

Advance Africa's Zimbabwe Program: Interventions, Achievements, and Lessons Learned, 2001 - 2005

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*Expanding family planning
and reproductive health
services in Africa*

Zimbabwe Program

Interventions, Achievements
and Lessons Learned

2001-2005

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**Advance Africa
Zimbabwe Program:**

**Interventions, Achievements,
and Lessons Learned**

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Working to improve the health and well-being of African families through strengthened reproductive health and family planning services

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Communication Change
CBD	Community-Based Distributor
CDC	Center for Disease Control
CPR	Contraceptive Prevalence Rate
CRS	Catholic Relief Services
DH	Depot Holder
DOMCCP	Diocese of Matare Community Care Project
FAWE	Forum for African Women Educationalists
FAWEZI	Forum for African Women Educationalists/ Zimbabwe
FHI	Family Health International
FP	Family Planning
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
LSE	Life Skills Education
M&E	Monitoring and Evaluation
MIS	Management Information System
NACP	National AIDS Coordination Program
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RH	Reproductive Health
RUDO	Rural Unity for Development
STI	Sexually Transmitted Infection
TOT	Training of Trainers
USAID	U.S. Agency for International Development
VCT	Voluntary Counseling and Testing
ZNFPC	Zimbabwe National Family Planning Council

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I. Executive Summary

At the request of USAID Zimbabwe Mission, Advance Africa provided technical assistance to the Zimbabwean National Family Planning Council (ZNFPC). The purpose of the assistance was to expand the roles of the CBDs beyond the provision of Family Planning information and services, and to integrate FP into other HIV/AIDS and non-health interventions.

The major reason for expanding the CBD program was because the CBD program's contribution to the country's high CPR (54%) was declining; from 25% in 1988, to 18% in 1994, and 6% in 1999. This continuous decline was mainly due to the growing number of public and NGO health facilities, which became more and more accessible to the majority of the urban and rural population. At the same time, the country was struggling to mitigate the dramatic HIV/AIDS epidemic. It appeared thus, very appropriate to expand the CBD work to include: STI/HIV/AIDS prevention; referral to VCT/PMTCT centers; and counseling support for women testing HIV positive that do not have access to qualified health personnel. This expanded program was successfully implemented in 16 health districts. The expanded work of the CBD agents led to an increase in use of male and female condom over a 3 year period. Male condom use increased from 175,100 to 1,041,958 and female condom use from 54,976 to 888,279. In addition, referrals to VCT centers increased from less than 50 to more than 2000. These achievements, based on service statistics, were confirmed by an impact evaluation/end-line study, conducted by an independent consult. Indeed the end-line study showed significant improvements in all areas related to HIV/AIDS/STIs education, testing, and referrals. There were 16% more males who reported having only one partner in the last 12 months than at the baseline. The proportion of males with three or more partners in the last 12 months fell by 13%. There was a 72% improvement of the respondents' awareness of at least one risk factor for HIV (from 23% at baseline to 95% at end line). The study also showed that 19% of respondents reported at the end-line that they had been tested for HIV/AIDS compared to 11% at the baseline (an 8% increase). There was a 10% increase in the proportion of clients referred by the CBDs, although their overall contribution to the CPR dropped to 6%. Even though the Advance Africa-ZNFPC intervention did not directly support family planning, it had a positive impact this activity. There was a 7% increase of awareness of the male condom among females' respondents and a 2.5% increase of people who had used a FP method (65% at end line vs 62.5% at baseline). The percentage of current users moved from 54% to more than 60%.

The integration of FP activities into HIV/AIDS programs (VCT, PMTCT) was implemented in three selected mission hospitals as a key component of Advance Africa intervention in the Zimbabwe. Two of the hospitals were also served by the ZNFPC expanded CBD program, linking CBDs' to mission hospital FP/HIV/AIDS services. The program focused on capacity building, community mobilization and involvement, and the development of management, supervision and monitoring tools and approaches. The intervention succeeded in generating new FP users of the various methods made available in the VCT centers. New FP users increased by almost 4% each month and represented 68% of all FP users among women tested in the VCT centers. The use of dual protection methods among women tested HIV positive was 27% compared to 3% for women tested HIV negative.

Advance Africa also supported Catholic Relief Service (CRS) to provide orphans and other vulnerable children with RH information through school and community-based programs. The model used included training of teachers, identification of orphans and engaging them to become involved in adolescent sexual reproductive health issues, and out-of-school peer education and care. At the end of this intervention, 23 OVC staff members were oriented in ASRH, 20 teachers were trained and 16,000 in and out-of-school youths were reached. .

Advance Africa supported the Zimbabwean chapter of the Forum of African Women Educationalist (FAWE) by developing Life Skills Education (LSE) training materials and training local teachers to start adolescent sexual reproductive health education within school clubs and peer education groups using the LSE curriculum. Teachers and peer educators were trained, and the curriculum was reviewed and adopted to include RH information in the adolescent education program at school.

In conclusion, the use of the HIV/AIDS funds allocated to Advance Africa to support ZNFPC allowed the Mission to assist in consolidating, maintaining and even strengthening the FP activities of the CBD agents, while at the same time, making them effective in referring to VCT Centers clients having limited access to health facilities. Given the complexity of the HIV/AIDS epidemic and its many negative effects, the Advance Africa intervention in Zimbabwe used a multifaceted intervention to work simultaneously on this critical issue with hospitals, orphans and vulnerable children, and schools. The strategic use of the integration principle and mechanism has been key to achieving Advance Africa's goals and objectives in Zimbabwe.

II. Introduction

Zimbabwe is a nation with a wealth of natural and human resources. The country, located in Southern Africa, between South Africa and Zambia, covers a total land area of total: 390,580 sq km and had a population of 12.3 million people in 2003. Long considered full of development potential, years of economic and political instability have taken their toll on the progress achieved since independence in 1980. The current economic and political crises ravaging the country have already destroyed much of the progress achieved since independence. The land redistribution program has disrupted agricultural production and has left farm workers without homes or jobs.

Family planning services were introduced in Zimbabwe in 1953 in urban and peri-urban areas with the establishment of a Community-Based Distribution (CBD) Program in 1967. The CBDs used adoor-to-door model, informing, educating, and motivating men and women about family planning methods and services and providing oral contraceptive pills and condoms to those who need them. They contributed tremendously to the acceptance of family planning and the adoption of norms encouraging small family size. However, this program's contribution to Zimbabwe's increased CPR rate has declined over time due to a variety of factors. The 1999 the Zimbabwe Demographic Health Survey (ZDHS) indicated a CPR of 54% (50% modern and 4% traditional methods). It is one of the highest in Sub Saharan Africa. The 1999 survey has also shown that the CBD program's contribution to the country's high CPR was declining year after year; from 25% in 1988 to 18% in 1994 and 6% in 1999. This continuous decline was mainly due to the growing number of the public and NGO health facilities, which became more and more accessible to the majority of the urban and even rural population. At the same time Zimbabwe was faced with an enormous challenge—the HIV/AIDS epidemic.

The HIV epidemic began in the early 1980s, spread rapidly, and it is now estimated that 2000 people countrywide die every week due to AIDS related illnesses. UNAIDS estimates the prevalence of HIV to be 24.6%, which is one of the highest in the world in 2000. AIDS, therefore has been accepted as both a public health and a development problem. It appeared thus crucial to expand the CBD work to include: STI/HIV/AIDS prevention; referral to VCT/PMTC centers; and counseling support to women testing HIV positive who that do not have access to qualified health personnel.

The U.S. Agency for International Development (USAID) has a long history of supporting Zimbabwe's family planning (FP) and reproductive health (RH) programs. The Zimbabwean mission had requested technical assistance from the Advance Africa project to continue providing support to the Zimbabwe National Family Planning Council (ZNFPC), a para-statal under the Ministry of Health and Child Welfare, in charge of implementing the expanded CBDs program, by focusing attention to HIV/AIDS interventions.

III. Activities

In 2001, USAID/Zimbabwe asked Advance Africa to implement a major program designed to strengthen the Zimbabwe CBD Program and provide more effective comprehensive RH services, including HIV/AIDS prevention and referral. Advance Africa supported the USAID/Zimbabwe strategic objective to mitigate the spread of HIV/AIDS through several interventions.

A key component was to integrate HIV services into the national CBD Program, creating an Expanded CBD Program. Advance Africa collaborated with the Zimbabwe National Family Planning Council (ZNFPC) to:

- Promote an integrated approach in 16 districts
- Develop a training program for CBD agents
- Train managers, group leaders, CBD agents and depot holders (DH)
- Strengthen the monitoring and evaluation system

Advance Africa also worked with USAID/Zimbabwe to identify activities that promoted comprehensive reproductive health service delivery and adequate access to services, including: volunteer control testing (VCT), prevention of mother-to-child transmission (PMTCT), HIV/AIDS services, and adolescent reproductive health (ARH) services for youth, orphans and vulnerable children (OVC). In addition to ZNFPC, Advance Africa worked with the Hospice Association of Zimbabwe, mission hospitals, the Zimbabwe chapter of the Forum for African Women Educationalists (FAWEZI), Populations Services International (PSI), and the Catholic Relief Services' (CRS) AIDS orphan program.

The program included the following components:

- Strengthening the ZNFPC Expanded CBD Program
- Strengthening the integration of FP into VCT, PMTCT, and other HIV/AIDS services in selected mission hospitals and strengthening community linkages to these services
- Reproductive health information for orphans and vulnerable children
- Improving life skills education (LSE) with FAWEZI

Advance Africa created partnerships with a number of organizations to implement various activities, including: ZNFPC, PSI, three selected mission hospitals, Center for Disease Control (CDC)/Zimbabwe, Elizabeth Glaser Pediatric AIDS Foundation, ZVITAMBO, and other local organizations (faith based, women's, youth---working in HIV/AIDS-related programs in the 16 program districts).

1. Expanded Community-Based Distribution Programme

Background

The history of the family planning CBD program in Zimbabwe dates back to 1967. The CBD program was established with a view to providing safe, low cost and effective family planning services in both rural and urban areas. The CBD model used then was the door-to-door approach,

that is, CBDs moved from one house to another in their catchment areas, informing, educating and motivating men and women about methods and services and providing pills to those who needed them. The door-to-door approach was the ideal model given the low level of family planning awareness, general resistance to contraceptive use and the perception by African politicians that the local family planning association was trying to reduce the African population while increasing that of the European settlers. The CBD program grew in both quantitative and qualitative terms and had 800 CBDs at the end of 1993. The number of CBDs has been declining since then due to financial considerations, which have constrained the ZNFPC from recruiting more CBDs.

The ZNFPC was concerned about (1) the decline in CBD program outcomes since its contribution to the CPR had declined from 18 percent in 1994 to 6 percent in 1999; (2) consequent relevance of a decreased CPR; and (3) the cost-effectiveness of running the CBD program. The ZNFPC sought assistance from USAID to review and redirect the CBD program.

In 1999, ZNFPC conducted an assessment of its CBD Program with technical support from the Population Council and Family Health International (FHI). The assessment provided a series of recommendations on how to redefine and broaden the role of CBD agents to provide comprehensive family planning, RH, and HIV/AIDS information and referral for services, and redirect the CBD program to focus on RH needs of young people, men, and low parity women.

The expanded program proposed to broaden the roles of CBDs beyond family planning, strengthen supervision skills of CBDs, devise an effective referral strategy for other reproductive health and HIV/AIDS services, improve the logistics management system to avoid stock outs of contraceptives and condoms, and revise the management information system (MIS) and monitoring and evaluation (M&E) strategy. The newly expanded program aimed at responding to the community members' needs within the context of the current HIV/AIDS pandemic in Zimbabwe.

In 2001, USAID in response to ZNFPC's request for assistance to redirect its CBD program invited Advance Africa to work with ZNFPC to develop a revised program for Zimbabwe. The objectives of the Expanded CBD Programme were:

- To increase access to and use of reproductive health, sexually transmitted infections (STIs), and HIV/AIDS information and services in communities served by the expanded program
- To strengthen the operational systems

Advance Africa developed a project implementation document that focused on the need to address the following areas:

- Strengthening the management capacity of the CBD program supervisors
- Revising the CBD protocols to reflect the new CBD program roles and responsibilities
- Clearly defining the operational CBD service delivery models based on settlement patterns to be used in the new expanded program districts

- Redefining the geographical area to be covered by a CBD in the expanded program districts, adjusting for a more realistic geographical area for an individual to cover (one ward instead of a 20 km radius that covered more than one ward)
- Improving the logistics management to address stock outs of contraceptives and other problems identified in the 1999 assessment of the ZNFPC CBD Programme
- Improving the Behavior Change Communication (BCC) strategies for the CBD program that included a strong advocacy component and effective communication messages
- Revising monitoring and evaluation activities, including designing and conducting specific surveys and setting up a user friendly MIS database

The main focus of Advance Africa's work with ZNFPC was to build the capacity of the CBDs in their expanded roles---going beyond the provision of family planning information and services. The expanded role of the CBD included:

- Increasing knowledge of transmission and prevention of HIV/AIDS/STIs among community members
- Ensuring outreach to young people and men whom CBDs previously excluded
- Motivating those at risk for VCT
- Providing supportive counseling to both the HIV/AIDS infected and affected
- Promoting adoption of safer sexual and RH behavior

The Expanded CBD Programme included:

- Increasing access to and use of reproductive health, STI, and HIV/AIDS information and services in communities served by the ZNFPC Expanded Programme CBD agents
- Strengthening the operational systems of the ZNFPC expanded program in 16 districts
- Training CBDs and supporting their expanded role
- Broadening the role and capacity of depot holders
- Training group leaders
- Strengthening linkages and referrals to VCT services

Interventions

To identify and test the appropriate cost-effective community based service delivery approaches to provide FP/RH/STI/HIV/AIDS services in the Expanded CBD Programme, two types of models were selected to build on the current door-to-door approach. The first model used the depot holder (DH), requiring the recruitment and training of depot holders who supplied oral contraceptives and condoms from their homes and made referrals to the CBD agent and health facility. The second approach, referred to as the satellite model, required the CBD to be stationed at a pre-arranged location in his/her catchment area on specified days so that clients came for services as opposed to the CBD providing door-to-door services. Sites selected for the DH model were densely populated as opposed to those selected for the satellite model. In all the Expanded CBD Programme districts, the CBD covered a ward (instead of a 20 km radius as in the traditional CBD program), an area usually made up of six villages with an estimated population of six thousand people. Both the DH and satellite approaches enabled the CBDs to spend more time providing services, such as presenting and discussing issues at group meetings

with men, women, youth, and community leaders. The DH and satellite models also supported home-based care (HBC) activities by visiting homes with sick people and making referrals to health centers and VCT centers.

The model used in the Traditional CBD Program:

The Door-to-Door Model:

The CBDs moved from one household to another in their respective catchment areas informing, educating and motivating women and men about family planning methods and services. In the case of the traditional CBD program, the catchment area was a 20 km radius and spanned more than one ward. In the Expanded CBD Programme, the catchment area was redefined to a ward, a smaller geographical area and administrative area. The door-to-door model was considered ideal where there was a low level of awareness as it placed emphasis on a one-to-one interaction between the CBD and the client. The CBD agent was an important member of the community and a change agent who understood the community dynamics, and could elicit community members' collaboration in addressing community reproductive health needs, including HIV/AIDS.

The additional models used in the Expanded CBD Programme:

The Depot Holder Model:

In this model, a DH provided FP/RH/STI/HIV/AIDS information and services from her home in a particular village. Each village had a population of approximate 1,000 residents. A DH was recruited for each village in a ward, except for the village in which the CBD lived. Her community chose her. The DH's main functions were to re-supply already established family planning clients with oral contraceptive pills, distribute condoms, and refer clients with reproductive health problems as needed to the CBD who supervised her and the health facility.

The Satellite Model:

In this model, which was one that was used in sparsely populated areas, the CBD provided RH/FP services at a site, like a church or school, where people gathered. The CBD scheduled appointments on selected days for each identified satellite point to re-supply clients with oral contraceptive pills and condoms so that more time could be allocated to recruit new family planning clients and focus more on reaching men and youth.

A comprehensive M&E plan was prepared to provide evidence of project implementation, outputs, effects and outcomes from baseline. The plan included:

- Baseline surveys in the relevant districts to document the situation prior to the implementation of both the first and second phases of the Expanded CBD Programme. The first phase baseline survey was carried out in August 2001, focusing only on men and women aged 15 to 29 years. Information was collected from 1,812 respondents on their knowledge of transmission and prevention of HIV/AIDS/STIs, utilization of VCT services, use of contraception, and use of condoms for infection prevention and contraception, and sexual behavior.
- Pre- and post-training tests to assess knowledge acquired during training

¹ See 2001 Baseline Survey Report for the Expanded Community Based Distribution Program, Harare: ZNFPC, December 2002.

- Regular supervisory visits to assess practice of new knowledge, skills, and responsibilities, using a checklist
- An initial assessment to provide early guidance and feedback on the initial implementation of the program²
- An end line survey to measure changes over time and to compare the effects and outcomes of the project

Service statistics forms were modified to reflect the expanded roles of the CBDs and the new roles of the DHs. Statistics on VCT referrals were collected both from the CBDs and from the VCT sites:

Prior to the implementation of the second phase, lessons learned from the first phase were used to improve the following areas:

- MIS: data collection forms were reviewed and modifications made to reporting forms, including the addition of a column for commodity logistics form to account for and correct stock outs, and the simplification of the revenue reporting form. An upgraded database was created for the data collected using revised MIS forms.
- Training: group leaders, CBDs, and DHs were trained on the importance of the MIS and on how to complete the revised MIS forms comprehensively and accurately.
- Program indicators: These were reviewed and revised.

Other important activities included:

- Re-orienting CBDs and group leaders in the project districts
- Equipping trainers with demonstration kits
- Training of group leaders in supervision, particularly for the expanded roles of the CBDs
- Conducting advocacy workshops for communities to mobilize support
- Recruit and train new depot holders
- Organizing coordination meetings between the CBD program and stakeholders to strengthen linkages among the relevant sectors

Results

As seen in the data presented in Graph 1, following the start of the “Expanded CBD Programme” in 2002, the number of male condoms distributed increased significantly from baseline by a factor of almost 6 or 595%. Within the new catchments areas, the distribution of oral contraceptives increased by 1,615% almost certainly due to the presence of depot holders.

Graph 1 also shows that though HIV prevention and awareness activities were added as part of the expanded role of CBDs and DHs, this apparently did not have a detrimental effect on family planning. What we see is quite the opposite. As people were eager to talk to the CBDs and DHs about HIV/AIDS, they learned more about RH/FP and commodity distribution increased. The

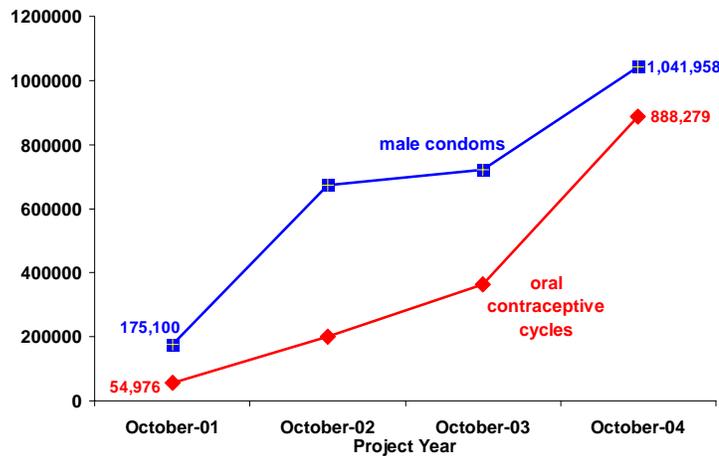
² Wazara, M.C., Initial Assessment of the Expanded CBD Programme, Harare: ZNFPC 2002.

data from October 2004 show that CBD workers can increase both family planning and HIV/VCT services. This graph also demonstrates the multiplied effect of this integration strategy.

Graph I

Contraceptive Distribution Increases in Zimbabwe Despite CBDs' Added Responsibilities

Commodity Distribution between 2002 and 2004



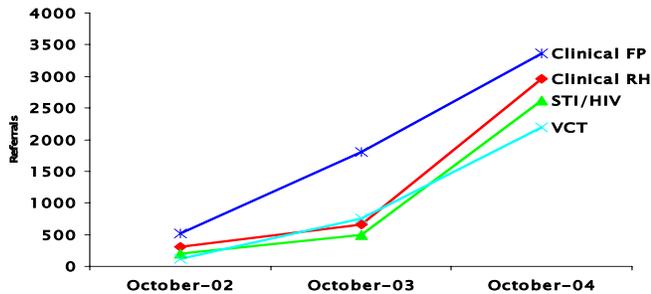
It is clear from the data that CBDs and DHs play a very important service delivery role in the community and in fact are able to cover several important functions, both for family planning and for HIV/AIDS.

Graph II below demonstrates how much integration can contribute to the effectiveness of combining services. Clinical FP clients increased from 514 in October 2002 to 3366 in October 2004. Clinical RH clients increased from 312 to 2962. STI/HIV clients increased from 203 to 2620. VCT clients increased from 115 in 2002 to 2189 in 2004. With the new knowledge about issues of concern to community members, CBDs and DHs were consulted more frequently not only about HIV, but also increasingly about RH/FP. Most CBDs were trained by the end of fiscal year 03, but only half of the total number of DHs was trained. Referrals for HIV, VCT, and other RH increased exponentially between 2003 and 2004. These increases cannot be solely due to an increased number of DHs.

Since adding VCT and HIV/AIDS functions were added as part of the new “Expanded CBD Programme,” we can assume that the baseline would have been 0 for VCT/HIV referrals prior to October 2001.

Graph II

Confirmed Clients Referred by CBDs to VCT Centers, Health Centers, and Hospitals - Zimbabwe 2002-2004



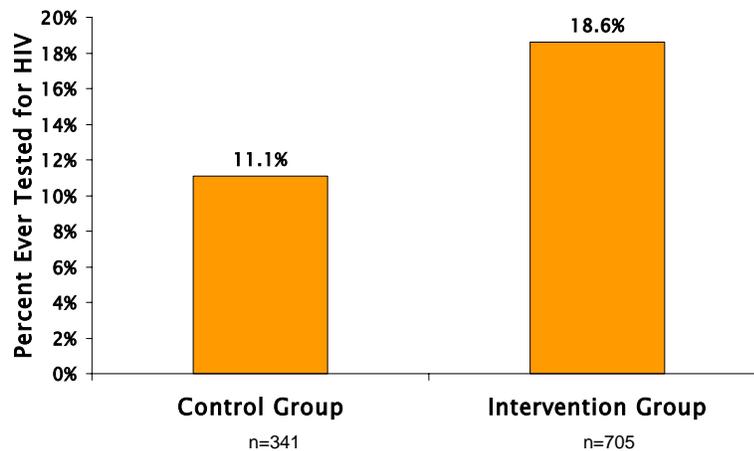
*Note: "Clinical FP" refers to methods the CBD could not provide—anything other than condoms and pills. "Other RH" refers to pregnancy, infertility, post abortion care, menopause, etc.

In Graph III, there was a significant increase in those who received both family planning and HIV services from CBD agents as part of the expanded CBD program.

Graph III

Integrated CBD Services: HIV testing was higher in Expanded CBD Programme districts

Endline Survey Percentage of Respondents Who Had Ever Been Tested for HIV/AIDS
February 2005



These results based on the services statistics data were somewhat validated by the comparison of the baseline data (1212 respondents) and end line (709 respondents) survey results that evaluated the population impact of the program. The end line survey (see impact evaluation report) has

shown an overall improvement of the population knowledge and attitude towards HIV/AIDS prevention and FP methods utilization. The study design included an intervention and control group. Given the alarming expansion of the disease, many other organizations and government structures were intervening through various programs to mitigate the dramatic HIV/AIDS epidemic in all districts. The so called “control zone” had received almost as much information and education messages on HIV/AIDS than the intervention zones. Therefore, except for the results specific to the CBDs’ new skills -such as the referrals to VCT centers- rates for many of the indicators were similar across control and intervention. However, the comparison between the baseline and end line data reveal positive improvement trends from the interventions provinces. The analysis and comments below only compare the baseline and the end line data from the intervention areas.

At the end line, there were 16% more males who reported having only one partner in the last 12 months than at the baseline (65% vs. 49%). While there was a reduction of multiple partners among men, there was a zero increase of partners among females. At the end line 7% and 93% of females reported having zero and one partner respectively, compared to 0% and 86% at the baseline. The proportion of males with three or more partners in the last 12 months fell from 15% at baseline and 7% at the end line. When asked to list specific HIV/AIDS risk factors, more end line respondents were able to correctly name a risk factor than at the baseline. At the end line, 95% of respondents were aware of at least one risk factor for HIV/AIDS, up from 23% at baseline (72% improvement). The study also showed that 19% of respondents reported at the end line that they had been tested for HIV/AIDS compared to 11% at the baseline (8% increases). There was a 10% increase in the proportion of respondents that were referred by the CBDs, although their overall contribution to the CPR had dropped to 6%. Even though the Advance Africa-ZNFPC intervention did not directly support the family planning activity, it did positively impact this activity. There was a 7% increase of awareness of the male condom among females’ respondents and a 4% increase of people who had ever used a FP method (65% at end line vs. 61% at baseline). The current users move from 54% to more than 60%. With regard to training, 174 current CBD agents were trained in addition to 708 new DHs, using an integrated curriculum package.

Lessons Learned

Overall, with the Expanded CBD Programme, Advance Africa showed that integration that did not over burden the CBD and produced improved results for both family planning and HIV. This is extremely important in light of the HIV/AIDS situation in Zimbabwe and in the increasingly deteriorating socio-economic environment in the country. The work of the CBDs can be expanded to include HIV/AIDS prevention and referral without undermining their good performance in FP method distribution. This integration has instead increased their performance in FP method distribution. Even with the overall deterioration in the economic situation, extreme inflation and lack of fuel, this intervention has demonstrated that there is still a possibility of achieving good results in the social sectors, such as health, if certain conditions are satisfied. These conditions included financial but mainly technical support.

There are still many challenges to address in Zimbabwe, including many related to the current country environment: increasing access to VCT centers for women living in remote areas, increasing access to resources needed for supervision activities, strengthening collaboration with other HIV/AIDS agencies, improving the management capacity of ZNFPC, and improving M&E and data collection. Even with the current environment, results of Advance Africa efforts proved that communities were eager to work together to increase access to services. Given the needs of the community and the educational level of the population, it is likely that the demand from the community will increase—more so as the overall formal health infrastructure in the country continues to deteriorate and unmet need for family planning still exists.

Community involvement and participation were a vital component in successfully implementing this community-based program and facilitated community partnership and ownership in managing the program. CBD agents were respected within the communities they lived in, often sought out for services by community members. It is clear that the strong commitment and high motivation of the CBDs, who welcomed this expansion, was partly due to the tremendous community support and recognition they received in addition to their small monthly government salaries. The depot holder concept was a cost effective and sustainable FP/RH delivery system that provided accessible, available and acceptable services at the grassroots level.

2. Integration of FP/PMTCT at Three Mission Hospitals

Background

A second major component of the Advance Africa's program in Zimbabwe was to strengthen the integration of family planning into VCT, PMTCT and other HIV/AIDS services in selected mission hospitals, together with strengthening community linkages to these services. There had never been a similar project design or activity in this type of setting in Zimbabwe, i.e., integrating FP with other services. All hospitals had parallel programs for HIV and FP where staff didn't communicate with each other, across program areas.

Advance Africa, in consultation with the Centers for Disease Control (CDC) Zimbabwe, partnered with three of the CHAPLL network hospitals, Howard Mission Hospital in Mazowe-Mashonaland Central, Gutu Mission Hospital in Chirumanzu-Midlands and Tshelanyemba Mission Hospital in Matobo-Matebeleland South, to integrate family planning into VCT, PMTCT, psychosocial support, and other HIV/AIDS services. Two of the three were also in ZNFPC Expanded CBD Programme districts, which enabled Advance Africa to strategically build on the ZNFPC Expanded CBD Programme, linking CBDs to the mission hospital FP/HIV/AIDS services. Tshelanyemba Mission Hospital, which was not in a ZNFPC Expanded CBD district, was chosen because the hospital had strong leadership and was in a district that had a large network of ZNFPC CBDs. These CBDs could be trained to take on HIV/AIDS and RH as part of the program activity.

Interventions

Program components included: capacity building, service delivery and community mobilization. Capacity building included training of service providers and orientation in the provision of family planning services within the context of HIV/AIDS, in specific clinical skills (voluntary surgical contraception, mini-laparotomy, implants insertion and removal reviewing) and adapting an integrated training curriculum to address FP/HIV/AIDS/PMTCT, logistics management, supervision, and data collection and management. Advance Africa worked with mission hospitals to develop referral systems and trained staff in FP counseling. The overall training strategy use a cascade training approach, which started by first the training of trainers to ensure rapid coverage of the need and sustainability of such crucial important too.

Service delivery activities included strengthening linkages to the provision of family planning services through the Expanded ZNFPC Programme agents and strengthening data collection. All clients that arrived for VCT services also received FP counseling as a group in the waiting room and then individualized VCT counseling. Small-scale research on family planning needs of HIV positive women was also conducted to develop services to respond to their specific needs.

Collaborating with the ZNFPC Provincial Office, Howard Hospital staff recruited 35 DHs. ZNFPC partnered to train new DHs who were also part of the program. A MIS database was installed on the hospital computer to collect and analyze data.

At Tshelanyemba Mission Hospital, staff had little experience in community outreach communication. Advance Africa addressed this gap and provided technical support to equip hospital staff to conduct community outreach. A stakeholders' meeting was also convened with community, church leaders, school heads, government district leaders, non-government organization (NGO) representatives to learn about the objectives and rationale for integrating FP/HIV/AIDS services and activities and to become advocates and owners of the new integrated program.

Advance Africa worked with Howard, Gutu, and Tshelanyemba staff to develop a BCC strategy for their programs. Community assessments of FP/RH services in the catchment areas of Howard, Gutu, and Tshelanyemba Hospitals were conducted and findings were used to develop the Tshelanyemba strategy. The three hospitals did not have the same prior experience and were not at the same level of development. Our technical assistance was therefore provided according to the specific need of each.

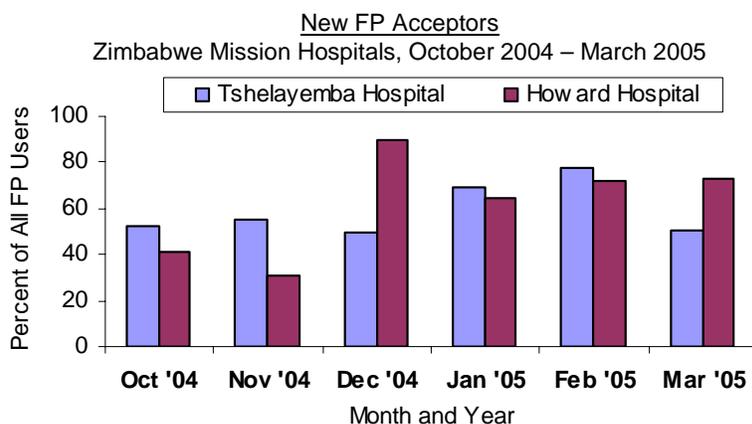
Results

Graph IV illustrated the success in generating new family planning acceptors among nonusers having HIV tests. The high proportion of new acceptors among all family planning users was very impressive because Zimbabwe already had a high contraceptive prevalence rate – about 55%. This was the value added of the integration strategy. Most of the women in this sample were not pregnant at the time of HIV testing (a small proportion was tested during the antenatal or postpartum periods).

Among all VCT clients that became FP users, the percentages showed that those women who left the clinic with a FP method, did so as a result of integrated VCT/FP counseling since they had not been using a FP method previously.

Graph IV³

Successful FP/VCT Integration: New FP acceptors at VCT sites constitute a high proportion of all FP users



Notes:

1. Family planning methods include condoms
2. New FP acceptors are previously non-users of any method
3. Low numbers of post-partum PMTCT clients are included in FP/HIV program at facilities

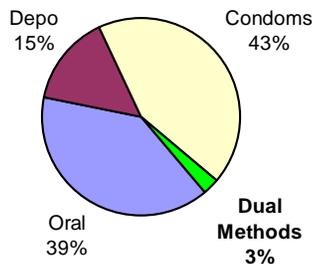
³ Gutu mission hospital was not included because its activities just start at the time of the evaluation of Howard and Tshelanyembas hospitals

In Graph V below, HIV-positive clients were using dual methods much more than HIV-negative clients, an indication that they were preventing partners from being infected, most like due to the emphasis on prevention among HIV positive clients during counseling. “Dual methods” means condoms plus another contraceptive.

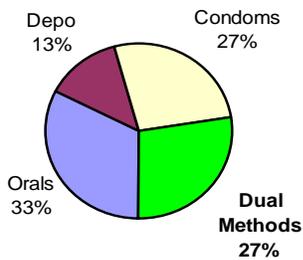
Graph V

FP/VCT Integration: HIV+ clients are using dual methods more than HIV- clients, thus preventing partners from becoming infected

Contraceptive use among HIV- VCT clients, Howard & Tshelayemba Hospitals Zimbabwe, Oct 2004 to Mar 2005



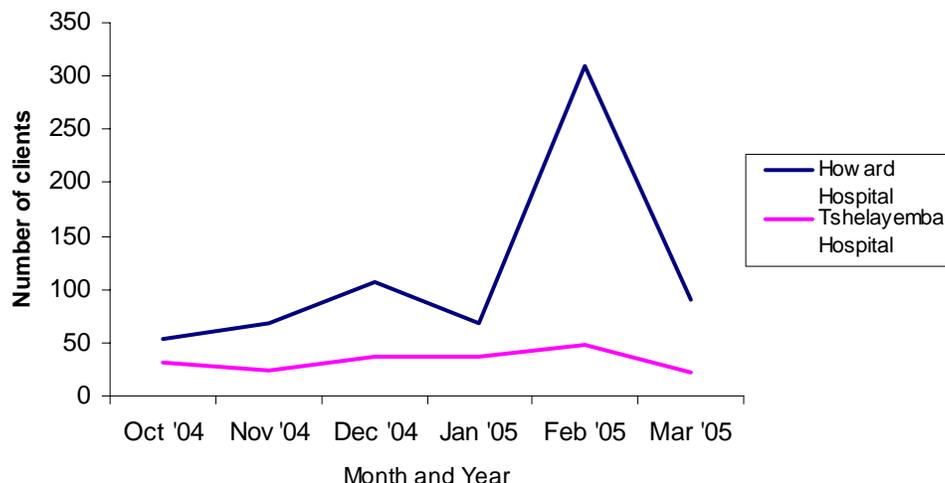
Contraceptive use among HIV+ VCT clients, Howard & Tshelayemba Hospitals, Zimbabwe, Oct 2004 to Mar 2005



Graph VI showed that even for HIV+ clients, there was a demand for family planning-- once clients increased their knowledge about and understood the benefits of FP. This is significant in averting potential vertical infections. The jump in February was a result of condom promotion in the catchment area at Howard Hospital.

Graph VI

Trends in New FP Acceptors among HIV+ Clients at VCT Sites in Zimbabwe Mission Hospitals, October 2004 – March 2005)



Through the successful integration of FP with facility-based VCT/PMTCT services, providers were trained, 100% of HIV services which clients received included FP counseling, referral systems were established, and FP services were available for VCT clients.

Lessons Learned

The integration of FP services to HIH/AIDS prevention activities within VCT/PMTCT centers was rendered possible mainly by the interest and commitment of those involved in the process... the mission hospital directors and their staff. The willingness of the mission hospitals to take ownership of the integration activity and make it happen was instrumental to the success of our collaboration. The integration demonstrated that it is possible to convince providers and managers of the mutual benefits of providing HIV prevention services to family planning clients, as well as providing family planning counseling and methods to clients who access HIV and AIDS services. The value added from this integration in both directions lays with the fact that previously, HIV and AIDS prevention discussions focused on safe sex with condoms, and did not stress the benefit of preventing unintended pregnancy. Condoms were not proposed in the ICE/BCC campaign to regular partners like husbands and wives who were not perceived as sexual risks. Married people did not see condoms as a contraceptive technology ideal for child spacing that they were willing to use. With the assistance of Advance Africa, the VCT/PMTCT centers are now able to stress the link between prevention of unintended pregnancies and prevention of HIV/AIDS. Although the results are very preliminary, because of the short implementation period, they are very encouraging and constitute a strong source of motivation for the providers and the managers.

3. Reproductive Health Information for Orphans and Vulnerable Children (OVC)

Background

In Zimbabwe, the National AIDS Coordination Program (NACP) (2000) reported that more than half of the HIV infections occurred under the age of 25 years because of high-risk sexual behavior and practice by young people. The number of orphans in Zimbabwe has also been rising sharply, as a result of the increasing loss of one or both parents to AIDS. To address youth needs, USAID Zimbabwe identified a program gap on limitations to adolescent, sexual and reproductive health (ASRH) information and services.

Interventions

Advance Africa initially supported the Catholic Relief Services (CRS) STRIVE partners to provide children with RH information through school and community-based programs. This collaboration was facilitated by the fact that CRS had already an ongoing contract with USAID. The RH needs of OVC were identified together with the appropriate community support structures. Eventually, Advance Africa targeted its support to three local NGOs: Diocese of Matare Community Care Project (DOMCCP) in Makoni district, Rural Unity for Development

(RUDO) in Gutu district, and Batsiranai in Buhera South district. The program was designed to increase the OVC access to RH information, as part of repositioning family planning in Zimbabwe.

Advance Africa provided support to develop appropriate school- and community-based programs to reach young people with RH information, particularly for OVC. A comprehensive BCC strategy was also developed and implemented as part of these programs.

Advance Africa supported capacity building activities conducted by the three local NGOs, all of which had their own specific strengths. RUDO assessed teachers' needs and trained teachers to start ASRH activities in schools. The RUDO model involved teachers in identifying orphans and engaging them to become involved in ASRH issues. This model also included out-of-school peer educators and caregivers. Caregivers talked with young people about ASRH issues and referred them to the school or clinic, depending on the nature of the problem. In Batsiranai and DOMCPP, caregivers were trained in ASRH skills.

The community was also engaged through meetings to discuss factors contributing to the increasing number of orphans and vulnerable children, covering all levels - family, community and school. Communities selected and recruited peer educators who were trained in ASRH. Caregivers, teachers and local based health care service providers were all trained in ASRH. Health center personnel were trained in youth friendly services to improve and increase access by youth to ASRH information and services.

Caregivers provided direct services to identified OVC and shared information with stakeholders such as the STRIVE partners using user-friendly MIS data collection forms designed by Advance Africa. There were OVC committees established to ensure that the voices of the infected and affected were heard and listened to.

Results

The time was too short to allow major expected changes within the population to occur. The following was accomplished in the process:

- 23 OVC staff members were oriented in ASRH
- 15 OVC partner staff members attended ASRH training of trainers
- 93 peer educators were trained and reached 2,790 adolescents including OVC
- 60 caregivers were trained, each reaching an average of 1,200 adolescents including OVC
- 20 teachers were trained reaching 16,000 in and out-of-school youth

Lessons Learned

Conducting community needs assessments using focus group discussions was important as the community and the facilitators developed a socially acceptable curriculum. Use of BCC/IEC materials, psychosocial support and life skills training were some approaches that can be utilized

in similar situations to reduce the effects of HIV and AIDS on OVC and support them in reintegrating into society. Active involvement of the local community is critical to promote ownership and sustainability.

4. Improving Life Skills Education (LSE) with FAWE/Zimbabwe (FAWEZI)

Background

One of Advance Africa's mandates was to build the capacity of the Forum for African Women Educationalists (FAWE), one of Advance Africa's consortium members. The objective was to increase the ability of adolescents to avoid unwanted pregnancy and STIs including HIV/AIDS.

Interventions

With core funding, Advance Africa supported FAWEZI in developing training materials and training local teachers to use LSE curriculum within school clubs and peer education groups. FAWEZI trained teacher TOTs who would then train teachers to cover RH information and services for youth. OVC program trainers were also included in one of the TOT workshops. FAWEZI reviewed and adapted the existing curricula to incorporate RH information.

Results

Teachers and peer educators were trained on RH. Curricula was reviewed and adapted to include RH information. Plans were developed to initiate Anti-AIDS Action clubs for school youth.

Lessons Learned

A major strength of FAWE was its linkages to schools in eradicating gender disparities in education by ensuring that African girls have access to school. FAWE advocates for the transformation of educational systems in Africa, linking educational, health and other policy reforms in the advance of women and community development. Though Advance Africa worked closely with FAWEZI to train trainers, more remains to be done in institutional capacity building to ensure that FAWEZI can sustain the work that they have begun. In particular, FAWE requires additional skills in monitoring and evaluation as well as in reporting.

The potential value of working with an organization like FAWE cannot be under-estimated, given the particular niche this network fills. FAWE provides an excellent opportunity to reach school-aged youth with important RH/FP information which will affect their future health and lives.

IV. Overall Outcomes

In 2001 the Government of Zimbabwe declared the HIV/AIDS pandemic a national disaster with the current HIV prevalence rate among those in the age group 15-49 to be 33.7%. In addition, the country has been experiencing serious socio-economic challenges with increasing inflation and frequent fuel shortages. Even with this environment, Advance Africa succeeded in

integrating family planning services (including referrals to CBDs and/or facilities) into HIV services as part of the Expanded CBD Programme and in selected mission hospitals. In fact, Advance Africa helped to revitalize and strengthen the CBD program through the new expanded model.

Through the Expanded CBD Programme, condom and pill distribution increased significantly since 2004, even with added responsibilities for the CBDs (595% increase since the expanded program was launched). Both FP and VCT services and referrals increased where these services were integrated (through the Expanded CBD Programme and in the three selected mission hospitals). Advance Africa also succeeded in integrating FP/RH information into non-health programs such as schools through collaboration with FAWEZI.

V. Lessons Learned

Integration of services addresses client needs at the community level more effectively than vertical programming. From this, future programmatic approaches should include:

- Taking advantage of opportunities as they arise
- Be participatory and supported at all levels, from the community to national stakeholders
- Be flexible to suit the local context
- Be multisectoral

Integrating services is feasible in spite of human and financial constraints. Both the CBDs in their expanded roles, DHs, and missions hospitals were providing family planning services to meet an unmet demand.

It is important to take advantage of strategic opportunities as they occur. CBDs were respected by their communities and were sought out for their services. They have existed for a number of years and are an integral part of the community in which they live and serve. Given this, Advance Africa grasped the opportunity to integrate FP with VCT services and expanded the role of CBD in collaboration with the ZNFPC. In fact, Advance Africa took advantage of several other strategic opportunities, responding to people's needs for both FP and HIV services. Advance Africa used several approaches of integrating family planning with both health and non-health programs, each designed for a different population group to ensure greater impact and effect. In this manner, coverage was expanded to include hospital clients, community clients, youth in- and out-of schools and OVCs.

VI. Recommendations/next steps

The results achieved through the expanded CBD program, as well as the integration of RH/FP services to the VCT/PMTC centers, must be maintained, strengthened and if possible, expanded. Both specific interventions have demonstrated how much can be accomplished in a very difficult and complex economic and social crisis environment. Advance Africa therefore, recommends that USAID/Zimbabwe consider maintaining the same strategy which, allows for an increase in FP services while expanding the CBDs' work to include HIV/AIDS prevention. The "strategic" use of HIV/AIDS funds allocated for HIV/AIDS emergency interventions to support existing

family planning services through integrating FP with HIV/AIDS appears to be an excellent alternative use to support the FP program during the very difficult situation currently prevailing in Zimbabwe.. From the results highlighted in this report, it is clear that through integrating FP with VCT/PMTCT and non-health programs, that knowledge on family planning and HIV/AIDS has increased as well as clients seeking FP and/or VCT/PMTCT services. At the least, it is important that what has been achieved be maintained and not lost. Advance Africa, through collaboration with ZNFPC and the other institutions has developed the capacity of these institutions and their ability to maintain the activities. The tools and approaches developed, as well as the management strategy applied since the beginning, constitute an important legacy that we recommend be used to sustain the major achievements of this program.

ANNEX I

Reports used in preparation of this report:

1. Final Report: A Community Assessment of Family Planning and Reproductive Health Services in the Catchment Areas of Howard, Gutu and Tshelanyemba Hospitals, A Consultancy Report for Advance Africa, by Zibusiso Nyati-Jokomo and Sunungurai Chingarande, June 2004
2. Advance Africa Zimbabwe Workplan, July 2004 – September 2005
3. Integration of adolescent reproductive health into FAWE-Zimbabwe educational program
Report on the training of trainer's workshops held for the provincial and district chapters by the forum for african women educationalists –Zimbabwe (Fawezi) in collaboration with Advance Africa (Harare), February 2004
4. Report on strategic planning meetings:
the integration of FP into Howard and Gutu mission hospitals' HIV/AIDS and PMTCT services
Gutu mission hospital- 20 July 2004
Howard mission hospital- 22 July 2004
purpose: 1. review progress, 2. Sensitise project coordination team on the project short and long term Objectives. 3. identify a team to formulate strategies and action plan for the project., **Zimbabwe, compiled by: Charles Marowa, July 2004**
5. 2001 Baseline Survey Report for the Expanded Community Based Distribution Program, Harare: ZNFPC, December 2002
6. Expanded Community Based Distribution (CBD) Program
Initial Assessment of the Expanded CBD Programme, Harare: ZNFPC 2002, M.C. Wazara
7. Expanded Community Based Distribution (CBD) Program
year 1-annual report, period covered-May 2001 to April 2002, Advance Africa, Arlington – US, June 25, 2002
8. Expanded Community Based Distribution (CBD) Program
Annual report for fy 2003 (1 October 2002—30 September 2003)
Advance Africa, Arlington – US, October 2003

9. Expanded Community Based Distribution (CBD) Programme
203 Baseline Survey Report, ZNFPC, Advance Africa, Ronika Nyakauru, and Pierre Ngom, September 2004
10. Expanded Community Based Distribution Project
Impact Evaluation Survey Draft Report, Advance Africa Zimbabwe and Zimbabwe Family Planning Council, Zimbabwe, December 2004
11. A Community Assessment of Family Planning and Reproductive Health Services in the Catchment Areas of Howard, Gutu and Tshelanyemba HospitalsFinal,
A consultancy Report for Advance AfricaBy Zibusiso Nyati-Jokomo and Sunungurai Chingarande, June, 2004
12. Expanded Community Based Distribution Project
Impact Analysis Report, Iga Adams, Hatai Kraushaar, Management Science for Health, Advance Africa, Arlington - US, September 2005