

**EVALUATION OF THE ZIMBABWE  
FAMILY PLANNING PROJECT  
(613-0230)**

POPTECH Report No. 94-002-002  
June 1994

by

Sallie Craig Huber  
Laurie Emrich  
Caroline Marangwanda  
Lazarus Zanamwe

Prepared for

U.S. Agency for International Development  
Bureau for Global Programs, Field Support  
and Research  
Office of Population  
Contract No. CCP-3024-Q-00-3012  
Project No. 936-3024

Edited and Produced By

Population Technical Assistance Project  
1611 North Kent Street  
Suite 508  
Arlington, VA 22209 USA  
Phone: 703/247-8630  
Fax: 703/247-8640



## TABLE OF CONTENTS

Abbreviations .....	v
Project Identification Data .....	vii
Executive Summary .....	ix
Summary of Recommendations .....	xi
1. Background and History .....	1
2. Methodology of the Evaluation .....	3
3. Project Conceptual Issues .....	5
3.1 Validity of Project Assumptions .....	5
3.2 Impact of a Changed Environment on Project Achievements .....	5
3.2.1 Reduced Fertility .....	6
3.2.2 Sustainability .....	6
3.3 The Present Role of ZNFPC .....	7
3.3.1 Added Responsibilities .....	7
3.3.2 Financial Status .....	7
3.3.3 Staffing Issues .....	9
3.3.4 The Restructuring of ZNFPC .....	9
3.3.5 Resolving Constraints .....	9
4. Project Design and Implementation Issues .....	11
4.1 Achievement of Objectives .....	11
4.1.1 Logframe/CPSP Outputs .....	11
4.1.2 Validity of the Implementation Plan .....	14
4.2 Method Diversification .....	15
4.2.1 Training .....	15
4.2.2 Specific LT/P Methods .....	17
4.3 Program Sustainability .....	20
4.3.1 Programmatic Impact of GOZ Purchase of Oral Contraceptives ..	20
4.3.2 Organizational and Operational Changes in ZNFPC .....	21

4.4	Private Sector Participation .....	22
4.4.1	Ongoing and Planned Activities .....	22
4.4.2	Private Sector Family Planning Financing Initiative .....	23
4.4.3	Components of the Financing Initiative .....	25
4.5	Procurement and Local Support .....	34
4.5.1	Vehicle Procurement .....	34
4.5.2	Contraceptive Procurement .....	34
4.5.3	The Use of Local Currency Support .....	35
4.6	Technical Assistance .....	38
4.6.1	CA Contributions to Project Goals .....	38
4.6.2	The Continued Role for CAs .....	40
4.7	Donor Coordination .....	42
4.8	Other Areas of Concern or Interest .....	43
4.8.1	Other Areas for Research .....	43
4.8.2	Improved Use of Contraception .....	44
4.8.3	Adolescent Reproductive Health Needs .....	45
4.8.4	HIV/AIDS .....	46
4.9	CPSP and Project Indicators .....	46
4.9.1	Project Inputs .....	46
4.9.2	Increased Prevalence and Use of LT/P Methods .....	47
4.9.3	Cost Recovery .....	48
5.	Policy Issues .....	51
5.1	Tax Incentives .....	51
5.2	Age Barriers .....	51
5.3	Personnel Training, Orientation, and Roles .....	52
5.4	Fee Structures .....	53
5.5	Other Issues .....	54

## APPENDICES

- A. Scope of Work
- B. Persons Contacted
- C. Documents Reviewed
- D. Medical Aid Society Beneficiaries
- E. ZNFPC Administration Requirements for Office Machines

## LIST OF TABLES

Table 1	Government of Zimbabwe Ministry of Health Budget 1989-93 . . . . .	8
Table 2	Comparison of ZFPP Logframe, ZNFPC, and CPSP Output Indicators . . . .	11
Table 3	Zimbabwe National Family Planning Council Charges for Services– November 1992 and 1993 and Insurance Reimbursements– November 1993 . . . . .	27
Table 4	Zimbabwe National Family Planning Council Prices for Drugs– November 1992 and 1993 and Insurance Reimbursements– November 1993 . . . . .	28
Table 5	Current Areas of Emphasis Among USAID-funded CAs in Zimbabwe . . . .	38
Table 6	Future Areas of Emphasis Among USAID-funded CAs in Zimbabwe . . . .	41
Table 7	Planned USAID Central and Bilateral Inputs to ZFPP . . . . .	47
Table 8	Percentage of Medical and Contraceptive Costs Recovered by ZNFPC–FY 1990-93 . . . . .	49



## ABBREVIATIONS

A/F	Administration and Finance (Division of ZNFPC)
AIDS	acquired immune deficiency syndrome
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CBD	community-based distributor, community-based distribution
CFU	Commercial Farmers Union
CIMAS	Commercial and Industrial Medical Aid Society
CPR	contraceptive prevalence rate
CPSP	Country Program Strategy Plan
CSO	Central Statistical Office
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
ERU	Evaluation and Research Unit
ESAP	Economic Structural Adjustment Program
FPLM	Family Planning Logistics Management
FPPMES	Family Planning Program Monitoring and Evaluation System
FHP	Family Health Project
FY	Fiscal Year
GOZ	Government of Zimbabwe
GTI	genital tract infection
GTZ	German Technical Assistance
HIV	human immunodeficiency virus
IBRD	International Bank for Reconstruction and Development (World Bank)
IEC	information, education, and communication
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU	Johns Hopkins University
J/J	Johnson & Johnson
LT/P	long-term/permanent (methods)
ML/LA	minilaparotomy under local anesthesia
MOH	Ministry of Health and Child Welfare
MSH	Management Sciences for Health
MWRA	married women of reproductive age
NAMAS	National Association of Medical Aid Societies
NACP	National AIDS Coordination Program
NGO	non-governmental organization
NPA	non-project assistance
ODA	Overseas Development Administration (United Kingdom)
OGIL	open general import license
OYB	operating year budget
PCS	Population Communication Services
PP	Project Paper
SEATS	Service Expansion and Technical Support Project

SOMARC	Contraceptive Social Marketing Project
SOW	Scope of Work
STD	sexually transmitted disease
TFR	total fertility rate
VSC	voluntary surgical contraception
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
ZFPP	Zimbabwe Family Planning Project
ZIMA	Zimbabwe Medical Association
ZNFPC	Zimbabwe National Family Planning Council
ZRHS	Zimbabwe Reproductive Health Survey

## PROJECT IDENTIFICATION DATA

1. **Project Title:** Zimbabwe Family Planning Project
2. **Country:** Zimbabwe
3. **Project Number:** 613-0230
4. **Project Dates:**
  - Agreement Signed: 8/29/90
  - End Date: 8/31/96
5. **Project Funding:**
  - Authorized LOP Funding: \$9.9 million (bilateral)
  - Funding to Date: \$7.7 million
  - Host Country Funding: \$5.238 million (LOP)
6. **Mode of Implementation:** Bilateral Grant Agreement
7. **Responsible USAID Officials:**
  - Mission Director: Ted D. Morse
  - Project Officer: Roxana Rogers
8. **Previous Evaluation:** None



## EXECUTIVE SUMMARY

The midterm evaluation of the Zimbabwe Family Planning Project (613-0230) was carried out by a four-person team between March 17 and April 13, 1994. This is a forward-looking evaluation because USAID/Zimbabwe plans to prepare a Project Paper Supplement and Project Grant Amendment which will add funds and extend the project by two years, until 1998. The project, implemented by the Zimbabwe National Family Planning Council (ZNFPC), is progressing satisfactorily and is predicted to meet or exceed most of its objectives by the extended project end date.

The project goals—to reduce the total fertility rate (TFR) and increase sustainability—were examined and found to remain sound. Environmental factors, including the economic structural adjustment program, the 1991-92 drought, the AIDS epidemic, upcoming elections and related political factors, and the economic recession have affected Government of Zimbabwe (GOZ) priorities and have had an impact on timely implementation of the project. Despite these constraints, the project remains essentially on track.

Progress is being made on the first two end-of-project indicators—increased use of modern methods and ensuring the availability of a wider variety of methods—and the team feels these are achievable within the extended life of the project. Achievement of the latter two—increased services provided and/or financed by the private sector and reduced net government costs for family planning services—appear less certain due to a number of factors described in the report.

Three project indicators—reduced TFR, increased use of modern methods, and increased private sector participation—were revised to more conservative levels in the 1993 USAID Country Program Strategic Plan (CPSP). The team does not feel the reductions in the first two are necessary, especially in light of the proposed time extension. The third indicator should remain at its reduced level or be further moderated unless the report recommendations aimed at strengthening private sector family planning financing are included in the project amendment.

Method diversification activities are proceeding as expected, with only slight delays. Suggestions and recommendations are made for enhanced use of technical assistance and local currency funding to address some of these delays and to enhance this effort.

Program sustainability is being affected by a number of policies and other factors which are beyond the direct control of ZNFPC and also its parent body, the Ministry of Health and Child Welfare (MOH). At the same time, ZNFPC is making significant progress in working toward cost recovery. Several recommendations are made to assist ZNFPC with its restructuring and organizational development so that project progress is not hampered by external factors any more than necessary.

As noted in the discussion of project outputs, much needs to be done to enhance progress in the private sector activity area. A number of suggestions are made regarding ways to strengthen specific private sector activities. More importantly, the team recommends integrating the activities in this area into a comprehensive, limited-term private sector family planning financing initiative and

presents several options for mechanisms to implement this recommendation. This initiative would be coordinated by ZNFPC and subcontracted to an external entity experienced in health care financing and working with the private sector, for implementation.

The use of planned local currency support appears to be lagging; however, the team was unable to obtain a complete picture of local currency expenditures by program area. Recommendations are made as to possible activities and items to be funded under this budgetary component in the project amendment, including the financing initiative noted above. An additional recommendation advises using the existing local currency budget to contract for assistance in the development of financial reporting systems.

The role of Cooperating Agencies (CAs) was examined and found to be acceptable. Technical assistance from USAID-funded CAs is generally appreciated by ZNFPC. The team recommends the continued use of this mechanism along with local contracts to assist with implementation of the amended project. The team did not find evidence of extensive duplication or project complications due to the lack of regular or formal coordination among the family planning donors.

A number of possible topics for research are noted with the suggestion that ZNFPC create a database of experienced individuals and research firms that can assist in undertaking some of the research.

Adolescent reproductive health is a new area of interest to ZNFPC and a new priority for the MOH. Suggestions are given for specific ways USAID funding can assist with the recommendation that this area be included in the amended PP.

A number of specific policy issues, which constrain full achievement of GOZ program and USAID project objectives, were identified during this evaluation. These are listed and discussed in some detail as background for USAID's upcoming non-project assistance program planning exercise.

## SUMMARY OF RECOMMENDATIONS

1. If the DHS results indicate a 1994 TFR of 5.0 or less, USAID should reconsider the TFR objective stated in its CPSP and reestablish the level of 4.5 as the indicator for the extended 1998 project end date. (Page 12)
2. USAID should examine the prevalence data produced by the upcoming 1994 DHS and revise the modern method prevalence objective back to 50 percent by 1998 if DHS findings confirm current modern method prevalence estimates of 43 percent or higher. (Page 13)
3. In the absence of a strategy to address the private sector, in its broadest context, and clearly delineated and assigned responsibilities for its implementation, USAID should reconsider the feasibility of achieving its CPSP Target 3-2 dealing with increased private sector participation. (Page 14)
4. The Training Unit of ZNFPC, with technical assistance from USAID-funded CAs if required, should undertake a review of on-site training experience in the various LT/P methods with a view to revising training protocols if necessary. This Unit should also be assisted to develop a strategy for follow-up individuals trained in LT/P methods. (Page 16)
5. ZNFPC and USAID should explore the potential for and USAID should provide funding for training additional groups, such as clinical officers and expatriate doctors, to provide ML/LA in underserved areas. (Page 17)
6. The funding for training private doctors in NORPLANT<sup>®</sup> insertion should be expanded to include training for all ZNFPC sessional doctors, and the experience should be reviewed for its cost recovery and expansion potential after a few years. (Page 18)
7. USAID should examine, with ZNFPC, the continued emphasis and expense of using USAID funding to promote IUDs due to the high incidence of GTIs and other cultural and labor patterns in many parts of Zimbabwe which contraindicate IUD use. (Page 19)
8. USAID should provide additional funding for Depo Provera reintroduction information efforts, including materials for both staff and clients, as well as funds to document the experience with reintroduction. (Page 19)
9. USAID and ZNFPC should undertake an annual review of the progress and problems, if any, related to GOZ funding for oral contraceptives at the time orders are placed for these commodities. (Page 21)
10. USAID, ZNFPC, and DANIDA should meet soon after the completion of the DANIDA sector assessment to clarify which technical assistance and other activities are currently being funded and which are planned by DANIDA in order to reach an agreement about

gaps in management assistance which could be funded by USAID under the amended project. (Page 21)

11. USAID should determine, in collaboration with ZNFPC, the ways in which increased project funds can be utilized to assist with organizational development and management interventions such as
  - the restructuring process
  - staff development
  - strengthening the Council's management capabilities
  - supporting a review of ZNFPC's strategy
  - the development of an implementation plan for the remaining years of the ZNFPC's strategy (Page 22)
12. USAID and ZNFPC should integrate the following activities into one private sector family planning financing initiative under the proposed PP amendment: expansion of medical aid coverage, increased employment-based service availability, and private practitioner mobilization efforts. This initiative should be coordinated by ZNFPC and implemented by an external entity experienced in private sector health care financing. (Page 24)
13. USAID and ZNFPC should fund a baseline needs assessment/constraints analysis as a preliminary step in finalizing the design of the private sector family planning financing initiative. (Page 25)
14. The family planning financing initiative should devote some of its resources to designing improved basic financial information systems and conducting comprehensive cost analyses to better support negotiations with medical aid societies for full cost recovery for family planning services provided to insured clients. (Page 26)
15. The family planning financing initiative should work with NAMAS to ensure that all beneficiaries and service providers are informed of both their rights and responsibilities regarding insurance coverage and the relative benefits of different packages. (Page 29)
16. The family planning financing initiative should assist ZNFPC to develop a mechanism whereby work-based programs could procure their contraceptive supplies from the Council at full cost. (Page 32)
17. The family planning financing initiative should continue support for ongoing work-based services and explore new efforts with additional companies. (Page 32)
18. The development and implementation of a more comprehensive private physician activity should be continued under the auspices of the family planning financing initiative. This activity should include training in all family planning methods, creation of client demand for private services, and monitoring and support of quality of care among trained physicians. (Page 34)

19. Using the USAID local currency budget, ZNFPC should contract immediately with a local accounting firm for consulting services to improve financial management and reporting systems to meet USAID's immediate needs for complete and comprehensive financial reports. If requested by ZNFPC, this activity should be expanded to serve the Council's needs to report on other donor contributions. (Page 37)
20. Continued USAID support for a combination of USAID/Washington-funded CAs, buy-ins or add-ons to CAs, and local consultants is recommended to supplement and complement the activities under the ZFPP carried out by ZNFPC directly. (Page 40)
21. The Council should call coordination meetings of the family planning donors at least annually to improve communication among donors and between the donors and ZNFPC management and professional staff. These meeting could assist in identifying gaps and other program issues before they become major problems and in forging joint solutions. Funding for these meetings should be shared among the donors. (Page 42)
22. A study should be undertaken by ZNFPC or a research organization subcontracted by the Council to investigate contraceptive use effectiveness (especially of oral contraceptives) and continuation studies, particularly reasons for discontinuation and correlates of failure, for all methods. (Page 45)
23. USAID should fund new ZNFPC activities designed to address the issue of youth sexuality, including assistance in the design and funding of family planning and reproductive health services for youth, in the amended project. (Page 46)



# 1. BACKGROUND AND HISTORY

---

The Zimbabwe Family Planning Project (ZFPP) (613-0230) was designed and signed in 1990 to be implemented over six years (1990-96). The original authorization was for US\$9.4 million with an additional US\$6.312 million anticipated through United States Agency for International Development (USAID)/Washington cooperative agreements. Approximately US\$5.238 million in counterpart funds were to be provided by the Government of Zimbabwe (GOZ). Total expected project resources were estimated at US\$20.95 million.

The ZFPP was designed in collaboration with and is implemented primarily by the Zimbabwe National Family Planning Council (ZNFPC or the Council), a parastatal organization under the general direction of the Ministry of Health and Child Welfare (MOH). The Permanent Secretary of the MOH is the Chairman of the Board of ZNFPC. The project responds to and supports the "Strategy for the Zimbabwe National Family Planning Programme" designed by ZNFPC to cover the years 1991-96.

ZNFPC has the responsibility to provide technical support, quality assurance, training, information, education, and communication (IEC), contraceptive commodities and logistics, and other support functions for the national family planning program. In addition, the Council plays a major role in service delivery. It employs approximately 700 community-based distributors (CBD) who work primarily in rural areas. It also operates 38 clinics, three of which are mobile units serving multiple rural locations, and youth centers in three of the largest cities of the country.

In addition to ZNFPC, the Ministries of Health and Child Welfare and Local Government, as well as other non-governmental and private entities, provide family planning services. While these institutions are responsible for the staffing and management of these services, ZNFPC plays an important role in training the staff and providing contraceptive commodities in support of staff services.

The family planning program of Zimbabwe is known as one of the most successful in sub-Saharan Africa. According to the 1988 Demographic and Health Survey (DHS), the overall contraceptive prevalence rate (CPR) was 43 percent, with 36 percent of married women using modern methods. Oral contraceptives dominated method mix; more than 85 percent of modern method users relied on pills. Another DHS will be undertaken later in 1994 with USAID funding.

As a parastatal organization, ZNFPC operates under a Board of Directors which represents primarily the various ministries with an interest in implementation of the family planning program. ZNFPC is currently undergoing organizational restructuring; however, the basic organizational chart will not be greatly affected in this process. The proposed revised management structure includes an Executive Director and two Directors, one for the Programs Division and one for the Administration and Finance (A/F) Division. A third Director for Operations may be added to serve as the liaison with field operations. At headquarters,

various support units including Training, IEC, Medical/Clinical/CBD, and Evaluation and Research are responsible to the Director of Programs. The administration, personnel, and finance units report to the Director of A/F. Field activities of ZNFPC are coordinated through eight provincial offices, each managed by a Provincial Manager. Provincial Nursing Officers in each of these offices oversee the program activities of the CBDs and ZNFPC clinics operating within their geographical jurisdiction. They also provide technical and commodity support for family planning services operated by other institutions in their respective provinces.

Other major donors to the national family planning program are the World Bank (IBRD) and the United Nations Population Fund (UNFPA). The governments of Denmark, Germany, Japan, the Netherlands, Norway, and the United Kingdom participate through World Bank projects. The International Planned Parenthood Federation, once a primary donor to ZNFPC, now provides limited support, as do several other small foundations.

## **2. METHODOLOGY OF THE EVALUATION**

---

The four-person evaluation team spent nearly four weeks (March 17 to April 13) in Zimbabwe undertaking the midterm evaluation of the USAID ZFPP (see Appendix A for the complete Scope of Work). Data were collected through various meetings and field visits. (Appendix B lists the persons contacted). The team also undertook an extensive document review (see Appendix C). This is, by design, a forward-looking evaluation as USAID plans to increase the level of funding and extend the life of this project by two years to 1998.

According to the Scope of Work (SOW), different members of the evaluation team took responsibility for data collection and analysis of specific components of the report. The team was indeed fortunate to have two participants from Zimbabwe—an independent consultant and the head of the Evaluation and Research Unit (ERU) of ZNFPC. Their participation was invaluable in bringing a local perspective and years of personal knowledge of the program and the setting to bear on the team's deliberations and conclusions.

The Scope of Work set out the format for this report by dividing the specific evaluation questions into three areas: project conceptual issues, project design and implementation issues, and policy issues. The presentation of findings and recommendations which follows corresponds with this outline. In responding to the questions about policy issues, the team identified and reviewed a number of policies which should be further investigated by a team which will visit Zimbabwe later in the year to assist USAID with the development of a non-project assistance (NPA) program for obligation in Fiscal Year 1995. These policy issues are discussed in the final section of this report, but no specific recommendations are made since they will be dealt with in greater depth by the NPA team.



### **3. PROJECT CONCEPTUAL ISSUES**

---

#### **3.1 Validity of Project Assumptions**

The current family planning project was conceived in 1990. Different socioeconomic circumstances underpinned the project's goals, purpose, and strategy at that time. For example, at the time the Project Paper (PP) was developed, the country was planning an economic structural adjustment program (ESAP) which had not yet been introduced for implementation. At the same time, the agricultural sector, which is the cornerstone of Zimbabwe's industrial and economic development, was fully buoyant and some reserve grain stocks were being exported.

Several events occurred in the interim, however, which have had a significant impact on the assumptions underlying the project. The drought of 1991-92 diverted GOZ resources which had been allocated to the productive and social sectors to meet the basic need of feeding the population, especially in rural areas. This natural disaster effectively plunged the economy into a severe crisis at the same time that citizens were struggling to adapt to the ESAP. Thus, calls to suspend ESAP and/or remove some of its more severe measures were heard in both business and political circles.

A current issue that might affect achievement of the project goals, especially in cost-recovery, is the forthcoming general election to be held before April 1995. This and other political matters, including participation in the upcoming Conference on Population and Development in Cairo and current controversial efforts to develop a national population policy, mean that confusing policy statements might be made to the electorate in an attempt to garner votes. These statements may confuse not only those who have to implement certain socioeconomic policies but also the wider business community and the public.

In spite of these events, the evaluation team feels the original project assumptions are still valid and do not require change. However, due consideration must be given during implementation of the amended project to the changing political and climatic/environmental situations. The possibilities of another severe drought or the government backtracking on some of its policies under pressure from the general electorate and/or from various interest groups opposed to ESAP may hinder the achievement of project goals.

#### **3.2 Impact of a Changed Environment on Project Achievements**

The socioeconomic upheavals of the early 1990s now seem to be under control. The economy is recovering slowly from the effects of the drought. At the same time, the government remains firmly committed to ESAP. Because of the GOZ's commitment to ESAP and to the related concepts of cost recovery and sustainability, and given the current socioeconomic environment which seems favorable to growth and investment, the twin project objectives of reduced fertility and increased sustainability are felt to be achievable. This is especially true in light of the proposed extended life of the project. It is important to

acknowledge, however, that recent hard data are very limited with regard to either the current total fertility rate (TFR) or changes in net government expenditures on family planning which would provide an indicator of sustainability.

### *3.2.1 Reduced Fertility*

Fertility has been declining in Zimbabwe. The 1984 Zimbabwe Reproductive Health Survey (ZRHS) documented a TFR of 6.5 children per woman, and a TFR of 5.5 was found in the 1988 DHS. The 1992 TFR was estimated to be 5.4 children per woman. This decline is not so large when compared with the 1988 DHS of 5.5; nonetheless, it is an encouraging sign that it is still on the decline. The program efforts currently underway to expand method mix (e.g., reintroduction of Depo Provera, expanded integrated training in intrauterine device (IUD) insertion and genital tract infection (GTI) diagnosis, promotion of permanent methods, and motivating males to participate in family planning) seem to be having the desired effect on reducing fertility. However, most of these efforts still have to be assessed in terms of their impact. In the amended project, more should be done to intensify these efforts as well as make sure that full and complete information about innovations in the program reaches the staff at the grassroots which implements the program. With the increased availability and range of contraceptive methods, it is possible to predict an accelerated rate of fertility decline; however, a complete picture of the current TFR will not be known until the results of the DHS are released later this year.

### *3.2.2 Sustainability*

Sustainability can be viewed in two ways as it relates to the Zimbabwe program and to the ZFPP: internal institutional sustainability of ZNFPC and program sustainability. ZNFPC has been encouraged to address its own sustainability through undertaking cost recovery efforts and institution-building activities. Overall program sustainability depends on increased participation of the private sector in providing services outside the public sector. Possible private sector interventions include insurance reimbursement of both public and private providers, work-based services for private sector employees, and services provided by private medical practitioners and the commercial sector.

With regard to internal sustainability and cost recovery, ZNFPC seems committed to enhancing its role and learning procurement and other commodity-related cost recovery tasks. In keeping with the PP's contraceptive commodity phase out/phase in plan, the Council procured 21 percent of oral contraceptive requirements for 1993 with assistance from the USAID/Washington-funded Family Planning Logistics Management (FPLM) Project.

Both ZNFPC and the MOH charge fees for family planning services and contraceptives. These fees represent an important element of cost recovery which appears firmly in place. It would help ZNFPC, though, if policies on charging for contraceptives were more clearly enunciated and were introduced in a reasoned and phased manner, i.e., time should be allowed to communicate changes to staff and to develop a strategy for communicating the changes to the public. The MOH pays a handling fee for condoms and purchases all other

contraceptives from ZNFPC. Also, ZNFPC has secured a 20 percent reduction in the in-country testing fee for condoms.

ZNFPC has increased its training role and introduced fees for training staff from other organizations. The Council has also carried out its own structural adjustment in terms of undertaking a management assessment and job evaluation. It has embraced new ideas and tried to make them work regarding sustainability and for the benefit of the national family planning program. All these activities would seem to be signs that, given enough time (as foreseen under the proposed amended project), the ZNFPC will be able to achieve increased organizational sustainability.

The sustainability indicator presently in question is increased private sector involvement. It has been argued that the widespread availability of free or very cheap contraceptives may undermine the interest of the private sector in providing family planning services in Zimbabwe. However, this argument has not been validated through research or by other means. A study of the private sector's current and potential future contributions to the family planning effort is required so a clearer picture of progress toward achieving this indicator can emerge. (This issue is discussed further in Section 4.4).

In summary, the project goal of reducing the TFR to 4.5 children per woman by 1995 continues to be relevant, and there is no need to revise the basic strategy expressed in the PP for attaining fertility reduction objectives given the planned extended project completion date. The same can be argued for most of the indices that measure progress toward achieving the goal of increased sustainability.

### **3.3 The Present Role of ZNFPC**

#### *3.3.1 Added Responsibilities*

ZNFPC management noted that the role of the Council has changed since the PP was written. The changes were imposed from the external environment as well as from internal assessments. ZNFPC management maintains that the Council was encouraged by the MOH and donors to undertake new activities as well as expand ongoing ones at a time when it was facing financial and personnel constraints. For example, added responsibilities for integrating HIV/STD training and services along with expanded involvement in condom logistics; taking on new training responsibilities; and increased involvement with private sector activities were placed on ZNFPC with little or no added budget or staff.

#### *3.3.2 Financial Status*

In keeping with the ESAP mandate that parastatals become self-sufficient, ZNFPC management pointed out that it should have greater autonomy in setting commodity prices and in other financial areas. Instead, more controls seem to have been added by its parent ministry, the MOH. For example, fees for services and for commodities have become both confused and controversial due to constant policy changes from the GOZ and the MOH.

Furthermore, ZNFPC desired to lift the Z\$150 per month salary limit which qualifies a family for free health services at its own clinics. Instead, the limit was raised by the MOH to Z\$400, thus qualifying more people for free services. This ceiling applies to all clinic- and hospital-based services provided by the MOH as well as by ZNFPC.

In terms of its budget, the Council receives its operating budget through a grant from the MOH. From 1989 through 1991, while the overall MOH budget declined as a proportion of the total government budget, the Council's budget actually increased for 1990 and 1991 and remained nearly level in 1992, as illustrated in Table 1.

When ZNFPC began to procure a proportion of pill requirements as agreed in the PP, its budget increased from its level position of about Z\$13 million in 1991 and 1992 to Z\$20 million in 1993, an increase of 54 percent. However, in the past two years inflation in Zimbabwe has ranged between 20 percent and 40 percent; therefore in real terms, ZNFPC's budget has declined.

**TABLE 1**

<b>GOVERNMENT OF ZIMBABWE MINISTRY OF HEALTH BUDGET 1989-93 (Z\$000)</b>				
<b>BUDGET ITEM</b>	<b>YEAR</b>			
	<b>1989/90</b>	<b>1990/91</b>	<b>1991/92</b>	<b>1992/93</b>
<b>ADMIN. &amp; GENERAL</b>	15,855	15,134	14,371	20,055
<b>MEDICAL CARE SERVICES</b>	327,630	382,592	499,474	556,750
- GRANT 1	66,955	83,500	104,008	113,200
- GRANT 2	51,293	51,700	60,200	74,300
<b>PREVENTATIVE SERVICES</b>	62,353	59,132	69,050	108,720
- GRANT 3 (ZNFPC)	10,307	11,807	13,050	13,000
<b>RESEARCH</b>	2,541	2,609	3,010	3,135
<b>GRAND TOTAL</b>	408,379	459,467	585,905	688,660
<b>% ANNUAL INCREASE IN MOH TOTAL BUDGET</b>	24.1	12.5	27.5	17.5
<b>% ANNUAL SHARE OF TOTAL GOVT. BUDGET</b>	5.6	5.1	4.8	4.7
<b>% ANNUAL INCREASE IN GRANT 3 (ZNFPC)</b>	—	14.6	10.5	0.0

Source: Murahwa and Gorosh, Appendix C (1993).

### *3.3.3 Staffing Issues*

The Council is facing constraints in its staffing. Unfavorable and uncompetitive salaries mean that ZNFPC is unable to hire the personnel it needs even when funds are available through other channels, such as donor funds. The Council is concerned about its post-grant absorptive capacity if new staff persons are hired for a few years with external funding. Existing labor practices mean that the Council cannot get rid of unproductive staff persons even if they cannot be pushed to improve their performance. This is a hangover from socialist days. Even though some of the restrictions on hiring and firing have been lifted, the new managerial freedom in revised personnel practices has not yet been put into practice by ZNFPC.

Certain project activities have been negatively affected by the inability to hire personnel or to fill vacant positions. Chief among areas affected are financial and management reforms, research and evaluation, aspects of training, and private sector activities. The effects have impacted negatively on efforts to increase financial accountability, deliver timely data required for management decisions, complete training manuals and materials and implement training, as well as fulfill the plans for an expanded role of the private sector.

### *3.3.4 The Restructuring of ZNFPC*

The restructuring of ZNFPC, which is currently in process, must ensure that all the Council's new programs are adequately covered by experienced technical staff. Despite pointing out the difficulties it has experienced, ZNFPC management feels that new initiatives, such as STD/HIV integration, private sector activities, and commodity procurement, should not be dropped. If ZNFPC becomes more autonomous or the restructuring is effected so that management is able to eliminate less productive staff, then a new team should be able to see most project activities through to a successful completion by the time the proposed extended USAID project ends in 1998.

### *3.3.5 Resolving Constraints*

Some of the constraints noted above have already been addressed. The MOH Permanent Secretary noted that the Ministry has won concessions which will enable them to hire more technical staff and obtain increased budget allocations provided it can justify the need. These concessions are expected to go into effect despite the fact that the ESAP budget freeze has not been officially lifted. ZNFPC's increased 1993-94 budget for the purchase of pills illustrates this situation. A further positive development is that government thinking has moved toward hiring subcontractors to fulfill tasks that can be better completed by the private sector. This will leave the technical staff to concentrate more on the day-to-day running, monitoring, and evaluation of its activities. Thus, the constraints brought about by the budgetary freeze experienced between 1990 and mid-1993 in the social sectors appear to have been eliminated. The national budget for 1994-95, to be announced in July, should clarify this trend.

An important constraint not yet addressed is the fact that salaries in the public sector are still too low compared to those in the private sector. This is a situation both the MOH and the Council must accept unless policies are reformed to allow donor funds to supplement salaries of staff considered crucial to the success of certain projects. This is a highly unlikely solution given the policies of most donors as well as those of ZNFPC. Another possible policy change regarding salaries would be to allow ZNFPC greater autonomy in determining its own salary levels, independent of government salary scales, as do selected other parastatals which generate their own income.

## 4. PROJECT DESIGN AND IMPLEMENTATION ISSUES

### 4.1 Achievement of Objectives

#### 4.1.1 Logframe/CPSP Outputs

Several project output indicators have been revised from the levels originally established in the PP prepared in 1990. The new indicators from the Country Program Strategic Plan (CPSP) prepared in 1993 are noted and compared with those from the PP logframe and from ZNFPC's own strategy in Table 2. Also, the anticipated completion dates are given for each source. Determination of achievement of these outputs is hampered by the absence of reliable national service statistics and other relevant information about services provided by the private sector. The 1994 DHS should provide updated information by the end of this year about all three of these output indicators.

TABLE 2

COMPARISON OF ZFPF LOGFRAME, ZNFPC, AND CPSP OUTPUT INDICATORS			
INDICATOR	SOURCE OF INDICATOR (TARGET YEAR)		
	LOGFRAME (1995)	ZNFPC (1996)	CPSP (1998)
TOTAL FERTILITY RATE	4.5	4.5	4.9
USE OF MODERN METHODS (AMONG MWRA*)	50%	48%	48%
INCREASED PROPORTION OF SERVICE DELIVERY BY THE PRIVATE SECTOR	15-20%	17%	10%

\*married women of reproductive age

Total Fertility Rate. The PP objective—to reduce the TFR from 5.5 children per woman as found in the 1988 DHS to 4.5 by 1995—was premised on the remarkable decline in the TFR from 6.5 in the 1984 ZRHS. This represents a decline of one child over this four-year period compared with a projected further decline of one child during the seven-year period between 1988 and 1995. A re-analysis of 1982 census data, the 1984 ZRHS, the 1987 Intercensal Demographic Survey, and the 1988 DHS, using the indirect method of calculating the TFR, was undertaken by the Central Statistical Office (CSO) in 1991. This exercise was done to eliminate inconsistencies in the fertility estimates used for GOZ planning purposes prior to the

availability of 1992 census results. A revised TFR of 6.1 was determined for the period of 1987-88. This figure should not be compared with the TFR of 5.5 found in the 1988 DHS, however, because the latter study covered a different period (1985-88) and used a direct method of collecting fertility data. Preliminary estimates of the 1992 census data indicate a TFR of approximately 5.4 by the second year of the current project.

The CPSP contains a revised TFR objective of 4.9 by 1998. The DHS is listed as the source of information about the achievement of this objective. By the end of the extended project there will be a series of four of these surveys for Zimbabwe (1984, 1988, 1994, and 1998). This will allow a review of trends using the same data collection techniques and the direct method of calculating the TFR. A reduced TFR is dependent largely on increased contraceptive use, especially of the more effective methods. Improved use effectiveness and continuation, especially of those methods which require client compliance, also impacts the TFR. The CPSP revision seems unnecessarily conservative given the continued momentum of the ongoing family planning program, changes being made in training curricula and training additional providers, advances in moving toward the increased use of more effective long-term/permanent (LT/P) methods, and evidence of a continued commitment of support for the program on the part of the GOZ and a commitment to use contraception by consumers.

**1. RECOMMENDATION: If the DHS results indicate a 1994 TFR of 5.0 or less, USAID should reconsider the TFR objective stated in its CPSP and reestablish the level of 4.5 as the indicator for the extended 1998 project end date.**

Increased Use of Modern Methods. The objective related to increased use of modern methods has been reduced from 50 percent by 1995 to 48 percent by 1998 in the CPSP. The project has undertaken a number of activities which should result in considerable change in overall levels of modern method use. Most notable are activities aimed at LT/P methods. These include extensive training in voluntary surgical contraception (VSC), IUD insertion, and NORPLANT<sup>®</sup> implant insertion, as well as provision of related equipment and supplies to encourage use of these methods. Training has also been increased in the areas of communication skills and counseling with a special emphasis on LT/P methods. IEC campaigns, such as the ongoing multi-media male motivation effort, have been funded through the project and by other donors. These campaigns have also focused on the increased use of modern methods. Workshops in counseling and interpersonal communication skills are planned for service providers. Plans are also underway to include two new family planning modules in the pre-service nursing curriculum. All of these training efforts should enhance and support increased use of modern methods. A major positive programmatic change since the design of the PP has been the reintroduction of the injectable contraceptive, Depo Provera, provided by UNFPA.

Several environmental factors may negatively affect the achievement of the objective to increase the use of modern contraceptive methods. The HIV/AIDS epidemic seems to be discouraging service providers from undertaking invasive procedures, such as IUD insertion.

Economic reforms affecting personal disposable income and pressures on the program to increase prices to enhance cost recovery may also impede the attainment of contraceptive prevalence objectives. These income/cost factors appear to have had a recent impact on the levels of use of certain methods. Distribution of condoms dropped sharply coincident with the introduction of charges for this commodity in November 1992. The impact of the recent lifting of fees for condoms should be monitored closely to see if this situation is reversed. The introduction of increased fees for other contraceptives, also in November 1992, appears to have affected the quantities of supplies provided to or requested by each client, according to the Family Planning Program Monitoring and Evaluation System (FPPMES) being implemented by ZNFPC in collaboration with the USAID-funded Cooperating Agency (CA) projects SEATS and FPLM.

**2. RECOMMENDATION: USAID should examine the prevalence data produced by the upcoming 1994 DHS and revise the 1998 modern method prevalence objective back to 50 percent if DHS findings confirm current modern method prevalence estimates of 43 percent or higher.**

Private Sector Participation. As indicated Table 2, the output indicator for the level of private sector provision of services was considerably reduced (by half over an extended time period) in the CPSP. The private sector involvement represents the main mechanism for reducing GOZ expenditures in meeting national family planning goals. In this context, the private sector refers to private practitioners, work-based services, insurance reimbursements, and pharmacies and other commercial retail outlets, such as those selling the Johnson & Johnson (J/J) Protector condoms.

The 1988 DHS found that the private, industrial, and commercial sector provided 4.2 percent of all contraceptive services used by the respondents. Non-governmental organizations (NGOs) and mission hospitals accounted for the provision of an additional 1.8 percent of contraceptive services. This small group of providers was responsible for providing more than 15 percent of all sterilizations reported by DHS respondents and over 34 percent of IUDs. These figures indicate a certain level of potential in this sector and possibly led to the objective set in the PP for increasing this sector's participation. This objective also relates to and supports the project's intent to reduce the financial and service provision burden on the GOZ.

Several factors may be responsible for the downward adjustment in the anticipated output level for this sector in the CPSP. USAID is the only major donor which placed emphasis on this sector in the design of its current project. Approximately 18 months after the PP was signed, the USAID Mission decided to reduce and restructure external technical assistance for the ZFPP. The Mission's intent in this process was to reduce its management burden and to eliminate activities which were considered not to be cost effective. However, almost all activities planned in the PP and in the CAs' work plans and proposals which dealt with efforts to promote private sector participation were the ones deleted or otherwise negatively affected. In some cases, the responsible CAs were restricted from undertaking further activities in

Zimbabwe. The Contraceptive Social Marketing Project (SOMARC) social marketing activity with Geddes, a local pharmaceutical distributor, was discontinued by mutual agreement between USAID, SOMARC, and Geddes. ZNFPC, however, feels it was not adequately consulted about these matters regarding changes in planned private sector activities.

The remaining CAs have provided limited assistance to private sector activities. The Association for Voluntary Surgical Contraception (AVSC) has supported training through a USAID buy-in for a small number of private practitioners in NORPLANT<sup>®</sup> and VSC. The Service Expansion and Technical Support (SEATS) Project has been involved with a few work-based service projects. In addition, SOMARC is providing limited technical assistance to Johnson & Johnson which took over the social marketing activities discontinued by Geddes. These activities appear to have had a certain degree of success. However, they have been planned and implemented without the benefit of a clearly stated and agreed-upon strategy for promoting the private sector. The 1994 DHS will provide more information about developments in the private sector since 1988. Until then, there is limited information on which to base recommendations for revised output levels since almost no data are readily available from this sector.

Other factors affecting progress in this area relate to the placement of responsibility for private sector activities within the understaffed and overloaded ZNFPC. Even if the Council had adequate staff to manage this activity, questions arise about the appropriateness of locating this activity within a parastatal which does not have a clear mandate or the expertise to undertake a major private sector initiative. The PP Institutional Analysis (Annex III.C) indicated that the stimulation of private sector family planning was a "recently acquired role" of the Council which was not stipulated in its Enabling Act.

**3. RECOMMENDATION: In the absence of a strategy to address the private sector, in its broadest context, and clearly delineated and assigned responsibilities for its implementation, USAID should reconsider the feasibility of achieving its CPSP Target 3-2 dealing with increased private sector participation.**

#### *4.1.2 Validity of the Implementation Plan*

The continued validity of the implementation plan (Annex II.C, p. 50 and Table II.E.4 of the PP) was discussed with ZNFPC staff and with the CAs present in Harare. A review of documents and responses to a questionnaire prepared as background for this evaluation was undertaken for the other CAs. The implementation plan, as set out in the PP, has been affected by a number of environmental changes described elsewhere in this report as well as by specific actions taken by USAID itself.

The original project design called for considerable inputs from USAID/Washington-funded CAs, amounting to approximately US\$6.3 million. Presumably this level of involvement recognized that when the project was being designed, ZNFPC had limited staff, funds, and/or

technical skills to carry out all the innovative new activities which made up the bulk of the project's technical interventions. These planned activities appear to have been in line with and responsive to the plans set out in ZNFPC's own strategy. Furthermore, the CAs identified in the PP to provide technical services under the various project components appear to have been appropriately selected to undertake the assigned activities.

The Mission review of CA participation noted above effectively eliminated participation of five of the 11 CAs originally included in the implementation plan. This action, no doubt, reduced the Mission's management burden of coping with such a large number of CAs. However, the revised plans, delayed start up of newly assigned CA activities, and increased responsibilities taken over by ZNFPC as a result of CA withdrawal seem to have had a significant impact on project implementation as follows:

- Several critical activities, e.g., curriculum review, development of the clinical manual and service delivery policies and standards, and CBD reorientation—all tied to revising the method mix—have fallen considerably behind schedule.
- Planned private sector activities—a major component in both the USAID PP and the ZNFPC strategy—have not developed as anticipated due to the lack of a clear implementation strategy and guidance from an appropriate CA or CAs concentrating solely or primarily on this effort.

Specific issues related to CA participation and performance, as well as a more complete review of the private sector initiative, are discussed and recommendations are given elsewhere in this report. (See Sections 4.6 and 4.4, respectively.)

## **4.2 Method Diversification**

The major program components affecting expansion of method mix and especially the access to and use of LT/P methods relate to the provision of training, commodities, and related equipment. In this program area, the activities aimed at the public sector appear to be moving ahead with assistance from the major donors (USAID bilateral and centrally-funded efforts, the World Bank, and UNFPA). Together the projects of these donors are ensuring adequate supplies of commodities and equipment for present public sector needs. Also, technical assistance is being provided, primarily through USAID centrally-funded CAs, to ensure high-quality training for provision of these methods in the public sector.

### *4.2.1 Training*

An issue affecting training for all LT/P methods is the length of training courses and the level of practical experience included in the training. ZNFPC management expressed a desire to streamline training and ensure that greater emphasis is placed on the practical aspects of each course. Another problem is the present arrangement for training at a central training site for most LT/P methods. An exception is IUD insertion for which practical training is provided at

the trainee's place of work through the Mutasa-Chitepo project, supported by SEATS, and elsewhere. For a private practitioner or the sole provider at an understaffed MOH or mission facility to leave his/her practice or post to be trained at a central site is usually impractical. This situation argues for the further exploration of on-site training or a greater decentralization of training if the caseload required for practical training can be ensured.

A few problems were noted in the follow-up after training. Provincial staff noted that the number of VSCs being performed is still low, even though teams have been trained and there seems to be demand for these services. Some of the low performance may be attributed to a lack of confidence in the early months following training and, in this regard, provincial staff also noted the lack of promised follow-up visits to VSC trainees. Also, the limited number of individuals trained in counseling for LT/P methods may be constraining the achievement of larger numbers of acceptors of these methods. There are also difficulties with obtaining the reagents necessary to carry out the genital tract infection (GTI) testing which was taught as part of CA-assisted IUD training. Certain basic equipment provided in connection with training is not being used due to limitations in local MOH/ZNFPC budgets. For example, the angle poise lamps provided with CA funding in the Mutasa-Chitepo project are not being used because funds for bulbs and plug adapters have not been made available from local budgets.

**4. RECOMMENDATION: The Training Unit of ZNFPC, with technical assistance from USAID-funded CAs if required, should undertake a review of on-site training experience in the various LT/P methods with a view to revising training protocols if necessary. This Unit should also be assisted to develop a strategy for follow-up of individuals trained in LT/P methods.**

The evaluation team noted recurrent problems with the introduction of LT/P methods in the private sector and commercial sectors. Despite the recent lifting of tariffs and taxes on imported contraceptives, the private sector does not appear inclined to contend with the bureaucracy required to import the limited quantities of commodities (IUDs, Depo Provera, and NORPLANT<sup>®</sup>) which are currently needed to meet private sector demand. The private sector also views public family planning services as strong competitors since they provide supplies and services at much cheaper rates. Private doctors and/or pharmaceutical importers and distributors fear that even if they were able to import contraceptives easily, these supplies would reach their expiration date before they could be sold.

USAID has provided funding and technical assistance for training a limited number of private practitioners in VSC and IUD and NORPLANT<sup>®</sup> insertion. Questions remain about whether the volume of services supplied by these individuals is sufficient to justify the cost of the training and other inputs and whether it will be sufficient to maintain their skills and interest in addition to covering the expenses involved in providing the services. The team met a private practitioner trained in VSC who is willing to provide these procedures at standard MOH charges one afternoon a week when he has surgical privileges at the General (MOH) Hospital in his town. However, linkages have not been made with MOH and/or ZNFPC referral sources

to ensure clients are booked on that day. The issue of private practitioner training and service provision is addressed further in Section 4.4.

#### 4.2.2 *Specific LT/P Methods*

Recent hard data are not available in Zimbabwe to indicate demand by method; however, this information will be collected in the upcoming DHS. A review of the potential for expansion of each LT/P method was determined from programmatic information and in consultation with several service providers and ZNFPC managers. Information on these findings follows with recommendations for USAID funding as appropriate.

Sterilization. There appears to be a growing demand for VSC, but training of doctor-nurse teams and counselors has been slow and the numbers limited. Efforts should be undertaken to speed up the training process through identification of underserved areas of high demand for VSC. Training in minilaparotomy under local anesthesia (ML/LA) and other long-term methods as well as GTI/STD (sexually transmitted disease) diagnosis and treatment should be made available to expatriate doctors who serve as the sole doctors in rural hospitals to ensure these facilities are covered with a full range of services. Follow-up of all VSC trainees in a timely fashion should be arranged and funded if necessary.

The team identified two potential ways in which training in ML/LA could be expanded. Two clinical officers, who are nurses with advanced clinical training including minor surgery, have been trained to perform ML/LA. This group, although limited in number, should be identified and trained in VSC as they generally serve in remote rural areas where there may be no other providers of these services. A second example of a practical and inexpensive way in which ML/LA training has been multiplied was identified at a mission hospital visited by the team. The doctors originally trained in VSC have provided on-the-job training for the other three doctors and additional nurse assistants at the facility.

**5. RECOMMENDATION: ZNFPC and USAID should explore the potential for and USAID should provide funding for training additional groups, such as clinical officers and expatriate doctors, to provide ML/LA in underserved areas.**

NORPLANT®. Use of this method is currently restricted to a limited number of facilities in a few urban areas. Although there is not a specific strategy or policy related to the national expansion of NORPLANT®, a proposal has been developed to expand NORPLANT® training with assistance from AVSC. This effort will be combined with promoting the availability of NORPLANT® services from these AVSC-trained doctors with assistance from the Johns Hopkins University Population Communication Service (JHU-PCS) Project. A donor, probably USAID, will need to supply the NORPLANT® sets to be used for training, and also supplies will need to be imported, either by a donor or commercially, for service delivery by these trainees. The team supports the ZNFPC proposal which targets the training of 19 private doctors in five

selected cities as an initial step. This activity is reported to have begun on a small scale in Bulawayo. In addition, NORPLANT<sup>®</sup> training should be made available for any ZNFPC sessional doctors who have not already received training. These trainees should also benefit from the related IEC efforts, and the entire NORPLANT<sup>®</sup> effort should be fully evaluated prior to undertaking an expanded training and service delivery activity.

Other activities are planned or underway related to implants. The University of Zimbabwe Medical School's Department of Obstetrics and Gynecology will participate in World Health Organization (WHO) trials of NORPLANT<sup>®</sup> II compared with a new implant being developed by Organon. This same department implemented the original trials of NORPLANT<sup>®</sup> in collaboration with ZNFPC and the Population Council. The department proposed a second project phase for assistance from the Population Council which was to demonstrate the feasibility of training nurses to insert NORPLANT<sup>®</sup>. This activity was put on hold, but it should be explored further during the PP extension.

**6. RECOMMENDATION:     The funding for training private doctors in NORPLANT<sup>®</sup> insertion should be expanded to include training for all ZNFPC sessional doctors, and the experience should be reviewed for its cost recovery and expansion potential after a few years.**

IUDs. ZNFPC feels that the IUD is an appropriate method for many women and that it should continue to be included in the program as an important alternative to hormonal methods. A 1990 study of acceptors showed a high level of satisfaction and continuation among IUD clients. However, a study of health care providers sponsored by the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) in 1992-93 revealed considerable concern among providers regarding the insertion of IUDs in light of the increasing human immunodeficiency virus (HIV) epidemic. Since GTIs are a co-risk factor of HIV, it was felt that the introduction of training for GTI diagnosis and treatment would assist in alleviating the providers' fears. However, field findings of the evaluation team indicate continuing provider concerns and the possible need to revise the IUD training strategy.

The IUD is not suitable for areas with a high incidence of GTIs, and this seems to be the case in most of Zimbabwe: five percent to ten percent of the reproductive age population is infected. The high GTI incidence rates are associated with seasonal labor migration patterns which force a significant number of households to undergo long periods of spousal separation. Thus, IUD training should include discussion of critical cultural issues affecting the selection and use of IUDs, such as the importance of screening out potential clients who are involved in polygamous marriages and/or have other lifestyle factors influencing the possibility of multiple GTI risk. Furthermore, individuals selected for IUD/GTI training should be carefully screened to ensure that they will return to practice in areas where factors militating against IUD acceptance and successful use are minimal. IUD training should be followed by regular provider orientations or updates on the IUD, as well as on all other LT/P methods.

The above concerns suggest that the project might need to reexamine the widespread promotion of the IUD as a long-term method.

- 7. RECOMMENDATION: USAID should examine, with ZNFPC, the continued emphasis and expense of using USAID funding to promote IUDs due to the high incidence of GTIs and other cultural and labor patterns in many parts of Zimbabwe which contraindicate IUD use.**

Depo Provera. This method, which was widely used in Zimbabwe prior to independence, was restricted to use by mentally deficient clients or those of very high parity from shortly after independence until its reintroduction in April 1992. Its reintroduction has enhanced the possibility of a changed method mix since demand for this method continued even when its use was restricted. The method appears to be making a rapid comeback and most providers were found to be very supportive of this method. The Z\$4 fee for each three-month injection may be a constraint to the use of Depo, especially for low income clients and those living in rural areas. In addition, there may remain some political opposition to the reintroduction of the method, especially at the central level. However, when questioned about possible opposition, the Permanent Secretary of the MOH informed the team that this is not a constraint to the increased promotion and use of the method in the national program. He stressed, however, the importance of monitoring and documenting the effect of Depo reintroduction on service delivery and contraceptive practice.

The team heard a few complaints from provincial ZNFPC staff about negative attitudes toward Depo Provera among MOH staff and poor cooperation from some provincial pharmacists in ordering supplies of the method. These problems may reflect a lack of information and preparation of these individuals prior to reintroduction rather than opposition to the method itself. Some confusion also remains about guidelines for the use of Depo. Some providers continue to adhere to the guidelines used during the period of restricted use. Client information about the availability of this method is also limited, especially in rural areas. Orientation workshops for providers and other opinion leaders aimed at smoothing the reintroduction of Depo were funded through the World Bank Family Health Project II (FHP II). However, these activities were planned and implemented at the provincial level without technical assistance, guidance, or a strategy from the national level, and the response and impact appears to be mixed.

- 8. RECOMMENDATION: USAID should provide additional funding for Depo Provera reintroduction information efforts, including materials for both staff and clients, as well as funds to document the experience with reintroduction.**

Although the team did not identify any USAID-funded activities in the area of method diversification which should be eliminated, priority can be placed on the efforts related to specific methods—if this is necessary—in developing the PP amendment. These priorities are assigned, taking into consideration such factors as ease of administration, apparent popularity with clients and providers, cost, and other related factors. The recommendations and suggestions related to LT/P methods contained in the sections immediately above should be assigned the following order of priority for USAID funding:

1. Depo Provera
2. Voluntary Surgical Contraception
3. NORPLANT® Implants
4. Intrauterine Devices

### **4.3 Program Sustainability**

#### *4.3.1 Programmatic Impact of GOZ Purchase of Oral Contraceptives*

The MOH appears to have recovered somewhat from the ESAP-driven budgetary constraints of the past several years. The Permanent Secretary described a changed climate and recent success in accessing additional funding through careful and proper accounting and justification of MOH needs and requests. This change bodes well for continued support to the national family planning effort. The team understood the Permanent Secretary to include in this changed situation the support of ZNFPC and the need to uphold GOZ agreements to continue funding an increased proportion of total oral contraceptive needs.

In 1993, the GOZ fulfilled its agreement with USAID to fund and procure 21 percent of the oral contraceptives purchased that year. ZNFPC managed the procurement of these supplies with technical assistance of the FPLM Project. Funds have been made available by the MOH for ZNFPC to procure the agreed-upon 25 percent of oral contraceptives for this year. However, the order, which should have been made in January, has not yet been placed. This may produce a shortfall in the supply of pills toward the end of 1994 unless the order is placed soon.

A similar agreement for the phase out/phase in of funding for condoms is included in the new Overseas Development Administration (ODA) proposal which provides condoms for family planning and AIDS prevention programs. The ODA proposes that the GOZ fund 30 percent of the entire national condom needs by the fifth year of the project. In light of the above developments, the evaluation team sees no reason at present to revise the plan for GOZ procurement of 100 percent of oral contraceptive needs by 1996; however, the team advises an annual review of progress on this issue.

- 9. RECOMMENDATION: USAID and ZNFPC should undertake an annual review of the progress and problems, if any, related to GOZ funding for oral contraceptives at the time orders are placed for these commodities.**

#### *4.3.2 Organizational and Operational Changes in ZNFPC*

At the end of 1991, Management Sciences for Health (MSH), using central USAID funds, assisted ZNFPC to undertake the "Manpower Planning Management Review for the 1991-1996 National Strategy." Due to changes in USAID Office of Population country focus, MSH was unable to use USAID funds to continue assisting ZNFPC in following up on the recommendations made in the 1991 study. The World Bank funded MSH to continue this intervention through an organizational needs assessment completed in early 1993. This study identified and described a number of areas in which the structure and systems of the Council could be improved.

The proposed restructuring has been reviewed and approved by the ZNFPC Board. A related compensation and job grading study, undertaken by Coopers and Lybrand Management Consultants, has also been approved by the Board, subject to certain revisions. A local firm will assist with the introduction and implementation of the results of these two studies. The Danish International Development Agency (DANIDA) will fund this firm to implement an audit of current ZNFPC staff, develop job descriptions, and undertake a market survey of regional and NGO salary scales. An additional study, "Report on Strengthening ZNFPC Accounting Systems and Procedures," including the development of an Accounting Procedures Manual, was undertaken in 1993 by KPMG Peat Marwick. The results of all these assessments present a picture of an organization which needs to give further attention to its overall structure and systems, possibly in conjunction with a thorough review of its operational and programmatic strategies.

DANIDA, through the World Bank FHP II, is providing a technical advisor and other support to the A/F Division of ZNFPC. However, the extent of this support is not entirely clear. Furthermore, DANIDA plans to undertake a full health sector assessment and review of its funding immediately following the present USAID project evaluation. This review may change the nature of Danish support to health and family planning in Zimbabwe.

- 10. RECOMMENDATION: USAID, ZNFPC, and DANIDA should meet soon after the completion of the DANIDA sector assessment to clarify which technical assistance and other activities are currently being funded and which are planned by DANIDA in order to reach an agreement about gaps in management assistance which could be funded by USAID under the amended project.**

The present five-year strategy of the Council, also developed with technical assistance from MSH and with funding from the World Bank, is at a critical juncture in implementation. The organizational restructuring presents an ideal opportunity to review this strategy and to begin planning for a follow-on strategy while, at the same time, planning for related staff development and operating systems and structures in support of the present and future strategies.

The new structure was slated for implementation in December 1993, but it has not been introduced to date. Several other ZNFPC structural and systems issues should be addressed once the restructuring plan is in place. One is the development of a full plan and strategy for decentralization, which has been agreed upon as part of the restructuring, and a plan for related staff development. A second activity, which was initiated with assistance from SEATS and postponed awaiting the outcome of the restructuring activity, is the development of a comprehensive supervisory strategy and a system for its implementation.

**11. RECOMMENDATION: USAID should determine, in collaboration with ZNFPC, the ways in which increased project funds can be utilized to assist with organizational development and management interventions such as**

- **the restructuring process**
- **staff development**
- **strengthening the Council's management capabilities**
- **supporting a review of ZNFPC's strategy**
- **the development of an implementation plan for the remaining years of the ZNFPC's strategy**

Some of these proposed activities have already been budgeted by ZNFPC. Should USAID and ZNFPC agree to USAID funding for any or all of the recommended activities, a budget can be provided by the A/F Division of ZNFPC.

#### **4.4 Private Sector Participation**

##### *4.4.1 Ongoing and Planned Activities*

In the context of this report, the private sector is discussed as the package of activities which was presented in the PP. A brief look at the historical context of this initiative is instructive. In the PP, USAID called for a private sector approach that combined private service provision (social marketing, employment-based services, and mobilization of private physicians) with private financing by medical aid societies. This package of activities was to be implemented with technical assistance provided by various CAs. A private sector unit at ZNFPC was to have one full-time staff person and two local assistants. The latter were to have been funded from the USAID local currency budget.

Efforts in this area have suffered from the lack of a clear strategy, staffing and budgetary limitations, USAID's cancellation and shifting of much of the planned support, and certain policies and practices which discourage private sector participation in family planning. In 1994 a clear and comprehensive strategy to guide the activities in the area of private sector family planning financing is still lacking. Pieces of the originally planned private sector activities have been parceled out to various USAID-funded CAs. The SEATS Project is funding employment-based subprojects and also provides assistance to the Council's training cost recovery efforts. AVSC has provided training in VSC for private doctors. PCS proposes to implement a program of information about and promotion of private practitioner services later this year.

Another constraint to progress in private sector activities concerns the Council's staffing in this area. The two local assistants were never hired. During the period from project inception to the present time, four different people have held the position of Private Sector Coordinator. None of these individuals had any previous experience working with the private sector. There were sometimes gaps of several months before replacement of the Private Sector Coordinator. The current plan, proposed as part of ZNFPC's restructuring, is to move quickly to decentralize all private sector activities to the provinces—where staff has even less private sector experience.

Policies inhibiting greater private sector participation in the family planning program will be addressed in detail by the NPA program to be designed later in 1994. Some of these policies, identified during this evaluation, are discussed in Section 5. All of these factors have had considerable influence on the implementation of the private sector activity components. They should be born in mind as progress to date is assessed and recommendations are considered for the future of each component.

#### *4.4.2 Private Sector Family Planning Financing Initiative*

Given the constraints described above that affected implementation of the private sector portfolio and the tentative nature of recovery as the country slowly moves beyond the economic squeeze of ESAP and the drought, the team believes that USAID should limit itself to the current package of private sector activities. Much remains to be done on these activities; their support over the next four years will take a significant amount of attention and resources. ZNFPC does not have a clear mandate nor does it have the necessary experience or staff allocations to successfully carry out all that needs to be done in this area to ensure that a significant proportion of financing for family planning is taken over by the private sector within a reasonable time frame.

The team envisions the following scenario: These private sector activities should be integrated into one comprehensive private sector family planning financing initiative, implemented by a single agency rather than a number of different CAs. ZNFPC would coordinate the initiative, playing the truly catalytic role envisioned by the Permanent Secretary of the MOH, who is also the Chair of the ZNFPC Board. Implementation of the initiative would be carried out by an external entity with substantial experience in the private sector. A technical advisory committee comprised of ZNFPC management, the implementing contractor, and

representatives of the private sector should be established within ZNFPC to oversee this effort.

Possible candidates for the implementing agency include the following:

- An international contractor with extensive private sector health financing experience and qualifications to provide the technical assistance.
- A local firm under contract to ZNFPC.
- A CA specializing in health finance and private sector medical services development.

If this initiative is successful, these private sector activities should become self-perpetuating within a matter of years—probably within the lifetime of the extended ZFPP—requiring no further technical assistance beyond a specified point in time. The Permanent Secretary indicated that the MOH would have no objection to any of these arrangements, as long as ZNFPC's coordinating role is maintained.

**12. RECOMMENDATION: USAID and ZNFPC should integrate the following activities into one private sector family planning financing initiative under the proposed PP amendment: expansion of medical aid coverage, increased employment-based service availability, and private practitioner mobilization efforts. This initiative should be coordinated by ZNFPC and implemented by an external entity experienced in private sector health care financing.**

To focus and guide an effective design and launch of this package, a substantial amount of formative research should be undertaken. Some of the elements that might be included are

- Desk research on efforts to promote the private sector in other countries.
- Identification and review of medical aid regulations and private practice standards. (This could be included as part of the NPA exercise.)
- The impact on family planning targets of the introduction, increase, and changes in fees charged for all contraceptives.
- Research on the numbers, distribution, and types of services currently provided by private practitioners.
- A review of the impact of training, commodity, and equipment support for LT/P methods on the output of private sector providers.

- Focus group discussions with private clients regarding their satisfaction with services and means to improve them, with potential clients on their attitudes toward services delivered by a nurse-midwife in private practice, and with private doctors regarding their views on the quality of their services and ways to support and improve them.
- Investigation of the potential for private practitioners to lease under-utilized ZNFPC and MOH facilities during evenings, weekends, or other periods when they are not used.
- A review of the cost recovery and sustainability experience of local health entrepreneurs, be they private (Population Services, Zimbabwe) or public (municipalities with cost recovery rates up to 30 percent, compared to 3 percent for the MOH).
- Examination of the potential for micro-enterprise development associated with family planning, such as a women's cooperative to make social marketing packaging and independent mobile condom peddlers, as suggested by Johnson and Johnson.
- A review of the extent to which companies are already providing work-based family planning and ways to improve quality and broaden method mix.

SEATS has indicated an ability and willingness to help with this review; the project has experience in carrying out similar studies in other settings. Several other CAs have such experience including Abt Associates, Deloitte & Touche, The Futures Group, Management Sciences for Health, and University Research Corporation, in addition to local management consulting firms. The final choice of an agency for the sector assessment may also depend on the implementation mechanism chosen for the proposed financing initiative.

**13. RECOMMENDATION: USAID and ZNFPC should fund a baseline needs assessment/constraints analysis as a preliminary step in finalizing the design of the private sector family planning financing initiative.**

#### *4.4.3. Components of the Financing Initiative*

Medical Aid Societies. These health insurance companies have operated in Zimbabwe for many years. The number of workers and dependents covered has steadily increased from approximately 220,000 at independence to more than 500,000 today. Some 30 societies listed in Appendix D serve both public and private sector employees under the umbrella of the National Association of Medical Aid Societies (NAMAS). Covered workers are estimated to be slightly less than 10 percent of those employed in the formal sector. Insurance payments are

deductible as business expenditures, thus encouraging companies to provide coverage for their employees.

When the PP was signed, only the Commercial and Industrial Medical Aid Society (CIMAS) and two small, limited medical aid societies, Railmed and The Engineering Medical Aid Society, reimbursed for family planning services. Under the project, 15 companies were targeted for expansion of coverage. According to the Council's Private Sector Coordinator, 14 companies now include family planning in their benefit package. Since these 14 include all of the largest aid societies, it is estimated that more than 90 percent of total beneficiaries are now covered. The Council should be commended for this high rate of success.

The Council is responsible for negotiating the reimbursement schedule for its clinics with NAMAS on an annual basis. Municipalities and district councils negotiate a separate schedule, as does the Zimbabwe Medical Association (ZIMA) on behalf of all private doctors. The negotiating skills of the Council have improved over the course of the project and the reimbursement rates have become increasingly reflective of the full cost of consultations and commodities. This year's rates are shown for selected services and commodities in Tables 3 and 4 which demonstrate that reimbursements are higher than clinic fees for all except two services. In several instances, reimbursements are substantially higher.

There are several areas for future consolidation and expansion of the insurance component. First, it is very important that the Council continue to develop its capacity to monitor actual service delivery and commodity costs at each of its facilities. As these figures are refined, the results must be fed back into the annual negotiating process with NAMAS. This will ensure that NAMAS member societies cover the full cost of Council services. The Council may even consider trying to negotiate a narrow profit margin for NAMAS beneficiaries to cross-subsidize services for their low-income clients employed in the informal sector.

**14. RECOMMENDATION: The family planning financing initiative should devote some of its resources to designing improved basic financial information systems and conducting comprehensive cost analyses to better support negotiations with medical aid societies for full cost recovery for family planning services provided to insured clients.**

TABLE 3

<b>ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL CHARGES FOR SERVICES–NOVEMBER 1992 AND 1993 AND INSURANCE REIMBURSEMENTS–NOVEMBER 1993</b>			
<i>SERVICES</i>	<i>CLIENT FEE NOVEMBER 1992 (Z\$)</i>	<i>CLIENT FEE NOVEMBER 1993 (Z\$)</i>	<i>CIMAS REIMBURSEMENT TO ZNFPC NOVEMBER 1993 (Z\$)</i>
IUD REMOVAL WITHIN 12 MONTHS FOR NON-MEDICAL REASONS	5.00	6.50	21.00/ 5.00 (MD/nurse)
<b>SUBFERTILITY</b>			
- INITIAL VISIT	10.00	13.00	13.00 (MD)
- SUBSEQUENT VISIT	3.00	3.90	9.00 (MD)
DIAGNOSTIC LAPAROSCOPY	40.00	52.00	52.00 (MD)
CRYOSURGERY	10.00	13.00	unknown
CERVICAL BIOPSY	20.00	26.00	unknown
PREMENSTRUAL BIOPSY	20.00	26.00	unknown
NORPLANT® INSERTION	10.00	13.00	unknown
TL/VASECTOMY PROCEDURE	10.00	13.00	77.00/ 46.00 (TL/vasectomy.)
PREGNANCY TEST	5.00	6.50	13.00
PAP SMEAR	15.00	20.00	20.00
TESTICULAR BIOPSY	20.00	30.00	35.00/ 46.00 (uni/bilat.)
SEMEN ANALYSIS	10.00	13.00	unknown
MINOR SURGERY, E.G., BREAST LUMP EXCISION	10.00	15.00	unknown
<b>BOOKING CLINIC SERVICE</b>			
- FOR DOCTOR	10.00	15.00	13.00
- FOR NURSE	5.00	7.50	6.50

TABLE 4

<b>ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL PRICES FOR DRUGS—NOVEMBER 1992 AND 1993 AND INSURANCE REIMBURSEMENTS—NOVEMBER 1993</b>					
<b>CONTRACEPTIVE</b>	<b>PREVIOUS PRICE (Z\$)</b>	<b>ZNFPC CHARGE TO CLIENTS NOVEMBER 1992 (Z\$)</b>	<b>ZNFPC CHARGE TO PRIVATE DOCTORS NOVEMBER 1993 (Z\$)</b>	<b>ZNFPC CHARGE TO CLIENTS NOVEMBER 1993 (Z\$)</b>	<b>CIMAS REIM- BURSEMENT TO ZNFPC NOVEMBER 1993 (Z\$)</b>
MICRONOR	0.20	1.60	25.00	2.10	19.98
OVERETTE	0.20	0.80	2.10	1.10	3.00
LOFEMENAL	0.20	0.80	2.10	1.10	3.00
TRINORDIOL	0.20	1.60	15.00	2.10	19.00
DEPO PROVERA	0.25	3.00	10.00	4.00	14.90
COPPER T IUD	2.00	5.00	10.00	6.50	30.00
MULTILOAD IUD	2.00	10.00	50.00	13.00	65.00
NORPLANT <sup>®</sup> IMPLANTS	—	80.00	300.00	100.00	171.50*
NEOSAMPOON	1.00/12	2.00	5.00	2.50	5.00
CONDOMS	FREE	0.10	0.10	0.10	N.A.
TUBAL LIGATION	10.00	25.00	—	32.50	77.00**
VASECTOMY	10.00	25.00	—	32.50	46.00

\* Total reimbursement (device plus insertion)

\*\* Total reimbursement for minilaparotomy

Many current insurance beneficiaries are not well informed about the details of their insurance coverage. First, there are some employees and their dependents who do not know that they have the right to be covered by their company. Also, many societies offer several categories of coverage; the premiums and benefits vary for each category. For example, all five of the CIMAS categories cover both family planning consultations and commodities, but this is not true of all medical aid schemes. These issues should be thoroughly investigated and the results disseminated to all public and private family planning service facilities and to the participants of the various schemes.

**15. RECOMMENDATION: The family planning financing initiative should work with NAMAS to ensure that all beneficiaries and service providers are informed of both their rights and responsibilities regarding insurance coverage and the relative benefits of different packages.**

The details of the tax break given to companies for their medical aid premiums should be explored to develop strategies to increase the numbers of formal sector employees covered by insurance. In addition, as indicated above, there is considerable room for growth in the numbers of formal sector employees covered; about 90 percent are not currently enrolled in a medical aid society. There is also room for growth in the family planning impact of coverage. Companies may subsidize the coverage only for their employee, leaving dependents without subsidized coverage. If male employees are unable to afford insuring their spouses, this may limit a household's access to family planning benefits.

The medical aid societies would have to aggressively seek new customers if they wished to substantially expand formal sector coverage. Historically the industry-specific societies have had no real motivation to do this. However, CIMAS recently launched an expansion initiative when it introduced a new, less expensive coverage plan targeted at companies seeking to cover lower income employees.

An important caveat should be noted in regard to the proposed expansion of medical aid coverage. Most medical aid subscribers are served by private practitioners. Therefore, the growth of medical aid membership could expand the market for private health care. Although this seems to be the preferred effect, a substantial brain drain of public sector doctors to the private sector (and to other countries) already exists. If even more doctors are tempted to respond to this hypothetical growth in private demand, it might lead to further deterioration in public sector programs.

Social Marketing. The SOMARC project began to work with a local distributor, Geddes, in 1987 to launch the social marketing of condoms, oral contraceptives, and IUDs. Geddes packaged and distributed these products primarily through pharmacies and to employment-based projects. These activities continued until 1992, when Geddes decided to cease its participation due to concerns about competition with low-cost public sector commodities and the economic slump. A decision was made, also in 1992, to discontinue the full-scale SOMARC intervention

in Zimbabwe when the USAID/Washington (SOMARC II) contract terminated in June 1993. Under its new centrally-funded contract, SOMARC III transferred the marketing responsibility, the remaining condoms, and the Protector condom brand name from Geddes to Johnson & Johnson. A two-year contract for limited technical assistance was signed in September 1993 formalizing this agreement.

Protector condom sales are going well; the balance of the donated product should be sold by mid-1994. SOMARC will provide technical assistance for the upcoming procurement process. J/J is enthusiastic about the prospects of expanding distribution from the "high end" urban pharmacy sales points to the rural areas. J/J attributes the strength of its current position to the product launch assistance provided by SOMARC. This included support for initial advertising that produced strong consumer awareness all the way to rural areas, technical assistance on product pricing, and "financing the learning curve" of developing a new market.

J/J welcomes a continuing, though limited, relationship with SOMARC over the next contract year for specific technical assistance needs, such as procurement of new condoms. However, J/J feels that it will not need another contract with SOMARC. It understands the dynamics of contraceptive product development in Zimbabwe. It is also considering starting a social marketing campaign for its own pills (Trinovum and Micronor) and KY Jelly with nonoxynol 9.

The prime impact of this social marketing intervention has been development of the capacity of a strong local company to participate in the private contraceptive market. The long-term viability of J/J's work in this market is questionable, not because of a lack of interest, motivation, and capacity, but due to the volatility of GOZ policy. The recent decision to provide free condoms in the public sector is a case in point. This will surely hurt the general condom market. On the other hand, J/J's present market segment may not necessarily be swayed from its brand loyalty by the GOZ's Z\$0.10 price change.

It may not be necessary for USAID to support further activities to stimulate private sector sales. The fact that contraceptives are included in the open general import license (OGIL) and that certain tariffs have been removed means that all interested public and private sector parties now have a more level playing field on which to compete. Additional pharmaceutical companies may now be able to respond to the increased demand that will presumably be created by economic recovery and client mobilization activities proposed under this financing initiative. Given the recent pressures to become a more commercial entity, ZNFPC may wish to supply some of this emerging market. USAID's upcoming NPA analysis may consider policies related to private sector procurement and sales of contraceptives which would further promote developments in this area.

Employer-Provided Services. Employer-provided or work-based family planning services were first promoted in 1988 in Zimbabwe, with support from the USAID/Washington-funded Enterprise Project and the newly created Private Sector Coordination Office of the Council. Work-based programs were established in five industries—Lonhro Zimbabwe Ltd., Triangle Ltd., British American Tobacco, the Commercial Farmers Union (CFU), and Hippo Valley Estates. All five have continued or expanded their provision of family planning services, even after the Enterprise Project ended in 1991.

The work-based initiative was strongly influenced by the 1991 economic slump and also by confusion in implementation that has characterized all private sector activities. In the 1992 USAID reorganization of the CA component of the PP, the employer-provided activities were removed from SEATS' responsibility. SEATS was later allowed to respond to Union Carbide's interest in starting a small-scale subproject in five of its locations and began subproject support in 1993. Over the last two years, various SEATS staff persons, from the IEC expert to the medical advisor, have been in charge of this activity. The staff's level of previous experience with the private sector is unknown. As noted above, ZNFPC staff turnover and the staff's relative lack of private sector experience has also affected this initiative.

Several environmental factors have influenced the potential for the transfer of social services, including primary health care, for at least a segment of the population from public to the private sector in Zimbabwe. After independence, the government took primary responsibility for social services. Tax rates were high, justified in part by the need to provide these public services. The government has recently begun to re-evaluate its role, but is still hesitant about entrusting social sector activities to the private sector. At the same time, the private sector has continued to resist taking responsibility for providing social services given the high taxes it pays. Even though corporate tax rates have decreased from 60 percent to 45 percent in recent years, industry still feels that it is up to the government to provide services for its citizens.

Another limiting factor has been the lack of government incentives, primarily in the form of tax breaks given to companies that provide on-site health services. As recommended in Section 5, USAID should investigate the potential to influence legislative and/or policy changes regarding industry's responsibility for employee health care through the upcoming NPA exercise.

A third and key practical constraint that has impeded this initiative is the policy regarding participating companies' procurement of contraceptive supplies. Initially, some companies participating in Enterprise-funded activities received free contraceptives. This policy changed in 1990 when companies were obliged to buy their contraceptives commercially or through the social marketing project. Then, during the recent economic downturn, this policy softened and former Enterprise Project companies were, and still are, allowed to purchase contraceptives from ZNFPC. However, the new policy, readopted under the SEATS-assisted subproject with Union Carbide, stipulates that the grantee must purchase its commodities from Geddes, J/J, or other commercial suppliers. This may be one of the reasons that only one company is participating in the SEATS-assisted subproject.

If companies could continue to purchase from ZNFPC, rather than being forced to undertake their own procurement of relatively small amounts of imported product with all the bureaucratic requirements that entails, two important objectives would be achieved. First, more companies would probably be interested in participating in this program during the interim period as Zimbabwe's economy continues to recover. More importantly, this fits very well with attempts to increase the financial sustainability of the Council. If self-sufficiency is a future goal for ZNFPC, one of its profit centers with the greatest potential is contraceptive sales to companies and/or private doctors at unsubsidized prices. Donor regulations would have to be followed in this regard.

**16. RECOMMENDATION: The family planning financing initiative should assist ZNFPC to develop a mechanism whereby work-based programs could procure their contraceptive supplies from the Council at full cost.**

Current tensions between the GOZ and commercial farmers are reported in the print media and were noted in several evaluation interviews. Political problems related to land reform policy have created an environment of suspicion, concern, and in some areas, outright hostility on the part of farmers toward government programs. Thus, it would seem unwise for ZNFPC to expand its plantation-based activities in the short run in spite of the attractiveness of the total numbers of people involved.

However, to protect current investments, ongoing activities with the CFU in Makoni District should continue to be supported with technical assistance and supervision. Meetings of the ZNFPC-sponsored private sector coordination committee should be convened on a more regular basis to provide moral support and networking opportunities to the limited remaining plantation-based efforts. The same recommendation of continued contact applies to the other former Enterprise subproject grantees.

An issue for further investigation is the importance of size of workforce on the sustainability of a company program. Three of the five initial Enterprise-funded sites had over 5,000 workers. Enterprise evaluations note the importance of this factor. However, the current ZNFPC criterion requires a company to have at least 1000 workers to participate in employer-based programs. Perhaps more study should be given to the threshold level of workers needed to influence program success.

An approach to reinvigorating the activities of this component might be to conduct a retrospective cost analysis at one of the original Enterprise subproject companies to determine if actual cost savings and impact have been substantial. This approach was used to good effect in the Philippines where the findings of a cost study were surprising—even to the company. As a result, company management chose to increase its investments in primary health care activities. If the results of such an analysis in Zimbabwe were also positive, their dissemination could help to motivate both the company under investigation as well as other businesses. The impact would be even greater if the economic recovery continues, thus encouraging companies to extend the frame of reference for their financial analyses beyond short-term survival.

**17. RECOMMENDATION: The family planning financing initiative should continue support for ongoing work-based services and explore new efforts with additional companies.**

Finally, the Council should enter discussions with the National AIDS Coordination Program (NACP) regarding its work-based AIDS efforts. The cost implications of the HIV/AIDS epidemic are immediately evident to managers—so much so that employers have approached NACP to request assistance. The Council should continue its cooperation with NACP, to ensure that messages and programs developed for the workplace have a strong reproductive health slant and that they include awareness of and support for comprehensive services, including family planning.

Mobilization of Private Practitioners. There are approximately 1,200 physicians currently practicing in Zimbabwe, two-thirds of whom are estimated to be in private practice. Until very recently, Zimbabwe has experienced significant migration of physicians, both from the public into the private sector and from Zimbabwe to neighboring countries. They are responding, as one of our interlocutors put it, to the following motivation: "Cross the Limpopo River (border with South Africa) and multiply your salary by three, cross the street (into private practice), and it increases by five."

The private medical sector in Zimbabwe is substantial and dynamic, thus constituting a promising, and as yet relatively untapped, environment for this component of the family planning financing package. There are indications among this group of a fairly high level of interest in providing family planning services. The ZNFPC Private Sector Coordinator attended a recent meeting of the Harare College of Primary Care Physicians. When she announced that training opportunities in VSC were available, 24 doctors signed up on the spot.

Of the four basic PP elements of the private sector approach, mobilization of private practitioners has received the least emphasis to date. It was only late last year when the Council, in collaboration with AVSC, began to include private sector physician/nurse teams in its VSC training sessions. Six teams have been trained thus far, with 12 more scheduled over the next year-and-a-half.

The Council is now considering a PCS proposal to provide IEC support to AVSC-assisted ZNFPC training for private practitioners. The PCS proposal emphasizes creating client demand for privately provided services. Objectives include increasing private clients by 20 percent and enhancing the image of private physicians as providers of high-quality LT/P methods. This demand creation emphasis is necessary and encouraged. The project will also need to devise mechanisms to monitor and support service quality in the early years after training.

One way to maintain contact with private practitioners would be to offer continuing education seminars on such topics as the means to monitor and improve client satisfaction, contraceptive updates, and improved office management techniques. A second way to ensure contact and continuous reporting of statistics is to allow the private practitioners trained by ZNFPC to buy their contraceptives from the Council, at an unsubsidized price, i.e., full cost plus a small profit margin. They would only be allowed to purchase from the Council if they submitted their service statistics. The Council has already established a two-tiered fee structure that allows for limited procurement by private physicians. (See ZNFPC prices in Table 4.)

**18. RECOMMENDATION:** The development and implementation of a more comprehensive private physician activity should be continued under the auspices of the family planning financing initiative. This activity should include training in all family planning methods, creation of client demand for private services, and monitoring and support of quality of care among trained physicians.

## **4.5 Procurement and Local Support**

### *4.5.1 Vehicle Procurement*

The PP included US\$1.2 million for the purchase of vehicles, approximately 75 percent of which had been disbursed as of this evaluation. Fifty-six vehicles have arrived in-country to date; 39 have been registered. The remaining 17 arrived within the past six months and are currently being held at ZNFPC headquarters pending registration. Eleven vehicles have been distributed among units at the central level, and 28 are in use by provincial staff, primarily for supervision purposes. The team notes that the cars have been well distributed, both among the different provinces and among programs.

The team had the opportunity to directly observe vehicle control at headquarters and in one province and to review the vehicle distribution list. In numerous interviews with project staff, lack of vehicles was never mentioned as a program constraint. In addition, the USAID-financed car stock is quite new, appears to be very stringently controlled, and thus will certainly last through 1998, given the good roads and maintenance procedures in Zimbabwe. Therefore it appears that the project will not need to procure additional vehicles.

### *4.5.2 Contraceptive Procurement*

The Mission has ordered and the Council has received the scheduled US\$4.4 million of oral contraceptives for 1994. USAID/Washington shipments valued at US\$1.75 million will continue to arrive in-country through February 1995. The team sees no major problems regarding the routine forecasting, procurement, handling, and distribution of oral contraceptives. The Council is experienced in all of these areas except procurement. ZNFPC seems to be ably assisted in procurement by the FPLM Project. During the field trip, the team saw no evidence of stock-outs or misuse of oral contraceptive stocks.

The only potential problem in this area is the difficulty ZNFPC seems to be having in recruiting an experienced Logistics Manager. This is an essential post that should be filled as soon as possible. Sustainability in the commodity procurement and logistics function depends on an adequately staffed and trained commodity unit.

The demand for Depo Provera is strong and growing. UNFPA is scheduled to provide 120,000 doses per year under its current project through 1995. According to FPLM contraceptive

estimates from August 1993, there should be adequate stocks of Depo Provera through 1995, but forecasting is difficult due to the lack of historical data. ZNFPC and UNFPA should closely monitor the results of the upcoming DHS and Depo distribution data to revise forecasts as necessary. In the case that UNFPA-funded stocks are insufficient and its funding cannot be increased in the short run, USAID is urged to reserve some funds for Depo Provera during the period 1996-98.

The team supports the proposed private sector physician training, particularly in NORPLANT<sup>®</sup> and VSC, and suggests that sessional doctors in the Council's urban booking and walk-in clinics also be trained to provide NORPLANT<sup>®</sup>. The team believes there is a need for USAID support for this effort through the amended project. The specific number of physicians and the training approach to be taken will be finalized in the coming months; however, the following assumptions have been used to estimate the number of NORPLANT<sup>®</sup> sets needed to support this effort: About 35 private physicians and a similar number of ZNFPC providers will be trained in the period 1995-97. Training requirements for NORPLANT<sup>®</sup> sets will be approximately 750, plus 70 insertion equipment sets. Estimates of potential client demand for NORPLANT<sup>®</sup> are based on numbers given in the ZNFPC NORPLANT<sup>®</sup> training proposal of approximately 20,000 potential users by the year 1998. If two-thirds of these clients obtain services from ZNFPC or from Council-trained private practitioners, ZNFPC will need to supply 13,000 NORPLANT<sup>®</sup> sets.

The team suggests that USAID supply the 750 training sets and an initial stock of 6,000 sets to satisfy consumer demand in the early stages of this activity. We concur with the arrangement already discussed by USAID and ZNFPC whereby the initial stock would be sold by ZNFPC to establish a revolving fund for future procurement of NORPLANT<sup>®</sup>. Private physicians participating in the program would purchase their supplies from ZNFPC at the full cost price. Similarly, Council clinics would charge their clients based on the full cost price. Thus, after the initial USAID-donated stock is exhausted, ZNFPC would have the means necessary to be self-sufficient in NORPLANT<sup>®</sup> procurement.

USAID has already ordered 2,000 NORPLANT<sup>®</sup> sets which will arrive this year. An additional 4,750 should thus be ordered soon after project amendment. If USAID/Washington establishes a multi-year contract for the purchase of NORPLANT<sup>®</sup> at the current price of US\$23, this would imply the need for an additional US\$110,000 for NORPLANT<sup>®</sup> procurement in the amended project.

#### *4.5.3 The Use of Local Currency Support*

The PP proposed that local currency support be used for limited-duration contracts with locally recruited individuals to supplement existing ZNFPC staff, printing materials, and training support costs. These funds were to be disbursed to and managed by ZNFPC. The PP contains an illustrative budget of US\$2.24 million for local currency expenses. To date, the use of local currency funds appears to have lagged behind other centrally-funded and foreign exchange expenses. By the end of 1993, approximately US\$450,000 in local currency expenses had been claimed by ZNFPC and US\$360,000 had been liquidated. The balance between these two figures represents disallowed or ineligible expenditures. Several

explanations are given for this slow rate of expenditure. First, the system originally required that advances be obtained. This procedure was found to be too cumbersome for ZNFPC management and may have discouraged the use of these funds. In December 1993 USAID and ZNFPC agreed to operate on a local currency reimbursement basis. This new arrangement has not been in effect long enough to test its effectiveness. However, ZNFPC's past delays in reporting to USAID cause some concern that the new system may tie up ZNFPC's liquid funds which may be needed for other uses.

The CAs report that obtaining local currency for sanctioned uses under the USAID PP from the ZNFPC financial system is complex and time consuming. Their counterparts in ZNFPC often apply to the CAs to fund project needs, such as printing materials or the purchase of other supplies, rather than going through the established channels to obtain these funds from ZNFPC. Solutions to this situation must be worked out as soon as possible to ensure that USAID-funded project activities are not held up unnecessarily and that progress on the ZNFPC strategy is not adversely affected.

The Council has been slow to furnish expenditure reports backed up by adequate receipts to USAID. This may be due to miscommunication between USAID and ZNFPC regarding the exact requirements for these reports. These problems are being reconciled. Nonetheless, many of the proposed new or continued activities in this report depend on local currency expenditures. The accounting system at ZNFPC makes it difficult to determine exactly how much of the local currency budget proposed in the PP has been expended and on which budget items. The evaluation team found that certain budget line items have not been touched at all. These include the following:

ZNFPC tutors (6 were to be funded)	US\$224,000
ZNFPC private sector staff persons (2 were to be funded)	120,000
Local consultants for ERU	90,000
Miscellaneous study costs	36,000
Cost recovery studies	<u>100,000</u>
<b>TOTAL</b>	<b>US\$570,000</b>

The unit heads who are implementing activities that were to be funded through the USAID local currency budget are not fully informed about the availability of these funds. When the PP amendment is developed, the USAID Family Planning Project Administrator and the ZNFPC Executive Director should meet with unit heads to brief them on the availability of local currency funds and to identify their needs for these funds before the budget is revised and finalized.

In the absence of complete financial information about expenditures to date, it is difficult to determine which activities included in the original local currency budget should be excluded and which should be expanded in the PP amendment. The evaluation team identified several

items or activities requiring local currency which seem to be held up due to inadequate funding. The following might be included in the amended budget:

- Reagents for GTI testing, training for which was centrally-funded.
- Contraceptive technology updates, including quality of care and LT/P method information, for service providers and other interested parties, e.g., Provincial Medical Directors and Pharmacists and District Medical and Nursing Officers.
- Certain items of equipment whose absence is hampering program progress and management, e.g., computers for improved accounting and enhanced evaluation and research capacity and other office equipment. (See Appendix E for an initial estimate of requirements in this area.)
- The activities recommended under the family planning financing initiative outlined in Section 4.
- Research studies enumerated in Sections 4.8.1 and 4.8.2.
- Adolescent reproductive health activities outlined in Section 4.8.3.

The situation discussed above regarding accountability for USAID funding indicates the need to take immediate action on this front. To ensure complete and timely reporting of local currency expenditures and to assist with the development of an accounting system which will meet USAID's reporting needs, ZNFPC should not await the conclusion of the DANIDA-assisted overhaul and computerization of the Finance and Accounting Unit of ZNFPC.

**19. RECOMMENDATION: Using the USAID local currency budget, ZNFPC should contract immediately with a local accounting firm for consulting services to improve financial management and reporting systems to meet USAID's immediate needs for complete and comprehensive financial reports. If requested by ZNFPC, this activity should be expanded to serve the Council's needs to report on other donor contributions.**

It would be most efficient for the same accounting firm which carried out the assessment of ZNFPC's A/F Division to provide these services since it is already familiar with the Division's needs.

## 4.6 Technical Assistance

### 4.6.1 CA Contributions to Project Goals

The USAID-funded CAs currently providing assistance in the ZFPP are performing admirably and their technical assistance is appreciated by the management of ZNFPC. Table 5 indicates the CA assistance being provided in Zimbabwe according to the areas of project intervention. On the whole, CAs are more involved with method diversification activities than with activities addressing private sector and/or sustainability efforts. All six of the actively participating CAs are providing some inputs to the former project component.

**TABLE 5**

<b>CURRENT AREAS OF EMPHASIS AMONG USAID-FUNDED CAs IN ZIMBABWE</b>	
<b>PROJECT COMPONENT</b>	<b>USAID COOPERATING AGENCY</b>
<b>I. DIVERSIFICATION OF METHODS</b>	
Promotion	PCS, SEATS
Training	AVSC, JHPIEGO, SEATS
Service Delivery	AVSC, JHPIEGO
Evaluation and Research	SEATS, Macro
Contraceptive Logistics Management	FPLM
<b>II. PRIVATE SECTOR</b>	
Social Marketing	SOMARC*
Employer Services	SEATS*
Private Physicians	AVSC*, PCS (Proposed)
Insurance Reimbursement	SEATS*
Corporate Contributions	—
<b>III. COORDINATION/ SUSTAINABILITY</b>	
Cost Recovery Studies	—

\*Indicates limited assistance

Source: Project Paper Table 11.4, modified.

A certain degree of overlap in CA activities is evident from the table and even more on the ground. For example, three CAs (AVSC, SEATS, and JHPIEGO) are involved with service

delivery and training. The evaluation found that these three agencies collaborate through meetings in Harare when representatives of the two non-resident CAs (AVSC and JHPIEGO) make site visits. However, who "gets credit" or reports the statistics for the procedures performed by individuals trained by one CA but receiving ongoing support from another is a concern to the CAs. Whether the ZNFPC units responsible for training and service delivery are adequately coordinating the work of these three CAs is not completely clear. However, both units commend and generally value the assistance provided by the CAs.

In the private sector and sustainability areas, the overall input of CAs has been far more limited. ZNFPC has achieved a considerable amount of success on its own, with limited CA assistance in the area of cost recovery and organizational sustainability, as noted in Section 3.2. However, more could be done in this area with increased CA assistance. ZNFPC's work with the private sector, however, has been less successful. This situation was exacerbated by the USAID decision to withdraw some of the CA support to this component. Staff availability and skills to deal with the private sector are lacking within ZNFPC, and staff allocations to this area are unlikely to increase in the short run. As a result, ZNFPC appears to have placed priority attention elsewhere. This raises questions about whether ZNFPC is the appropriate agency to play the lead role in the development of and support for private sector participation in the national family planning program, given its emphasis on other activities and staff limitations. This is the genesis of the recommendations made to increase private sector family planning financing activities through an external implementing body as noted in Section 4.4.

The evaluation team notes that a number of CA-assisted activities have been delayed or left incomplete. Individual ZNFPC support unit heads indicated a lack of clarity about the terms of agreement with some of the CAs. This appears to be a particular problem with regard to "open-ended" technical assistance provided by CAs as opposed to specified subproject activities. This confusion may be a major cause of delays in completing some CA-assisted activities. Another cause for delays in CA-implemented activities may be the difficulty in obtaining USAID local currency funding through the ZNFPC system, as noted above. Structural and staff changes within ZNFPC have also led to delayed or incomplete implementation of several activities.

Several examples of delayed or discontinued activities are drawn from ZNFPC's work with SEATS. Possibly because this CA has resident staff in Zimbabwe and is providing a greater variety of technical assistance than the other CAs, it was cited more often as the CA involved with delayed or incomplete assistance. For example, SEATS' assistance with the development of a strategy to work with medical aid societies was discontinued when the previous Private Sector Coordinator left the Council, and this issue has not been taken up with the new Coordinator. According to the Training Unit, the SEATS activity related to fixing fees for training activities is on hold, although SEATS staff is of the opinion it is awaiting further information from the Training Unit to complete this task. SEATS' assistance with the development of a supervisory strategy was put on hold until ZNFPC restructuring is completed. These examples point out the need for ZNFPC to negotiate clear agreements for "open-ended" technical assistance of the type being provided by SEATS. ZNFPC finds the more structured type of subproject agreements being implemented by other, non-resident CAs are run more smoothly.

#### 4.6.2 *The Continued Role for CAs*

The use of CAs is one of USAID's most effective means of assisting ZNFPC, as is the case in most USAID bilateral population projects worldwide. The CA mechanism, as utilized successfully for several decades by the Office of Population, is one of the reasons that USAID-funded population projects are generally judged—by donors and recipients alike—to be among the most efficient and effective donor-supported population efforts in the world. This was confirmed by the ZNFPC Executive Director and the other family planning donors in Zimbabwe.

ZNFPC feels over stretched and underserved by expatriate resident technical advisors—those individuals provided to the Council as part of other donors' contributions to the national family planning program. These advisors come with too many strings attached and generally do not make a significant contribution to the program, according to ZNFPC management. On the other hand, the Council is not opposed to the use of local consultants on an as-needed basis, if appropriate skills are available in-country. For instance, ZNFPC is currently liaising with Blair Research Institute which is undertaking a WHO-funded study on adolescent sexuality. ZNFPC also has a contract with a member of the faculty of the University of Zimbabwe to collect background information to assist in the development of a strategy for serving youth. ZNFPC is also agreeable to the possibility of USAID providing funding for a local accounting firm to provide consulting services related to improving financial management and reporting systems, as discussed in Section 4.5. The GOZ and ZNFPC also support and openly welcome the recommendation for an external entity (CA or local firm) to take over implementation of the limited-term family planning financing initiative described in Section 4.4.

Table 6 indicates the evaluation team's suggestions for ongoing CA assistance. These suggestions are made to streamline activities, to assign CAs those tasks for which they are best prepared, and to avoid overlap between CAs.

In keeping with the discussion in this section, the previous section, the ongoing needs of the national family planning program, and USAID and ZNFPC strategies, the evaluation team recommends continued CA involvement in ZNFPC.

**20. RECOMMENDATION: Continued USAID support for a combination of USAID/Washington-funded CAs, buy-ins or add-ons to CAs, and local consultants is recommended to supplement and complement the activities under the ZFPP carried out by ZNFPC directly.**

**TABLE 6**

<b>FUTURE AREAS OF EMPHASIS AMONG USAID-FUNDED CAs IN ZIMBABWE</b>	
<b>PROJECT COMPONENT</b>	<b>USAID COOPERATING AGENCY</b>
<b>I. DIVERSIFICATION OF METHODS</b>	
Promotion	PCS
Training	AVSC (in-service) JHPIEGO (pre-service)
Service Delivery	SEATS <sup>1</sup> or Pathfinder
Evaluation and Research	Macro <sup>2</sup>
Contraceptive Logistics Management	FPLM <sup>3</sup>
<b>II. PRIVATE SECTOR</b>	
Social Marketing	SOMARC <sup>4</sup>
Employer Services	(These three categories of assistance are to be undertaken by one contractor)
Private Physicians	
Insurance Reimbursement	
<b>III. COORDINATION/ SUSTAINABILITY</b>	
Cost	(This activity is included in the proposed financing initiative)

<sup>1</sup>SEATS' central agreement will end soon; its successor may be considered for this activity if it has a similar mandate to assist with service delivery activities.

<sup>2</sup>Macro or its successor project will assist with the 1998 DHS. Other evaluation and research activities may be implemented by local firms or by the Population Council, especially for operations research.

<sup>3</sup>FPLM assistance may be required for several more years until ZNFPC'S logistics staff vacancies are filled, the staff trained, and pill procurement skills are fully developed. ODA plans to provide technical assistance in the area of condom procurement in their next project.

<sup>4</sup>This limited assistance to Johnson & Johnson should continue only until the termination of the current contract in mid-1995.

## 4.7 Donor Coordination

Donor coordination in Zimbabwe, as elsewhere, is an elusive objective. According to the donors, ZNFPC is supposed to have responsibility for coordination of the population donors, but this has been delegated, by mutual agreement, to UNFPA. Meetings of the donors are held periodically, but these meetings seem to be primarily for the purpose of crisis management. For example, budgetary shortfalls or commodity stock-outs seem to be on the agenda of these infrequent meetings more often than not. ZNFPC management is of the opinion that donors give lip service to coordination and follow any discussion of coordination by doing exactly what they did before the discussion. ZNFPC staff feels the need to meet with all donors together at least once a year. The donors, on the other hand, feel that coordination and encouragement of donor meetings is not felt by the GOZ and ZNFPC to be in their own best interest and thus is not encouraged.

The World Bank does not have a resident project manager in Zimbabwe. The Washington-based manager calls on the other major donors when he is in-country several times each year and communicates through USAID or UNFPA desk officers in the U.S. at other times. The allocation of project activities to the various donors as outlined in the project description of the PP still applies. Implementation of the respective donor projects appears to be moving forward in tandem, even though there is a certain amount of slippage in timing for some activities.

The evaluation team heard several examples of actions undertaken in one donor's project affecting those of another donor. For instance, the FHP II (World Bank) project procurement process was cited as holding up project activities being funded by USAID and DANIDA, such as the purchase of computers needed by the A/F Division and the ERU of ZNFPC. Also the delayed delivery of mobile clinic units funded by FHP II has led to staffing problems for these units due to ESAP-related hiring freezes and budget shortfalls.

By agreement with the other donors, USAID was the only donor initially committed to addressing the private sector aspect of national family planning program sustainability. The subsequent cancellation or elimination of many of the plans for support to this sector has left a gap in support of this program element. Recommendations elsewhere in this report deal with possible solutions to this problem for USAID's consideration.

**21. RECOMMENDATION: The Council should call coordination meetings of the family planning donors at least annually to improve communication among donors and between the donors and ZNFPC management and professional staff. These meeting could assist in identifying gaps and other program issues before they become major problems and in forging joint solutions. Funding for these meetings should be shared among the donors.**

## **4.8. Other Areas of Concern or Interest**

### *4.8.1 Other Areas for Research*

In addition to those mentioned elsewhere in relation to specific topics, the following areas are suggested as those requiring further research. These were identified because they have bearing on increased contraceptive prevalence and/or long-term sustainability of the program. They are presented in priority order.

1. The acceptability, accessibility, and use of Depo Provera among providers, users, and policy-makers in family planning and the wider public.
2. Study of ZNFPC's youth-related activities and services and how these relate to reproductive health and other youth needs.
3. Study of condom use (i.e., use patterns, sources of supply, free condoms versus a small fee, and influence of a fee on actual use).
4. Baseline study prior to widespread integration of STD/GTI diagnosis and treatment into family planning services (to include provider and user attitudes and knowledge).
5. Follow-up of the Zimbabwe Family Planning Situation Analysis in 1996 at the end of the ZNFPC strategy implementation.
6. Study of the effects of spousal separation on fertility regulation, contraceptive use patterns, and methods used.
7. New brand introduction strategies for family planning products and services to enhance public awareness of the products and services as well as their continued use.
8. Study of the effectiveness and efficiency of all modes of ZNFPC service delivery, including services which are co-located in MOH facilities, booking and walk-in clinics, mobile clinics, and CBD. This research should also assess client preferences for location of services and times of operation.

An additional priority research topic—the improved use of contraception—is discussed in the next section. A recommendation is made to undertake studies of use effectiveness of pills and of continuation rates for all methods.

Project response to future research priorities will depend on the methods and procedures laid down for disbursing funds set out for this purpose. If these are fairly simple and straightforward, then finding individuals or research firms to undertake such research should be simple. Also, the computing capacity of the ZNFPC's Evaluation and Research Unit needs to be strengthened through the acquisition of more modern multi-user systems and user-friendly software. The installation of an electronic computer network would enable the ERU to search literature and other databases outside the country, especially for methodology,

references, and technical assistance in relation to its research efforts, as well as access remote technical assistance.

If the ERU is overloaded, subcontracting is an acceptable alternative, especially for short-term and special needs research. This would free the ERU to attend to the ongoing studies and data collection essential for management of the organization and in support of its management needs. It is recommended that ERU, together with other ZNFPC units, be assisted to develop and maintain a computerized database of companies and researchers with proven track records of providing services to ZNFPC. These individuals and companies could then be used as subcontractors, depending on the size and scale of the projects or research tasks to be undertaken. The University of Zimbabwe is a good source of individual researchers, especially the Departments of Community Medicine and Geography and the Population Studies Unit of the Sociology Department.

#### *4.8.2 Improved Use of Contraception*

As far as the evaluation team was able to determine, there are no concerted efforts being made to address the issue of improved use of contraceptives. There are a few examples of studies undertaken to investigate aspects of this issue. For example, a study of the optimal timing of introduction of progestin-only pills is in process with assistance from Family Health International. Also a regional workshop was held recently in Zimbabwe on the subject of reducing medical barriers to contraceptive use. The latter was sponsored by ZNFPC and various USAID-supported projects, including JHPIEGO.

Given the discrepancies in Zimbabwe between the CPR and the TFR, it would seem that more should be done to improve contraceptive use. Since oral contraceptives predominate as the method of choice, special research attention is required to determine the use effectiveness of this method. The 1988 DHS examined, in a limited way, pill use compliance. Findings reveal that 21 percent of pill-users reported they had interrupted use at least once in the previous month. Nearly two-thirds (63 percent) indicated they had forgotten to take one or more pills at least once during their pill-using career. Of this latter group, only about one-half indicated they had taken appropriate preventive action after discovering they had forgotten the pill. The balance ran the risk of conceiving due to poor user compliance and lack of knowledge of remedial action.

Low continuation rates of all methods could also produce an unexpectedly high TFR. ZNFPC and the Population Council undertook "The Zimbabwe Community Based Distribution Validation Study" to look at aspects of CBD performance including continuation rates of CBD-supplied oral contraceptive clients. This study focused on the years 1987-89 and found very low continuation rates among the group of users studied. Thus, these two areas—pill use effectiveness and continuation of all methods—are priorities for research. They are closely related issues and could be covered in the same research study.

**22. RECOMMENDATION: A study should be undertaken by ZNFPC or a research organization subcontracted by the Council to investigate contraceptive use effectiveness (especially of oral contraceptives) and continuation studies, particularly reasons for discontinuation and correlates of failure, for all methods.**

#### *4.8.3 Adolescent Reproductive Health Needs*

The Permanent Secretary of the MOH indicated an increased interest on the part of the MOH and ZNFPC in providing for adolescent reproductive health needs. This interest was echoed by ZNFPC which has several activities underway to begin addressing this issue. At least three other donors have expressed interest in assisting ZNFPC with limited funding in the area of adolescent reproductive health. These donors are the following:

- German Technical Assistance (GTZ), which is supporting documentation of needs and issues.
- The Rockefeller Foundation, which is funding demonstration service projects.
- Johns Hopkins University-PCS, which is providing IEC assistance in support of the Rockefeller-funded activities.

The GTZ-funded desk study reviews all literature on youth-related research and included a survey of organizations involved in providing services for youth. It found that a number of NGOs and churches were in the forefront of providing services to youth, such as counseling, career guidance, crafts, and skills or vocational training. The study recommended that ZNFPC should buy into some of these programs to piggyback its family life messages onto them. This recommendation recognized the Council's limited success in working with youth in schools and even less with those who are out of school. The latter are difficult to locate and, at times, can only be reached through NGOs, church groups, and peer counseling programs which operate mostly on a very localized scale.

USAID's increased support of youth services would contribute to reduced fertility by disseminating information about small family and safe motherhood advantages to adolescents before they begin childbearing. Delayed childbearing often leads to reduced overall fertility. Also, contraceptive prevalence would be increased through providing services to greater numbers of sexually active youth. USAID funding could contribute to ZNFPC's developing strategy to serve youth in four ways:

- Assist ZNFPC to fully define its strategy and coordinate the activities of donors which have begun to work in this field. This could include strengthening the integrated approach to reproductive health, i.e., treating STDs at the same time family planning services are provided for sexually active youth.

- Assist ZNFPC to join with NGO/church-related activities in order to reach out-of-school youth. Since most of these NGOs and churches already have their own centers and trainers, this could significantly reduce the cost of providing services at single purpose centers built by ZNFPC. The Council could assist with reproductive health training for the NGO trainers.
- Assist in meeting the adolescent fertility challenge through advocating policy reform to increase access to contraceptives for youth.
- Provide funds for study tours to visit successful adolescent reproductive health programs in other countries.

**23. RECOMMENDATION: USAID should fund new ZNFPC activities designed to address the issue of youth sexuality, including assistance in the design and funding of family planning and reproductive health services for youth, in the amended project.**

#### 4.8.4 HIV/AIDS

The threat of HIV infection is very real in Zimbabwe with approximately 800,000 to one million individuals infected with HIV and approximately 20,000 deaths attributed to acquired immune deficiency syndrome (AIDS) overall. USAID and the GOZ recently signed an agreement for the support of HIV/AIDS prevention and treatment activities in Zimbabwe. A new World Bank project, the Sexually Transmitted Infections Project, is also being negotiated with the GOZ. This project is expected to include considerable amounts of funding for HIV/AIDS activities. Therefore, it is doubtful that the amended ZFPF will need to include additional funding for work in this area. However, several ongoing activities may need to be reconsidered in light of the growing HIV/AIDS epidemic.

The well-documented fear among Zimbabwe family planning providers of contracting HIV should come as no surprise. The expansion of LT/P methods, especially IUDs, NORPLANT<sup>®</sup>, and VSC, depends upon allaying these providers' fears regarding HIV. These fears could be overcome through the continued training and retraining of service providers. As new technologies and better methods of protection from HIV become available, providers should receive such information as quickly as possible.

## 4.9 CPSP and Project Indicators

### 4.9.1 Project Inputs

The ZFPF inputs originally planned by USAID, as outlined in the PP (Annex II.A), are summarized in Table 7. More than half of the central and over two-thirds of the bilateral inputs were planned to address the method diversification component of the project. Less than 10

percent of funding was originally indicated for support to the project components aimed at enhancement of private sector involvement and improved program continuation/sustainability. The centrally-funded activities originally planned to address the private sector contribution to sustainability of the national program were affected by USAID decisions to reduce CA involvement with this sector. Since USAID is the sole donor contributing to this component of the national family planning program (see PP Annex II.B), it should come as little surprise that there has been limited impact on this component. Therefore, it is doubtful that the private sector participation aspect of the CPSP Strategic Objective 3 will be achieved without dedicating increased and enhanced technical and financial inputs to this project component. Specific recommendations in this regard are covered elsewhere (see Section 4.4).

**TABLE 7**

<b>PLANNED USAID CENTRAL AND BILATERAL INPUTS TO ZFPP</b>						
<b>(US\$000 AND PERCENT OF TOTAL)</b>						
<b>INPUTS</b>	<b>CENTRAL</b>		<b>BILATERAL</b>		<b>TOTAL</b>	
<b>METHOD DIVERSIFICATION</b>	\$3,471	55.0%	\$6,478	68.9%	\$9,949	63.3%
<b>PRIVATE SECTOR</b>	745	11.8%	166	1.8%	911	5.8%
<b>CONTINUATION/ SUSTAINABILITY</b>	205	3.2%	300	3.2%	505	3.2%
<b>OTHER</b>	1,891*	30.0%	2,456	26.1%	4,347	27.7%
<b>TOTAL</b>	<b>\$6,312</b>	<b>100%</b>	<b>\$9,400</b>	<b>100%</b>	<b>\$15,712</b>	<b>100%</b>

\* The centrally-funded "other" input category was planned for support of the Project Administrator. This plan was later changed and the position was funded through a combination of operating year budget (OYB) and bilateral funds.

#### *4.9.2 Increased Prevalence and Use of LT/P Methods*

According to the Executive Director of ZNFPC, there is high demand for long-term methods. This was confirmed during clinic visits and in discussions with providers. However, some of this demand remains unmet because certain LT/P methods cannot be provided by persons below the level of a physician. Such policies need to be changed if a more balanced and effective method mix is to be sustained. A broader range of providers should be trained in VSC and in IUD and NORPLANT® insertion. Nurses must be given a broader role as independent providers of family planning services.

If the above policy changes are implemented, it is most probable that modern method use will increase to the original PP target of 50 percent given the proposed extension of the project. The use of modern methods has increased from 36 percent in 1988 to a current level of about 43 percent according to the 1993 Family Planning Program Monitoring and Evaluation System (FPPMES). It would seem that, with the increased IEC activities currently underway and the increasing availability of a wider variety of methods, another such increase is also possible over the next four to five years.

The reintroduction of Depo Provera makes the use and take-off of long-term methods a clearly achievable target, although provider and user biases still must be overcome. Depo Provera seems to be competing against IUDs and VSC, in addition to replacing some pill use. In the near future, Depo may become the method of choice for many women, rivaling the more universal pill. A clearer picture will emerge when the 1994 DHS data are available.

With regard to permanent methods, steady gains have been made in this area, especially among women. The current male motivation campaign could also have an impact, although this has not yet been assessed. While steady progress is being made, it is difficult to assess whether the target of reaching 12 percent of all married women of reproductive age (MWRA) with LT/P methods is achievable. The DHS will shed more light on this. It would seem safe to leave this target as it is until the results of various assessments, e.g., the male motivation campaign and the DHS, become available.

#### *4.9.3 Cost Recovery*

In the last several years, the Council has made significant strides in its cost recovery efforts. In November 1992, ZNFPC modified its fees for contraceptives and medical services prices for the first time in many years. The price increases were substantial; for example, the pill price more than quadrupled, the IUD price doubled, consultation fees tripled for nurses and increased by 47 percent for doctors (see Tables 3 and 4 for details). In November 1993, prices rose again by approximately 30 percent and 50 percent for most contraceptives and for medical consultations, respectively. Accordingly, audited annual financial statements for Fiscal Years 1990-93 show the actual amounts "recovered" for contraceptives and medical fees increasing by five and four times, respectively.

Table 8 illustrates the change from a different angle, showing the trends in percentage of costs recovered for services and contraceptives.

**TABLE 8**

<b>PERCENTAGE OF MEDICAL AND CONTRACEPTIVE COSTS RECOVERED BY ZNFPC FY 1990-93</b>				
	<b>1990</b>	<b>1991</b>	<b>1992</b>	<b>1993</b>
<b>MEDICAL FEES</b>	2.2	2.1	1.9	4.4
<b>CONTRACEPTIVES</b>	10.7	10.8	5.4	56.9

The causes of the dip in cost recovery rates in 1992 and the significant increase in 1993 are not entirely clear. It may be that demand initially fell in response to the extreme and sudden price increase of 1992, or perhaps the collection, accounting, and reporting procedures were considerably strengthened when prices were increased. In any case, 1993 remains surprisingly high given the expected recovery of demand over time after a price increase. The Council is currently examining these data and the effect of price increases on service utilization in its facilities over the last two years. The results of this analysis should be an important guide in the further development of ZNFPC's cost recovery strategy. This initial analysis should be considered and expanded as part of the formative research for the financing initiative proposed in Section 4.4.

Several observations can be made regarding these findings. It appears that the current financial information system is arranged so that the recoveries from contraceptive sales are shown as a combination of contraceptive sales to other providers and contraceptive charges to individual clients. The amount classified as medical fees, however, represents only the consultation fees paid by individuals at ZNFPC's booking clinics. Second, it appears that the cost of contraceptives in these reports does not represent the full cost, i.e., it does not include associated charges for customs clearance, storage and handling, product testing, and distribution. The Council is currently working to quantify these associated costs to determine a more accurate full cost for each contraceptive. The team believes that once these more accurate costs are calculated and applied, ZNFPC's measures of cost recovery will be adequate and appropriate. To conform with one of the CPSP indicators of ZNFPC's progress in cost recovery, the Council should also be assisted to determine the revenues generated from all other operations, i.e., sales of IEC materials, training fees, and hostel and canteen income, in addition to contraceptive and medical consultation income, as a percent of its total operating budget.

Despite the anomalies and unanswered questions noted above, these results indicate that the Council is making some progress in monitoring its costs and is using the information to set pricing policy. This should enable it to improve cost recovery; however, much remains to be done in this area. A recommendation is made in Section 4.5.3 for further technical assistance to improve ZNFPC's basic financial information

system. Using the resulting system to conduct comprehensive cost analyses will significantly improve the Council's cost recovery activities.

The cost recovery results illustrated above suggest that the PP objective of 25 percent recovery of contraceptive costs is too low. Given this year's much more realistic contraceptive prices and reimbursement rates, it appears that a 1998 rate of 65 percent to 70 percent may be attainable. The objective for recovery of medical costs also may be too low. A more reasonable objective for 1998 would be 20 percent.

In both cases, urban clinics should be able to recover a much larger portion of their costs. The potential for cost recovery for the rural delivery system is more difficult to estimate. This will depend on whether the depot holder system, currently being tested with funding from UNFPA, will achieve significant cost savings. The other unknown is whether the Council might be able to seek some reimbursement from the ESAP-related Social Dimensions Fund to cover its costs of serving poor clients who are exempted from paying a fee for services. The MOH expects to be reimbursed for its services to these clients.

Attainment of cost recovery objectives will depend on the timing of the current management reorganization; consideration and implementation of changes suggested in the DANIDA-financed report on ZNFPC's finance and accounting management; and this report's recommendation that the A/F Division seek assistance with placing a revised financial information system into operation and improving its cost analysis capability. Contraceptive cost recovery achievements will depend also on whether the Council decides to continue its policy of selling commodities to selected private sector providers, using the existing two-tiered pricing system. These factors are within the Council's control. If it can move quickly on these changes and if general economic conditions continue to improve, new cost recovery targets should be well within ZNFPC's grasp.

## **5. POLICY ISSUES**

---

Several policies which constrain increased contraceptive prevalence and discourage sustainability were identified during the course of the evaluation. These cover a wide range of laws, regulations, and certain administrative barriers which may be of value in designing the amendment to the ZFPP and in planning for the NPA. These issues and policies are discussed below.

### **5.1 Tax Incentives**

One of the major issues which most family planning service providers feel is a stumbling block to the small family norm is the issue of tax incentives. The current structure encourages individual households to have large families. A tax rebate of Z\$120 per annum is currently given for each child up to a maximum of six children. The motivation to fulfill this quota to reduce the family's tax burden is great. The small family norm can not be met until there is a review of this tax incentive.

The participation of the private sector in family planning could be encouraged further through tax incentives. This is especially true of work-based family planning programs.

If companies provide family planning services on behalf of the state, they feel that the state should recognize their contributions through tax relief in one form or another. Again, the Ministries of Health, Finance, Labor and Social Welfare, ZNFPC, and representatives of employer organizations need to work together to facilitate an understanding on this issue. Work-based services are also an important way to reinforce family planning because they reach males in the workplace.

The proposed Zimbabwe National Population Policy, funding for which is being provided by UNFPA to the National Economic Planning Commission, does not address the issue of taxation or tax incentives for smaller family sizes; neither does it address the private sector tax issues. This oversight must be rectified as part of an effort to strengthen and maintain the momentum of the family planning program.

### **5.2 Age Barriers**

Certain policies related to age limits and the use of contraceptive services need to be revisited and/or clarified. Two issues are pertinent: The first is related to the access of youth to contraceptives. The second regards age limits imposed for access to particular family planning methods. Current policy stipulates that no one below the age of 16 can be provided contraceptives. This policy contradicts or is in conflict with efforts to prevent unwanted pregnancies and STDs, including HIV. Several studies in Zimbabwe have revealed that sexual activity starts several years before the age of 16.

Indeed, providers note that some parents bring in their sexually active teen children for

contraception even though they are below this age. Thus, this area needs a serious review in light of the current sexual behavior of youth.

In some clinics, certain methods are withheld from women who have not attained a certain age and parity. For example, when the use of Depo Provera was restricted, it was only available to women who were 35 years and above with five or more children. The same applied to sterilizations and, to a certain extent, IUDs. Although new guidelines have been issued to revise these policies, some providers still follow the old practices. Thus, a woman in her 20s who has decided that she has achieved her desired family size may not be given a LT/P method because she is considered to be too young. Since the bulk of women in the childbearing age groups are below thirty, these continued practices clearly militate against the increased use of LT/P methods.

### **5.3 Personnel Training, Orientation, and Roles**

Certain policies related to the training, orientation, roles, and career prospects of current and potential family planning personnel need to be addressed. Clinical officers, who are nurses with advanced training to perform minor surgery, have come to be considered mini-doctors. Of the 11 clinical officers presently practicing in Zimbabwe, two have been trained in VSC. It is apparent, however, that the career structure for this cadre was not thought through in full. Neither the nursing structure, from which they are drawn, nor the physician's structure make provision for their further advancement or promotion. Thus, few nurses are encouraged to pursue this advanced training. Yet, this cadre of worker could provide an important backup for family planning in Zimbabwe where public sector doctors are scarce and many are moving into the private sector or emigrating to practice elsewhere.

The proposed Nurses Act, if approved in the form in which it was designed by the Nursing Association, would address the issue of clinical officers by creating the grade and position of clinical nursing officer. Such a person would be able to advance through the nursing career structure to head a department within the Ministry's headquarters. Ensuring that the grade of clinical nursing officer is left intact in this Act, more nurses will be encouraged to apply for training in this field, including training in VSC.

Related to the issue of clinical officers is that of nurses and midwives offering family planning services on their own. Currently, family planning services can only be offered by doctors or by nurses or midwives under the supervision of a doctor. This is especially true of methods that require minor surgery, such as VSC and NORPLANT®. As this report was being written, a test court case was scheduled of a nurse who offered family planning services, probably without the required supervision of a doctor. Such cases would not occur if the law allowed nurses to set up their own clinics with minimum backup and referral arrangements with a doctor. Perhaps this backup could be provided by ZNFPC staff, thus relieving the burden of supervision from private doctors.

Another related personnel issue is that of CBDs being sanctioned and trained to administer injectables. According to the MOH Permanent Secretary, this intervention may be tested in a few years after the Depo Provera reintroduction experience is well documented. Proper supervisory and referral systems would need to be firmly established to support such an effort.

The provision of services in rural hospitals and health centers seems to rely on a large contingent of expatriate doctors. While most of these doctors probably received some exposure to the provision of basic family planning and STD services during their training, orienting this group to the provision of these services in Zimbabwe would seem to be in order. As part of their terms of recruitment, they should be expected to spend a period of time with ZNFPC to be oriented to the history and practice of family planning in Zimbabwe. This is especially true if they are going to work within facilities where family planning services are offered. In many cases these doctors are called upon to perform the role of hospital administrator if the post is vacant. Their appreciation of family planning is therefore important, and they can, with the right orientation, provide the necessary supervision and backup support. At the end of the orientation, the doctors would be certified/licensed by ZNFPC to offer and supervise family planning services within the health institutions where they are posted.

#### **5.4 Fee Structures**

The issue of fees for public sector health services is being hotly debated in Zimbabwe. The Minister of Health recently defended the new fee structures as being introduced to improve or enhance the referral systems in the health sector. He pointed out that the fees do not even represent full cost recovery, but everyone must pay something for the services rendered. The application of the fee structure in family planning services requires close monitoring, especially for LT/P methods. NORPLANT<sup>®</sup> is of particular interest because it carries a high initial cost but gives long-term protection—up to five years. A clear policy on use and cost of NORPLANT<sup>®</sup> in the public sector is required. If the use of NORPLANT<sup>®</sup> is to be encouraged in the public sector, then a fee that encourages its utilization by more women should be adopted.

Another issue related to fees, especially for medical aid societies, is the way in which they are set. More transparency in the process is required, especially from NAMAS, the body that sets reimbursement levels for all health services, including family planning. Currently, the body has not set a fee for ML/LA, yet some physicians in both the public and private sectors have been trained to provide this procedure. Regular updates by NAMAS to its membership should be part and parcel of its policy.

Uniformity in basic family planning coverage by medical aid societies should be encouraged. Some societies have several grades of coverage ranging from covering consultation fees to full coverage for hospital admissions and drugs. Basic coverage should include all LT/P methods, some of which also entail coverage for hospital admission and some drugs.

## 5.5 Other Issues

Other policies that require consideration to enhance attainment of national family planning goals include the following:

- The potential for leasing ZNFPC, public health, or government operating rooms for VSC operations should be addressed. Many of these facilities only use their surgical facilities one day a week, except for emergencies. The lease of these facilities to private practitioners when they are not otherwise in use would aid in cost recovery as well as give general practitioners access to facilities that allow them to provide LT/P methods.
- The question of whether support for the private sector will have a negative impact on the public sector needs to be answered and addressed.
- Legislation that requires all employers over a certain size to either provide in-house health services or finance external health services, including family planning, for their employees should be considered.
- The Enabling Act which created ZNFPC should be reviewed and amended as necessary to ensure that the actual and desired roles and responsibilities of this parastatal are clearly spelled out.
- The use of the Social Dimensions Fund to reimburse ZNFPC for its service to those clients who are exempt from paying fees should be explored.
- Regulations and policies affecting the advertising and over-the-counter sales of contraceptives should be reviewed and revised, if necessary.
- Donor regulations regarding the sale of donated contraceptives and the deposit of grant funds in interest-bearing accounts should be reviewed and revised, if possible.

## **APPENDICES**



## APPENDIX A































## APPENDIX B

### PERSONS CONTACTED

#### DONORS

##### World Bank

Joy DeBeyer	Task Manager, FHP II (on leave)
Keith Hansen	Task Manager, FHP II

##### Overseas Development Administration/U.K.

Neil Miller	Health and Administration Field Manager
-------------	---

##### USAID/Harare

Ted Morse	Director
Robert Armstrong	General Development Officer
Melissa Stephens	Project Development Officer
Roxana Rogers	Administrator, Family Planning Project
Mercia Davids	Health Program Specialist
Margot Ellis	Program Officer

##### Royal Danish Embassy

Ove Elvekjaer	Counselor
Christian Jorgensen	Senior Management Advisor, ZNFPC (DANIDA)

##### United Nations Population Fund

Yoshiko Zenda	Country Representative
Tsitsi Nheta	Program Officer

#### COOPERATING AGENCIES

##### Columbia University

Martin E. Gorosh	
------------------	--

##### AIDSCAP Design Team

Debrework Zewdie	Deputy Director, Africa Regional Office
Cheryl Sonnichsen	Evaluation Officer, Africa Regional Office
Denise Rouse	USAID/W G/H/HIV/AIDS Division

##### Family Planning Logistics Management Project

Peter J. Halpert	Regional Director
------------------	-------------------

##### SEATS Project

Marc Okunu	Regional Director
Ade Adelakun	Management Training Specialist
Madzivanyika Moto	Finance and Administration Manager

Malinda Ojermark  
Ndungu Wamburu

MIS/Evaluation Specialist  
Medical Advisor

## **GOVERNMENT OF ZIMBABWE**

### **National Economic Planning Commission**

Ozias Hove                      Planning Commission Population  
T. Mutandwa                      Assistant

### **Ministry of Health and Child Welfare**

R. Chatora                      Permanent Secretary  
Felicity Zawaira                Director of MCH/FP  
Clara Mufuka Rinomhota        Acting Director of Nursing Services  
Mrs. Dube                        Assistant Director of Nurse Education  
Willy Pfunya                      Assistant Secretary, FHP II Project  
Dr. Boom                         District Medical Officer, Chipinge  
Mr. Sithole                        Principal ACN, Tsonzo Rural Hospital  
M. Masukume                      Nurse, Tsonzo Rural Hospital  
R.P. Masukume                      Nurse, Tsonzo Rural Hospital

### **ZNFPC**

Alex Zinanga                      Executive Director  
T. Nerwande                        ZNFPC Senior Nurse/Chipinge District Hospital  
E. Muchirahondo                 Matabeleland North PNO  
R. Huni                              Mashonaland Central Acting PNO  
J.B. Ndenda                        Midlands Provincial Manager  
B. Nkomo                            Matabeleland South Acting Provincial Manager  
K. Dhlakama                        Midlands PNO  
A.E. Mashiri                        Masvingo PNO  
N. Shoniwa                         Mashonaland Central Provincial Manager  
E.K. Makoni                        Manicaland Acting Provincial Manager  
F.E.W. Masakadza                 Masvingo Provincial Manager  
H. Soganile                         Matabeleland North Provincial Manager  
I. Makozhombwe                 Mashonaland West Provincial Manager  
B. Matabela                        Mashonaland East PNO  
M.H. Sibindi                        Mashonaland East PNO  
M. Mazingaizo                      Mashonaland West PNO  
T. Nhliziyo                         Chief, Service Delivery  
J.B. Moyo                          Deputy Director for Programs  
Mr. Kazuva                         Deputy Director, A/F  
L. Botsh                            Chief Training Officer  
A. Chibhamu                        Internal Auditor  
A.M. Chiguvare                      Accountant  
F. Chikara                         Chief of IEC  
L.B. Lunga                         Private Sector Coordinator  
T. Rwodzi                          Youth Advisory Service

G. Muzimba	Group Leader
C. Machipira	CBD
A. Kadira	SCN-in-Charge, Mobile Clinic Manicaland
M. Matiza	SCN-in-Charge, Mobile Clinic Manicaland
G. Chifamba	Driver, Mobile Clinic Manicaland
B. Mhlanga	Youth Centre, Mutare
G. Tekere	Matron, Spilhaus Clinic

## **OTHERS**

Carri Crockart	Senior Product Manager, Johnson & Johnson
L. Mbengeranwa	Director of Health Services, Harare City Health
Agnes Zivanai	CBD Client, Manicaland
S.U. Sakupwany	Private Practitioner, Rusape
Patience Sakupwany	Clinic Administrator, Rusape
Philip Chideme	Private Practitioner, Rusape
G. Muziti	Sister, Zongoro Clinic, Mutasa District
Dr. McNally	District Medical Officer, Bonda Mission Hospital
R. Chasakara	Matron, Bonda Mission Hospital
C. Sagwete	Sister, MCH Clinic, Bonda Mission Hospital
MacDonald Chaora	General Manager CIMAS



## APPENDIX C

### DOCUMENTS REVIEWED

- Awari, Joy. "Sustainability of Enterprise Program Projects". DRAFT, December 1993.
- Central Statistical Office of Zimbabwe. "Combined Demographic Analysis, Volume I". November 1992.
- CIMAS Medical Aid Society. "Promotional Packet of Five Coverage Programs". January 1994.
- "Family Planning Services Through Private Medical Practitioners Proposal". Pathfinder International, 1992.
- Foltz, Anne-Marie and Gary Engelberg. "Report on the USAID/Niger Health/Population Sector Workshop: Lessons Learned and Future Strategies". Health and Human Resources for Africa, March 1993.
- Fort, Catherine J. "Enterprise in Zimbabwe: A Strategic Approach to Private Sector Family Planning". The Enterprise Program, June 1990.
- Gaffikin, Lynne, DrPH, I. Mvandi, Connie Husman, Dr. Alex Zinanga, and John McGrath. "A Study on the Acceptability of IUDs Among Family Planning Providers in Zimbabwe". Paper presented at American Public Health Association, October 1993.
- German Technical Cooperation. "Plan of Operations May 1993-April 1995". December 1992.
- Government of Zimbabwe. "National Population Report". DRAFT, March 1994.
- Halpert, Peter J. "Local Production of Contraceptives in Zimbabwe: A Background Study". Family Planning Logistics Management, February 1993.
- Halpert, Peter, Carl Hawkins and Steve Perry. "Zimbabwe Trip Report". Family Planning Logistics Management Project.
- Halpert, Peter and Karen Ampeh. "Zimbabwe Trip Report". Contraceptive Estimates. Family Planning Logistics Management Project, August 16-September 3, 1993.
- Institute for Resource Development/Macro Systems, Inc. and Central Statistical Office. "Zimbabwe Demographic and Health Survey 1988". Ministry of Finance, Economic Planning and Development, Harare, Zimbabwe, December 1989.
- KPMG Peat Marwick, Chartered Accountants, Zimbabwe. "Report on Strengthening ZNFPC Accounting Systems and Procedures". November 1993.

"Manpower Planning Management Review for the 1991-1996 National Strategy, December 1991".  
Family Planning Management Development.

Mitchell, Susan, Lisa Elam, and Catherine Connor. "Local Condom Testing and Packaging in Zimbabwe". September 1993.

Murahwa, Lazarus and Martin Gorosh. "Zimbabwe Family Planning Program Sustainability Study".  
Unpublished. Center for Population and Family Health Columbia University, February 1993.

Ojermark, Melinda, Peter Halpert, Martin Gorosh, Caroline Marangwanda and Benedict H. Dlodlo.  
"Application of the Family Planning Program Monitoring and Evaluation System (FPPMES)  
to the National Family Planning Program of Zimbabwe". Zimbabwe National Family  
Planning Council, March 1994.

Phiri, Alford. "The Zimbabwe Community Based Distribution (CBD) Validation Study". Zimbabwe  
National Family Planning Council Evaluation and Research Unit, November 1990.

Population Services International. "Expansion of a Maternal Health and Family Planning  
Programme in Cheziya Gokwe District in Zimbabwe". Marie Stopes International, June  
1993.

Rogers, Roxana. "Memo on the Regional Medical Barriers Conference". February 1994.

Seims, Sara, and Saul Helfenbein. "Zimbabwe National Family Planning Council. Organizational  
Needs Assessment". Management Sciences for Health, January 1991.

Shefner, Corinne L. "Zimbabwe Trip Report PCS and Pro-Approach Project Design". Johns  
Hopkins University, Population Communication Services, September 1993.

Skibiak, John C. "Employer-Provided Family Planning in the Private Sector: The Lessons of  
Enterprise". The Enterprise Project, March 1991.

USAID Mission/Harare. "Assessment of Program Impact". November 1993.

USAID Mission/Harare. "Country Program Strategy Statement". 1993.

USAID Mission/Harare. "Project Grant Agreement between The Republic of Zimbabwe and the  
United States of America for Zimbabwe Family Planning". A.I.D. Project Number 613-0230  
dated August 29, 1990.

USAID Mission/Harare. "Zimbabwe Family Planning, Project Paper (613-0230)". August 15, 1990.

World Bank. "Staff Appraisal Report. Zimbabwe Second Family Health Project". Document of the  
World Bank Report No 9318-ZIM. Southern Africa Department, Population and Human  
Resources Division.

World Bank. "Zimbabwe: Issues in the Financing of Health Services". February 5, 1990.

Zimbabwe National Family Planning Council and The Population Council's Africa OR/TA Project.  
"Zimbabwe: A Situation Analysis of the Family Programme". Family Planning Services  
Expansion and Technical Support (SEATS) Project, Harare, Zimbabwe, March 1992.

"Zimbabwe Country Profile 1991-92". The Economist Intelligence Unit, Limited, 1991.

"Zimbabwe Country Report Third Quarter 1993". The Economist Intelligence Unit, Limited, 1993.

"Zimbabwe National Family Planning Council Baseline Costing Study". Organization for  
Socioeconomic Research and Consultancy Services Ltd. and Africa Consulting Associates,  
Harare, March 1994.

"Zimbabwe National Family Planning Council in the Province of Manicaland". International Planned  
Parenthood Federation Evaluation and Management Audit Department, July 1990.

Zinanga, Dr. Alex, Dr. J.B. Moyo, and C. Jorgensen. "The Integration of STD, HIV and AIDS  
Services into Family Planning". 1993.

ZNFPC. "Strategy for the Zimbabwe National Family Planning Programme for the Five Years from  
1991 to 1996: Plan Now for the Better Life". 1990.



## APPENDIX D

<b>MEDICAL AID SOCIETIES' ANNUAL SUBSCRIPTIONS</b>	
<b>SOCIETY</b>	<b>BENEFICIARIES</b>
Anglo-American Medical Aid Fund	1,097
Bnakmed	7,965
Beverly Building Society Medical Aid Scheme	360
Building Industry Medical Fund	1,238
Cement Medical Benefit Society	393
Chibuku Breweries Ltd.	946
CIMAS	127,389 <sup>1</sup>
Engineering Medical Fund	12,878
Harare Municipal Medical Aid Society	6,285
Industrial Steel & Pipe Medical Fund	747
Legal and General Medical Aid Society	899
Lonrho Medical Aid Fund	3,250
Manica Medical Aid Society	910
M.A.S.C.A.	29,183
Motor Industry Medical Fund	2,065 <sup>2</sup>
Municipality of Bulawayo Medical Aid Society	5,740
Northern Medical Aid Society	4,767
Oxyco Group Medical Aid Society	604
Prudential Medical Aid Scheme	503
P.S.M.A.S.	101,720
Railmed	43,568
Rio Tinto Group Medical Benefit Society	1,300
Shell/BP Medical Aid Society	1,473
Triangle Ltd. Medical Aid Scheme	1,503
Turnall Medical Aid Scheme	Unknown <sup>3</sup>
Union Carbide Medical Benefit Society	2,085
Workers Compensation Insurance Fund	Unknown
Zimbabwe Newspapers Medical Benefit Society	1,373
Zimglass Medical Aid Society	329
ZISCO Medical Benefit Society	8,815
<b>TOTAL</b>	<b>369,385</b>

Source: National Association of Medical Aid Societies, 1987.

<sup>1</sup> With special schemes: 150,233

<sup>2</sup> Merged with M.A.S.C.A. in 1987

<sup>3</sup> No longer exists



**APPENDIX E**

<b>ZNFPC ADMINISTRATION REQUIREMENTS FOR OFFICE MACHINES</b>				
		<b>TOTAL</b>	<b>ESTIMATED UNIT COST</b>	<b>TOTAL</b>
<b>COMPUTERS</b>				
• Private Secretaries	3			
• Personnel Secretary	1			
• Typing Pool	6			
• Provinces 1 Each	8	18	\$80,000.00	\$1,280,000.00
• Printers		10	\$30,000.00	\$ 300,000.00
<b>TYPEWRITERS</b>				
• Head Office	3			
• Provinces 2 Each	16	19	\$14,000.00	\$ 266,000.00
<b>PHOTOCOPIERS</b>				
• Head Office	2			
• Provinces	8	10	\$1,577,300.00	\$1,577,300.00
<b>DUPLICATING MACHINES</b>				
• Head Office	2			
• Provinces	8	10	\$20,000.00	\$200,000.00
<b>GRAND TOTAL</b>				
				<b>\$3,623,300.00</b>

