Africa Unit

ENVIRONMENTAL CONTEXT FOR THE NEXT FIVE YEAR PLAN FOR THE ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL

Family Planning Management Development (FPMD)
Project Number: 936-3055
Agreement Number: CCP-A-00-95-00000-02

Office of Population, USAID

Management Sciences for Health
165 Allandale Road
Boston, MA 02130

1996

ENVIRONMENTAL CONTEXT FOR THE NEXT FIVE YEAR PLAN FOR THE ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL

Demographic Background

The population of Zimbabwe has more than doubled between 1962 census, the first to undertake a total head count of all the people residing in the country, and the 1992 census. Enumerated population increased from 4 098 300 people in 1962 to 7 608 432 and 10 412 548 in 1982 and 1992 respectively. Although anual growth rate remain high, it has declined from 3.3 in 1969 to 3.0 and 2.5 percent in 1982 and 1992 respectively (Central Statistical Office (CSO), 1994). On the other hand, mortality has decreased. Infant mortality rate declined from 83 to to 66 deaths per 1000 in 1978 and 1990 respectively. Life expectancy at birth increased, albeit slowly, from 57 to 61 in 1978 and 1990 respectively. Fertility has declined somewhat presipitously over the past ten years. Total fertility rates declined from 7.9 in 1969 to 6.5 in 1984. It subsequently declined to 5.5 and 4.3 during the 1985-88 and 1991-94 period (CSO, 1995). It has been shown over the years that mortality tends to be positively related to fertility and many have argued that in the face of high mortality especially infant, their is a tendency for couples to have many children as a hoarding mechanism. In Zimbabwe couples, maintained that they were desiring fewer children because there was no need to hoard such children (Mhloyi, 1991). What is the impact of HIV/AIDS on the demographich scenario, and what is the role of family planning in such a cintext?

Sich the first HIV case was diagnosed in 1985, prevalence levels have increased at an alarrming rate and are is now estimated at 18.1 percent of the population above fifteen years in 1994 (Marindo-Ranganai, work in progress). In this case mortality is expected to increase five fold by year 2005. Tuberculosis is expected to increease by 490 percent. It is estimated that population growth rate will decrease by about 1.5 percent during the 1996-2000 period. It is important to note that mortality will increase beyond these estimates especially when one considers a couple of related issues. First, there will be direct and direct impacts of AIDS and are close to those modelled. Mortality will increase from the the parallel epidemics especially the TB epidemic; this will spread a lot faster in the sence that it is quite infectious and is largely airborne. In addition, mortality will increase due to an increase in malnutrition. As the productive age group die and leave dependants, the young and the aged, the chances are that both groups will suffer from mulnutrition which is already rampant and remain the most important underlying cause of death. The youth, a significant proportion of which will be orphans, are more likely to further expose themselves to HIV infection given their obvious socio-economic vulnerability (Mhloyi, 1995).

Although the fertility impact of AIDS was not incporated in the model it is however expected that fertility will decline further as men and women in the reproductive ages succumb to the epidemic. The positive effect of high mortality on fertility will most likely be counterracted by the concerted effort of couples to limit fertility. But from a polic perspecitive should coulpes be encouraged to limit their families in the face of the HIV/AIDS epidemic?

Granted that couples had many children in the face of mortality as an inssuarance that some of the children will survive, this arguement is not tenable in the face of hiogh mortality as a result of AIDS. This is so becuase in a context of high sero-prevalence levels, their are chance

that some of the infants will be vertically infected and consequently die too. If they survive HIV infection, children oif HIV positive couples are more likely to die even in childhood as they remain orphans. In the context of AIDS, before couples think of their own old age security, they should think of the security of their children. That is, couples should be able not only to support their children on a day-to-day basis, but should be able to invest for each of their children in the form of education, health and other forms of insuarance just in case the parents get infected and die of AIDS before the children are grown. Thus only a limited number of children can be afforded by most couples. It is also important for couples to have a limited number of children such that in case of parents death, it is easier for other relatives to absorb the orphans in their families. Imagin even the average number of children of 4.3 per couple. If there are two families of siblings with the same family size, and one of the couple dies, the other sibling will suddenly have 8.6 children in a soci-economic context which has become increasingly more expensive to raise children. It is important to also note that while AIDS is estimated to

It is clear that family planning program in necessary in the face of AIDS; however, it has to emphasize not only family planning but also reproductive health, prevention of STIs including HIV/AIDS. ZNFPC has long realized the need to intregrate AIDS/HIV with family planning since 1991. Under the Family Health Project , ZNFPC agreed with the MOH to intergrate STD prevention and treatement with family planning. In addition, ZNFPC has also engaged in the following activities pertaining to reproductive health:

The male motivation program

Youth service provision activities which address problems of access to services, sexual and reproductive needs addressed through counselling. Soci-political constraints remain an impediment in this area.

addressing problems of male and female infertility through clinical examination and provision of psychological counselling.

Migration, the other component of population growth, is biased towrds urban areas. Data from the 1992 census shows that 6 of the ten provinces lost people to the other provinces. The largest recipients of the migrants are Harare and Bulawayo which are provinces on their own right. However, the volume of migration to Harare is almost four times that of Bulawayo (CSO,1994). The predominance of the rural-urban migration is expected to increase during the next five years especially with the increasing diminshig returns from land as a consequency not only of increasing population densities and over utilization of land, but also, as part of the general modernization process.

In summary, the demographich situation is conducive to increased adoption of family planning for a number of reasons:

As the educated cohort goes through its reproductive ages during the last half of the 20th century, they will demand smaller family sizes with a consequent need for contraception.

While the AIDS epidemic will somewhat decrease the rate of population growth, it will increase the burdern of dependence since it is age selective with a bias towards the middle age group. This will undermine the countries saving capacity hance investment and development. This will further undermine the ability of the government to carry the burdern, the extended family will also be eroded. Family planning becomes one of the important solutions.

The rural-to-urban population which has increased urban population from 25 percent in 1982 to 31 pecent in 1992 is expected to continue. Granted that people in urban areas tend to desire smaller family sizes than their rural counterparts, the demand for family planning is expected to increase partly from this aspect of population redistribution.

> "The Zimbabwe program is presently blessed with high levels of financial and political support from government. The donor community, primarily the World Bank, USAID, and UNFPA, also provide major support to the program." (ZNFPC,1991).

??? Move this to the beggining of the demographic situation ??? The demographic and socio-economic context of the first half of the 1990's differs significantly from that which pertains today. The total population in Zimbabwe as of 1982 was and this had increased to 10 412 548 . The rate of population growth remained above 3 percent ------

The socio-economic context within which the next five year plan is planned is conducive to increased contraceptive demand and use. The most immediate factors of interest are the determinants of fertility and their policy implications.

The Socio-economic Situation

Since independence in 1980, the Zimbabwean Governement endeavoured to redress the socio-economic inequities which existed during the colonial regime. Significant progress has been made in the areas of health and education especcially in the 1980s. Primary school enrollment doubled and intermediate intake has increased ten fold. However; the heavy investments into the social sector diverted resources away from the economic sector. In 1990, the national debt was culculated at 82 percent and interest expenditure at 9 percent of GNP (Government of Zimbabwe, (GOZ), 1991, 1993, 1996) . Parallel to the this, the deficit on public finances gave rise to increasing inflation which reached 46 percent in 1992 which was a serious drought year. While the number of public sector employees increased, the number of provate sector employees decreased. The balance of payments deficit grew from and was met by means of increased borrowing and development assistance. This untanable economic sitaution prompted government to embark on radical economic reform program, the Economic Structural Adjustment Program (ESAP) in 19991. The program includes reforms to the public sector, trade liberaliztion, deregulation and sector specific initiatives. The economically deprived people were to be cushioned in this program.

The ESAP has been criticised in a number of areas. First, it has not been possible to to maintain high levels within the health and education sectors. User fees which were expected to have raised the additional reasources needed seem to have instaed restricted poorer groups' use of the health care system. From an economic perspective, although growth rates were estimated at 5.2 percent, no firm bais has been created for dynamic economic development (Danida, 1995). Public deficit remains high, a situation which keep inflation and interest rates with consequent minimal incentive for investment.

Another aspect of the economy is that land is the resource base for the poorest group in the rural areas who happen to be women; most of them do not have access to productive land. Government is still struggling to undertake its resettlement program to move people away form the unpriductive to productive land. A number of issues which shuold be note in comming up with the next five plan are thus as follows:

The majority of the population which is rural may not afford the user fees in both the health and education sector.

There may be increased rural-urban migration which will be conducive to increased demand for family planning.

the high levels of inflation will increasingly make the cost of living more expensive, the basic necessities such food, clothing and housing will continue to be out of reach of most people.

Fertility reducticion will continue to one of the adaptive strategies.

The budget for the MIO is not expected to increease significantly; given the increased burdern of disease from HIV/AIDS, the meagre resources will inevitably be devorted to phamaceuticals for curative purposes.

The Socio-economic Determinants of Fertility

Marriage remains the socially sanctioned unit within which procreation should take place. While mean age at marriage remains fairly low, approximately 18 years, early marriages are discouraged (CSO and Macro International, 1995; ZNFPC and UNFPA, 1995). There are however double standards on the determinants for marriage for men and women. For instance, the determinants of marriage for men are that they should have a job and acquire some household goods before they can get married. On the other hand, if a young woman is not in school, the determinant of marriage for her physical maturity, that is having reached aged at menarche and menstraution for at least four years, and being able to take care of household chores. For such young women who are educated, the determinant of marriage is that they should complete tertiary training, and worked for at least two years assisting siblings before overage at which point the beneficiaries of a young woman's income is her husband and his next of kin. Note that the mean age of marriage for and uneducated woman would translate to approximately 17 years while that for educated women would translate to 22 years (Mhloyi, 1991). Indeed the Demographic and Health Survey (DHS) showed that there is a negative relationship between education and marriage. For instance the median age at marriage for women was 17.5, 18.5 and 20.8 for women with no education, primary education and secondary or higher education respectively (CSO et. al, 1995). The median age at first marriage increased from 18.9 years among women age 40-49 to 19.8 among women aged 20-24. Education of women increased significantly in the 1980s soon after independence; education was largely free. However, the economic reforms which, among other things, transfer the cost of educating children on the parents, will undermine these gains especially for women. It was shown that parents prefer to send sons to school in the face of economic hardships (Mhloyi. 1994).

While marriage is often taken as a proxy for exposure to intercourse, the DHS results show an earlier onset of sexual activity than marriage. The median age at first intercourse is reported to have increased from 18 years for 30-34 year cohort to 18.8 among the 20-24 year age group. While this increase is consistent with that in marriage, it shows that there is premarital

sexual exposure which suggests the importance of protection among the youth. And the socio-cultural study revealed that adult and youths of both sexes put the ideal age of sexual intercourse at two years more than the ideal age for women to become sexually active. While the 1988 Survey of Young Adults in Harare showed that young men would eventually look for virgins when they want to get married, which was echoed by a study in Triangle, which tends to suggest that premarital sex is not socially sanctioned it shows that it is tolerated. Protection from pregnancy and infections becomes one of the most important concerns during the next strategic plan.

Polygny is another marital factor which may play some counteracting role on fertility to the decline in proportions married. In high fertility regimes, polygny tends to have a negative relationship with fertility; however, in transitional and low fertility situations polygny tends to have a positive effect on fertility since women tend to compete. It was shown that 19 percent of currently in union females in 1994 were in polygnous unions. This proportion is increased from 17 percent in 1988 (CSO et. al. 1995). Polygny was also shown to be negatively related to education and urbanization. Note that the disadvantaged women tend to be prone to the involvement in polygamous marriages. This can be explained by two factors: the pool of eligible men gets small during the hard economic times given the determinants of marriage for males; and that women who find themselves out of school and with no jobs find marriage the only option for survival.

There are a number of legal reforms which make divorce easier for women. For instance the Matrimonial Causes Act of 198??? and The Legal age of majority act. These two acts has made conditions for divorce equal between males and females, and custody for children is based on the interest of the children. Note that at divorce women would automatically loose custody of the children which made women remain even in very abusive marriage. After these legal changes divorce rates have since increased with consequent decreasing proportions of the proportions of women currently in marriage.

Another legal instrument which has a bearing on family planning in Zimbabwe is the legal age of consent. While the legal age of consent is sixteen, the practice is that the youth who are sixteen and not married are discriminated upon when they seek family planning services. This is an attitudinal rather than a legal barrier. The socio-cultural study amply demonstrated that Zimbabweans are supportive of family planning by married couples, this precludes the youth. The youth remain the most disadvantaged group and the least reached by family planning services be they private or public (ZNFPC and UNFPA, 1995). For instance, in a study of Triangle Limited, the youth were complaining that they did not only have problems of access to family planning, but even to crucial information on sexuality. The youth should be the most important target group for the next family planning strategy.

It is often assumed that men are a deterrent to the adoption of family planning. However, the socio-cultural study showed men are more positively disposed to the use of contraception than is generally assumed (ZNFPC and UNFPA, 1995). However, it was shown that discussions on family planning are more likely to be initiated by men; that both men and women state that men should and often make decisions on a couple's use of contraception; and men are more likely than men to report that family planning information should be obtained by men.

Another important determinant of fertility, hence use or non-use of family planning is the demand for children. The ideal number of children has declined since 1988; it was 4.9 in 1988 and it was 4.3 in 1994 (Ibid.) While desired number of children was higher than actual fertility in

1988, the two were the same in 1994. However, approximately 19 percent of the women reported that they did not want any more children or they did not want to have children in the next two years and were using contraceptives, and that they were not using contraceptives - the unmet need. While socio-cultural study findings suggest that having children is just the normal thing to do after marriage to the extent that people do not weigh the costs and benefits per se of children, it was shown in another study that couples are adjusting their fertility downwards especially because of the hard economic times coupled with the recurrent droughts (Mhloyi, 1991). Most couples maintained in the rural areas maintained that children are a security to them; However, they reported the need to educate such children if such security was to be realized. The increased minimization of the economy was reported to be an important determinant of the cost for children which were perceived as increasing. The actual costs mentioned were education, clothing and food as reported by males, the reversed sequence was followed by women. And yet couples also reported that they were not getting as much as they expected from their children. The children echoed this sentiment and gave the explanations that the hard economic times make it difficult for them to meet their own basic needs let alone their parents'. Thus, given the increasing costs of living in Zimbabwe and the persistent droughts, it is most likely that couples' desire for children will continue to decrease.

What are the prospects for contraception increase given the decreasing demand for children ? The extent to which couples' will increasingly adopt family planning will depend on the balance between demand for children, and the costs of fertility regulation and the knowledge that they have on contraceptives. These costs include both subjective and economic costs of fertility regulation.

Knowledge on contraceptives is almost universal; 99 percent of all married women and 100 percent of men covered by the DHS were able to cite at least one method of contraception. The pill, condoms, female sterilization and injectables are the most commonly cited methods. This limited variety of methods known is also reflected in the limited method mix shown by current contraceptors. However, there is still a gap in the knowledge that some people have. For instance there are still misconceptions regarding contraception. A significant number of people who participated in the socio-cultural study believed that use of family planning can easily cause sterility (ZNFPC et. al). On other hand, it was shown that Zimbabweans are favorably disposed to the use of family planning by couples although some women would like to avoid having children do not use family planning because they are afraid of physiological effects of family planning such as pain and bleeding, the possible long term effects on health and fecundity, the psychological costs of guilt, fear and exposure to criticism and ridicule, and for some the expense of buying condoms. However, non of these fears were reported by more than ten percent of the participants in the study which tends to suggest that by and large contraceptive use is not blocked by attitudes and beliefs which are widely and strongly held. Nonetheless, in addition to citing the importance of family planning for spacing and limiting of births, it is necessary to include in information, education and communication (IEC) programs messages which will reduce the subjective costs. In addition, it is important to encourage contraceptors to continue.

Another important determinant of fertility which often decreases with the increase in contraceptive use is breastfeeding. In Zimbabwe the formula fed did not catch up. Breastfeeding is practiced for its correctly perceived immunological effects on children. A few women, at most 15 percent reported in one study that they practiced breastfeeding also as a contraceptive (MHLOYI, 1991). However, such women reported such protection was only individual specific

and that individual women would know that breastfeeding suppresses their ovulation only after the first birth. To some degree, breastfeeding is also used as a chastity barometer for women. With the increasing diminishing returns of agricultural investment due to recurrent droughts and the increasing costs of food, it extremely necessary that the breastfeeding continues to be encouraged.

In summary, one can confidently conclude that overall socio-economic environment is conducive to an increase in the adoption of family planning. The following findings from the body of knowledge available are the bases for this conclusion.
The economic situation will increasingly make it difficult to have many children since the economic reform program is shifting the burden of educating and providing health to children to the parents in a context where the cost of all consumer goods which include food and clothing are also increasing. Parents will inevitably perceive an extra child as an extra mouth to feed, body to cloth, and brain to educate.

Although education of girls is not expected to increase beyond that which currently pertains, the educated cohort of the 1980's will comprise the mothers of the 1995 -2001 period. Such educated mothers as is evident in all the current statistics would want fewer children.
The urban population which will inevitably increase especially with the diminishing return from land. Demand for contraception will thus increase given the high cost of living and the consequent low demand for children in the urban areas.

Current statistics show that there is premarital sexual exposure.

There are issues which will have to be considered during the next strategic plan and these include, among other things:

Decision on contraceptive use is determined by couples and the men was reported to be the most important person in this decision making. Effort will thus have to be made to reach couples. There is a problem of attempting to reach men and women separately . Studies have shown that both men and women are afraid to initiate discussions especially sexuality, programs targeting the couples should be considered. In two studies on HIV/AIDS both men and women requested for joint sessions between men and women on sexuality and protection since that would make it a lot easier for couples to continue their discussions after they have been introduced to the issues together (Mhloyi, forth coming).
The youth need information on family life including how they deal with issues of sexuality and protection. Service delivery programs should seriously meet the needs of the youth..
There is need to increase the variety of methods available.
IEC should not only concentrate on the benefits of family planning on spacing and limitation of births, but also of information that would reduce the subjective costs of using family planning.
There is still a substantial group of couples in Zimbabwe which still cannot afford to meet the costs of contraceptives.

How will the development of an explicit population policy affect the National Family Planning Strategy (NFPS)? The impact of a population policy will depend to a large extent on the

importance attached to it by government. By and large, it is expected that the population policy will enhance the strategy as it will most likely increase the demand for family. The reason for this is that the population policy combines will most likely consider the population and development interrelationship. The range of issues which are currently being covered in the development of the population policy do cover the population and development inter-relationship. One can only speculate that the final population policy will reflect the approach already taken in its development hithertofore.

THE RELATIONSHIP BETWEEN THE ZNFPC STRATEGY AND THE HEALTH POLICY REFORMS

It is important to place the Health Reform Policy (HRP) in the developmental context of the country. In 1987 government appointed the Public Service Commission to undertake a general and in-depth review of structures, functions, management and procedures in use in the Public Service (PS) and the following recommendations were made:

that the PS was too large and cumbersome
managed by a high proportion of inexperienced officers
had several areas of overlap and duplication of functions resulting in unclear areas of responsibility
secretive, with very poor communication with the public
that the PS had complicated rules and procedures (MOH, 1996).

In addition to this, Government adopted the economic reform program which included PS reform since 1991. And the objectives of the Civil Service Reform Program are to address :

issues concerning personnel matters which relate to recruitment, motivation, personnel procedures and training
issues concerning functions of various levels in the administrative structures with emphasis on efficiency and effectiveness
establishment of an information data base system
decentralization of operational and administrative functions currently carried out by the PSC to line Ministries and the ministries in decentralizing function from headquarters to Provincial and District Offices
issues concerning value for money in utilization of Public Resources
introduction of Performance Management (ibid).

As argued, these, and many other issues, if not addressed, will work against aquity, improved access, efficiency, patient satisfaction, and improved outcomes (ibid). And it is further argued that through the Health Sector Reform, Government seeks to reaffirm, in very visible ways, its commitment to the following principle:

improving health status and consumer satisfaction by increasing the effectiveness and quality of

services.
obtaining cost effectiveness, allocative and technical efficiency ; and,
obtaining greater equity by improving the access of disadvantaged groups to quality care.

To achieve these goals, decentralization of services was considered the best approach since it is perceived to promote and strengthen democracy and civic responsibility as citizens participate in their governance and development (ibid). For the Health Sector, it is currently proposed that Rural District Councils (RDC) be responsible for the provision and management of the Core health services which are provided at district level and in particular:

provision and management of ambulances
hiring of all staff
provision of public sanitary services
provision of child welfare and nutrition services
provision of environmental health services (ibid).

This decentralization means a legislative transfer of function and authority from central government to local authorities such as the rural district councils on a permanent basis. And all Ministries will use the same local institutions for the implementation and management of decentralized functions. In the Health Reform it is argued:

"An important element in improving the functioning of the health services is the need to define achievable objectives and implementing transparent systems capable of tracking the flow of resources and measuring performance. This is achievable when the roles of purchaser and provider are split so that the government, through the Ministry of Health and Child Welfare, assumes the role of institutional purchaser responsible for specifying priorities, defining needs and monitoring performance and expenditures. The actual provision of service becoming the responsibility of Rural District Councils and Hospital Boards. In other words, greater efficiencies are achieved when relationships move away from an integrated hierarchy, towards a network of purchasers and providers. These relationships become more dependent on contractual rather than bureaucratic controls" (MOH, 1996, p.4)

While these principles will definitely guide towards a decentralized Health system, there are a number of issues that need to be considered. Among the many of these issues are the following:

While utility of Local Government does reduce redundancy, there is an obvious cluttering of responsibilities to the one Ministry which does not necessarily translate into the efficiency desired granted that there is need for time to prepare Local Government by way of transferring technical expertise for the various activities emanating from Ministries with technical expertise. Such transfer of expertise is a gradual, arduous and time consuming exercise whose completion might not take less than five years.
There is need of allocation of resources to the Ministry of local Government for the respective services. And yet in such allocations of resources in an economic context with limited financial resources the chances are that the resources may not necessarily be adequate for the task at hand. There is need for a gradual transfer of responsibilities especially if one maintains the importance of quality care to the consumers who cannot afford a gap in their services precipitated by the change

over process.
While greater involvement of people in their own gorvenance and development is the sin-qua-non of democracy, it must be appreciated that the bulk of knowledge needed to carry local communities, indeed countries is not necessarily common which emphasizes the need for ample time for the transition.
Reduction of costs being one other fundamental principle underlying this approach, and the fact that the preparation of the transfers will also be expensive, situations where transfer might end up as abrogation of responsibilities should be avoided at all costs. Thus, a phased approach is needed.

What does this all mean for the ZNFPC? In the document so far family planning is not explicitly considered one of the core services among the five which would be provided and managed by the RDCs. One might want to surmise that family planning is subsumed under child welfare. As noted earlier, one of the most important aspects of the decentraliztion process is its financing. Who will be the major financiers of this process and where is family planning in the funding plan?

One of the major funding organization for the Ministry during the period coinciding with the ZNFPC next strategic plan is Danida . Danish funding increased from DKK115 million to DKK 150 by 1999 (Ministry of Foreign Affairs, 1995). Danida funding will shift from focusing of specific projects to sectors assigned high priority by the governement of Zimbabwe. The funding covers four specific sectors: agriculture, health, private sector and infrastructure. While infrasture funding will comprise ??? percent of the total funding during the funding period, the other sectors will get ??? percent each. In the health sector, the Danish funding will concentrate on general health from district level down to village level (ibid). The sector support will be carried out decentrally and will include capacity and institution building, infrastural development, sumpplementary training, modernisation and maintainance of health facilites. Approximately 50 percent of the funds to the MOH will be spent on the decentralization activities. Funding for ZNFPC will be incorperated in the sector investments. As noted earlier, Danida will fund priority areas as identified by the Gorvernement. However, Danida gives some broad guidelines. For instance, Danida will expect the MIO to spend up to 30 percent on allowances, 7 percent on HIV/AIDS related activities, and 12 percent on transport. These are the specific limitations articulated so. Note that family planning is not necessarily a specific area although there is the expectation that family planning will be incorperated in the MOH strategic plan.

So far, family planning is not explicitly identified as one of the core services in the Health Sector Reform.

Danida has a 15-year long funding commitment which it hopes to honour ceteris paribus.
A major funding agent for ZNFPC during the during the 1991-96 strategic plan is the USAID which was, among other things, largely responsible for
the funding and procurement of contraceptives excet for condoms. USAID is undergoing through sever budget cuts to the extent that significant funding for ZNFPC will not go beyond 1998.
Another funding organization is the GTZ. GTZ will be involved in the evaluation of successes and failures in order to determine those areas which need continued funding. However, the parent Ministry will determine what they need to be funded. Thus, an

decentralized system as currently being funded by the MOH will be funded which will mean no direct funds to ZNFPC.

UNFPA, World Bank.

This section needs additional information.

CONTRACEPTIVE SUPPLIES

Given the level of contraceptive prevalence which is most likely to increase substantially in the next six years, contraceptive needs are also expected to increase. For instance, it has been estimated that while the number of condoms needed in 1996 was 40, 401, 200 this number is expected to increase to 41, 613, 300 in 1997 (ZNFPC, USAID and CDC, 1996). Given the increasing awareness of HIV and STD infections, it is expected that the need for condoms will increase gradually for the next six years. It has also been projected that while 4, 535,300 , and 4, 097, 200 lo-femenal and ovrette pills were needed in 1996, approximately 4, 671, 300 and 4, 220, 100 of the same will be needed in 1997. Depo-provera needs are expected to almost double during the same period. Overall , contraceptive prevalence may increase by about 50 percent within the next six years.

A study on procurement of contraceptives revealed that there is a highly centralized and well maintained warehouse facility at the ZNFPC for nationwide receipt and distribution of an extremely large volume of contraceptives. However, it was also shown that there are severe constraints for contraceptive procurement due largely to commingling of contraceptives and pharmaceutical products in the budgetary process. These problems were noted mostly in the Ministry of Health system (ibid) . One aspect about contraceptives, especially condoms, which makes them different from pharmaceuticals is that they are bulky and thus difficult to store and also to transport. These problems have made it difficult for those organizations currently involved in condom distribution to get their needed supplies at local levels. It is maintained that currently condom distribution at a wider level has been facilitated by donor funding. Most organization argue that they would find it extremely difficult to meet their goals if condom procurement and distribution were to be decentralized for these three reasons:

condoms are bulky and thus makes it difficult for most organizations to have adequate storage for them.

for the same reason, condoms are very difficult to transport; and

there are no staff assigned for condom distribution in the respective health facilities.

It is important to note that currently procurement for most of the contraceptives is undertaken by USAID while ODA procures condoms. While ODA will be procuring condoms for ZNFPC at least for the period 1995 -2000, USAID will not be able to continue its support beyond 1998; this support includes the procurement of contraceptives. In general the funding situation for USAID is rather dull to the extent that most missions all over the world are experiencing extensive budget cuts while a significant number of them might be closed by year

2000.
A sustained supply of contraceptives will remain vital to the success of family planning in the country. The central procurement is needed at a national level ; however, as noted before, commingling of pharmaceuticals and contraceptives at local levels has sustained contraceptive stocks at very low levels at service delivery points (ibid). In the next five year development plan, there are a few options:
The Ministry of Health may procure contraceptives for the family planning. This problem has a serious potential problem of resource allocation between pharmaceuticals and contraceptives. Given the limited budget in the Ministry and the increased disease prevalence, contraceptives may not necessarily get the needed attention. For instance, given limited resource in a situation where one has to procure anti-biotics, pain killers and contraceptives, it appears somewhat obvious that one will have to procure such in the same order. However, this compassion between pharmaceuticals and contraceptives can be avoided if concerted efforts are made on the outset to separate such funds; the funds have to b made available.

The procurement of contraceptives will best be done by ZNFPC whose major mandate is family planning. Indeed, funds will still have to be sourced.
And ZNFPC, is in a position to source funds for a wider variety of sources including government especially if a situation were to arise where it could be autonomous of government.

Other donor agencies may replace the USAID mission in this procurement responsibility. Are there any on the horizon to take up this responsibility???

Because of decreasing MOH and donor resources, it is vital that contraceptive purchases be coordinated to insure that all needs may be met. Whatever the option is chosen , there is need for the transfer of technical expertise with regards to procurement of contraceptives to such a procurement organ. This will entail the acquisition of knowledge on, among other things, specifications and markets. This transfer of technical expertise has to be done at least prior the end of 1998, that is during the first two years of the next development plan of ZNFPC.

It is important at this point to assess the potential of the private sector in the procurement and supply and provision of contraceptives. It is not perceived at this point in the economic development of the country where cost recovery is emphasized, that public sector commodities will be made available to the private sector. However, there are a number of limitations, indeed some strengths, that the private sector has in terms of provision of family planning . The limitations are as follows:
It was shown that the private sector lacks an effective distribution infrastructure throughout the country, and a national market penetration (Node, 1996).
Even where the private sector may have penetration such as in the urban areas, there commodities will suffer from low subsidized market prices of contraceptives.
To enhance the capabilities of the private sector there are a number of contextual changes to be effected before an effective take off of the private sector. These include, among other things:
The need for ZNFPC to phase out its responsibilities in the urban areas to allow private sector participation.
The need to streamline methods for particular outlets to enhance efficiency in terms of

the necessary training of the staff.
ZNFPC should charge market prices wherever possible and provide subsidized contraceptives only to those who cannot afford .
Yes, the public needs coverage for their family planning services once they get them form the private sector. It has been shown that while there were only two MAS providing coverage for family planning in the 1980s, today almost all MAS provide some level of coverage for family planning (Deloitte Touche Tohmatsu, 1996). While most commodities, excluding condoms are reimbursed regardless of source, reimbursement for supplies obtained from pharmacists do not include dispensing fee. However, the general public is not quite aware of these benefits. For coverage to enhance private sector participation in family planning provision, there is need for:

information dissemination to the public of their benefits.

a comprehensive coverage of family planning by all MAS

Strengthening of the private sector will enhance its expansion. A few discrete activities can be undertaken:
there is need for training and updates on contraceptives to private practitioners. While nurse- midwives are anxious to open private practices, they lack knowledge of the processes they must follow and the capital needed. Such knowledge and capital assistance to the nurses is thus necessary.
companies which are already providing services at an ad hoc basis need assistance in the areas of program planning, distribution of commodities, and dissemination of information materials (ibid).

It should be noted that for the private to expand their family planning services the ZNFPC will play a major role. ZNFPC will be the right body to provide the technical training and assistance and they can charge for services rendered to the private sector. However, ZNFPC might find it difficult to change for the same to the public sector under the present act.

FAMILY PLANNING PROGRAM

The Zimbabwe National Family Planning program has been considered one of the most successful programs in sub-Saharan Africa. Current use of contraceptives by currently married women was 38.4, 43.1 and 48.1 in 1984, 1988 and 1994 respectively (CSO et. al. 1995). Current use of modern contraceptives was 26.6, 36.1 and 42.2 for the same periods respectively. Thus, the program did not only gain new acceptors but also more utilizers of more efficient methods over the past ten years. However, the program the program relied heavily on one method, the pill. In 1984, 1988 and 1994, current use of the pill was 22.6, 31.0 and 42.2 percent respectively. There has been conncern that the program is somewhat plateauing. It is important to note that contraceptive prevalence is still higher than the expected fertility. For instance the contraceptive prevalence of was consistent with a total fertility rate of approxiamtely 4 children. And total fertility rates have since declined from 6.5 in 1984 to 4.3 in 1994. Thus, in addition to the gains in terms of new acceptors and the shifting from tradiotional to modern methods, their is a change in reasons for contraception. The proportionate increase in contraception is lower that the proportionate decline in fertility suggesting that more and more couples were aslo shifting

from contracepting for spacing to contraception for limitation. Also note that the 1991-1996 strategic plan's objective was to achieve a total fertility rate of 4.5 by 1996; this was surpassed two years before the end of the
planning period. Note that It is therefore not quite correct to describe the program as plateauing. The program gained in three areas:

increase in the contraceptive prevalence by 10 percentage points during the 10-year period.
a shift by some contraceptors from spacing to limitation
a precipitous fertility decline during the ten-year period.