these calculations follow:

Host Country Contribution to the Zimbabwe Family Planning Project
1990-1995
U.S.$,000

ITEM	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	TOTAL
TRAINING	54	54	53	53	53	53	320
PROMOTION-IEC	177	177	177	177	177	177	1,062
CBD	86	86	86	87	87	87	519
MEDICAL CLINIC	305	305	305	305	305	305	1,830
ERU	95	95	96	95	95	95	571
CONTRACEPTIVES			234	234	234	234	936
TOTAL	717	717	951	951	951	951	5,238
TOTAL PROJECT COSTS	3,685	4,124	4,073	3,361	3,381	2,326	20,950
% HOST COUNTRY CONTRIBUTION	19	17	23	28	28	41	25

Recurrent Cost Analysis

The proposed project attempts to minimize the recurrent cost elements of support activities, but those present are phasing out in the last part of the project. By the end of year 5 very few recurrent cost items will be covered, and these will phase out completely in year 6.

The main recurrent cost supported by the project is the cost of contraceptive commodities. In the past, virtually all commodities have been provided by A.I.D.. The project will support only oral contraceptives, as UNFPA and other donors will provide the balance of contraceptive requirements.

The promotion of longer term methods, the reduced reliance on pills, and charging higher fees for pills, will change the proportion of the recurrent cost related to pills. As it is likely that availability of foreign currency will continue to be a major constraint to purchase of commodities, Government will be asked to commit itself to the allocation of required resources over the life of the project. Local production of orals could alleviate this problem, but does not appear likely at this time, due to high production cost that results from the limited market size.

Cost Recovery

Up to now, cost recovery, and income generating activities have not been considered a very important source of revenue for the ZNFPC, as the main purpose and policy has been to ensure that the people receive adequate family planning services and contraceptives at very little or no cost.

Table III.D.3: Zimbabwe Family Planning Project
Summary Cost Estimate and Financial Plan
(US$,000)

Item	TOTAL A. I. D. Fx	TOTAL A. I. D. Local	Host Country Fx	Host Country Local	Total
I. Diversification					
A. Promotion	235	560		1,581	2,376
B. Training	660	464		320	1,444
C. Service Delivery	656	220		1,830	2,706
D. Evaluation/Research	933	626		571	2,130
E. Contraceptives	5,525	70			5,595
II. Private Sector					
A. Social Marketing	286				286
B. Employer Services	110				110
C. Physicians	400				400
D. Insurance	75				75
E. Contributions	40				40
III. Coordination/Sustainability					
A. ZNFPC Coordination	5	200			205
B. Cost Recovery	200	100	936		1,236
C. Source Diversification					
IV. Pronect Administration	1,500				1,500
V. Vehicles	1,200				1,200
VI. Evaluation/Audit	210				210
VII. Contingencies/Inflation	1,437				1,437
Totals	$13,472	$2,240	$ 936	$4,302	$20,950

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Charges at the present time are:

Orals	Z$0.20
Condoms	free
Foaming tablets	Z$1.00 for 12 tablets
IUD	Z$2.00
Depo	Z$0.25 vial for 3 months
Sterilization	Z$10.00

The income generated during the last 5 years at ZNFPC by the sale of family planning services and contraceptives was (in thousands of Z$):

1988/89	Z$458
1987/88	523
1986/87	383
1985/86	406
1984/85	294

In general, it is considered that ZNFPC have a great income generating potential and will be able to reach a reasonable level of self sufficiency. Revenue collected through contraceptive sales in both MOH and ZNFPC clinics is treated as general income to ZNFPC. Efforts in 1985 to establish a trust fund for re-purchase of contraceptives were rejected by the Government.

A. Cost Recovery In International Training

Although no specific figures were provided for cost recovery at the international training program, this figure is minimal, as the number of trainees is very limited and the fee has been considered a "promotional one", in order to have the training program known in the international scene.

The fee and estimated cost per trainee, at the present time are:

Training Activity	Fee	Estimated Cost
Community Based Distribution course (six weeks)	6,620	4,200 (1988/89)
Family Planning Clinical Skills course (four weeks)	4,414	2,462 (1990)
Intra-uterine Device Insertion course (two weeks)	2,207	793
Male Motivation Program	N/A	200
Communication Module	N/A	1,500

The cost recovery program will not only provide information about the cost, but about promotion fees and possible income. There is an interesting potential for this activitiy as an income generating source.

B. Fees for Services

Up to now the policy of the GOZ has been to provide free services to those earning less than the minimum salary (Z$150 per month), with a very low fee for those in the minimum salary bracket, and somwwhat greater fees for those in the higher income group, but the main policy is to promote family planning and to ensure the provision of services or the contraceptives. As mentioned in another part of this Project Paper, the Cost Recovery Program will provide ZNFPC with an interesting tool, in the cost recovery area, and this could be developed into an important source of income.

Note:

Inflation. A yearly 5% inflation factor was included for all budget items, except for commodities and contingency. For the calculation of the inflation factor, Year 1 was considered the base, equivalent to 100%. For Year 2 the inflation index is 105; that is comparing the cost of Year 2 with Year 1, a 5% increase is expected. When comparing Year 3 with cost figures of Year 1, the inflation index is 110; for Year 4, 116; Year 5, 122; and Year 6, 128.

Another way to look at the inflation factor, can be illustrated by the fact that an item that costs $100 in year 1, will cost $105 in year 2, Z$110 in year 3, 16 in year 4, $122 in year 5 and $128 in year 6.

Contingency. Was calculated as 5% of total yearly cost of all items (before inflation), for years 3 to 6 of project life, for years 1 and 2, it was considered that as these years were closer and a lesser variation could be expected.

Financial Analysis Appendix I

In the following pages, Tables 3.12 to 4.5 from the World Bank Report No. 7703-ZIM - Zimbabwe Population Sector Report (October 18, 1989 - Population and Human Resources Division - Southern Africa Department) are presented, and they cover the following aspects:

Table 3.12 - Summary of Income and Expenditure Statements Fiscal Years 1981-88 (Z$).

Table 3.13 - ZNFPC: Source of Funds in Total Income 1981-88 (Z$).

Table 3.14 - Total Monetary Value and Percentage Distribution Sources of Funds and In-kind Contribution to ZNFPC - 1984-88 (Z$).

Table 3.15 - ZNFPC: Total Expenditure and Expenditure by Function, 1981-88 (Z$)

Table 4.4 - Projected Revenues for All Family Planning and Donor Guaranteed Revenues (Z$)

Table 2.5 - Projected Total Family Planning Cost 1990-2015.

Table 3.12

ZNFPC: Summary of Income and Expenditure Statements
Fiscal Years 1981-88 (Z$)

Fiscal Year	Totals Income	USAID Donations	Deficit on Contraceptives Supplied	Total Net Income	Total Expenditure	Surplus Transferred to Reserve
1981	1,399,040		403,800	995,244	1,108,501	[113,257]
1982	1,684,170 (1,539,188)	144,982	286,419	1,397,751 (1,252,769)	1,360,877 (1,215,895)	36,874
1983	2,877,365 (2,477,365)	400,000	376,694	2,500,671 (2,100,671)	2,178,911 (1,778,911)	321,760
1984	4,707,686 (3,807,686)	900,000	1,029,529	3,678,157 (2,778,157)	3,156,158 (2,256,158)	521,999
1985	7,039,880 (5,939,880)	1,100,000	70,226	6,969,654 (5,869,654)	3,669,916 (2,569,916)	3,299,738
1986	9,996,632 (8,004,537)	1,992,299	1,549,762	8,447.074 (6,454,775)	5,454,853 (3,462,554)	2,992,221
1987	8,582,632 (6,535,913)	2,046,719	1,297,020	7,285,612 (5,238,893)	6,816,954 (4,770,235)	468,658
1988	18,500,000	N/A	N/A	N/A	N/A	N/A
TOTALS	36,287,613	8,584,000	5,013,450	31,274,163	23,746,170	7,527,993

* The numbers in the rounded brackets represent the actual entries for these items for the years in question on the audited statements. Prior to fiscal1987, the USAID donations were netted out of both income and expenditure in the audit statements. The numbers not in the rounded brackets represent the addition of USAID donations in both the income and expenditure entries and more clearly reflect the amount of economic resources consumed by family planning. For 1987, the USAID donation was included in the income and expenditure statement by the auditors, and 1986 was also accordingly adjusted in the same audit statement.

** Preliminary estimate.

SOURCE:

(1) ZNFPC annual audit statement by Deloitte Haskins and Sells, Chartered Accountants Zimbabwe.

(2) USAID, Zimbabwe

Table 3.13

ZNFPC: Source of Funds in Total Income 1981-88 (Z$)

Income	1981	1982	1983	1984	1985	1986	1987	1988
Grants Received	1,331,324	1,504,462	2,415,036	3,411,000	4,605,000	5,015,000	5,042,000	10,400,000
Local Gov't	14,660	13,448	5,250					
Ministry of Health	19,550	1,470,204	2,399,786	3,400,000	4,594,000	5,004,000	10,400,000	10,400,000
City of Harare	13,114	10,000	10,000	11,000	11,000	11,000		
Other	27,613	10,810						
Donations		146,885	404,220	1,228,895	2,304,179	4,760,316	3,011,757	8,100,000
USAID		144,982	400,000	900,000	1,100,000	1,992,299	2,046,719	1,657,760
Other		1,903	4,220	328,875	1,204,179	2,768,017	965,037	6,442,260
Other Income	40,107	32,823	58,109	67,811	130,701	221,520	528,876	
TOTAL	1,399,044	1,684,170	2,877,365	4,707,686	7,039,880	9,996,836	8,582,632	18,500,000

* Although USAID bilateral aid ended in 1987, it continues to fund other agencies that work in the family planning field and that contribute to ZNFPC.

** Family Planning International Assistance for years 1987 (948,629); 1988 (2,745,017).

SOURCE: ZNFPC and USAID, Zimbabwe.

Table 3.14

Total Monetary Value and Percentage Distribution of Sources of Funds and In-Kind Contribution to ZNFPC 1984-88 (Z$)

Source of Funds and/ or Contributions	Total Monetory Value (Z$)	Percent of Total
Ministry of Health	28.4	50.1
USAID	16.0	28.2
Pathfinder	1.8	3.2
GTZ	6.6	11.7
IPPF	1.2	2.1
JHPIEGO	.45	.8
Kubatsirana	.36	.6
UNDP	.25	.4
UNFPA	1.2	2.1
Others	.38	.8
Total	56.64	100.0

SOURCE: ZNFPC, Financial Controller.

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Table 3.15
ZNFPC: Total Expenditure and Expenditure by Function, 1981-88 (Z$)

Year	Expenditure and USAID Donation	Administration and Head Office	Education and Field Work	Medical and Clinical	Training	Youth Advisory Services	Depreciation	Information Education and Communication	Motor Vehicles	Motor Cycles	Kitchen	and Research Unit
1987	6,816,964 (4,770,235) [2,046,719]	1,827,456	2,139,752	1,262,683	300,545	443,776	197,305	181,646	333,241	5,482	23,385	102,683
1986	5,454,863 (3,462,564) [1,992,299]	1,111,221 (1,039,226)	1,798,511 (1,069,420)	1,457,489 (873,828)	434,077 (206,278)	54,603 (9,435)	189,975 (189,975)	124,493 (8,629)	282,248		2,236 (2,236)	
1985	3,569,916 (2,569,916) [1,992,299]	615,475 (575,875)	969,696 (567,096)	1,007,135 (684,835)	336,525 (211,125)	218,164 (192,864)	169,149 (169,149)	93,129 (29,329)	260,643	(63,527)		
1984	3,156,158 (2,256,916) [900,000]	587,297 (554,897)	1,088,265 (758,865)	874,332 (610,632)	206,272 (103,672)	88,673 (67,973)	32,290 (32,290)	67,194 (14,994)	211,835	(139,643)		
1983	2,178,911 (1,778,911) [400,000]	298,109 (277,842)	851,382 (701,115)	418,476 (375,996)	140,737 (91,270)	81,402 (68,335)	22,512 (22,512)	•••	132,979	(112,835)		
1982	1,360,877 (1,215,895) [144,982]	257,898 (252,679)	535,930 (482,867)	369,221	60,354 (43,826)	38,686 (35,351)	25,176 (25,176)	•••	•••	(85,112)		
1981	1,108,501	236,999	402,318		43,497	28,022	28,444					

• The first figure in this column for each year is the total amount spent. The second figure (in rounded brackets) is the amount reported in the ZNFPC audit report each year, prior to the report for fiscal 1987 that gives 1987 data that includes USAID Donations; before the fiscal 1987 report, the USAID donation was netted out of both income and expenditure in the ZNFPC report. The third figure [in squared brackets] gives the total USAID donation for that year.

•• Prior to the 1986 data contained in the 1987 audit report, there are no data on the functional expenditure distribution of the USAID Donations. Therefore, as an heuristic exercise, the USAID Donations were distributed, by function, for the years 1981-85, according to the 1986 distribution.

••• For 1983, the remainder of the IEC percentage was spread evenly over the other 6 categories (23,000 for 1985), excluding depreciation and for 1982, the remainder of the Motor Vehicle percentage and the IEC percentage was spread evenly over the other 5 categoreis (24,357 for 1982), excluding depreciation.

SOURCES: ZNFPC Annual Audit Statements and USAID, Zimbabwe.

Table 4.4

Projected Revenues for All Family Planning and Donor Guaranteed Revenues (Z$)

Year	MOH Grant To ZNFPC1	USAID* Grantees2	World Bank Project3	Other4
1987/88	10,400,000	1,657,750	2,841,600	
1988/89	12,287,773	2,890,581	2,841,600	382,233
1989/90	14,499,572	1,535,866	2,841,600	458,679
1990/91	17,399,486	214,694	2,841,600	550,415
1991/92	20,879,384	29,694	2,841,600	
1992/93	25,055,260	29,694	386,127	
1993/94		29,694	386,127	
TOTALS	100,521,475	6,387,973		

SOURCE:

(1) ZNFPC, Office of the Financial Controller
(2) USAID, Zimbabwe.
(3) World Bank, Project Appraisal Report 1986, World Bank Project Coordinator Estimates and World Bank Estimates.
(4) ZNFPC, Office of the Financial Controller.

Note: These figures do not include the considerable cost (economic value) of contraceptives supplied in kind by donors; for example USAID estimates that it contributed about Z$ 1.8 million worth of contraceptives, including shipping costs, in FY 1986 over and above financial contributions in that year. Contraceptives are an important element of costs, amounting, for example, to nearly two-thirds of total field expenditure on CBDs and ZNFPC clinics in FY 1987.

Table 4.5
Projected Total Family Planning Costs 1990-2015

Years	Contraceptive Prevalence Rate		Annual Number of Users ('000s)		Total Cost (US$ million)		Total Cost as % of 1986 GDP		Total Cost as % of GDP at 4% GR	
	Moderate Decline	Rapid Decline	Moderate Decline	Rapid Decline	Moderate Decline	Rapid Decline	Moderate Decline	Rapid Decline	Moderate Decline	Rapid Decline
1990	44	48	630	700	18.9	21.0	.3	.4	.3	.4
1995	52	64	893	1091	26.8	32.7	.4	.5	.4	.5
2000	59	73	1233	1529	37.0	45.9	.5	.7	.4	.5
2005	66	76	1607	1846	48.2	55.4	.6	.7	.5	.5
2010	72	76	1981	2028	59.4	60.8	.6	.7	.5	.5
2015	75	76	2304	2120	69.1	63.6	.7	.6	.4	4

SOURCE: Interpolated total fertility rates from Bank Population Projections (Demographic Annex Tables A.A.4) inputted into the Population Council TARGET program.

- The contraceptive method mix was assumed in both scenarios to evolve towards greater shares going to semi-permanent and permanent methods (i.e. female sterilization, the IUD and injectables such as Norplant). However the effect on estimated effectiveness of contraception was not large (a rise from .84 to .91), since the Bongaarts formula attaches a value of high effectiveness to the pill, which already dominates Zimbabwe users current method mix. Note also that all contraceptive use, not just of modern methods, was included (following the usual TARGET specifications) and is for all women, not just currently married women.

- The average annual growth rate in GDP between 1990 and 1986 (See Table of Comparative Indicators for Zimbabwe and Sub-Saharan Africa averages, page 3).

ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL (ZNFPC)

BUDGETING PROCEDURE

SOURCE: ZNFPC BUDGET

The ZNFPC like similar non-profit organizations prepares an annual budget each financial year and uses the budget as a management tool for planning and controlling its activities.

At the provincial level, budgets are prepared by the departmental heads and consolidated by the manager who in turn forwards the provincial budget to the Financial Controller.

At head office, the unit heads prepare their budgets and forward them to the Financial Controller for consolidation.

The role of the Financial Controller is to assist the unit heads and provincial managers with the preparation of the budgets, to co-ordinate the compilation thereof, and to present the final budget, through the Deputy Director Admin/Finance, to the Executive Director. The Executive Director as Chief Executive, is ultimately responsible for the budget. He presents, after reviewing it, the budget to the Board for approval.

At provincial level the manager is responsible for preparing reports on budget performance and submitting them to the Financial Controller with explanations for variances monthly. He is also responsible for giving provincial heads feedback on the performance of their departmental budgets.

At head office the Financial Controller is responsible for preparing reports on budget performance and disseminating these reports to the director and the unit heads. The unit head must give explanations to the variances reflected in the budget performance of their respective unit budgets.

ZNFPC Budget Cycle

1. Initial Budget: Provinces and units submit their budget by 30th October for consolidation by Financial Controller and onward transmission to the Ministry of Health. The initial budget is prepared for the purpose of obtaining grants from Government.

2. Detailed Budget: Provinces and units submit their detailed budgets by 30th April for consolidation by Financial Controller by 31st May.

3. Approved Budget: Based on grant allocation from MOH provinces and units are advised on their approved budgets allocation for the year by 31st July.

4. Revised Budget: Budget revision is prepared half yearly. This should be ready by 31st January .

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5. Performance against budget is reported monthly and quarterly.

Types of Budgets

ZNFPC operated basically on a line item structure budget which is funded by grants from Ministry of Health and Council's own funds derived from investments.

Alongside the council's budget the ZNFPC runs budgets for some of its programs which are funded by donors.

In compiling the institutional budget every effort is made to align these program budgets funded by donors to our own line item structure.

Cash Flow Budgets

At provincial level managers prepare quarterly cash flow budgets or forecasts. At head office these are prepared by the Financial Controller. Cash flow forecasts are used for estimating the cash available for investment on daily, fortnightly or on longer terms, and also to determine the cash available for expenditure during the forecast period. Cash flow forecasts are based on the budget.

Capital Budgets

The ZNFPC budget structure incorporates the budgeting of capital expenditure for such capital items as motor vehicles, equipment and furniture.

Capital expenditure relating to construction of buildings is not however incorporated in the budget structure.

SOCIAL SOUNDNESS AND WID ANALYSES

A. SOCIOCULTURAL CONTEXT

1. Socioeconomic Context

The current population of Zimbabwe is estimated to be 10 million. Zimbabwean households regardless of location are highly tied to the cash economy; those engaged in agriculture on communal lands derive an important part of total income from cash remittances and gifts from those working in the wage economy (CSO 1988). However, the economic growth rate has been erratic since 1980 and when coupled with the population growth rate, there have been only small gains. Employment in the formal sector has stagnated the past few years. Fewer than 10 percent of the 300,000 labor market entries per year in the next five years are expected to secure jobs in the formal sector. The government's new economic reform program addresses some of the macro level constraints to increased employment.

The economic constraints faced by the vast majority of the households encourage greater receptivity to family planning and limitation.

2. Health Context

Since Independence in 1980 the government has emphasized improving and expanding health care services. Women and children are particular targets not only because they have a higher risk of morbidity and mortality but also because they are among the most socioeconomically disadvantaged.

Life expectancy is 63 due to relatively low infant and child mortality. Only about nine percent of children die in their first five years of life (World Bank 1989). The infant and child mortality rates for the period 1983-88 are 53 and 24 deaths per 1,000, respectively. While the differences between rural and urban areas have narrowed over the past decade, the prospects for survival are still much better for urban than for rural children. The under-five mortality in rural areas is almost double that in urban areas (CSO 1989).

Infant mortality is associated with maternal age at birth. The highest mortality risk occurs for children of very young mothers and mothers nearing the end of their reproductive lives. The lowest infant mortality occurs when mothers are between ages 20 and 29 (CSO 1989).

A 1987 Ministry of Health (MOH) report indicates a maternal mortality rate (MMR) of 87 per 100,000 live births, a reduction of 41 percent from the 1980 estimates. Based on statistics from health facilities the MMR was 76 per 100,000 births in 1988. The rural estimate ranges from 137/100,000 in Mashonaland Central to 51/100,000 in Matabeleland North. While the use of health facilities for deliveries varies by province, the overall rate is relatively high: 70 percent of the births in the five years before the 1988 Demographic Health Survey (DHS) were attended by medical personnel.

Data on women's general health problems are scant. Information which does exist indicates higher burdens of disease in rural areas, higher disease rates in the large scale farming areas, and increased experience of ill health in the more marginal socioeconomic groups (Loewenson, 1990).

One area of concern is the rising level of reported sexually transmitted diseases (STD) and AIDS/HIV positive cases. The extent of awareness of AIDS has meant people report to health services for STD more readily, inflating the apparent increase. The reported STD incidence rose from 559,500 in 1986 to 973,097 in 1987. In the Bulawayo urban area, reported STDs doubled from 1980 to 1986 (Loewenson 1990). AIDS/HIV has also increased markedly, although the absolute numbers are unknown. In 1989, of the 33,716 requests for HIV testing made by doctors because of suspicion of infection, 42% or 14,225 were positive. A significant portion of infants has been recorded as being HIV-positive. In terms of actual AIDS victims, to date over 4,000 cases have been reported to the AIDS control program (Family AIDS 1990).

3. Overview of Acceptance of Family Planning

The Zimbabwe family planning program has received public support from the President of Zimbabwe and critical political acceptance which has contributed to its success. For example, the Zimbabwe National Family Planning Council's (ZNFPC) Youth Advisory Service provides family life education in the schools beginning at the upper primary school level, and access to contraceptives through community based distributors (CBDs) is not hampered by unnecessary restrictions. Moreover, the maternity law favors smaller families by limiting the frequency of paid maternity leave to not more than once every 24 months and a total of three times with respect to total service to any one employer.

The Government's political and financial support for family planning, and for ZNFPC in particular, has enabled it to be well-established and to be the most successful program in sub-Saharan Africa.

Like other African countries, the culturally accepted practices of prolonged breastfeeding and post-partum abstinence have contributed historically to healthy birth spacing. As a result of these practices, a significant proportion of Zimbabwean women have accepted modern family planning methods to space births.

Presently, however, it appears that a plateau has been reached in creating and meeting the demand for modern family planning methods under the current organizational network, and a service delivery system centered primarily on oral contraceptives.

Therefore the family planning program needs to expand to provide more persons with easy access to information, education and communication, and to services, and to address groups who are not currently using modern family planning methods but who indicate receptivity. In focusing on the latter, the project has correctly decided to improve the mix of contraceptives readily available, with particular attention on clinical methods, including those suitable for women who desire to cease bearing children. To focus on postponement of birth by younger women is a much more difficult endeavor due to sociocultural and gender-related issues.

B. SOCIOCULTURAL FEASIBILITY

1. Population Size and Distribution

The 1982 census showed a population of 7.5 million, giving a national population density of 19 persons per square kilometer and a rural density of 15 persons per km2. In general the densities are highest in the central and eastern parts of the country, and lowest along the western and southern borders.

The pattern of population distribution varies by type of land use, with the higher densities in the communal lands. In 1985 there were 1,676,167 households with an estimated total of 8.4 million people (CSO 1988). Forty-eight percent of the households are located on communal lands, where agricultural production and involvement in informal and formal sector activities provide the main sources of income. Within the communal lands, 52 percent of the households are headed by females. Most of the females who head households are married, and their husbands reside and work elsewhere.

Thirty-three percent of the households, or some 559,000, are located in urban and semi-urban areas. These households are mainly engaged in jobs in the formal sector. Among the other 19 percent of the households, most (15 percent) reside on large scale commercial farms. The others are on small scale commercial farms and resettlement schemes.

The 1982 census found 26 percent of the population living in the 63 towns and cities with at least 2,500 inhabitants. Most urban dwellers reside in the three largest towns: Harare, Bulawayo and Mutare. In 1982 the population of Harare was 656,000, which accounted for a third of the country's urban dwellers, and Bulawayo contained 414,000 persons.

According to World Bank projections, 47 percent of the population is currently aged under 15 years, and only 2.5 percent aged 65 years or over. The current rate of natural increase and population growth is estimated to be around 3.2 percent (World Bank 1989). This represents a decline in the population growth, with the decline in fertility more than compensating for the simultaneous decline in mortality.

2. Gender Considerations Related to Use of Modern Family Planning Methods

Maleness and Femaleness

Gender "norms" or ideals, which define social expectations and values related to being a male and a female, still favor relatively large families, virginity at the time of marriage, male control over decisions affecting the family, taboos associated with discussion about sex between husbands and wives, and proof of virility and fertility.

Definitions of being male and being female are socially tied to producing children. For males this is linked to having male heirs who will continue the name of the lineage. Females are expected to bear children to perpetuate the lineage of their husbands, and the tradition of brideprice, which is still practiced, relates to women's procreative function.

Proof of virility and fertility, therefore, become significant, particularly in the teenage years. Ideally a female should be a virgin when she marrie;, however, it is accepted that modern-day girls lose their virginity at an early age. In a 1987 study of young adults in Harare, the mean age among those woman aged 14 - 24, who had ever been pregnant was 18. (In comparison, the median age at first birth for women 25 -49 covered in the DHS was 19.5.) In the Harare study the mean age at first sexual intercourse was 18 among women aged 14-24 who had ever been sexually active. (Of the total sample of women, 39 percent reported having ever been sexually active.) Of these women, 55 percent said that they did not use contraception at that time because they wanted to become pregnant: 23 percent for whom it was premarital sex and 89 percent who were married at the time. Data from a recent study of males also indicates the emphasis on early childbearing: only 25 percent said a female should use a family planning method before her first pregnancy.

Extramarital Sex

In Zimbabwe, as in other countries,it is socially condoned for men but not women to have extramarital sex. As a result some men are suspicious if their wives want to use a family planning method; they think that it will encourage undetected promiscuity. This view is particularly prevalent among men who do not reside permanently with their wife.

With increasing awareness of AIDS, men are prone to use condoms to prevent STD and AIDS. However, condoms are not considered as a method of family planning, possibly because this is a less reliable method but also it may also be related to it placing responsbility on the male (see Quest 1987 and ZNFPC 1987). When asked about the person responsible for preventing pregnancy outside marriage, only 22 percent of the male respondents in the study of young adults in Harare, said that men were and 26 percent said both partners were.

Ideal Number of Children

The preferred number of children varies by socioeconomic characteristics. Table 1 below shows differences by level of education and residency for all women covered in the national survey in 1988. The trend is similar to that found in other countries: the number of children desired decreases according to level of education, and urban women tend to desire fewer children than do rural women. In addition, the preferred number of children tends to increase with the age of the respondent.

Table III.E.1: Mean Ideal Number of Children for All Women by Age, According to Selected Background Characteristics, 1988

Background Characteristic	Ideal Number Children
Urban	4.2
Rural	5.3
No Education	6.3
Primary	5.2
Secondary or Higher	3.8
Total	4.9

Source: Zimbabwe Demographic and Health Survey 1988. CSO 1989.

Studies among men show a similar pattern: those who are older, less educated, and with more children tend to favor larger sized families. The response probably relates to self-confirmation that the number of children which they already have were wanted. Only to a small portion of rural farmers is the labor from children probably an economic asset and hence related to their response.

Although there has been a decline in the ideal number of children among married women from 6.8 in 1984 to 5.4 in 1988, this question is probably interpreted to mean given the prevailing economic conditions in your life. Other data sources indicate that it was generally felt that if money were not a constraint, a person should have several children (ZNFPC 1987, and ZNFPC 1989).

Difficulty arises when the actual number of children desired differs between a woman and her husband. The DHS 1988 did not cover this topic, but it was included in the 1984 national reproductive health survey. The 1984 results show that 76 percent of the women reported that both they and their partner wanted more children (62 percent) or that neither wanted more children (14 percent). Although this survey indicates a high degree of agreement between couples, other evidence does not support this level of agreement (e.g. discussions with Family Planning nurses and CBDs, and ZNFPC 1987).

Loci of Decision Making and Responsibility for Use of Family Planning Methods

Both men and women acknowledge that men are the decision makers about family matters. When it comes to the locus of final decision making about whether or not to use a family planning method or to limit the size of the family, women usually say that the man decides. (The latter does not negate the fact that some women will use a method even though the husband disapproves.)

The response among men tends to vary by socioeconomic characteristic, although relatively few (13 percent) believe that the decision resides solely with the wife. (In extramarital sexual encounters, however, men tend to think that it is the woman's responsibility to avoid pregnancy. See section above.) Uneducated men are more inclined to say that the man makes the decision rather than regard it as a matter for joint decision making. Only after some secondary education does the proportion of men who assert that their men make the decision decline and the proportion of those saying that both should make the decision increase. Urban men more than rural men say the man and wife should jointly make the decision.

If they approve of family planning, Zimbabwean men, like those worldwide, consider use of modern methods a women's responsibility. Only about 20 percent of men regard male sterilization as an acceptable method of family planning, and few regard it as a method that they would personally adopt.

Males may use condoms and the incidence of use appears to be increasing, but the male motive is primarily to avoid sexually transmitted diseases, although the partner benefits from avoidance of an unwanted pregnancy. Married men may use condoms when engaged in extramarital sex, but only a small proportion use condoms with their wives and these tend to be men not residing permanently with their wife.

In regard to the choice of method that the woman should use, most men consider that it is the decision of the woman and medical personnel. However, for female sterilization the written permission of the husband (or for unmarried women their father or guardian) is required. Most men say that if the doctor recommended that the wife be sterilized, then they would agree, and if their family were complete and the wife agreeable, they would agree to the wife being sterilized. Difficulties arise with the latter if the husband and wife do not agree on the number of children which constitutes having "completed" their family.

ZNFPC has recently begun promotion of family planning among males. This is particularly important when it comes to improving the mix of contraceptive use towards clinical methods, especially female sterilization.

Discussion of Sex and Family Planning

In Zimbabwean society it is considered taboo for a male and female to discuss sex. Even between members of the same sex, there are parameters. Fortunately discussion of family planning is not strictly considered discussion of sex between a husband and wife, but of the number of children and spacing of children . Nevertheless, except among the more highly educated younger couples discussion appears to be limited. Otherwise, the subject is usually raised after the wife has had one or two children (ZNFPC 1987).

The DHS inquired about the number of times currently married women who knew of a contraceptive method discussed family planning with the husband during the year before the survey. About half of the women said that they had discussed it more than twice, 20 percent had discussed it once or twice, and about 30 percent had never discussed family planning with their husband. An analysis of those who reported that they had never discussed family planning during the year (Table 2) shows the following characteristics. About half of those aged 15-19 had not discussed it, indicating that it is only after children are born and a woman's fertility proven that discussion of family planning occurs. Also, in the higher age ranges almost half had not discussed it with their husband; this may be related to their thinking of themselves as "too old", a concept discussed later.

Table III.E.2: Percent Distribution of Currently Married Women Who Know a Contraceptive Method Who Had Not Discussed Family Planning With Husband During the Year Before the Survey

Background Characteristic	% Who Had Never Discussed FP
Age	
15 - 19	43
40 - 44	40
45 - 49	46
Residence	
Urban	21
Rural	35
Level of Education	
No Education	51
Primary	29
Secondary or Higher	18
Total	31

Source: DHS 1988.

The relatively low levels of discussion between spouses in certain socioeconomic groups limits the potential impact of certain types of activities unless this factor is taken into account. For example, information does not tend to get passed from many of the male employees to their spouses about the provision for reimbursement of family planning services through medical insurance schemes and, thus, other means are being sought to communicate the information.

Economic Status of Women

A woman's economic status and her degree of economic dependency on men affects her willingness and ability to adopt family planning. Only 17 percent of the some 1.1 million employees (1984) in the formal sector are women and most of these are engaged as casual laborers (CSO 1987). While women do engage in such informal or microenterprise activities as sewing, handicrafts and trade, the sector is relatively small due to government regulations and the income levels usually inadequate to maintain a person, especially with dependents.

The majority of adult women reside in rural areas, and it is primarily through marriage that they obtain access to land to support themselves. Women's ability to retain rights to land depend upon remaining married and producing children. Particularly those with little or no education are in a precarious economic situation if domestic insecurity arises.

Thus, motivation of men to encourage their wives/partners to use family planning is important to a significant proportion of the adult female population. (This does not negate those who use a method without the knowledge of their husband, but usually this tactic can be employed only to delay pregnancy.)

For some women their economic dependency on men affects their attitudes toward family planning. Some men claim, probably correctly, that poor girls see their future security through marriage and hence want to get pregnant to force a marriage. Also, some men report that some women believe that if they do not produce more children their husbands will divorce them and look for another wife. Related to this, they say that a wife becomes very suspicious if the husband suggests not having more children; this is taken as a sign that the man intends to divorce or leave her for another woman (ZNFPC 1987).

3. Sociocultural Considerations Related to IEC, Service Delivery and Research

Information, Education and Communication

The level of education indicates not only a person's level of literacy but also their predisposition to "modern" or different ways of thinking. Most younger Zimbabweans have at least a primary school education. It is in the ages above 40 that almost a third of the women have had no education and those with a primary school education may have not completed their schooling, although the adult education program has resulted in a number of older women having gained literacy skills.

In terms of potential channels for information, education and communication (IEC), men more than women tend to listen to the radio and read newspapers. However, urban women have greater exposure to the media than do rural counterparts (CSO 1989). Only 26 percent of the rural women report reading a newspaper or magazine at least once a week and 22 percent listen to the radio every day.

Reaching people inprivate sector worksites is proving successful. However, women comprise a very small proportion of permanent employees, although they often comprise over a third of the casual laborers employed. It is particularly on plantations, mines, and commercial farms where families reside that both men and women can be reached with IEC. Thus, with the exception of the few businesses like textiles which mainly employ women, private sector initiatives in urban areas will be geared primarily at men.

Service Delivery

Zimbabwean women prefer being treated by female nurses and doctors. A very high proportion of the nurses are women, and although no statistics are available, it is estimated that at least two-thirds of nurses are female. In regard to doctors, however, it is estimated that fewer than 20 percent are female.

This sex preference could affect the inclination of women accept clinical methods. Thus, attention should be given to ensure that female doctors are given priority for training in clinical methods. In regard to NORPLANT$_R$, it is hoped that nurses will eventually be able to provide the method, which will help to ensure greater acceptability.

Research

All three project components include operations research to provide information to project implementers about the acceptability of their activities. ZNFPC has a good record of adjusting implementation based on feedback. For major research activities, a combination of methods are employed: community level surveys, focal group interviews, survey questionnaires administered to clients or potential clients, and discussions or questionnaires with service providers. Sometimes in-depth interviews based on questionnaires are carried out.

Discussion of sex and hence family planning practices, however, is not socially condoned. Such topics are considered private and personal. As a recent study among urban men points out, "there still exists sociocultural constraints that have yet to be fully addressed in order to allow for free conversation on matters pertaining to family planning methods, practices and perceptions without the apparent embarrassment observed in interviews with the majority of employees (interviewed)."

Furthermore, difficulties arise with the different research methods used. In one-time surveys based on structured questionnaires there is the likelihood that responses are biased by the respondent giving answers which he or she think the interviewer wants. This bias is probably even stronger among those covered by employer-based services. Difficulties arise with focal group sessions when a few persons dominate and hence influence the response of others. To take such bases into account, in major studies ZNFPC often employs several research methods but this is tends to be very time consuming. Under the project it is recommended that less structured interviews be conducted by well trained semi-professionals, under the guidance of an experienced researcher, especially on sensitive topics, to obtain more reliable information.

The research carried out under this project should:

- use interview guides and probe, and

- ensure that in studies carried out by local consultants, interviewers or discussion leaders are carefully selected, adequately trained and have the skills to establish rapport and trust

The ability of the Evaluation and Research Unit to carry out the above guidance will be enhanced through involving them as partners in the design and execution of research with assistance from Cooperating Agencies. It will be the responsibility of the AID project manager to make sure that planned formal training is provided by some of the Cooperating Agencies so that meaningful on the job training is carried out.

4. Knowledge and Attitudes About Family Planning

Clinical Methods

Basically there is a relatively high level of awareness by both females and males about at least some contraceptive methods. The pill and condom are the most commonly known, and almost everyone knows sources for acquiring these. Less commonly known are other methods, as shown in Table 3.

Table III.E.3: Percentage of Respondents Who Know Of Certain Family Planning Methods

	IUD	Inject-ion	Female Steri-lization	Male Steri-lization
DHS 1988 (national sample)				
All Women (4,201)	52	62	50	16
Currently Married Women (2,643)	60	72	55	18
Young Adults in Harare, 1986				
Women aged 14-24 (1,206)	39	56	32	19
Men aged 14-21 (647)	24	43	38	32

In parenthesis is the number of respondents.

Sources: CSO 1989, and Reproductive Health Survey of Young Adults in Harare, 1988.

A recently completed study of men shows a much lower level of awareness of the methods listed above. All data sources indicate that awareness needs to be increased about clincial methods of contraception. Moreover, there are various attitudes and misconceptions about these methods which need to be taken into account when developing or adapting IEC material for distribution in Zimbabwe.

There are several negative perceptions about IUDs, such as: the IUD can disappear in the uterus and then appear attached to the baby; and the IUD diminishes the woman's desire for sex. In regard to female sterilization, many men and women seem to regard it as meaning that one is no longer a woman.

Men

Various attitudes of men have been explained in the section above on gender considerations. It is important here, however, to point out that men tend to have only a superficial knowledge about various family planning methods (see for example, ZNFPC 1987). Also some tend to have an exaggerated fear of the side effects of some of the methods, such as the pill. In addition, men sometimes have a psychological barrier to their partner using a family planning method: they think that it will cause impotence or claim that it makes sex less pleasurable.

The study of young adults in Harare revealed that 31 percent of the males aged 14-21 thought that conception was not possible at first sexual intercourse for the woman, while another 7 percent said that they did not know.

In general men acknowledge that they lack sufficient information about family planning methods, and desire to be better informed. This suggests that it is insufficient to provide only cursory information to raise awareness. Rather, men should be provided with adequate information about the various methods including the probability of side effects, and reliability.

Young Women

As explained in the section on gender considerations, there is a social emphasis on bearing children at a young age. When women age 15-19 were asked the ideal age at pregnancy, 19 percent thought 15-17 years and 26 percent consider it to be between 18 and 19 years old. In terms of area of residence, 36 percent of the urban young women and 53 percent of the rural young women considered 19 years or less the ideal age of first pregnancy (ZNFPC 1985).

Information in the 1987 study of young adults in Harare show that a significant proportion of the young females have never personally discussed family planning, pregnancy, or labor and delivery, and the level of knowledge about pregnancy and family planning is relatively low. In spite of the high percent of women who said that they had heard of a family planning method, fewer than half reported that they had personally discussed it with anyone. Those who had discussed family planning tended to be older and sexually active.

Moreover, many young women are misinformed about when pregnancy is likely to occur. Nineteen percent said that pregnancy was not possible at first intercourse and 16 percent did not know. Those without knowledge tended to be age 19 or younger (Youth 1988) .

Although the project will not directly address the lack of knowledge among young women, the project activities in the private sector should assist in educating more female youth about family planning and related topics.

Older Women

Most women by the time they reach the age of 35 have had all the children they wish to have (Table III.E.4). In fact, most want to stop bearing children. However, many of these woman are either using an inappropriate contraceptive method or no method at all. It is particularly these women that the project intends to benefit by expanding the availability and access to clinical methods.

Table III.E.4: Percent Distribution of Future Reproduction Desire of Currently Married Women Aged 35-49, According to Age

	35-39	40-44	45-49	% of Total
Want Another Child Within 2 Yrs	24	16	14	19
Want Another After 2 or More Yrs	16	6	3	10
Want Another, Unsure When	--	--	--	1
Undecided	8	6	4	6
Want No More *	49	65	71	59
Unable to Have Child	3	6	7	5
Total Percent	100	99**	99**	100
Number of Women	403	253	232	887

--- signifies less than one percent.
*Includes 55 sterilized women who represent 10.5 percent of the respondents who want no more children.
**Does not add up to 100 because of rounding.

Source: Derived from Table 5.2, DHS 1988.

In reaching these women, however, one aspect needs further attention to help develop the training for Community Based Distributors (CBDs) and the IEC materials. Two studies indicate that some men and women consider that over age 35 is too old to be concerned about family planning. As the analyst of the Kubatsirana project data point out, this answer was given by women who were less than 40 years old and it was consistent through the baseline, midpoint evaluation and final evaluation of the project, indicating that the family planning IEC activities did not address this perception. The analyst points out that some women considered themselves too old based on the number of children and grandchildren they had. One respondent said: " Why should I have sexual desires as my child. This is the time I should demonstrate that I have now moved to another age group."

This perception of sexual behavior based on age places these women at risk of pregnancy. Also, some answers imply that the women genuinely perceived themselves as being incapable of reproduction. This idea about being "too old" is also revealed in the evaluation of men involved in motivation efforts under the British Tobacco Company and ZNFPC private sector family planning activities.

5. Ability to Pay for Family Planning Services

As part of the project, actions should be taken to ensure that ZNFPC activities are financially sustainable. Not only should attention be given to improve collection of fees but also to increase user fees. The study to be carried out should take the following into account.

First, currently there is a two tier scale: those who receive a minimum wage are charged a small fee, whereas those with lower incomes receive services and commodities free of charge. This policy refers to the income of the woman or her husband. As such it assumes that the woman has access to money from her husband or some income of her own. This is not always the case. In fact, evidence from communal lands show that poor women often receive food not cash for casual labor performed (Adams 1989). Regrettably, no data exist about intrahousehold flows of funds, but it can be assumed that not all women have access to the wages of the husband.

Second, and maybe even more important, the cost associated with obtaining the services ought to be analyzed. Particularly when assessing clinical methods, transportation and related costs will affect the total cost borne by the client who may have to make more than one trip. For example, a woman wanting sterilization will probably have to go for consultation and a physical and return later for surgery. Thus, it is possible that the associated costs will be higher for rural than urban women.

Third, for poorer people it is easier to pay a little money periodically than to pay a larger sum at one point in time. While the cost of clinical methods may in the medium term be cheaper for the client than the purchase of pills it will be more difficult to have more money at one point in time since critical demands arise which tend to deplete any savings.

Thus, care should be taken in the project related to increasing user fees so that the fee levels and structure do not discourage use of family planning methods, particularly clinical methods.

C. PARTICIPATION

ZNFPC managers have been involved in discussions about the project at both the PID and PP stage, and their ideas taken into account. Not only

top managers but also heads of the key divisions have participated in development of the project paper. In addition, key persons from the private sector were contacted about their receptivity to participating in implementing the private sector component of the project.

The views of potential family planning users have been factored into project design. First, the 1988 DHS indicated that a significant number of women who are not currently using a modern family planning method would like to cease or delay childbearing and are receptive to using a method. Second, studies carried out by ZNFPC show that men would like to be better informed about different family planning methods particularly since most consider themselves to be the final decision-makers about such matters.

In regard to implementation, the project includes operations research, monitoring and a midterm evaluation which will provide feedback from potential users or partners of users. The information will be used to guide project implementation.

D. BENEFICIARIES AND SOCIAL CONSEQUENCES

1. Family Planning Related Service Personnel

Several persons, mainly women, will receive training funded by the project. First, some 637 ZNFPC CBDs and their supervisors, approximately 90 percent of whom are female, will receive training about longer-term family planning methods and promotion. The CBDs work primarily in the communal lands and hence residents in these areas are expected to benefit from CBD training.

In addition, training will be provided to approximately 100 CBDs and Motivators who are or will be employed under the private sector. The CBDs operate on commercial farms and on industrial complexes, such as mines, and approximately 60 percent of the trainees will probably be females. Motivators are engaged in private sector activities undertaken in urban and semi-urban work places. Approximately 66 percent of the Motivators trained are expected to be men since they will be working among employees, most of whom are male. However, the project intends to seek out the participation of those firms who employ primarily women, as in the textile industry.

Under the private sector component, initiation of family planning activities through employers will actually lead to the creation of some part time and fulltime jobs for men and women. Since it is the policy of ZNFPC to recruit persons with at least a primary school education as CBDs and Motivators, these men and women will be in the lower to middle socioeconomic classes.

Employer-based health personnel will receive training in counseling and provision of family planning services. Approximately 50 percent of these trainees are expected to be women.

In addition, training in clinical family planning methods will be given to approximately 19 ZNFPC tutors who will then train Ministry of Health (MOH) tutors, and 127 ZNFPC clinic staff. Since the ZNFPC clinic staff and tutors are female, the training will mainly enhance the skills of female medical staff.

To complement the training in clinical methods, each clinic or hospital participating in the training will also have a nurse trained in counseling and screening. Almost all of these are expected to be female.

In prioritizing employer-based health personnel for training under this project, attention should be given to women's preference for receiving family planning services from females. This appears particularly important in terms of examinations and IUD insertions, especially when the client has not had previous contact with the service provider.

Lastly under the project the staff of ZNFPC will increase. Two local consultants will be hired for a five year period to assist the Private Sector Coordinator. Also six new tutors will be hired to expand the teaching capacity of ZNFPC. It is expected that at least 75 percent of the new staff will be female.

2. Family Planning Service Users

Thousands of women and men reached by those trained under the project and by other project-funded activities will benefits from the project. Urban, semi-urban and rural dwellers will be reached by the project. However, since the data on existing users of longer-term family planning methods show that these methods appeal more to women who have jobs and more than 2 years of secondary school education, it is anticipated that a smaller portion of rural than other women will benefit from this aspect of the project. Nevertheless, the portion of rural women using a longer term method is expected to increase. Longer term methods are expected to appeal to poor rural women who already have some children and want to cease or delay childbearing, including those who are unmarried, those abandoned by their spouse, and those whose husbands approve.

The private sector component will reach urban, semi-urban and rural persons. The social marketing and medical aid society sub-components will primarily benefit urban and semi-urban dwellers, unless there is a change in regulations so that certain types of contraceptives may be sold more widely in such places as stores and bars. Presently the pharmacies involved in the social marketing activities are all located in major urban centers.

The employer-based schemes will extend services to rural areas as well as urban and semi-urban areas. Potentially all geographic areas of the country will be served under the private sector component but the actual outcome will depend mainly on employers willingness to take financial responsibility.

3. Social Consequences

Promotion of service delivery by the private sector is expected not only to increase access to such services but also to ease the financial burden upon the Government. Thus, the cost will be placed more on employers and medical aid societies as part of their benefit package for employees, but employers and medical aid societies will also gain from reduction in the cost of maternity payments and related expenses.

The project will investigate the effect of current service fees upon different economic classes. Particular attention should be given to ensure that assessed fees do not inhibit access by lower socioeconomic groups, especially for the longer term methods which require a greater expenditure at one point in time. In this way, the project should relieve the financial costs to those in the lower economic groups who desire to use contraception, especially longer-term methods.

4. Spread Effects

The project is intended to have a spread effect through its success in obtaining the commitment of private enterprises to sponsor family planning services. In particular, those business which have their own medical personnel are expected to begin to incorporate family planning IEC and services, particularly non-clinical methods which do not rely on outside inputs. To be tested is the extent to which private businesses will contribute to fundraising by the ZNFPC, but this holds potential which could expand after the end of the project.

Project funded training of Ministry of Health (MOH) personnel is likely to have a spread effect in that these people will then train others in the methods learned. Also, the international persons trained by ZNFPC will probably serve as trainers in their own countries and carry back information about factors which contribute to the success of the Zimbabwe family planning program.

Those men and women receiving IEC and services who are not inhibited about discussion of these with friends and relatives are expected to spread information about clinical methods. In particular, this will probably be very important related to the acceptance and demand for NORPLANT$_R$.

E. IMPACT

The project is expected to have a positive impact on a large number of Zimbabwe families, but especially women. Impact is expected to be felt in three areas. First, by enabling couples to have the number of children they desire and to space children as they desire, activities should result in healthier childbearing. Consequently, there should be lower levels of maternal and child mortality and morbidity. Second, the quality of childrearing should be enhanced through devoting more resources to nurturing and educating each child. Parents will be better able to meet the cost of educating their children, such as uniform, tuition and book fees that are required for secondary and higher levels of schooling. Third, control over their fertility will enable women to pursue educational and non-household work opportunities.

To assess the actual impact, as part of the project's final evaluation, a special study will be carried out based on a sub-sample of approximately 120 of the women interviewed in the 1994 DHS. The sub-sample will include those women who have adopted a longer term family planning method and a control group. The control group will consist of women equally matched with FP adopters in terms of critical factors such as educational level, ethnicity, area of residence, age, marital status and age of children. The study will focus on obtaining information about a 4 - 5 year period on a) major health problems of the woman and her children, b) the educational levels of the children and type of job, if any, c) husband's level of income and type of job, and d) the woman's level and sources of income. The study will also assess if the adopters have acquired or expect to assume financial obligations for extended family members, such as responsibility for relatives school fees as a result of their having fewer children. Also perceptions about impact will be sought from those women who are using a longer term method.

The results of the study will provide USAID and the Government of Zimbabwe with good information on the actual benefits derived by women and families who adopt longer term family planning methods. Furthermore, the results should provide insights that could be used in future programming.

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6.6. Economic Analysis

Numerous economic benefits are associated with averting unwanted births and postponing mistimed births. Some, such as recurrent education costs, are more easily measured; others, such as reduced medical costs attributed to high-risk births (e.g., high-parity and closely-spaced births) are more difficult to quantify. Some, such as school fees, are measured at the family level; others, such as recurrent health care costs, are measured at the national level. The present analysis compares the costs of expanding Zimbabwe's family planning program with the savings associated with reduced government expenditures in the education and health sectors.

The analysis is limited in a number of ways. Two are noted here. First, family planning costs are estimated without distringuished financed sources. Obviously, there are a number of sources, including international donors, Zimbabwe's Ministry of Health, private sector organizations, and individual couples. Second, avings associated with averted and postponed births are estimated for the Government of Zimbabwe alone. ignored are the savings relaized by families and private service providers through reduced expenses for education and health care. Both limitations casue the results of this analysis to be more conservative than would be derived through a more conprehensive analysis.

Table III.F.1 presents the results of this analysis, which are adapted from data presented in the World Bank's 1989 "Zimbabwe Population Sector Report." The analysis compares two scenarios of fertility decline. The first assumed a moderate decline in fertility, where the total fertility rate (TFR) falls from 5.4 to 2.3 over the thirty year period 1985-2015. The cost implications of this scenario are displayed in the first panel of the table. The number of users of family planning required to achieve moderate fertility decline increases from under half a million to 2.3 million over this period. The analysis assumes a constant per user cost of $30 throughout the period. The result is an increase in total family costs from $12 million to $69 million over this period. Under this scenario also rise dramatically, owing to increasing numbers of school-age children and MOH clients (the number of mother delivering plus the number of children under 5). The education estimates assume a maintenance of current enrollment rates (100 percent for primary and 40 percent for secondary school) and a constant per-student per annum recurrent cost of $120 for primary and $300 for secondary school. The health estimates assume a constant per-client, per annum recurrent cost of $40.

The second scenario assumes no change in fertility over this thirty-year period. The cost implications of this scenario are displayed in the second panel of this table. Dueto the effects of population growth, the number of family planning users must rise substantially in order to maintain the 1985 TFR of 5.4. Family planning costs are estimated to

increase commensurately from $12 to $35 million over this period. Due to maintained high levels of fertility, both education and health sectors are affected dramatically. Total education costs nearly triple and health costs more than double over this period.

A completion of costs between these two scenarios completes this cost-benefit analysis. Differential costs are displayed in the final panel of the tablel The marginal program costs of a moderate decline in fertility are $4 million in 1990, increase to $15 million by 1995 and to $23 million by 2000. Combined savings (shown as negative values in this table) from the education and health sectors are $2 million in 1990, increase to $18 million by 1995 and to $74 million by 2000. Thus, the break-even" point, where annual savings are double the annual costs of family planning. By 2000, savings grows to five-times costs, In successive periods, these savings grow proportionately greater than costs.

The "pay-back" point, where cumulative savings equal cumulative costs, occurs in 1993. So within eight years of program initiation, total savings begin to outweigh the costs associated with a stronger program. These estimates, of course, ignore discounting, and in effect equate future with present values of both savings and costs. The internal rate of return (IRR), which is the discount rate that equates the present value of expected costs with the present value of expected savings, provides a single measure of returns on investment. The IRR for the stream of savings and costs observed over this thirty-year period is 56 percent. This means that one would have to discount future benefits by well over 50 percent annually for the investment in family planning program not to be cost-beneficial. Hence, the benefit-to-cost ratio for family planning in Zimbabwe is extremely favorable.

Table III.F.1

Estimated Costs of Family Planning
and Associated Reductions in Public Sector Expenditures
in Education and Health Sectors: 1985-2015
(all estimates in millions) *

	Family Planning		Education		Health: MCH		Total Ed/He
Year	Users	Costs	Students	Costs	Clients	Costs	Costs
Moderate Decline in Fertility							
1985	0.4	$12	2.1	$345	2.0	$81	$426
1990	0.6	$19	2.6	$417	2.1	$82	$499
1995	0.9	$27	3.0	$481	2.1	$84	$565
2000	1.2	$37	3.2	$534	2.1	$85	$621
2005	1.6	$48	3.2	$536	2.1	$85	$621
2010	2.0	$59	3.3	$546	2.1	$83	$629
2015	2.3	$69	3.2	$546	2.0	$79	$625
No Change in Fertility							
1985	0.4	$12	2.1	$345	2.0	$81	$426
1990	0.5	$15	2.6	$417	2.1	$84	$501
1995	0.6	$18	3.0	$481	2.5	$102	$583
2000	0.7	$22	3.5	$571	3.0	$121	$692
2005	0.8	$25	4.2	$657	3.6	$144	$802
2010	0.9	$30	5.1	$797	4.3	$170	$967
2015	1.2	$35	6.0	$948	5.0	$200	$1,148
Difference							
1985	-.-	--	-.-	---	-.-	--	---
1990	0.1	$4	0.0	$0	(0.1)	($2)	($2)
1995	0.3	$9	0.0	$0	(0.4)	($18)	($18)
2000	0.5	$15	(0.3)	($37)	(0.9)	($37)	($74)
2005	0.8	$23	(1.0)	($121)	(1.5)	($59)	($181)
2010	1.0	$30	(1.7)	($251)	(2.2)	($87)	($338)
2015	1.1	$34	(2.6)	($402)	(3.0)	($121)	($523)

* All costs are expressed in 1990 U.S. dollars.