

ZIMBABWE POPULATION SECTORAL ASSESSMENT

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by

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CBD	community-based distribution/distributor
CEA	cost-effectiveness analysis
CIMAS	Commercial and Industrial Medical Aid Society
COC	combined oral contraceptives
CPR	contraceptive prevalence rate
CSO	Central Statistical Office
CYP	couple year of protection
DCC	Drugs Control Council
DHS	Demographic and Health Surveys
DNO	District Nursing Officer
EPI	Expanded Program on Immunization
ERU	Evaluation and Research Unit
ESAP	Economic Structural Adjustment Program
FHP	Family Health Project
FOB	freight on board
FP	family planning
FPP	Family Planning Project
GDP	gross domestic product
GL	Group Leader
GOZ	Government of Zimbabwe
GTI	genital tract infection
GTZ	Association for Technical Cooperation (Germany)
HIV	human immunodeficiency virus
IBRD	International Bank for Reconstruction and Development (World Bank)
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
J&J	Johnson and Johnson
LT/P	long-term and permanent (methods)
MCH	maternal and child health
ML/LA	minilaparotomy under local anesthesia
MOHCW	Ministry of Health and Child Welfare
NaFPAP	National Family Planning Action Plan
NACP	National AIDS Coordination Program
NAMAS	National Association of Medical Aid Societies
NEPC	National Economic Planning Commission
NGO	nongovernmental Organization
NPA	non-project assistance
NSSA	National Social Security Authority

OB/GYN	Obstetrics and Gynecology
OC	oral contraceptive
ODA	Overseas Development Administration (United Kingdom)
PNO	Provincial Nursing Officer
POP	progestin-only pills
REDSO	Regional Economic Development Services Office
RHC	Rural Health Center
SCN	State Certified Nurse
SDF	Social Dimensions Fund
SEATS	Family Planning Services Expansion and Technical Support Project
SOMARC	Social Marketing for Change Project
SRN	State Registered Nurse
STD	sexually transmitted disease
STI	Sexually Transmitted Infections Project
TA	technical assistance
TFR	total fertility rate
TL	tubal ligation
TMT	Top Management Team
TOT	training of trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UZ	University of Zimbabwe
UZ/Med	University of Zimbabwe/Medical School
VSC	voluntary surgical contraception
ZDHS	Zimbabwe Demographic and Health Survey
ZINA	Zimbabwe Nurses Association
ZNFPC	Zimbabwe National Family Planning Council
ZRHS	Zimbabwe Reproductive Health Survey

EXECUTIVE SUMMARY

A sectoral assessment of population and family planning activities in Zimbabwe was undertaken by a five-person team during August and September, 1994. Data were collected through a review of documents, interviews, and a one-day workshop attended by representatives of the Government of Zimbabwe, nongovernmental organizations, and the private medical and commercial sectors. The workshop was designed to assist in the identification and determination of priority constraints or barriers to the expansion of family planning services in Zimbabwe.

Workshop participants assisted in developing a preliminary list of 50 constraints affecting the family planning program. These constraints were grouped into legal/regulatory, administrative, economic and commercial, political/social/cultural, and inter-organizational categories. Through a process of examining the costs (financial, human, and political) and benefits of addressing each barrier, the list was narrowed to 15 priorities for consideration and further study by the team.

Two specific constraints were identified in relation to the work of the Zimbabwe National Family Planning Council (ZNFPC), the parastatal body charged with overall coordination of the national family planning program. One is the lack of a coordinated national implementation or action plan to direct family planning service delivery. Such a plan is needed to ensure that all possible sectors are involved in the delivery of services; to alleviate duplication; and to foster better coordination among the various donors to the program.

The second constraint is a regulatory matter related to the need for a thorough review and possible amendment of the 1985 Act of Parliament which created the ZNFPC. Changing circumstances and program directions require this review to ensure that the role of the Council, as mandated by the Act, is fully responsive to the present needs of the national program. An amendment to the Act should also be aimed at giving the ZNFPC proper authority to operate as efficiently and effectively as possible.

The constraints relating to which services can be provided by nurses and midwives and under what conditions were examined in some detail. Findings indicate that administrative and customary practices rather than legal barriers determine what procedures non-physician clinical personnel can provide in the public sector. In the private sector, there are legal barriers against nurses prescribing contraceptives. Private sector physicians are also barred from dispensing contraceptives and other drugs without a license or if they practice within five kilometers of a pharmacy. There are some strictures on nurses performing invasive procedures; however, most informants felt that this cadre could and should be trained to insert NORPLANT[®] implants. A new Masters of Science in Nursing course is expected to offer training necessary to upgrade the level of clinical practice of nurses in Zimbabwe. Clarification of the status of nurses will be assisted by the early approval of the draft Nurses Act or an amendment to the Medical, Dental and Allied Health Professionals Act.

The team also reviewed the constraints to the provision of family planning information and services to adolescents. This is a critical issue as there is a need to address both the growing number of teen pregnancies and the prevention of sexually transmitted diseases, including HIV/AIDS, among this age group in Zimbabwe. There are strongly held social and cultural

convictions against providing services to youth as well as legal barriers to serving the needs of young people below the age of majority, which is 16 years.

Adding in-service training in several new subjects and the investigation and possible expansion of who can provide services and where are administrative barriers addressed by the assessment. Solutions are suggested to alleviate these barriers, which include developing a regular newsletter for all providers; developing an integrated family planning supervisory system and training for supervisors; orientation to the Zimbabwe family planning program for expatriate physicians serving in rural areas; and including a module on family planning in the one-year course to upgrade state certified nurses to state registered nurses. Additional suggestions are made to study and pilot test methodologies to expand the provision of injectable, oral, and surgical contraception through new and different outlets and service providers.

A major barrier to increased commercial sector participation in the family planning program is the sales tax applied to condoms and the duties and disbursing fee applied to oral contraceptives. A recommendation is made to alleviate these surcharges in order to stabilize prices and increase sales of these methods in the private sector.

Finally, the assessment team undertook a review of possible options for institutional reform of the ZNFPC. Advantages and disadvantages of several options for reform are examined which may assist in shaping the review of the 1985 Act which created the Council.

SUMMARY OF RECOMMENDATIONS

Recommendations made in this report fall into several categories. First there are priority recommendations relating to barriers or programmatic constraints which could become conditionalities in a non-project assistance grant. There are secondary recommendations which support or amplify the NPA conditionality recommendations. Finally, there is a group of recommendations which appear to be addressed or which could be addressed in the USAID Family Planning Project amendment. This last group is noted here to give extra support or amplification to the importance of their inclusion in the FPP amendment.

Priority Recommendations/Potential Conditionalities for an NPA

The ZNFPC Act of 1985 should be reviewed and amended, as necessary, during the first two years of the proposed USAID-funded NPA. Recommendation 1, pg. 7

The ZNFPC should undertake, with USAID-provided technical assistance during the first two-year period, the development of coordinated National Family Planning Action Plans over the life of the NPA. Recommendation 24, pg.45

Commercially sold condoms should be excluded from attracting sales tax. Recommendation 14, pg.37

All remaining import duties and surtax charges relating to commercially imported contraceptives should be removed. Recommendation 15, pg.37

Private practice for nurses should be explored through research on international experience. Implications for Zimbabwe should be estimated with special consideration given to service coverage, financial implications for the MOHCW in terms of lost personnel, and insurance liability. Recommendation 4, pg.11

A family planning module should be developed for incorporation in the orientation course for expatriate doctors provided by the UZ/Med Department of Obstetrics and Gynecology. Recommendation 12, pg.27

Plans for development of a Nurse Practitioner specialization in MCH/FP that emphasizes clinical skills in LT/P family planning methods are encouraged and steps should be taken to speed curriculum development and begin training the first group as soon as possible. Recommendation 2, pg.11

The amount of family planning training included in the curriculum for upgrading SCNs to SRNs should be increased and clinical training, in particular, should be emphasized. Recommendation 13, pg.27

Supplementary Recommendations

Support should be provided for either a new Nurses Act or a compromise Act negotiated between the MOHCW and ZINA. Recommendation 3, pg.11

Various scenarios should be tested to increase training and expand coverage in LT/P methods. These may include using mobile training teams, carrying out training over a longer time period, and hiring a physician to temporarily replace physicians when they are absent from their practices for training. Recommendation 8, pg.22

A desk review should be conducted of the experience of other countries in the provision of OCs over-the-counter without prescription. If results are favorable, the process should be initiated through submission to the DCC. Recommendation 7, pg.22

The DCC regulations governing the importation, registration, testing, and sale of contraceptive products should be reviewed with the objective of facilitating the development of the commercial family planning sector. Recommendation 16, pg.37

Support should be given to DCC to strengthen and expand its monitoring capabilities throughout the country. Recommendation 17, pg.37

Additional tax benefits should be estimated and considered to offer financial incentives for companies that provide family planning services. Recommendation 22, pg.42

Recommendations to be Addressed in the Family Planning Project Amendment

A pilot study should be fielded to test the feasibility of CBDs offering Depo-Provera. Recommendation 5, pg.22

Measures should be implemented to reduce local reliance on POPs through reinforcement of existing protocols, better counseling, more intensive supervision, and, possibly, restricting the supply of POPs. Recommendation 6, pg.22

A family planning supervision course curriculum should be developed and specific training in supervisory skills should begin as soon as possible. Recommendation 10, pg.27

A variety of means should be introduced to convey new information to the field, including introduction of a twice-yearly bulletin, regular quarterly meetings of provincial and district staff, and technical sessions introduced into annual meetings of ZINA. Recommendation 11, pg.27

Work on the revised MCH/FP course should be completed as soon as possible. Technological and service delivery changes can be included as updates as they arise and conveyed to previously trained field workers through other means. Recommendation 9, pg.26

A review of past research should be conducted to preface a local, private physician cost/benefit analysis of family planning activities that should be undertaken to demonstrate improvements in profitability for private doctors offering family planning services. Recommendation 18, pg.37

Work-based program coordinators should be trained in recruitment skills within the private sector. Furthermore, they should be able to deal with the authority of the ZNFPC behind them

and should, perceptually at least, be "in charge" when negotiating with senior executives in the private sector. Recommendation 19, pg.41

A system should be developed to permit thorough and repetitive canvassing of the private sector to establish more work-based family planning services. Recommendation 20, pg.42

An updated cost-benefit model should be produced and circulated to all work-based coordinators. Recommendation 21, pg.42

Full reimbursement for family planning services provided through work-based programs should be made by medical aid societies to facilitate increased utilization of these services. Recommendation 23, pg.42

1. INTRODUCTION

1.1 Background

The history of family planning in Zimbabwe dates back to 1953 when a group of volunteer women began to provide community-based information and services in the urban areas. The first family planning clinic for the majority black population was sanctioned by the Ministry of Health and Child Welfare (MOHCW) and opened by this same group of volunteers at Harare Central Hospital in 1959. This effort was backed up by mobile services offered in the communities surrounding Harare. In 1965, these various voluntary efforts were consolidated to form the Family Planning Association of Rhodesia which became an affiliate of the International Planned Parenthood Federation (IPPF).

Inspired by the findings of the 1961/62 national census of a population growth rate of 3.5 percent, the MOHCW allowed contraceptives to be provided at all government health facilities. Public sector services spread rapidly through an increased number of mobile and static family planning clinics and through the introduction of community-based distribution of contraceptives (pills and condoms).

Following independence in 1980, the new Government of Zimbabwe (GOZ) announced major changes in the health sector, including the promotion of a primary health care program. A Maternal and Child Health/Family Planning (MCH/FP) Unit was established in the MOHCW to oversee the delivery of these services throughout the country. In September 1981, the GOZ took over the operation of the Family Planning Association placing it under the jurisdiction of the MOHCW. Over the succeeding years the name of the association was changed several times, finally becoming the Zimbabwe National Family Planning Council (ZNFPC) in 1984. This body was established as a parastatal agency with ties to the MOHCW by a 1985 Act of Parliament and was given a number of responsibilities including coordination of the provision of family planning services in Zimbabwe. (Other responsibilities are discussed further in Section 2.1).

Major donor support has been provided for family planning initiatives through the International Bank for Reconstruction and Development (IBRD or World Bank), the United Nations Population Fund (UNFPA), and several European donors. The United States Agency for International Development (USAID) began providing funding for family planning activities shortly after independence. USAID's present country strategy includes, as one of its three major objectives, the achievement of a sustainable reduction in the total fertility rate (TFR) to 4.9 by 1998. This objective is supported by efforts undertaken through a bilateral project that provides funding to assist the ZNFPC in carrying out its programmatic objectives of diversifying method mix and increasing sustainability. This project has recently been amended to extend the life of the project to 1998 and to increase the level of bilateral funding to a total of US\$16.9 million.

The 1988 Zimbabwe Demographic and Health Survey (ZDHS) indicated a level of contraceptive prevalence which is very high for Africa (36.1 percent for modern methods). This represented an increase of 9.5 percent over the modern method prevalence documented in the 1984 survey. However, the use of contraception, measured by commodity distribution and by survey data, appears to have grown very little during the succeeding years. Concerns among the various family planning program players, including the MOHCW, ZNFPC, and donors, over the

apparent plateau reached in the program led to this sectoral assessment. The purpose of this review is to identify and analyze the possible policy and institutional constraints and barriers to continued program growth and to make recommendations for addressing these barriers, possibly through the non-project assistance (NPA) funding mechanism. (See Appendix A for the Scope of Work).

1.2 Methodology

1.2.1 Team Composition

A five-person team implemented the sectoral assessment in Zimbabwe August 14–September 9, 1994. This team included a team leader and specialist in family planning service delivery and policy (Sallie Craig Huber), a health and population economist (John L. Fiedler), a social scientist/demographer (Susan Enea Adamchak), a private sector specialist (Craig Naudé), and a population geographer (Lazarus Zanamwe). The latter two members are resident Zimbabweans. The team was assisted during the first week and the workshop, as well as in the last week of fieldwork, by a health policy advisor from USAID's Regional Economic Development Services Office (REDSO) in Nairobi (Richard Sturgis).

1.2.2 Pre-travel Briefings

The three U.S.-based team members spent five days in Washington preparing for the assessment. This preparation included interviews with and briefings by individuals knowledgeable about population/family planning policy reform, USAID population funding priorities, and the present family planning program situation in Zimbabwe. The team collected and reviewed relevant documents (see Appendix B for the report bibliography) and clarified the Scope of Work for the assessment during this period. Plans also were made for a workshop that was held during the second week in-country (see Section 1.2.4).

1.2.3 Field Data Collection

While in the field, the team interviewed numerous individuals representing the GOZ, family planning providers, the private commercial sector, nongovernmental organizations (NGOs), and the donor community (see Appendix C). Additional documents were collected and reviewed, and a two-day field visit was made to Masvingo Province to observe the implementation of the family planning program.

1.2.4 Workshop

On August 22 USAID hosted and the assessment team facilitated a workshop for participants representing key agencies of the GOZ and the private commercial and nongovernmental sectors. The workshop was designed so the participants could assist the assessment team in the identification and preliminary analysis of barriers and constraints impeding the Zimbabwe family planning program and in setting priorities for addressing the constraints identified. (See Appendix D for a full report of the workshop). The workshop resulted in the development of a list of 15 priority constraints which was used by the team to focus its strategy for the balance of

the assessment. Most of the constraints identified are addressed in detail in the following report which is organized according to the categories of constraints discussed during the workshop.

1.3 The Recent Evolution of Zimbabwe's Family Planning Sector

A major component of this sectoral assessment was a review of the recent evolution of the national family planning sector and factors influencing family planning acceptance and use. The review was undertaken by the health economist on the team and the results are presented in Appendix E. The Appendix discusses the impediments and other conditioning factors that influence the coverage of family planning services in urban versus rural areas. It identifies six recent changes in laws, rules, and regulations governing the demand for, use, and cost of contraceptives that are expected to improve the general family planning climate in Zimbabwe and notes that these changes, by their nature, will likely impact the private sector more than the public sector.

The analysis narrows to the public subsector and discusses changes during the 1987–1993 era in the proportion of contraceptive commodities supplied by the ZNFPC, the MOHCW, and the three largest Municipal Health Departments. There is a brief exploration of some causes of the changes in relative importance of these different public sector sources of contraceptives.

In the final section of the Appendix, the analysis focuses on the performance of the ZNFPC in the 1987–1993 era. Topics covered include the falling productivity of the community-based distributors (CBDs) and the faltering efficiency of the CBD program. In addition, two simple, cost-effectiveness analyses are presented. One describes ZNFPC's CBD versus clinic efforts. The second analyzes the cost-effectiveness of ZNFPC versus MOHCW clinic-based family planning services. The question of whether ZNFPC can serve as the national catalyst for promoting a change in the contraceptive method mix, moving the program toward long term/permanent (LT/P) methods, while its organizational structure and financing remains dominated by the pill and condom CBD program is raised. Finally, several financing and sustainability issues are discussed.

1.4 National Population Policy

Zimbabwe has no explicit population policy, and there is some concern that this may have contributed to the stalling of national family planning program efforts. This does not appear to be the case. However, for more than a decade, high-level political leaders have made very supportive statements about family planning—in effect establishing an implicit policy for distribution and use of contraception. During the same period, population growth and its impact on different social sectors has been a frequent topic of media articles contributing to a lively public debate.

Other evidence of Zimbabwe's strong implicit support for family planning is seen in the detailed five-year (1991–1996) strategy for the Zimbabwe National Family Planning Program and by the continued financial support provided by the government.

Zimbabwe sent a very large delegation to the 1994 International Conference on Population and Development in Cairo, Egypt. There, the Government presented its "National Report on

Population," summarizing recent demographic trends in the country. The report also notes that the results of the 1992 population census provide a basis "for the development of a national population policy." The National Economic Planning Commission (NEPC) has been charged with the development of a population policy and has received support from the United Nations Population Fund for the process. The assessment team learned there is mixed support within the government for the development of a population policy, however the NEPC will advance the process soon.

A national population policy will encompass more sectors than just health and family planning. Nevertheless, it will be essential that both public and private sector programmatic and administrative constraints to family planning program expansion be identified in the policy and in the implementation plan developed to achieve the policy goals. Some constraints are identified in this report. Others, not considered to be high priority for this assessment, are identified in the workshop report (Appendix D).

2. LEGAL CONSTRAINTS

2.1 Review of the 1985 ZNFPC Act

2.1.1 Findings

The nongovernmental IPPF-affiliated Family Planning Association established in 1965 was transferred to the government in 1981 shortly after independence. In the 1981–1985 National Development Plan, Zimbabwe stated its commitment to family planning as part of the Maternal and Child Health program. The Plan held that "family planning should be tackled as a developmental package which aims at raising the socio-economic conditions of all Zimbabweans."

During the period 1981–1984, the new government undertook the task of reforming the image and operations of the family planning program. The name of the Association was changed several times, finally becoming the Zimbabwe National Family Planning Council in 1984. The ZNFPC was established as a parastatal body affiliated with the Ministry of Health by a 1985 Act of Parliament. The functions of the Council, as outlined in the 1985 Act (Section 22), include responsibility for the general promotion of child spacing and family planning; training medical students and other personnel in family planning; establishing facilities for diagnosis and treatment of infertility, sexually transmitted diseases (STDs) and cancer of the cervix; research on family planning and contraceptive use; provision and management of services for infertility and sterilization surgery; and participation with other organizations in programs for primary health care and other community development activities. (See Appendix F for a copy of the ZNFPC Act of 1985).

The ZNFPC Board is charged, in Section 23 of the Act, with the responsibility of ensuring that the Council carries out its work in full coordination with the various disciplines and agencies associated with family planning services. Furthermore, the Board is given responsibility for ensuring that ZNFPC operations are implemented in concert with national development plans.

The Act sets out precisely who shall be represented as members of the Board and the Executive Committees of the Council. The Secretary of the MOHCW is designated by the Act as chair of the Board. A number of other ministries are represented as are relevant voluntary organizations and the private commercial sector.

In discussing the Act as a potential barrier to expanded and enhanced family planning, the management of ZNFPC proposed a review of the Act asking the following questions:

- What was the original intent of the Act?
- Are the provisions of the Act still appropriate?
- Should the Act be changed?
- If so, what should the "new" ZNFPC look like under an amended Act?

2.1.2 Analysis

The ZNFPC Act has not been reviewed or amended since its passage in 1985. In the interim, however, a number of events have occurred which render portions of the Act less relevant than when it was created. For example, through the exceptional work of the ZNFPC and the interest and inputs of other sectors (the MOHCW, the private commercial sector, and the international donor community), the family planning program has grown and developed over the intervening nine years. The interest in and demand for family planning services created by promotional efforts of the ZNFPC have increased the need for more human and financial resources to deliver family planning services. Other programs and services have developed elsewhere in the health system, rendering redundant some of ZNFPC's functions outlined in the Act.

Several recent environmental factors also have impacted the family planning program and the role of the ZNFPC. These include the social and economic impact of the 1992 drought, the introduction of the economic structural adjustment program (ESAP), and the growing epidemic of sexually transmitted diseases, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). All three factors have created a significant drain on health resources and financing, ultimately affecting the ZNFPC and the delivery of family planning services in general.

Requirements for drought relief taxed the overall GOZ budget as well as that of the MOHCW. Since ZNFPC is highly dependent on the annual grant from the MOHCW for its operating budget, the drought can be said to have played a significant, although possibly indirect, role in the reduction in the ZNFPC's support from public funds over the past few years.

Conditions of the ESAP have called into question the need to revise the role of parastatal agencies giving them more sovereignty while at the same time demanding greater self-sufficiency. However, questions have been raised about whether ZNFPC, as a social welfare parastatal, should be held to the same requirements as the commercially oriented parastatals. Initiatives within ZNFPC to recover costs have had limited success to date.

On the other hand, both the drought and ESAP may have had a role to play in increased demand for family planning services. Times of economic crisis often create conditions that couples feel are less than ideal for conceiving and giving birth to another mouth to feed, body to clothe, and mind to educate. This increased demand may have put an additional burden on the provision of family planning services in times of financial shortfalls in support of the program.

The need to provide for diagnosis and treatment of STDs, including HIV/AIDS, is also putting an additional burden on the human and financial resources of the health sector. Fears about AIDS among providers also affect the promotion and provision of certain invasive methods of contraception. As other programs have sprung up to address the HIV/STD epidemic, the role of ZNFPC with regard to these diseases has been called into question and perhaps requires revision.

The ZNFPC Act calls for designated representation on the Board of the Council. Some of the names of represented ministries have been changed since the Act was passed. Other specified members participate in Board deliberations on a very irregular basis, if at all.

Provisions are made for revision and amendment of acts of Parliament. The review and revision of the ZNFPC Act of 1985 is overdue and could be accomplished in short order. A

committee of select ZNFPC Board and staff members as well as others, including possibly representatives from the National Economic Planning Commission and the private sector, should be designated to undertake the review of the present Act and to make suggestions for revision. Technical assistance from someone who has broad international experience in the development and review of population and family planning programs and institutions, such as John Ross of The Futures Group, should be provided by USAID to assist in this task. Legal advice should be sought to examine the revisions and place them into proper language for submission, as an amendment to the Act. The proposed amendment must be presented to the Ministry of Justice, Legal and Parliamentary Affairs for approval.

2.1.3 Indicators of Achievement

An amended ZNFPC Act should produce several outcomes. A streamlined, action-oriented Council and Board should be a primary objective of any revisions to the Act. To ensure enhanced operation of the national family planning program, the Council also should be endowed with enhanced decision-making powers and approved procedures to guide the decision-making process. Finally, the ultimate impact of any change in the Council's structure and mandate should be increased efficiency in program operations.

1. RECOMMENDATION: The ZNFPC Act of 1985 should be reviewed and amended, as necessary, during the first two years of the proposed USAID-funded NPA.

2.2 Restrictions to Service Provision by Nurses and Midwives

2.2.1 Findings

Zimbabwe is facing a severe shortage of doctors, particularly in rural areas of the country. Evidence indicates that in recent years more than 100 young doctors have left the country annually to work in nearby countries. Currently about 80 students are accepted for training each year. The MOHCW recently proposed doubling the medical school intake to 160 students, but the existing infrastructure and staffing levels cannot support such an increase. Instead, numbers will grow more gradually, starting with about 100 students for the 1995 class.

The limited number of doctors available is forcing the MOHCW to turn increasingly to nurses to perform basic medical services, including family planning. Nurses comprise a massive source of possible family planning service providers; there are approximately 9,000 nurses in public service. It appears that only about one-third have been trained in family planning, either in their preservice training or in-service courses. Clearly, there is a need to increase and improve their ability to provide services in order to speed diversification of method mix and increase use of LT/P methods.

There are indications that training of nurses in NORPLANT[®] insertion will soon begin. The MOHCW is awaiting a report of the clinical trial results that was being drafted simultaneously with this assessment before making its final decision. So far, there are no negative results to report. It is anticipated that nurses training will begin within a few months.

The MOHCW is not sure that nurses see family planning service provision, particularly NORPLANT® insertions, as an opportunity. Rather they may view it as an additional demand on already over-worked cadre. At the same time, doctors are referred to as a "dying breed," and it is acknowledged that nurses will have to assume increasing responsibility for various medical procedures. With proper training, it is thought that nurses can take on an enhanced role. The Permanent Secretary sees "room for flexibility," depending on the intervention in question and agrees that, in theory, the shift to LT/P methods can be implemented by nurses at primary care facilities.

Nurses are now trained as part of doctor-nurse teams in the provision of tubal ligation (TL) using minilaparotomy under local anesthesia (ML/LA). A tutor at ZNFPC thinks nurses, especially experienced theater nurses, could easily be trained to carry out the procedures on their own. She suggested that doctors could train their own staff once they were comfortable with the procedure.

The Nursing Directorate of the MOHCW is preparing a position paper on the feasibility of developing a cadre of Nurse Practitioners. If approved, their training would be provided through the Masters in Nursing Science program scheduled to be introduced in January 1995. It appears that the Nurse Practitioner cadre is intended to replace the cadre of Clinical Officer and that the MOHCW is willing to develop a clearly defined career structure for the new cadre with opportunities for advancement. Also, the Nursing Directorate is pressuring the Ministry to upgrade clinics and accommodations in the rural areas so they can attract more highly trained nurses to the lower levels of the health care system to better meet local health care needs.

Under the leadership of the Zimbabwe Nurses Association (ZINA), nurses have drafted a new Nurses Act that will remove them from the authority of the old Medical, Dental and Allied Professions Act (dating from May 1971). The nurses feel their role is not well defined in the existing Act and their professional needs are not being well served by the Health Professions Council that governs all medical practitioners. Indeed, the language of the Act restricts the Presidency and Vice Presidency to medical practitioners, i.e., doctors.

The proposed Nurses Act has been drafted, discussed, and submitted to the MOHCW for its reaction. So far, no feedback has been given on the draft. At the same time, the MOHCW has undertaken a review of the old Act, apparently without soliciting input from ZINA or the Nursing Directorate. Influential nurses offer mixed predictions as to the next steps. Those within the MOHCW suggest that negotiation and compromise with the Ministry is possible; those within ZINA argue it is not. ZINA stresses that it plans to forge ahead with lobbying Parliamentarians in order to have the new Act passed before the MOHCW submits its own version.

The proposed Act is under discussion by nurses in each province. Among other tasks, the Act will create a Nursing Council of Zimbabwe with a governing board, set regulations regarding a training curriculum, establish an Education Committee to supervise nurse training, establish licensing procedures, set fees that nurses may charge for their services, and maintain a registry of nurses by specialty.

The Act implies that nurses may be able to develop private practices, although the circumstances are not clear from the language used. The proposed Act states

The Council may, with the approval of the Minister, make regulations not inconsistent with this Act in relation to: ...the form of a license to carry on the

business of a nursing agency, the circumstances in which such a license may be issued, suspended or canceled, the conditions subject to which business may be carried on; ... [and] the maximum fees that may be charged by registered nurses for professional services rendered by them [Sections 12.1.q (p.15) and 12.1.t (p. 17)].

Nurses are now able to conduct private practice, provided they are under the regular supervision of a physician.

2.2.2 Analysis

There continues to be conflict between MOHCW and ZNFPC over responsibility for family planning services and technical support. This needs to be ironed out before MOHCW nurses will be willing and/or able to take on a much-expanded role. Conflicts will only be exacerbated if efforts are made to increase nurses' responsibility for clinical methods without adequate provisions made for training, supervision, and technical support.

The proposed Nurses Act may be important in offering nurses greater autonomy and authority vis-à-vis the rest of the health and medical community. It may be the vehicle needed to assure greater bargaining power for assuming new roles and responsibilities in the changing medical conditions in Zimbabwe.

In response to assessment team queries, there were mixed responses regarding the development of private practices by nurses and midwives. One MOHCW official stated categorically that nurses cannot start private practices, and they will not be allowed to do so in the near future. Others interpreted the current law more loosely, noting that several nurses have practices of their own with only infrequent backup by doctors. Indeed, several respondents pointed out that nurses operating in Rural Health Centers carry out all the same tasks that a private nurse would with virtually no backup support by doctors. Nevertheless, after witnessing the continued flow of physicians from the public to the private sector, MOHCW may fear a similar exodus among nurses if private practice were considered a more viable career option for them.

In part, the limited number of practices started by nurses may reflect limited awareness of their right to do so. It may also be a function of the limited number of doctors available or willing to take on the supervisory role. Several informants noted that doctors probably want to limit competition with their urban-based practices and thus are unlikely to encourage nurses to establish practices nearby. The question of private practices for nurses will most likely arise again if the Nurse Practitioner cadre is approved and becomes well established. Similarly, if there is growth in the work-based family planning programs discussed below in Section 4.2, more nurses may wish to pursue this professional path.

2.2.3 Constraints

One major constraint to the increased participation of nurses in the delivery of family planning services is the number that still have had insufficient training. This is being addressed by the Ministry and support for the training updates has been secured from other donors.

There continues to be some ambivalence about offering nurses increased responsibility for LT/P methods. The opposition does not appear to be strongly entrenched; the MOHCW officials probably could be persuaded of the benefits of such action with appropriate research, documentation from other countries, and from Zimbabwe's own experience in pilot projects. Indeed, it appears the groundwork has been laid to train nurses in NORPLANT[®] insertions as soon as research results are confirmed, the drug is registered, and promised funding is obtained from donors. As discussed elsewhere in this report, if services are expanded through different providers, there needs to be a concomitant development of better and more comprehensive supervisory practices.

If the Nurse Practitioner specialization is developed, it implies that a new set of interorganizational relationships must be developed. For example, ZNFPC might be called upon to provide future refresher training in addition to participating in the initial curriculum development. Should Nurse Practitioners develop private practices, ZNFPC would also be obligated to provide information, education, and communication (IEC) materials, and, in turn, Nurse Practitioners would be expected to supply service statistics to ZNFPC. Commodity purchases would have to be negotiated either with the ZNFPC or the commercial wholesalers.

2.2.4 Reforms

Zimbabwe continues to rely on nurses as essential service providers in the health system. If anything, their role is expanding as they take on new clinical tasks. This enhanced role suggests several specific reforms in relation to family planning services:

- Support for a Nurse Practitioner specialization in MCH/FP, particularly emphasizing clinical skills in LT/P family planning methods, is needed.
- Support for the new Nurses Act or a compromise Act negotiated between MOHCW and ZINA should be provided in order to clarify nurses' roles and responsibilities and to reinforce pride and professional standards.
- Private practice for nurses should be explored through research on international experience. At the same time, the implications for Zimbabwe should be estimated, considering service coverage, financial implications for the MOHCW in terms of lost personnel, insurance liability, and so on.

2.2.5 Feasibility

Each reform proposed is feasible in the Zimbabwean context, although privatizing nursing care may be opposed. There are certainly many questions to be addressed. These include whether nurses would be innovative enough to establish private practices in the rural areas and high-density urban areas where they are most needed. The former may not be feasible due to the limited financial resources among rural dwellers to pay private practitioners; the latter may be opposed as it would present a potential competitive threat to urban medical practitioners. There are also implied conflicts if the MOHCW attempts to place more highly trained nurses and Nurse Practitioners in the rural areas, thereby meeting more local needs through public sector sources. Ultimately, the major issue is the need to enhance access through whatever means are most feasible.

The Nurse Practitioner program also appears to be on a track for implementation, although the timing may be ambitious to start in the next academic year. The position paper requested by the Permanent Secretary has not yet been submitted, therefore it is not clear that suitable curricula can be developed and appropriate students recruited in time to inaugurate the program in 1995.

2.2.6 Impact

As with many of the other reforms suggested in this assessment, the development of nurses' family planning skills and the formation of a new cadre trained in a range of LT/P methods can only add to the viability and quality of Zimbabwe's family planning program. Many recent surveys in Zimbabwe show that women and men are well aware of LT/P methods and many indicate that they would choose to use such methods in the future. Making these methods more widely available throughout the country may encourage contraceptors and new users to select these methods earlier in their reproductive years.

The development of private practices for nurses will serve to further expand choice of service providers, meeting the purchase needs of lower- and middle-income Zimbabweans. It will reduce demand on public sector services and possibly release funds for better targeting of services to the poorest of the poor.

- 2. RECOMMENDATION:** Plans for development of a Nurse Practitioner specialization in MCH/FP that emphasizes clinical skills in LT/P family planning methods are encouraged and steps should be taken to speed curriculum development and to begin training the first group as soon as possible.
- 3. RECOMMENDATION:** Support should be provided for either a new Nurses Act or a compromise Act negotiated between the MOHCW and ZINA.
- 4. RECOMMENDATION:** Private practice for nurses should be explored through research on international experience. Implications for Zimbabwe should be estimated with special consideration given to service coverage, financial implications for the MOHCW in terms of lost personnel, and insurance liability.

2.3 Counseling and Services for Youth

Concerns about the family planning and STD prevention needs of adolescents were raised in the workshop. These issues have also been discussed in many other fora in Zimbabwe, including the recent workshops on population for parliamentarians. Workshop participants felt this was an important issue affecting the family planning program and thus listed it among the top 15 priorities to be addressed. However, they concluded it could only be addressed through policy change at a very high cost. Therefore, this section is written to highlight some of the

problems faced by youth in Zimbabwe and efforts being taken to address them. Since it is a section meant more for information than specific program action, it does not make any specific recommendations for policy change at this time.

2.3.1 Findings

An area of concern for both MOHCW and ZNFPC as well as other groups interested in family planning is access to and availability of reproductive health services for youth. Current studies indicate that youth, especially in rural areas, have poor access to reproductive health services. This is the result of a combination of factors, chief among which is the legal age of consent, currently set at 16 years. Also, provider attitudes often prevent the provision of family planning or reproductive health services to youth even if they are above the age of consent.

The age of consent works chiefly through two mechanisms. One is the fact that if the legal age of sexual consent is 16 years, then providers prescribing or giving contraceptives to youth below this age might be seen as effectively condoning statutory rape. This explains, in part, the reluctance of service providers to dispense reproductive health services to youth, in general, and to those below 16 years, in particular, even to those youth who demonstrate clearly that they are sexually active.

The second mechanism is related to regulations governing prescription laws and applies mainly to oral contraceptives (OCs). Current regulations require that a physician prescribing any drugs to a minor also informs a parent or legal guardian of that minor. Consequently, physicians feel inhibited to prescribe contraceptives to youth under the age of 16, even to those who are already sexually active, because they may be accused by the parents of turning their daughters into prostitutes. Thus, there is a lack of understanding among parents of the physician's position as well as that of the youth involved. Also, there is clearly an irrational association among parents and the general population about the relationship between contraceptives and prostitution which needs to be allayed through vigorous education campaigns.

Studies have also indicated that youth are uncomfortable with the current sites where reproductive health services are delivered. This arises from the fact that the service providers know the youths who might come to the centers and that confidentiality might not be assured. Youth the world over are very sensitive at this stage in their physical and biological development to service settings and their conformance with the expected social and cultural norms of their generation. If they feel exposed to ridicule or censure they will shy away from utilizing any services even if they are in urgent need of such services.

The issue of confidentiality constrains the early detection and cure of STDs as well as prevention through education or provision of information to youth. This situation is further compounded because the provider of reproductive health services at most health centers, who is usually a nurse, provides a host of other services which leaves very little time for basic counseling in family life and reproductive health.

The noted consequences of some of these legal, regulatory, and administrative constraints which combine to limit access of youth to reproductive health services have been increases in unwanted pregnancies and unsafe abortions as well as an increased incidence of STDs, including HIV/AIDS. These consequences have raised a warning flag to MOHCW, ZNFPC, NGOs, and donors in terms of the urgent need to address the problem of youth needs. The

"National Population Report," prepared by the National Economic Planning Commission for the International Conference on Population and Development in Cairo in September 1994, devotes some attention to the problems of youth. It notes the need to expand the activities of the Youth Advisory Unit of the ZNFPC by targeting youth in and out of school in the age group 11–24 years, with appropriate family life education messages. It acknowledges that activities of the unit have mainly focused on IEC and that services in the form of contraceptive supplies as well as diagnosis and treatment of STDs and HIV/AIDS have been very limited or virtually non-existent.

The report further notes the difficulties of reaching out-of-school youth and recognizes the need to piggyback onto existing youth organizations in order to reach this difficult group. It also notes the important role that parental education could play in encouraging a better flow of information between parents and children. This recognizes the current unsatisfactory state of affairs in which the majority of what youth learn about sex is gained from friends in the school playground. Such knowledge is often inaccurate, exposing the youth to the dangers of unprotected sex. Statistics show initiation of sexual activity, even among married adolescents, often takes place without contraception. Among the unmarried, these practices often lead to early marriage as an alternative to unwanted pregnancy, abortion, or baby abandonment.

An additional concern is the lack of knowledge younger children ages 10–14 years possess about sexual activities, family planning, and reproductive health. Most surveys and studies concentrate on the age group 15–19 which is considered the lower limit of the female reproductive age group. However, sociological evidence is emerging which shows that female youths in Zimbabwe are becoming sexually active at very young ages. Studies by Run'anga at Blair Research Laboratory have suggested sexual activity among girls begins as young as 10 or 11 years. This finding suggests a need to rethink strategies and approaches to collecting survey data so the age group 10–14 is included. These data might act as a sentinel warning about the likely future reproductive health behavior and contraceptive needs of this youth group. Since most definitions of youth consider the age group 10–14 an integral part of this population subgroup, consideration and special attention to this group's needs must be kept in mind, especially in light of the epidemic of STDs, including HIV/AIDS.

2.3.2 Responses to Reproductive Health Needs of Youth

Some of the concerns highlighted above are being addressed by government and the donor community as well as NGOs and other interested community groups. For example, USAID has devoted some US\$90,000 to a study of adolescent needs in its amended Family Planning Project (August 1994). The proposed study, to be undertaken with technical assistance from The Population Council, will concentrate on answering questions on youth needs, IEC for youth, access to contraceptives that are acceptable to young people, and providers of family planning and reproductive health that carry authority with youth, among others. The study will also look at groups that oppose exposure of youth to family planning messages and seek ways to allay their fears, as well as identify other social groups that might be drawn upon to support these activities.

Further funding for youth studies, to be undertaken in conjunction with those funded by USAID, is being provided by The Rockefeller Foundation. This project examines models of providing access to reproductive health services to youth. The research will investigate existing means of access by youth as well as provide pilot programs for alternative methods. The work is being

done through the Population Council's regional office in Nairobi in conjunction with the Evaluation and Research Unit at ZNFPC and local researchers from the University of Zimbabwe (UZ). This research will also consider out-of-school youth and urban-rural differences.

Funding for youth studies is also provided by the German Association for Technical Cooperation (GTZ). A comprehensive review of the present status of youth problems and prospects has already been completed. Further funding may be provided for a nationwide study of youth needs to highlight rural-urban differences. This is of great value because rural youth seem to have greater difficulties accessing reproductive health services than their urban counterparts. Attention will also be paid to the feasibility of peer counseling. Though this notion is resisted by some social groups and even some providers, it is, in fact, the means by which most youth gain their knowledge about sex and reproductive health. Making youth counseling official through funding support may help ensure that youth receive more accurate information. Indeed, field visits revealed that the demand for information is greater than the demand for contraceptives by both youth and their parents.

Local NGOs appear to be in the forefront of providing youth with counseling as well as advice on their reproductive health and family life. Even church groups, including those sponsored by the Roman Catholic Church, request that the ZNFPC talk to youth gatherings about family planning.

2.3.3 Suggested Future Activities

In addition to ongoing and future studies, there is need for an analysis of the amount of training time devoted in the various family planning and nursing curricula to counseling and advice for adolescents, especially for the 10–14 age group. If this group is counseled and advised properly at an early age then it might avoid the pitfalls of previous cohorts. The curricula should also attempt to overcome provider bias in prescribing contraceptives to youth, even to those who clearly need them and might qualify, i.e., those between 16 and 19 years.

Under the proposed action planning process (see Chapter 5), one area that certainly should be addressed is better donor and local community coordination of all efforts aimed at achieving better access to information and services for the youth. The plan could also target a time frame for introducing better training in guidance and counseling, especially of youth aged 10–14 years, for service providers as well as overcoming the noted provider bias in serving youth.

3. ADMINISTRATIVE CONSTRAINTS

3.1 Who Can Provide or Distribute Contraceptives

3.1.1 Findings

While family planning services in Zimbabwe offer a broad array of methods, OCs continue to dominate actual use. The 1988 DHS reported heavy reliance on OCs, and recent service statistics of ZNFPC show that 85 percent of the total couple years of protection (CYPs) produced in 1993 were attributable to OCs (see Appendix E, Table 9C). Pills are available by prescription after an examination by a nurse or physician. ZNFPC has recently revised its guidelines to waive the need for a vaginal examination as part of this requirement. CBDs can resupply users once they have been examined by a nurse. Pills are available free to those with monthly earnings below Z\$ 400 and at low cost to others through public health outlets. Costs are significantly higher at pharmacies where consumers pay a Z\$ 2.00 dispensing fee in addition to the actual cost of the product.

Within the past two years, Zimbabwe has taken steps to encourage the use of long-term and permanent methods. Depo-Provera was reintroduced to the country in 1992 after being banned for eight years, and NORPLANT[®] clinical trials have been completed. Service providers are being trained to perform minilaparotomies under local anesthesia. The Permanent Secretary of the MOHCW has stated that it is time to change the emphasis of family planning messages from spacing to limitation, and ZNFPC has recast many of its motivational materials to highlight the benefits of LT/P methods.

Diversification of the method mix implies that new consideration must be given to service providers. That is, making available a wider array of methods requires changes in the roles of providers, with different cadres assuming responsibility for methods not previously under their purview. Several factors are converging that present opportunities for innovative application of service provider skills in Zimbabwe. Foremost, the country is faced with a severe shortage of doctors, particularly in the rural areas. Professional salaries are low and conditions of service are difficult relative to those in neighboring countries. As a consequence, hundreds of junior doctors have left Zimbabwe in recent years to take positions elsewhere in the region. Others have left the public sector to establish private practices. Nurses bear the main responsibility for health care in rural posts and the country continues to rely on expatriate doctors to meet its needs. Even so, most hospitals have unfilled medical positions. The MOHCW recently gave permission for public sector doctors to conduct private practices "on their own time" in order to meet demand for services, increase individual income, and induce doctors to remain in Zimbabwe.

To address the need for more skilled medical professionals and also reflecting the maturation of the nursing profession in Zimbabwe, a new Masters of Nursing Science degree will be introduced in 1995. As part of this program, Zimbabwe will begin training a new cadre of Nurse Practitioners with specialized skills in MCH/FP and community nursing.

Finally, the expanded contraceptive mix includes a variety of methods that can be offered in a variety of settings. While NORPLANT[®] and ML/LA require clean and sterile conditions, Depo-Provera can easily be administered anywhere that other injections are given and some privacy can be assured.

What is the present method availability situation in Zimbabwe? For urban residents, removing OCs from prescription may increase availability and improve access to this method. Such a move might also spur growth within the commercial sector as pharmaceutical companies increase imports in order to meet consumer demand.

Pill distribution through all sources shows an unusually high reliance on progestin-only pills (POP), typically prescribed for breastfeeding women. While in most countries these pills generally account for about 20 percent of the OCs used (combined oral contraceptives [COCs] making up the other 80 percent), POPs account for almost half of all OCs distributed in Zimbabwe and in recent years have exceeded 60 percent in Harare and Chitungwiza (see Appendix E, Table 8). One ramification of continued use of this method during the latter stages of breastfeeding or when full ovulation has returned is that women face a much higher risk of method failure and unplanned pregnancy. A recent study concluded that 25 percent of unwanted pregnancies in Zimbabwe could be attributed to method failure and 90 percent of those pregnancies resulted from the improper use of POPs.

NORPLANT[®] clinical trials were recently completed and research results are being summarized by the Department of Obstetrics and Gynecology (OB/GYN) of the University of Zimbabwe Medical School (UZ/Med). Experience among women participating in the trials was positive, with only a few reports of irregular menses. Most women, if adequately counseled ahead of time, did not mind this side effect. Physicians are being trained in NORPLANT[®] insertion as part of the OB/GYN residency program. Nurses are not yet being trained in this procedure; however, UZ faculty recently trained nurses from Botswana to do insertions, much to the frustration and dismay of local nursing professionals. While there are no legal or administrative restrictions to nurses learning the procedure, official sanction for them to do so has not yet been issued by the Ministry nor have training courses been announced. Also, the Drugs Control Council (DCC) has not yet registered NORPLANT[®], which may delay start-up of nurse training programs.

The reintroduction of Depo-Provera was welcomed in Zimbabwe, and the method is being rapidly accepted. It is available at all levels of the health structure, down to Rural Health Centers (RHCs). CBDs are not presently permitted to administer Depo-Provera. Key informants were queried as to whether it would be feasible and desirable to allow CBDs to offer this contraceptive; responses were mixed. On one hand, concern was expressed that CBDs should not undertake "invasive" procedures. It was thought that they would not be able to adequately screen and counsel clients, they would not be able to administer the injection safely, and they were not knowledgeable enough to handle quarterly exams and client follow-up. Furthermore, it was argued that proper handling of the drug and the accompanying syringes might be difficult for some CBDs.

On the other hand, a MOHCW official noted that it is important to "optimally utilize what [staff] we have" and that CBDs provide ready access to family planning services in villages. A CBD supervisor, or group leader (GL), with whom the team met thought that CBDs could offer this service with appropriate training and supervision; her sentiments were echoed by an RHC nurse.

Finally, the MOHCW announcement permitting private practice by public doctors led to a substantial increase in the number of doctors registering with the National Association of Medical Aid Societies (NAMAS), making them eligible for reimbursement from the various medical aid societies. The Commercial and Industrial Medical Aid Society (CIMAS), the largest of the medical aid societies, now reimburses more than 1,000 physicians, including 571 general practitioners and 32 obstetricians/gynecologists. (NAMAS shows 645 general practitioners and 36 obstetricians/gynecologists registered, but some may not be in active practice.)

3.1.2 Analysis

ZNFPC cites a lack of clear guidelines from the MOHCW about who can do what regarding NORPLANT[®], Depo-Provera, intrauterine devices (IUDs), and voluntary surgical contraception (VSC). The ZNFPC is now developing standards and practice guidelines, which were to have been developed in collaboration with MOHCW. Ultimately ZNFPC was asked to take the lead in the development process and is now frustrated by mixed reactions from the MOHCW. In part, there is a perception that the MOHCW is not aware of work being done in the field. For example, the MOHCW thinks that IUDs are only being inserted at the district level, while the ZNFPC knows they are being offered by nurses at some RHCs.

The over-reliance on POPs among OC users points to problems in the correct application of existing protocols and in supervision of staff. In some cases, it appears that service providers are unduly cautious in switching women from POPs to COCs for fear of women discontinuing use altogether. This is not just a problem among lower-level health staff members such as CBDs; one physician reported reluctance to change clients from one pill to another.

Field supervision evidently remains uneven, though little or no research has been done to monitor or evaluate this situation. While some Provincial Nursing Officers (PNOs) have been trained in supervisory skills, neither MOHCW nor ZNFPC offers a specific course on supervision. Some ZNFPC staff members have been sent to the Center for African Family Studies in Nairobi to take a course.

There also continues to be a problem in the division of labor for field supervision between the ZNFPC and the MOHCW. The PNOs and District Nursing Officers (DNO) of the MOHCW must supervise lower-level service providers in all elements of MCH/FP, usually under conditions of very limited resources and inadequate or non-existent transport. In contrast, ZNFPC PNOs supervise only family planning activities and typically have transportation and other resources at their disposal. Efforts are underway to improve field coordination, and some joint supervision is being carried out. This issue, however, continues to warrant attention.

In urban areas, many OC users purchase supplies from pharmacies. Pills are now a Pharmacy Initiated Drug, controlled by the DCC which administers prescription laws and determines distribution and prescription categories. Supplies available in urban pharmacies are significantly more costly than those offered through ZNFPC, MOHCW, or municipal sources. Moving OCs to a full over-the-counter status would improve distribution and make the product more widely available.

It is "in the pipeline" to train nurses for NORPLANT[®] insertion. The MOHCW is waiting to obtain the results of the NORPLANT[®] clinical trials before approving the expansion of training

and services. The report of research results was being drafted at the time of this assessment and should be submitted to the MOHCW by mid-September 1994.

It does not appear that private physicians are moving rapidly to include LT/P methods as part of their practices, although at present it is difficult to track the number or proportion of consultations done for family planning. Observers claim, for instance, that voluntary surgical contraception is not offered often outside the urban centers in part because private doctors seek incentives to do so. More likely, private doctors, like many in the MOHCW, consider family planning to be the purview of ZNFPC and see little reason to offer a service already provided at low cost elsewhere. Many who might be interested find it difficult to leave their practices for the two or three weeks that are required for training in VSC.

3.1.3 Constraints

The analysis of local conditions of service providers and method availability point to several constraints to expanded service. First, it appears that supervision needs to be strengthened at all levels of the health system. Service providers must be reminded of method protocols and held to their application.

The DCC is quite strict and conservative in its evaluation of imported drugs. It is not likely to respond enthusiastically to the suggestion to make OCs over-the-counter products unless very authoritative examples of successful experiences in other countries are compiled and brought to bear on the discussion.

The major constraint to CBD distribution of Depo-Provera appears to be one of training. CBD workers would need to be trained in a new protocol to identify appropriate users, correct techniques of administration, contraindications, management or referral for side effects, and appropriate disposal of used syringes. While none of these are difficult tasks in and of themselves, they might require closer supervision than is now evidently available for many of the CBDs.

Also, CBDs now spend a major portion of their time visiting and resupplying current users. A pilot project is underway to test whether local depot-holders offer a satisfactory means to resupply users, freeing the CBDs to focus more on motivation and recruitment of new users.

The single major constraint to expanded service provision by private practitioners appears to be that of time availability. Also, at present it is difficult to track their delivery of family planning services, making it harder to target them for special training interventions.

3.1.4 Reforms

A number of specific and well-defined interventions for reform are suggested by the above description and analysis:

- Monitor results of the pilot depot-holder project, with an eye to possibly expand it if successful.

- Review and change supply orders to reduce the proportion of POPs as a share of the total supply.
- Disseminate protocols and intensify field supervision to move non-breastfeeding women from POPs to COCs.
- Field a pilot study of CBDs offering Depo-Provera with appropriate training.
- Clarify the lines of responsibility for family planning supervision at the provincial level. This must be specified and not merely left to the provincial staff to determine on its own. While the provincial staff can certainly develop a compromise solution, this must be backed by some authority to ensure its implementation beyond the goodwill of the individuals who accept it.
- Develop a family planning supervision curriculum and begin training.
- Improve supervision of CBDs and other service providers. Assess whether GLs need increased mileage allowances and an additional night on the road for adequate supervision.
- Conduct a desk review of the experience of other countries in removing OCs from prescription registers. If results are favorable, the process should be initiated through submission to the DCC.
- Use mobile training teams to train physicians and nurses in LT/P methods at local sites. Possibly carry out training over a longer period of time, i.e., two days every few weeks.
- Propose that the ZNFPC hire a physician on a long-term contract (two to three years or some other suitable duration) to serve as temporary replacement for periods of up to three weeks to free physicians for training.
- Conduct a study to demonstrate improvements in profitability for private doctors offering FP services.

3.1.5 Feasibility

The reforms suggested above are neither radical nor unduly costly. Many of the interventions have been or are being tested in Zimbabwe under experimental conditions. Others have been tried in other countries with similar family planning programs. All should be feasible to consider in the context of Zimbabwe, given appropriate allocation of resources and suitable technical input.

3.1.6 Impact

The impact of the interventions, in sum, would go far to establish a truly diversified method mix in Zimbabwe. While technically a wide variety of methods are available in the country, in actual fact access to many methods is limited to women in urban areas or within very close range of a fixed health center. Allowing a broad range of providers to offer a wider method mix might increase use, reduce unwanted pregnancies, and improve the efficiency and quality of the care offered, particularly for women living in rural areas.

- 5. RECOMMENDATION:** A pilot study should be fielded to test the feasibility of CBDs offering Depo-Provera.
- 6. RECOMMENDATION:** Measures should be implemented to reduce local reliance on POPs through reinforcement of existing protocols, better counseling, more intensive supervision, and, possibly, restricting the supply of POPs.
- 7. RECOMMENDATION:** A desk review should be conducted of the experience of other countries in the provision of OCs over-the-counter without prescription. If results are favorable, the process should be initiated through submission to the DCC.
- 8. RECOMMENDATION:** Various scenarios should be tested to increase training and expand coverage in LT/P methods. These may include using mobile training teams, carrying out training over a longer time period, and hiring a physician to temporarily replace physicians when they are absent from their practices for training.

3.2 Preservice and Refresher Training in Family Planning

3.2.1 Findings

Overall, preservice training is on track at all levels. Family planning topics have been covered in nurses' training since the mid-1980s. Nurses receive both theoretical and practical training, although it appears there may be insufficient time allocated for the clinical aspect. Until recently, Zimbabwe trained two cadres of nurses, state certified nurses (SCNs) and state registered nurses (SRNs), both of which received training in family planning. SCNs are being phased out with the final class having graduating in 1994. The MOHCW has now begun an eight-year program to upgrade SCNs to SRNs, following completion of three "O" level exams and one year of dedicated training. The upgrading course includes about 70 hours in MCH/FP. Of this, about 15 hours are dedicated to family planning topics. This training is theoretical rather than clinical and is treated as an update, assuming that most of the SCNs are either already performing family planning tasks in their work assignments or will be referring patients to a higher level in the health system.

Medical students also receive compulsory family planning training. This includes theoretical training in family planning during their fourth and fifth years. During the fifth year, all students make a rotation through ZNFPC clinics and some are also exposed to family planning services through their rural attachments. During the second year of internship, it is compulsory that all students have the opportunity to perform IUD insertions and tubal ligations. Faculty at UZ/Med plan to submit a proposal next year for external funding to train interns in NORPLANT[®] insertion. Also, plans are being made to ensure that all interns do at least one week of practical family planning service training, including inserting IUDs and performing TLs.

While preservice training is now well established, there are areas for continued work and improvement evident in in-service training programs. The MOHCW has identified approximately 6,000 nurses and midwives, out of about 9,000 in government service, who were trained prior to introducing the preservice curriculum in 1986 and now require updating of their family planning skills. An in-service MCH/FP training curriculum is now being developed for the first time since 1984 in collaboration with ZNFPC. It will include information on new developments in long-term and permanent methods, as well as STDs, HIV, and AIDS. A special effort will also be made to strengthen the IUD training, especially for midwives.

Some information updates and practice changes are not reaching people in the field. For example, one respondent cited the need to educate service providers that general anesthesia is no longer needed when performing VSC; that it is now possible to do minilaparotomy using local anesthesia. Also, it is no longer necessary to obtain the signature of the client's husband prior to performing a sterilization, and VSC can be offered to women under the age of 35. Although workshops are held and circulars distributed, they do not reach all service providers or are ignored.

Expatriate doctors are widely employed, usually for two to three years, under contract to the MOHCW to serve primarily in rural Zimbabwe where severe shortages of local doctors exist. An MOHCW three-month orientation to the management of patients in Zimbabwe is available for expatriate doctors. Some do not participate, however, in this orientation because they are so urgently needed at their assigned posts they are unable to spare the time. Most do pass through the UZ/Med Department of Obstetrics and Gynecology for about four weeks where they may have some exposure to ML/LA. ZNFPC makes no special effort to include family planning information in the orientation for new arrivals, although it reports that "many" of the doctors who participate in the routine ML/LA training courses are expatriates.

Efforts are underway to decentralize family planning training with provincial and district training centers being built or refurbished with World Bank funding. Ten of these training centers have been completed. In theory, each should be staffed by two trainers, but in actuality there may be only one or no trainers posted at these centers. As pointed out in a recent World Bank mission report, many trainers have not been trained as trainers. Nurses may be seconded from nearby facilities to conduct training or courses may be postponed until a trainer can be assigned.

The MCH/FP clinical course offered by the MOHCW is now conducted in the districts by Community Nursing Services. As the ZNFPC training facilities in Harare and Bulawayo are perceived to be better and more affordable, most other courses, e.g., CBD, training of trainers, and genital tract infection (GTI)/IUD, continue to be offered there.

ZNFPC is in the process of revising and increasing its training courses. It has just prepared a written curriculum on diagnosis and management of genital tract infections combined with

training in IUD insertion. This course had previously focused only on clinical aspects and is now expanded and routinized. A new training course for GLs (CBD supervisors) is in a "bare bones" state, needing some additional material. There is also an experimental training program for depot holders and trainers of depot holders to accompany the pilot activity which tests this means of contraceptive resupply. Should the program be adopted for wider use in the country, the training will become institutionalized. Finally, plans are underway to develop a training curriculum for HIV counseling. At present, some elements of this are included in counseling modules offered in other training courses, but there is no dedicated effort to address this subject.

3.2.2 Analysis

Revision of the in-service training curriculum in MCH/FP is proceeding very slowly and is now scheduled for completion in June 1995. Work is evidently delayed because new issues, such as medical barriers, are continually being introduced for inclusion. Evidently few refresher courses are being offered to nurses while the revision is in progress, slowing the updating process for existing staff. Eventually the MOHCW would like to offer biannual refresher courses for everyone with family planning training.

Although field supervision of MCH/FP services continues to be erratic, there are no courses dedicated to the development of supervisory skills or systems offered by the ZNFPC.

The MOHCW and ZNFPC are both developing computerized databases that will allow them to track nurses' training, including subject matter and date of training as well as training needs. Use of the system should result in improved planning and scheduling for training.

3.2.3 Constraints

As discussed above in Section 3.1, supervision by PNOs is limited by access to vehicles and scheduling constraints. It is also limited by inadequate training of supervisory personnel. Thorough and consistent supervision should accompany new training to ensure that new knowledge and techniques are properly applied. It cannot be assumed that good supervision is assured if carried out by an individual of higher rank or more training. Rather, supervision is a process requiring specific skills and planning abilities that must be learned.

Circulars are often slowly disseminated because only one copy is sent from the central level, and they must be duplicated one at a time in places that do not have access to photocopiers or computers.

Some constraints are also presented by training staff. There is apparently frequent turnover among ZNFPC trainers. Turnover in trainers may be alleviated as provincial training centers are enhanced. Assignment to a single training post may encourage women to stay with the program longer. Although the clinical family planning course is being decentralized to the districts, many of the instructors there have not been trained as trainers. That is, nurses are pulled from their usual work on the wards to carry out the training. Also, there is evidently only one or two MOHCW midwifery tutors able to do the IUD training; the MOHCW would like ZNFPC to assume responsibility for offering this practicum.

3.2.4 Reforms

Much attention has been devoted to MCH/FP training in Zimbabwe, and the system for this training is increasingly more rational and well established. This assessment has identified several points of intervention that would serve to strengthen the training and the follow-up use of new skills learned:

- Complete work on the revised MCH/FP course as soon as possible. Technological and service delivery changes can be included as updates as they arise and conveyed through other means to previously trained field workers.
- Develop a family planning supervision course curriculum and begin training in supervisory skills.
- Make use of quarterly meetings held in districts and provinces for nursing staff to convey and emphasize updated family planning information.
- Introduce a family planning update—a single-page, bulletin-type newsletter to be disseminated on a quarterly or semiannual basis to all providers in country: ZNFPC, MOHCW, local and municipal health staff, NGOs, and the private sector. This can be used to announce changes in technology, policy, administration, and procedures. As many copies as possible should be prepared at the central level.
- Explore with the Zimbabwe Nurses Association the introduction of a one-day, in-service course or technical sessions on family planning updates in conjunction with its annual meeting.
- Instruct district-level MOHCW trainers in training techniques and provide them with adequate materials to carry out their task properly.
- Develop a brief family planning module to include in the orientation for expatriate doctors.
- If possible, increase the family planning training that is included in the curriculum used in upgrading SCNs to SRNs and give particular emphasis to clinical training.

3.2.5 Feasibility

The ZNFPC has a proven record in the development of family planning training materials. It should not be difficult to prepare the new curricula and modules suggested here, especially as models exist from training programs in other countries that can be adapted for local conditions.

USAID has indicated that The SEATS Project is about to begin some activities aimed at strengthening supervisory capacity within the ZNFPC that will possibly include some participants from the MOHCW. This may provide a starting point for a larger program that targets both ZNFPC and MOHCW supervisory staff.

Similarly, ZNFPC has state-of-the-art production facilities for IEC materials at its headquarters in Harare. Production of a biannual bulletin for field staff should not pose technical problems.

What will be required is an acknowledgment by ZNFPC management and the MOHCW that such a product will be useful and valuable as a means to maintain communication with the field and the dedication of a staff member to undertake this activity twice a year. Evidently the ZNFPC has a line item for a similar activity in its project funding from UNFPA, but these funds have not been expended. (The UNFPA-funded newsletter is apparently defined as one internal to the ZNFPC, whereas the one suggested here is intended for distribution to all service providers in government, private, and NGO sectors.) Obviously, this assessment team is not the first to detect the need for such a communication channel.

It is envisioned that a bulletin would be clear, concise, and convenient. All CBDs are required to have English language capabilities, therefore it would need to be produced in only one language. The bulletin would not need to include lengthy reporting articles; rather it should emphasize technical and administrative changes that affect service delivery at all levels. This might include information on user fees and commodity prices, changes in service guidelines or reporting practices, introduction of new methods or brands, updates on contraceptive acceptor trends in different parts of the country, promotions, and training opportunities.

The decentralization of training implies a need for additional qualified trainers. Special attention should be paid to developing the didactic skills of a training cadre in the provinces and districts, particularly in view of the great number of nursing personnel the MOHCW has identified as requiring family planning training. It is not clear that the biannual refresher courses proposed by the MOHCW for all family planning workers will be needed, particularly if the MOHCW and ZNFPC are able to improve other means of communication with field staff.

Finally, The Population Council has negotiated funding from UNFPA to support the expansion of NORPLANT[®] services in the public sector. The project will include training of trainers and supporting nurses in the MCH/FP training course. The availability of these resources may help speed the retraining process.

3.2.6 Impact

Continued attention devoted to preservice and in-service training can only serve to improve the quantity and quality of service providers in Zimbabwe and increase the access and use of FP services. In turn, additional and more-qualified service providers should better counsel family planning users and new acceptors and improve the selection of appropriate contraceptive methods.

9. RECOMMENDATION: Work on the revised MCH/FP course should be completed as soon as possible. Technological and service delivery changes can be included as updates as they arise and conveyed to previously trained field workers through other means.

10. RECOMMENDATION: A family planning supervision course curriculum should be developed and specific training in supervisory skills should begin as soon as possible.

- 11. RECOMMENDATION:** A variety of means should be introduced to convey new information to the field, including introduction of a twice-yearly bulletin, regular quarterly meetings of provincial and district staff, and technical sessions introduced into annual meetings of ZINA.
- 12. RECOMMENDATION:** A family planning module should be developed for incorporation in the orientation course for expatriate doctors provided by the UZ/Med Department of OB/GYN.
- 13. RECOMMENDATION:** The amount of family planning training included in the curriculum for upgrading SCNs to SRNs should be increased and clinical training, in particular, should be emphasized.

4. ECONOMIC AND COMMERCIAL CONSTRAINTS

Traditionally in Zimbabwe, the bulk of health delivery services relating to family planning have been provided by the public sector. The establishment of the ZNFPC marked the commencement of active interest by the GOZ in developing an appropriate long-term strategy for the provision of family planning services throughout the country. Since that time, when the activities previously undertaken by private individuals and NGOs were absorbed into this newly created government institution, national family planning activities have been dominated by the Council.

The cost of these services has escalated enormously as the level of infrastructural development has increased, and the public sector is now having to fund very high levels of expenditure in support of its family planning activities. At the same time, the rate of population growth in Zimbabwe, while declining from 3.80 percent in 1980 to 3.13 percent in 1992, is nevertheless running ahead of the country's rate of economic growth. Thus, health services must cope with the problem of diminishing per capita resources.

In view of this domination by the public sector—characterized by widespread distribution of heavily subsidized contraceptives which accompany such programs—the private sector has been comparatively disinterested in the family planning market until recently. With the exception of OCs, for which a market niche at the top end of the social grades has existed for many years, there has been very little demand to stimulate development of commercial family planning markets. Although a substantial number of consumers exists which is capable of financing its own consumption through medical insurance (approximately 700,000 persons insured through 26 medical aid societies) and which could make use of commercial family planning services and products, the bulk of this potential market has been historically serviced by the public sector. Consequently, commercial interest in the family planning subsector has remained low.

4.1 Sales Tax and Duties on Condoms and Contraceptives

4.1.1 Findings

The public sector has achieved considerable penetration into the rural areas of the country in addition to providing increasingly sophisticated services in urban areas. These services have been facilitated through a network of urban clinics, rural CBD workers, and staffing at all levels of the MOHCW health delivery network (see Table 1).

TABLE 1

THE FAMILY PLANNING DELIVERY NETWORK IN ZIMBABWE	
TYPE OF OUTLET	NUMBER AS OF JUNE 1994
REFERRAL HOSPITAL	6
PROVINCIAL HOSPITAL	7
MATERNITY HOSPITAL	6
DISTRICT HOSPITAL	37
RURAL HEALTH CENTER/CLINIC	886
SUBTOTAL MOHCW FACILITIES	942
MISSION HOSPITAL	120
MUNICIPAL CLINIC	102
INDUSTRIAL CLINIC	185
PRIVATE HOSPITAL	40
PRIVATE/MINE CLINIC	62
SUBTOTAL PRIVATE/NGO FACILITIES	509
ZNFPC CLINIC	25
ZNFPC CBD WORKER	780
SUBTOTAL ZNFPC FACILITIES	805
TOTAL FACILITIES	2,256

Source: MOHCW Annual Report 1993; ZIMA; ZNFPC Statistics

The commercial sector has been reluctant to enter this market aggressively since there has generally been a regular, if somewhat unreliable, supply of high-quality, free, or highly subsidized products available. Historically, the only available target market for pharmaceutical companies in the family planning subsector has been the high cost, branded end which relies on low volume/high margin business. A selection of comparative prices is shown in Table 2, from which it may be seen that the prices of fully commercial products range from five to almost nine times the price of their subsidized equivalents.

TABLE 2

PRICE COMPARISONS FOR A SELECTION OF COMMERCIAL AND PUBLIC FAMILY PLANNING PRODUCTS AS OF AUGUST 1994		
PRODUCT	SUPPLIER	RECOMMENDED RETAIL PRICE (Z\$)
CONDOMS:		
Durex	Zimbabwe Pharmaceuticals	\$ 7.40/3-pack
Protector	Johnson & Johnson (J&J)	1.80/3-pack
PILLS:		
Ovrette	ZNFPC	2.10/cycle
Lo-Femenal	Family of The Future	4.00/cycle
Norquest	Geddes/J&J	4.75/cycle
Nordette	Geddes	10.96/cycle
Micronor	J&J	17.58/cycle
Trinovum	J&J	17.10/cycle
LoGynon	Schering	9.58/cycle

Source: Assessment Team's Findings

To compound the problem, there is very little collaboration between the ZNFPC, whose stated objective in its current five-year strategy is to expand the role of the private sector in the delivery of family planning products and services, and the health industry principally because

- The mechanisms for such collaboration do not exist.
- There is no incentive, by way of policy, to foster private sector development.
- The success of the public sector program reduces market pressure on the private sector by providing products to consumers at all socioeconomic levels.

As a result, there have been comparatively few competitors in this market. Additionally, it should be noted that the distribution channels available to the private sector have been somewhat limited. There are only 130-160 pharmacies in the country for dispensing OCs and other prescription products, and new outlets are very expensive to develop. Potential marketing costs of promotions, detailing to doctors/prescribers of the products, and distribution are comparatively high. Also, advertising opportunities have been limited by legislation. Pills cannot be advertised in the mass media, therefore potential consumers of the respective brands have not been able to influence choice to any degree.

At present, the commercial sector of the family planning market comprises five principal companies, covering four main products:

- Two prominent private marketing organizations cover the range of OCs (Geddes and Johnson and Johnson [J&J]), together with several other peripheral players whose influence is extremely small (DAB Marketing, Datlabs, and Zimpharm). Profit margins for products in this category are estimated to range from 40 percent to 80 percent.
- There are two significant marketers of condoms (J&J and Zimpharm), with the J&J socially marketed brand (PROTECTOR) being most prominent in the market. Geddes, which previously marketed the PROTECTOR brand and which, until recently, held the franchise for Durex, has completely abandoned the condom market, citing lack of profitability as the principal reason. Although high margins are sought by the companies at the top end of the market, it is clear that profit levels for commercially marketed condoms are no higher than 25 percent.
- Geddes is the only significant company in the market with regard to IUDs and injectables. In addition, Geddes holds the Upjohn franchise and hence controls the private Depo-Provera market. Nevertheless, with Depo-Provera shortly coming off patent internationally, generic versions are already available, and it is likely that more vigorous competition will ensue in the future. Of all the family planning products available, Depo-Provera is most likely to succeed in the medium term, because profit margins are still attractive, even in its generic form. Typically, Depo-Provera can carry a 40 percent margin in either form.

Private doctors are reluctant to become too involved in the provision of family planning services. They tend, already, to be overloaded with patients and perceive family planning business to be "marginal" in terms of potential income. This has already resulted in a very poor response to the earlier Social Marketing for Change Project (SOMARC) initiative to train private doctors in IUD insertion.

Historically, condoms distributed by the ZNFPC and by other projects such as the National AIDS Control Program (NACP) have been distributed at no charge to the consumer. However, in 1992, following a GOZ directive to move the ZNFPC toward cost recovery, a price of Z\$0.10/piece was established and effected toward the end of the year. Condom CYP fell dramatically between 1992 and 1993 from 82,444 to 23,800 within the ZNFPC service delivery system (see Appendix E, Table 9B). While this cannot be entirely attributed to price because other variables, such as stock availability, are unknown, it is clear that the introduction of a charge for condoms played a significant role in this drop. This suggests that demand for condoms is not at all price elastic, at least at lower socioeconomic levels. This is true despite the fact that at the present price, a one-year supply of condoms comprises less than three percent of the average annual household expenditure of the C1/C2 and D socioeconomic groups.

At present, there are three principal sources of commercial condoms. Donors including USAID, UNFPA, and the Overseas Development Administration (ODA) charge up to US\$0.0535/condom, usually on a counterpart-funded basis. Thus, the commodities are sourced by the donor in foreign currency, shipped to Zimbabwe, and paid for locally by the recipient commercial company in the case of social marketing activities. The world market is a second source, and prices are lowest from the Far East (Korea, Taiwan, and Malaysia). Prices from these sources currently stand at approximately US\$0.025/condom freight on board (FOB).

There are also brand owners such as The London Rubber Company (Durex), whose prices to their franchise holders tend to be considerably higher and profit based.

A similar scenario exists for the other commercial contraceptives. OCs available on the market range in cost from US\$0.265 (Z\$2.12 FOB) upwards, compared with the base selling price of Z\$2.10 from the ZNFPC. Demand by new consumers for commercial products is, therefore, benchmarked by these very low/subsidized prices, and it is possible that this contributes to the price inelasticity of contraceptives on the commercial market.

Estimates of market potential are difficult to compile with any accuracy, given the lack of reliable data, particularly market research. Nevertheless, some estimates have been compiled and are contained in Table 3. This assessment correlates quite well with the 1988 DHS finding that approximately four percent of all contraceptive users receive their services/products from the private and commercial sectors.

TABLE 3

ESTIMATED COMMERCIAL MARKET FOR CONTRACEPTIVES IN ZIMBABWE AS OF DECEMBER 1993				
PRODUCT GROUP	COMMERCIAL SALES (UNITS '000)			
	1991	1992	1993	1994
1. COMMERCIAL				
CONDOMS	100.0	235.0	481.5	1,018.5
ORAL CONTRACEPTIVES	36.0	62.3	33.7	40.8
IUDs	0.3	0.3	0.3	0.3
INJECTABLES	0.0	0.5	7.6	11.4
SUBTOTAL COMMERCIAL CYPs	5.0	8.5	10.6	17.4
2. SOCIAL MARKETING				
CONDOM	1,232.1	1,105.0	1,412.2	1,519.5
ORAL CONTRACEPTIVES	67.5	107.0	17.3	10.5
IUDs	1.5	0.8	0.6	0.1
SUBTOTAL SOCIAL MARKETING CYPs	25.2	23.5	18.7	16.5
TOTAL PRIVATE SECTOR CYPs	30.2	32.0	29.3	33.9

Source: Commercial Companies; CIMAS; SOMARC

The GOZ still tends to overlook the potential outcomes for the private sector when dealing with commodity issues at the central level. For example, a waiver was recently obtained from the GOZ to permit the ZNFPC to buy oral contraceptives (Lo-Femeral and Ovrette) directly from the manufacturer (Wyeth) without going through the regular tender process. The implications of this development are to further erode the profitability of the local agents and distributors, through whom such purchases would normally be made, and to erode existing GOZ relationships with these local actors.

By March 1995, 66.5 million condoms donated to the GOZ by ODA are anticipated to arrive in Zimbabwe. A further 277 million ODA-donated condoms are expected to arrive over the next five years. The private sector is seeking some of these commodities as a means of sustaining a marginal social marketing program over the next few years. Since they have already been donated to the ZNFPC, approval for their use in this way needs to come from the ZNFPC. There is grave concern that the availability of so many donated condoms will seriously affect the viability of the fledgling commercial condom market if the condoms are not very carefully managed and secured.

There is evidence that the ZNFPC sells commodities to the commercial sector at prices which are impossible to match within the normal importing system. This fact, which arises from the subsidized nature of ZNFPC commodities, undermines the long-term viability of the commercial sector.

The imposition of dispensing fees on certain classes of products, including OCs, sold through pharmacies raises the perceived price of the product quite substantially. In the case of OCs, however, this problem has already been recognized, and the regular dispensing fee of Z\$7.00/cycle has been reduced by the Retail Pharmacists Association to Z\$2.00/cycle. In fact, in the case of the SOMARC brand, Norquest, the fee has been further reduced to Z\$2.00/box of three cycles as of November 1993. This development has been well received by the consuming public, although its effect on the overall level of OC sales is difficult to determine.

4.1.2 Constraints

It is clear that cost is a major constraint for the commercial sector. Even the lowest international price for condoms mentioned above (US\$0.025) represents a cost to the importer of more than Z\$0.20 per condom. This is double the price of the product available from the ZNFPC, whose "private sector price" is Z\$0.10 each, and more than six times the handling fee of Z\$0.03 which the ZNFPC charges the public sector, i.e., the MOHCW. The commercial sector is squeezed between high landed costs for its commodity supplies and artificially depressed selling prices as a result of the successful public sector program. The GOZ reintroduced free provision of condoms to public sector clients in April 1994. While the reasons for this decision are entirely supported, this leads to significant problems in the development and viability of the commercial sector when these products "leak" into the private sector and find their way onto supermarket and pharmacy shelves.

The lack of a clearly defined family planning policy which stipulates and encourages the relationship between the public and private sectors is a significant constraint both in terms of cooperation and commercial participation. There is evidence that, although the need for

commercial participation is accepted in the public sector, the development of an appropriate mechanism by which this can be accomplished is simply not occurring.

Perhaps the biggest current barrier to increased participation by the private sector in the provision of family planning products and services in Zimbabwe is the burgeoning "grey market." This has come about both because of the presence of large quantities of donated products and because, with the relaxation of import restrictions, imported finished products have been easier to procure. For example, Nordette has been coming into Zimbabwe as a donated product purchased from Wyeth by UNFPA/Zambia and brought into the country by the GOZ. This trend applies to all donor-related products, where difficulties and indifference toward stock control encourage the establishment of conduits between the public and private sectors.

In addition, Nordette can be purchased at very competitive prices by the private sector from sources which are not registered with the DCC. Stocks of the product manufactured in India, for instance, can be found throughout the retail sector. Since the registration process has been circumvented, these products are much cheaper than the registered, agent-imported equivalent. Accordingly, sales of all OCs by Geddes became erratic and dropped dramatically over the past three years (see Table 4).

TABLE 4

SALES TRENDS FOR GEDDES LTD. ORAL CONTRACEPTIVES, 1990-94				
PRODUCT	COMPARATIVE SALES (BASE YEAR 1990/1991)			
	1990/1991	1991/1992	1992/1993	1993/1994
Microval	100	16.0	0	56.0
Nordette	100	29.0	4	8.0
Tri-Nordiol	100	17.5	0	20.0

Source: Geddes Ltd.

DCC is becoming more strict with regard to the distribution classification criteria for drugs. This suggests that the ability of the private sector to market more aggressively may be limited by the activities of the regulatory body. Because of this and for the reasons outlined above, Geddes does not view the family planning market having great potential. Accordingly, family planning has not been identified as a core business market for the future.

Finally, the growth of the commercial market is constrained by the limited distribution capabilities which are available into rural areas. It is axiomatic that commercial distribution channels extend only as far as they generate profit for a company and the family planning market has not yielded the potential necessary to foster such growth. This problem is compounded by the reluctance of private physicians in Zimbabwe to participate in the distribution chain.

4.1.3 Potential Reforms

Within the last year, some of the problems related to the "grey-market" parallel importation of contraceptives (particularly OCs) have been alleviated by the imposition of much tighter controls by DCC. Presently, if a retailer of registered products is found to be selling a product which is unregistered either by brand, product, or even source of manufacture, a spot fine of Z\$50.00 may be imposed by the recently established Drugs Inspectorate, a national team of eight inspectors. Because such a fine is classified as a criminal offense, it may lead to barring the offender and the premises from retailing for up to three years.

The benefits of this development are well illustrated by Geddes' experience. As a result of the above, Geddes' sales of Nordette have jumped from approximately 150 cycles/month to more than 8,000/month over the past six months. Strengthening of this capability within DCC is desirable and will help to channel public and commercial products more appropriately. At the same time, it would be of great practical use to review the DCC regulations governing the importation, registration, testing, and sale of contraceptives. In discussions with the commercial players in the market, these regulations were cited as being restrictive and discouraging of market development. Specifically, the following issues need to be addressed:

- The newly enforced requirement that all imported condoms must be registered before being able to be sold (hence the considerable delay in commencing marketing activities)
- The high cost of testing every batch of condoms, together with the number of units needed for testing
- The delays which invariably occur when these products are submitted for testing

The removal of sales tax on commercially sold condoms (10 percent at the retail level), together with the removal of the residual duty/surtax components on all other contraceptive products (currently 20 percent on oral contraceptives), is a simple process, requiring only a directive from the Ministry of Trade and Commerce to be enacted. The directive would need to be motivated through the ZNFPC and would require the approval of the Ministries of Justice, Legal and Parliamentary Affairs, and Finance. Its implementation would offer an immediate amelioration of commercial concerns regarding pricing. At the same time, the GOZ would be endorsing its encouragement of the family planning program by endowing condoms with an essential product status, the rationale behind the identification of tax-exclusive products at present.

The removal of duties would, of course, have a financial impact, because it would deprive the Treasury of revenue. However, on the basis of the market estimation developed in Table 3 above, it is likely that lost income from sales tax on condoms would not exceed Z\$250,000 per annum, at current sales levels, and lost income from the importation of oral contraceptives would not exceed Z\$100,000 per annum, at current sales levels. Motivation of this reform would be stimulated through the ZNFPC, although the directive would need the approval of the Collector of Customs in addition to those mentioned above. In this regard, it is noted that, in terms of the existing USAID Family Planning Project (Number 613-0230), covenant number B3 under the Project Authorization Memorandum stipulates that the GOZ will develop a plan and initiate a process to eliminate import duties on all contraceptives within two years after the execution of the Grant Agreement. Clearly, this activity is desirable, but, although the process

has begun with the removal of duties on condoms and reduction in the duty on OCs, it is not yet complete.

Efforts to encourage the participation of private physicians in the commercial distribution and marketing of contraceptive products must be undertaken if the sector is to grow. These efforts will have to focus on demonstrating to them that the inclusion of this type of activity in their practices can lead to a demonstrable increase in profitability in the medium term, with no loss of income in the short term. In this way, the commercial sector may expand more rapidly and, hence, become more viable.

4.1.4 Assessment of Feasibility

The reforms recommended above are considered to be simple, inexpensive, and quick to implement. They are clearly feasible inasmuch as they do not require substantial resources and will yield almost immediate benefits.

4.1.5 Impact on Population Segments

The population segments which will be most affected by the above reforms are the A, B, and C1/C2 income groups, primarily in the urban areas of the country, at least at first. This represents approximately two million people, all with disposable income, who may become less reliant on the public sector for this component of their health delivery needs.

- 14. RECOMMENDATION: Commercially sold condoms should be excluded from attracting sales tax.**
- 15. RECOMMENDATION: All remaining import duties and surtax charges relating to commercially imported contraceptives should be removed.**
- 16. RECOMMENDATION: The DCC regulations governing the importation, registration, testing, and sale of contraceptive products should be reviewed with the objective of facilitating the development of the commercial family planning sector.**
- 17. RECOMMENDATION: Support should be given to DCC to strengthen and expand its monitoring capabilities throughout the country.**
- 18. RECOMMENDATION: A review of past research should be conducted to preface a local, private physician cost/benefit analysis of family planning activities that should be undertaken to demonstrate improvements in profitability for private doctors offering family planning services.**

4.2 Expansion of Work-based Family Planning Services

4.2.1 Findings

Work-based family planning programs first began to receive formal attention from the ZNFPC in 1987–88, although these activities were not unknown in the workplace prior to that time, notably within the mining industry with companies such as Trojan Nickel Mine, Zimalloys, and Union Carbide. The ZNFPC, however, was able to strengthen this component and commenced a work-based project in five large companies under the auspices of The Enterprise Project. This project was terminated in 1990 and, with its limited resources, ZNFPC headquarters staff was unable to follow up and monitor progress effectively at these sites thereafter. Indeed, there have been several complaints regarding this situation by the participating companies, whose family planning activities have been set back as a result. Only one major company, Union Carbide, still collaborates with the ZNFPC at the headquarters level.

The initial impetus imparted to work-based programs by The Enterprise Project was lost when the Zimbabwe Economic Structural Adjustment Program was initiated in 1991. Between the close of the Enterprise program and the introduction of the ESAP, the ZNFPC had identified the need for a continuation of the work-based program and had identified 42 appropriate companies for participation (see Appendix H). From these companies, 10 were finally selected for further consultation at which time the process stalled because of the tenuous financial environment generated by ESAP. Only toward the end of 1993 did the commercial sector again start expressing interest in implementing work-based programs, but this has not yet been followed up by the ZNFPC due to resource constraints. Furthermore, the concept is still viewed with caution by the commercial sector even though the macroeconomic constraints mentioned earlier are now easing.

Following the contraction of the work-based program at ZNFPC headquarters, recruitment of employers to the scheme was delegated to the provincial level, whereas previously recruitment was administered centrally. This change was also motivated by the decentralization policy effected within the ZNFPC last year. Nevertheless, PNOs given responsibility for company recruitment have no training in recruitment skills, as no such skills exist at the ZNFPC itself.

The medical insurance coverage now provided by the health insurance industry is very comprehensive and covers approximately 15 percent of the formally employed sector (see Appendix G, Table 3)—approximately 700,000 workers and beneficiaries combined. In the light of this growth, it is not surprising that many companies now consider it more cost-effective to buy medical coverage for their workers, as most medical aid societies now include reimbursement for family planning activities, than to lay out capital for the provision of such services in the workplace.

The commercial farming sector in Zimbabwe has also been the recipient of significant work-based intervention studies and activities. It employs over 20 percent of the population, either directly or indirectly, with approximately 1.8 million people living on commercial farms throughout the country. There is already an active (though small) FP project in place on a number of commercial farms under the auspices of the Commercial Farmers Union (CFU). Previously, The Enterprise Project included a CFU component involving between eight and 20 farms during its tenure. On the face of it, therefore, there are significant opportunities for expanded FP activities within this sector. However, the success of the current and past

interventions has been disappointingly low and is believed to be due, at least in part, to the following factors:

- Residual political sensitivity to the concept of FP in an “agricultural” setting.
- Preoccupation with rising input costs, the immediate concerns associated with the AIDS epidemic and the necessity for commercial farmers to provide a correspondingly higher proportion of health care for workers as a result. In this regard, there has also been concern that the private sector is being called upon to shoulder too much of what has been traditionally viewed as GOZ responsibility.
- Concerns over the future of commercial farming in the light of the land tenure reforms (the situation, although stable, has not yet been fully resolved).
- Short-term survival prospects related to the spate of poor rains/droughts which have plagued the country over the past five years. In this context, FP activities (which require a long-term perspective) have much less significance and tend to be seen as “unaffordable.”

4.2.2 Constraints

One of the most significant problems encountered in the expansion of work-based family planning programs is the lack of rapport between ZNFPC staff members and the companies which they are tasked with recruiting. This is due to staff members’ lack of skills training, their unfamiliarity with the private sector and its financial and operational framework, and the lack of appropriate evidence to support cost-benefit claims. This issue has already been recognized and, indeed, has been included in the amendment to the USAID Family Planning Project (FPP) currently under consideration.

The possibility of recruiting depot holders for family planning products within the ZNFPC is a suggestion which lends itself to application in work-based programs. However, while the use of depot holders may possibly increase accessibility and convenience of resupply for short-term method users, it will not help to achieve the objective of encouraging a move toward LT/P methods. Thus, in considering the expansion of work-based programs, the possible placement of depot-holders at work sites would need to be supported by other activities to foster the latter objective. Expanding LT/P method use in this context could be motivated by having an “immunization program-type” approach, i.e., doctor/nurse teams carrying the whole package of methods into the work site and being able to offer them on demand. It is worth noting that this approach has been found in two UNICEF cost studies as cost-effective and accounts for a large fraction of all new acceptors relative to fixed-facility services.

The systematic identification of potential companies for recruitment is a minor, but significant, constraint in expanding work-based programs. There is no evidence of a system within the ZNFPC to facilitate the promotion of the scheme in the past. Equally, the fact that no follow-up activities were undertaken after the Enterprise and subsequent projects were abandoned is evidence of a constraint on the likelihood of achieving successful and, hence, marketable results in the future.

With regard to the potential for expanded FP activities in the commercial farming sector, the issues mentioned under Section 4.2.1 are far from being resolved. The only obvious prospect for policy intervention would seem to be in respect of tax incentives to encourage commercial farmers to offer FP services. However, this constitutes another sensitive issue because CFU and GOZ already differ with regard to the level of relief that is necessary to sustain the industry. Accordingly, it is not recommended that policy change be considered at this point.

Despite the foregoing, however, it is clear that the CFU would benefit from a more comprehensive commercial approach, if this could be demonstrably cost-effective and introduced and properly maintained. Thus, it is recommended consideration be given to providing this analytical momentum within the private sector through a facilitating partner, such as The PROFIT Project.

4.2.3 Potential Reforms

There are a number of observations relating to the work-based motivators which may be relevant in the design of a possible request for proposals to manage private sector family planning activities, including work-based programs, anticipated in the USAID project amendment and which will help to put the reform recommendations which follow into perspective.

- There is a need to train work-based program coordinators in recruitment skills within the private sector. Such training should include a period of observation/instruction in the sales, production, and finance departments of one or two selected private sector companies.
- Protocol within the private sector dictates that those negotiating a deal should have a similar status in their respective organizations. Accordingly, work-based motivators should be able to deal with the authority of the ZNFPC behind them and should, perceptually at least, be "in charge" when negotiating with senior executives in the private sector.
- A system must be developed to permit thorough and repetitive canvassing of the private sector. For instance, The Enterprise Project initiated the compilation of a substantial amount of appropriate marketing information which could now be usefully exploited to revive communications with the private sector. Foremost in this data is the list of companies which was originally identified as being appropriate and from which a "short-list" of candidates was drawn for The Enterprise Project (see Appendix H). In addition, there is a substantial database relating to company size and activity (see Appendix G) which could also provide targeting information. Such information would need to be carefully back-checked, and it is recommended that the start-up criteria should also be reviewed to provide a broader base of potential candidates for follow-up.
- An updated cost-benefit model needs to be produced and circulated to all work-based coordinators. Thereafter, these coordinators will need to be thoroughly conversant in its application in order to demonstrate real benefits to their private

sector target companies. Several such models have been developed by USAID projects and are be available for adaptation in Zimbabwe.

- Resolution of the above issues is a necessary prerequisite to the establishment of good working relations between the motivators and the private sector. However, active encouragement of participation in the work-based program will still need to be provided. This is best accomplished through financial stimulus and, since medical costs are already allowed for tax purposes, it is recommended that additional tax benefits be considered. For instance, each dollar spent on family planning in the workplace could earn two dollars of tax relief for the company.
- Another area for consideration concerns the regulations governing participation by company workers in medical insurance schemes. This issue is already under discussion by a subcommittee at the National Social Security Authority (NSSA). However, uncertainty surrounding the modus operandi, the potential for conflict with established schemes, and the general dissatisfaction over the terms of reference for an NSSA health scheme do not bode well for successful implementation of change, at least in the medium term. Nevertheless, it is recommended that, regardless of the level of coverage by a medical insurance scheme, family planning services should be fully reimbursed through work-based programs to facilitate increased utilization of these services.

4.2.4 Assessment of Feasibility

The needs of the work-based program have been documented in the past and are already being addressed through the proposed USAID project amendment. In that sense, the feasibility of the proposal has already been assessed. Nevertheless, the above-named reform proposals are considered to be of immediate benefit and have been adjudged to be feasible in both the short- and medium-term, primarily because they involve minimal capital expenditure and have clearly defined operational parameters.

4.2.5 Impact on Population Segments

The population segment likely to be most affected by reforms relating to work-based family planning programs is the lower-level, formally employed segment. This comprises the C2 and D socioeconomic groups, together with their dependents, representing a potential total of approximately 2.2 million adults.

19. RECOMMENDATION: Work-based program coordinators should be trained in recruitment skills within the private sector. Furthermore, they should be able to deal with the authority of the ZNFPC behind them and should, perceptually at least, be "in charge" when negotiating with senior executives in the private sector.

- 20. RECOMMENDATION:** A system should be developed to permit thorough and repetitive canvassing of the private sector to establish more work-based family planning services.
- 21. RECOMMENDATION:** An updated cost-benefit model should be produced and circulated to all work-based coordinators.
- 22. RECOMMENDATION:** Additional tax benefits should be estimated and considered to offer financial incentives for companies that provide family planning services.
- 23. RECOMMENDATION:** Full reimbursement for family planning services provided through work-based programs should be made by medical aid societies to facilitate increased utilization of these services.

5. NATIONAL FAMILY PLANNING ACTION PLAN

5.1 Justification and Goal

An issue identified in the Scope of Work for this assessment was whether the time has come for possible institutional reform of the ZNFPC. This issue is directly addressed in more depth in the Chapter 6. The team concluded, however, that an important element of institutional reform could be addressed by the ZNFPC if it were to assume its mandated responsibility as coordinator of the national family planning program.

While the family planning program in Zimbabwe has been heralded as one of the most advanced in sub-Saharan Africa, it is also growing and becoming more complex. A number of players participate in service delivery and other aspects of the program, but their activities are not coordinated. Lack of coordination results in costly duplication of services and less than fully efficient service delivery, among other problems. The team feels that many of the barriers established as priority issues during the workshop would receive attention and, in fact, would be alleviated if the ZNFPC would spearhead the periodic preparation of a national family planning action plan (NaFPAP). This activity was outlined by the ZNFPC in its five-year strategy for 1991–1996, but its achievement has not been realized.

The goal of the NaFPAP would be to ensure that all parties involved with the implementation of family planning services in Zimbabwe actively participate in the formulation of up-to-date action plans or work plans for family planning service delivery. The NaFPAP will set out targets, resources, and responsibilities of each participating entity. The overall objective of this exercise is to strengthen the likelihood of attaining the national family planning program objectives which, at present, include increased prevalence, enhanced coverage, and improved method mix.

5.2 Interorganizational Coordination

The NaFPAP exercise should be one in which the national family planning service delivery effort is assessed and the various components of the program reviewed for necessary action over the succeeding 24-month period. Provision should be made for a review and update of the plan after 12 months. All parties to the program—the ZNFPC, the MOHCW, municipalities and local governments, NGOs, the private commercial sector, and donors—should be active participants in the planning exercise.

Targets and goals expressed in existing documents such as the GOZ and MOHCW five-year plans and the five-year strategy of the ZNFPC will be reviewed and will provide important guidelines for content of the action plan. Statistics including commodity information, surveys, and service data will be reviewed to assess past performance so that decision making for future service plans will be firmly grounded in actualities and experience to date. Donor funding documents and regulations also will be reviewed to ensure that the action plan takes into consideration those aspects of the program that may be funded by donor contributions.

Because coordinated action planning for the national program has not been done before by the ZNFPC, USAID should provide the necessary technical assistance for this task during the first

two years of the NPA. This assistance could be provided by an independent consultant or by one of the population Cooperating Agencies (CAs) dealing with management development, such as The Family Planning Management Development Project of Management Sciences for Health.

5.3 Other Issues to be Addressed

Several barriers to efficient and effective delivery of family planning services in Zimbabwe that were identified in the workshop and by the assessment team should be examined and addressed as part of the NaFPAP planning process. These include the following:

- Lack of coordination of NGO and donor activities.
- Lack of sensitivity (among donors) to cultural values.
- Lack of or poor dissemination of policies and regulations.
- Lack of accurate, transparent, and consistent messages about family planning.
- Targeting program activities to ensure full and complete coverage and access to family planning—coverage in this context refers to geographical distribution, addressing needs of different population groups (males and youth, in particular, in addition to reproductive age women), method mix, and identifying, developing, and addressing various market niches.

Bringing all participants in family planning service delivery in Zimbabwe together on a regular basis to assess and plan activities will provide an excellent opportunity to ensure the coordination of the activities of all participating parties. Donors can be invited to participate in these exercises for development and review of the plan. The work of the donors will be better coordinated as a result of their participation in the action planning exercise.

Furthermore, undertaking a regular exercise to plan the activities leading to a coordinated national family planning program will provide a regularly scheduled opportunity to address a number of other issues that will enhance program implementation, such as

- Ensuring that the program is flexible in its response to changing needs and conditions.
- Conveying messages that impact the direction of the program to all parties to the program—messages such as program objectives related to method mix, e.g., over reliance on the progestin-only pill, or plans for the reintroduction of the injectable contraceptive.
- Introducing new activities and efforts related to the proposed national population policy, when it is enacted, as it affects the provision of family planning information and services.

- Identifying gaps in service delivery as well as duplication of services so that family planning access can be equalized throughout the country.
- Clarifying and encouraging an enhanced role in family planning service delivery for the private sector wherever possible, including building agreements about referrals from one sector to the other and the provision of commodities to the noncommercial private sector, e.g., work-based services and NGOs.

5.4 Indicators of Achievement

Successful implementation of a process for and the regular development and use of an NaFPAP will be measured through more complete family planning service coverage and targeting of services. The planning process, if successful, will also produce a clearer indication of funding requirements, thus providing a means for the enhancement of overall donor coordination.

24. RECOMMENDATION: The ZNFPC should undertake, with USAID-provided technical assistance during the first two-year period, the development of coordinated National Family Planning Action Plans over the life of the NPA.

6. INSTITUTIONAL REFORM OF ZNFPC

6.1 Findings

The ZNFPC receives much of the credit for the success of national family planning efforts even though a relatively high percentage (63 percent in the 1988 Zimbabwe Demographic and Health Survey) of clients receive family planning services from sources other than the ZNFPC. (Thirteen percent of all users were served by ZNFPC clinics and 24 percent by community-based distributors supervised and paid by ZNFPC). Nevertheless, several recent assessments have suggested the need for the ZNFPC to review its roles and responsibilities with an eye to reform.

One of the concerns about ZNFPC's responsibilities may be related to the natural conflict and potential confusion created by its multifaceted mandate that includes the coordination of the family planning program, provision of family planning services, and other activities. It has been speculated that the Council's assigned roles as a coordinating body and provider of support services such as training, research, IEC, and commodity management are compromised or at least diminished by its emphasis on, and the large proportion of its budget allocated to, the provision of services.

The Council's recent erratic performance in the area of service delivery offers another rationale for change. Between 1989 and 1993, ZNFPC's share of total CYPs produced in the public sector dropped from 51 to 38 percent while the combined MOHCW and City Health share increased correspondingly (see Appendix E, Table 1). From 1987 to 1993, new acceptors of family planning served by ZNFPC clinics and CBDs declined from about 112,500 to 55,500, and revisits declined from about 1.8 million to 1.3 million (see Appendix E, Table 4).

A recommendation is made in Section 2.1 for the review and amendment of the 1985 Act of Parliament that created the ZNFPC. In light of that recommendation, the team does not feel it appropriate to recommend specific changes in the role or institutional structure of the ZNFPC at this time. However, the advantages and disadvantages of the five options for the ZNFPC's future structure listed in the Scope of Work for this assessment are reviewed below, and several questions are posed that might be used to guide further deliberations on this topic.

ZNFPC Management pointed out several constraints which should be considered in any decisions relating to institutional reform of the ZNFPC. The team was told that the Council would like to have more autonomy to seek its own funding from various sources. Also, there is a feeling among some in ZNFPC management that the MOHCW will not wish to release the Council from its present parastatal ties to the Ministry.

6.2 Options for Change in the ZNFPC Structure

Five possible options for change in the ZNFPC structure were listed in the Scope of Work. These are reproduced below and followed by a discussion of each option.

6.2.1 Option 1

ZNFPC should remain as is, a parastatal under the Ministry of Health and Child Welfare, keeping intact the existing organizational structure.

The organizational structure of the ZNFPC is presently undergoing review and is subject to change in the near future. Jobs are being evaluated and new job descriptions are being prepared as part of this process. Therefore, the question of keeping the existing internal structure intact has already been addressed and is likely to result in some change.

Advantages

- The ZNFPC is in place as a parastatal supported by an Act of Parliament.
- The ZNFPC is a well established and respected organization, both within Zimbabwe and outside, with accepted roles and responsibilities.
- The ZNFPC has several comparative advantages in its training, commodity logistics, and IEC units.

Disadvantages

- The Council complains of a lack of autonomy relative to other parastatals and believes itself to be constrained by the authority exercised by its parent Ministry.
- The present structure suffers from a potential conflict of interest stemming from the Permanent Secretary of the parent Ministry (MOHCW) serving as Chair of the Council's Board of Directors.
- The present structure is expensive and creates some real and implied duplication of MOHCW services and systems.
- The ZNFPC has not effectively performed one of its most important mandated roles, i.e., coordination of the national family planning program, under its current structure.

6.2.2 Option 2

ZNFPC should remain a parastatal under the MOHCW but with a reduced staff and functions.

Consideration of this option gives rise to questions regarding which ZNFPC functions and/or staff would be eliminated. ZNFPC's current five-year strategy indicates that the Council will gradually discontinue its involvement in the provision of services as the MOHCW takes on correspondingly more of this responsibility. This appears the most logical of all ZNFPC functions to be considered for a reduced role. Statistics indicate such a shift has been occurring for the past several years on a de facto, rather than a planned, basis. ZNFPC informants contend, however, that the MOHCW is less inclined now to take on more responsibility for service delivery than when the strategy was being developed in 1989–1990.

There are concerns about the continued role and involvement of the CBD cadre if the service function is dropped from ZNFPC's responsibilities. Experience with Village Health Workers being absorbed by the then-Ministry of Community Development and Women's Affairs and basically losing their health intervention functions haunts discussion of the CBDs being taken over by any institution other than the ZNFPC. However, the cost of maintaining this group of workers is high and their benefit to the program may be declining as evidenced by the reduction in CYPs produced by this group over recent years. Although the absolute number of CBDs has increased in recent years, the approximately 232,000 CYPs provided by CBDs in 1987 declined to about 201,000 in 1993 (see Appendix E, Table 5). Moreover, the high proportion of ZNFPC's budget that is devoted to CBDs and their exclusive focus on pills and condoms may be slowing the Council's efforts to promote long-term and permanent methods.

Advantages (Same as those listed above plus the following:)

- A reduction in functions and staff, e.g., provincial management staff, might alleviate some duplication of MOHCW services and structures.
- A narrower mandate might increase the focus on central, technical functions.

Disadvantages

- The ZNFPC might lose some of its national stature and authority if its size or functions are reduced, thus diminishing its effectiveness.
- The CBD effort may be difficult to maintain at a high level of effort if the ZNFPC relinquishes its authority over the program.
- Even if service delivery is greatly reduced or eliminated, the ZNFPC will likely have a continued need for some service sites for clinical training.

6.2.3 Option 3

ZNFPC should remain a government institution (possibly still a parastatal), but no longer under the MOHCW, and report directly to a higher authority.

If this option is to be pursued, the operative question becomes moving the ZNFPC where to do what? There are precedents in Zimbabwe for such a move: the Central Statistical Office and the National Economic Planning Commission, both formerly housed within ministries, are now under the direct authority of the Office of the President. Other countries, including Bangladesh, Egypt, Indonesia, and Kenya, have either placed a family planning/population coordinating entity directly under the office of the head of state, created separate Ministries for Family Planning, or designated divisions for family planning within the MOHCW. These efforts have met with mixed success.

Such a move should not be considered lightly in Zimbabwe. If the ZNFPC left its direct partnership with the MOHCW, its roles in service delivery, setting of clinical and service delivery

standards, and perhaps clinical training would probably be eliminated. That leaves the question of exactly which roles and responsibilities the Council would retain.

Advantages

- The ZNFPC would achieve a degree of autonomy in programming, fiscal authority, and relations with other government ministries, the private sector, and NGOs that it does not currently possess.
- The Council might be able to play a greater coordinating role of multisectoral actors in the family planning program if it were not constrained by its connection with the MOHCW.
- The ZNFPC might become more objective with regard to the respective roles of the public and private sectors.

Disadvantages

- As the NEPC expects to be named the coordinating body for the new national population policy, moving the ZNFPC outside the MOHCW and into possible direct competition with the NEPC as a coordinating body for family planning and population activities might cause disruption in the smooth implementation of the Policy.
- If the ZNFPC were moved outside the MOHCW, it would most likely become a very different organization with a completely revised mandate, causing a possible loss in momentum in the national family planning effort while the new organization took up its new roles and responsibilities.

6.2.4 Option 4

Disband the ZNFPC as a parastatal and integrate into fully in the MOHCW, either as a separate Division of Family Planning or as part of the MCH/FP Division.

The primary reaction to this option is that the absorption of the ZNFPC's current functions into the MOHCW would exacerbate the current problem of poor coordination of the family planning program. This concern arises from the fact that the MOHCW, while an important player, is not at present the only player in the provision of family planning services and related activities. While coordination of the family planning program is a legal mandate of the ZNFPC as a parastatal, it has not been an important or effective activity of the Council. Little energy and few resources have been devoted to it, with predictable results. The MOHCW, which has no mandate to coordinate the family planning program, may be even less inclined to undertake this role.

Advantages

- Absorption of ZNFPC functions into the MOHCW would probably create cost savings and alleviate duplication of services and certain systems such as supervision and service statistics.

Disadvantages

- Family planning might be de-emphasized in the MOHCW.
- Certain very successful current functions of the ZNFPC, e.g., contraceptive commodity distribution, may be negatively impacted by absorption into the MOHCW.
- MOHCW resources, which are insufficient at present, would become more stressed, and family planning would necessarily be affected.

6.2.5 Option 5

ZNFPC to become an NGO with a diversified funding base.

ZNFPC began as an NGO family planning association affiliated with the IPPF. A move to return the Council to this state would be a return to its organizational roots, possibly qualifying it once again for IPPF membership.

In 1993, the Council received funding from 21 sources, including donor support. It also recovered Z\$4.3 million from various user fee charges (primarily contraceptive sales) and other income-generating schemes. This income represented 22 percent of the Council's recurrent costs for that year.

One family planning NGO that has enjoyed a degree of success in Zimbabwe is Population Services Zimbabwe, operating clinics in Chitungwiza and several other cities. This organization has managed to maximize quality services and become self-sufficient with a limited initial grant of external funds. It should be noted that these facilities are supplied contraceptives by ZNFPC at cost and that much of their family planning activities are subsidized by STD diagnosis and treatment services. Nevertheless, since the NGO sector does not play a very significant role in the national family planning program now, the future role of the ZNFPC as an NGO would need very careful consideration.

Advantages

- As an NGO, the ZNFPC might have more room to fully explore cost recovery without present MOHCW/GOZ-imposed constraints.
- A move to a more self-sufficient, NGO status implies the need for the ZNFPC to become more cost-effective in order to recover a greater share of costs.

Disadvantages

- The ZNFPC would probably lose its MOHCW grant if it became an NGO or at least lose a sizable portion of this grant, as have missions and local and municipal health systems in the past few years. (The share of the MOHCW budget allocated in 1993–95 to these institutions is 37 percent of what it was in 1989–92).
- As an NGO, the Council would not have the same stature or authority to develop and apply standards; to develop curricula; or to speak on behalf of or otherwise represent the national family planning program.
- As an NGO within the current context of Zimbabwe's family planning program, the ZNFPC would most likely have less rather than more access to additional funding resources.
- New and different constraints might arise for the ZNFPC based on NGO regulations.

Another possible option for institutional reform that was not listed in the Scope of Work was discussed by the assessment team, i.e., the possibility of privatizing all or part of the ZNFPC. This would mean spinning off certain functions of the Council as fully private, commercial activities. The two functions which seem most amenable to this possibility are the community-based distribution activity and the commodity management operation.

Privatizing the CBD function would respond to concerns stated above about absorption of this group of workers if the ZNFPC was divested of the service delivery function. However, considerable research and planning will need to be undertaken to ensure the commercial viability of such an arrangement. The sale of contraceptives alone probably would not lead to commercial viability for these distributors. However, the addition of other small products which are in demand in the rural areas to the contraceptives currently delivered by CBDs might enhance the viability of this option.

Johnson and Johnson, the present contraceptive social marketing company, is seeking ways to encourage rural dwellers to take small loans for the purchase of vehicles so they might become social marketing distributors. The team discovered that the Social Dimensions Fund (SDF) provides this type of small loan to stimulate entrepreneurial development in Zimbabwe. Perhaps a pilot demonstration of this option could be encouraged with a small group of CBDs in connection with J&J and the SDF.

Among family planning programs worldwide, ZNFPC's commodities management unit is recognized for its exceptional success. This unit is beginning to take on a more commercial role with the introduction of a handling fee for the contraceptives it distributes to the MOHCW and other providers. Questions have been raised about whether this function could be completely privatized. More study, and perhaps the addition of more products, will be needed before the viability of this proposition can be more fully determined and recommended.

7. PROGRAM AND DONOR COMPLEMENTARITY

7.1 Relationship of Proposed Activities to the Current USAID Program

The summary matrix of recommendations or possible conditionalities for NPA presented in Chapter 8 lists some of the constraints and barriers to expansion of the family planning program that have been identified as needing attention. Some of these programmatic areas have a degree of complementarity with the current USAID Family Planning Project in its amended form and activities being funded by other donor and lending organizations.

The call for a reduction or abolishment of sales taxes on condoms and duties on OCs finds an echo in the private sector component of the amended FPP. USAID has been instrumental in negotiating reductions of duties on OCs (from 45 percent to 20 percent). However, further success of private sector activities might depend on zero taxes and duties on these low-value commodities in the commercial market. The development of a Nurse Practitioner cadre might also be seen as complementing the efforts of the private sector activities to the extent that the Nurse Practitioners might be permitted to develop private practices.

The calls for research and pilot testing of various modes of delivering LT/P methods in terms of who might provide these methods and where complements the FPP component on improved contraceptive use as well as attempts at method mix diversification and the expansion of services to reach more consumers. Strengthened training for the service providers also contributes to these goals.

The development of supervisory systems and skills in the ZNFPC is an activity which is currently covered through activities of The SEATS Project of John Snow, Inc. and the Association for Voluntary Surgical Contraception (AVSC). A difference between these activities and the efforts proposed here is that the two CAs are focusing on management skills for the ZNFPC and quality assurance, while the proposed activities are broader, looking much more closely at supervisory systems and skills across both MOHCW and ZNFPC services. The proposed attempts to better coordinate CA activities under the current FPP would complement this activity.

7.2 Relationship of Proposed Activities to Other Donor Programs

Various other donors are working in the area of family health through The Family Health Project II (FHP-II). Most of these donors work mainly through the MOHCW, sourcing technical assistance from the ZNFPC.

Annex 2 of the World Bank Aide-Memoir of November 1993 indicated that ZNFPC's current strategy proposes a changed role from direct provision of services to that of technical support. Its main functions would then be the promotion of family planning, guidance and support to other FP providers, and technical assistance in special areas of service delivery, such as VSC and NORPLANT[®] as well as the provision of training and IEC. If the donors providing support under the Bank's FHP-II Project and the review of the ZNFPC Act encourage such organizational reform, the modifications discussed in Chapter 6 (Institutional Reforms) might

offer ground for further cooperation among donors, including USAID. However, the most recent Bank Aide-Memoir (June 1994) did not address the issue of institutional reform, perhaps indicating that donors under the FHP feel that the ZNFPC might continue as is or that it is too early to evaluate Council attempts to move away from service delivery.

This assessment suggests several areas of project complementarity with the activities proposed by other donors. Areas of overlap include developing supervisory systems and skills, a newsletter, and curriculum development.

Supervisory systems and management skills have been supported by various donors in different areas of reproductive health and family planning. For example, the British ODA has supported the development of a Top Management Team (TMT) of the MOHCW, the enhancement of financial planning and management, and the expansion of existing management information systems. This project is aimed mainly at improving systems within the MOHCW. However, the MOHCW and the ZNFPC have expressed an interest in working closely together in order to identify and correct supervision problems that hamper the program at the provincial and district levels. If the expressed interest of working together translates into reality, then the training of the TMT would complement the activities envisaged throughout this report, including the development of a NaFPAP. The TMT training is aimed at making the team more able to produce a corporate plan as well as annual management plans. The proposed NaFPAP calls for a longer period for its action plan, i.e., 18–24 months, as opposed to the annual management plan supported by the ODA project.

The call for a newsletter echoes a project already funded by UNFPA. While articles have been collected, production of the newsletter has been hampered by the lack of staff in the ZNFPC with journalistic or editorial skills. The ODA-funded Sexually Transmitted Infections (STI) Project also calls for the production of a newsletter aimed at the MOHCW, ZNFPC, and NACP as well as others working in the family planning area. This responds to the need to integrate family planning and STD prevention and treatment. There seems to be room under the proposed set of activities for some form of cooperation to be worked out among the donors to ensure that the idea of a newsletter or technical bulletin becomes a reality.

A major activity under the World Bank FHP-II is the revision of the family planning curriculum and the improvement of pass rates under the MCH/FP course. This could complement calls for the development of Nurse Practitioners specialized in MCH/FP as part of the Masters of Nursing course that is due to start in January 1995. Since the activity also contains some elements of training and retraining, it complements all the recommendations and suggestions outlined in previous sections that call for research and training. In the long run, such activities will produce a cadre of service providers who are well equipped to serve the community, and the activities will lead to an expansion of services and increase service providers' accessibility to a greater number of people.

8. SUMMARY OF PROGRAM AND POLICY CONSTRAINTS

The following matrix summarizes the key policy and program constraint areas discussed in the preceding sections of this report. Here, they are presented with suggested remedial actions that can be taken over a period of five years. In some instances the actions or "activities" can be thought of as conditions to be met if the constraint areas are considered most amenable to non-project assistance. However, it is clear that while all of the areas of constraint can be thought of as appropriate to NPA, some are probably better resolved through project-type assistance. The last two columns of the matrix list the expected program and impact indicators that will demonstrate success from removing the policy and program constraints.

The family planning program in Zimbabwe is at a stage of development where the complexities of coordination and management have mushroomed, e.g., multiple elements delivering services, multiple donors, increased array of methods, the increasing need to strengthen financial sustainability, and program complications brought on by the AIDS epidemic.

This is the stage of development where it becomes necessary, if programs are to move ahead, to review the whole family planning program to rationally develop target groups and determine which elements of service delivery can be most efficient and effective in reaching the target groups. In private sector terminology, it is necessary to segment the market for family planning. For example, which segments, in terms of geography, age, sex, and socioeconomic position, does it make sense for each provider sector (commercial, MOHCW, ZNFPC, NGO) to address? In addition and just as important, how can all of these providers be coordinated to ensure widely available, safe, high-quality services?

To achieve the next level of program performance, increased attention needs to be paid to strategic and operational planning for all elements of the program and the coordinated implementation of those plans. To successfully carry out the implementation, much more attention will have to be paid to the development of stronger overall management systems, e.g., information, finance, supervisory and monitoring, and logistics. Since sustainable development becomes ever more important as a program expands, there is no dimension that is more important than the development of organizational and managerial capacity.

The identified Zimbabwe program constraints are presented in the following matrix to reflect three important areas that require concerted attention and effort to move the program to the next level: overall program planning (including a review and enhancement of the ZNFPC 1985 Act), expansion of high-quality services, and program coordination.

POLICY/PROGRAM MATRIX

Policy/ Program Constraints	Activities/Conditions						Success Indicators
	Year 1	Year 2	Year 3	Year 4	Year 5	Program	Impact
Planning for Overall Family Planning Program							
ZNFPC 1985 Act	Review Act	Amend Act				Role of ZNFPC Clarified & Enhanced, Council has more Autonomy	
National Family Planning Action Plan	Plan Developed with TA for Application in Year 2	Action Plan Developed and used	Action plan Developed and used	Action Plan Developed and used	Action plan Developed and used	A better coordinated FP Service Delivery System	Greater participation of all Sectors; Less duplication; Better Donor Coordination
Expanding Service Delivery							
Sales Tax on Condoms, Duties on Orals	Ministry of Trade and Commerce Directive to remove Taxes and Duties					Stabilized Prices of Condoms and Orals to Consumers	Increased Sales of Condoms and Orals in the Private Sector by XX Percent
Nurses Providing Private FP Services		Research/Studies on Private Practice for Nurses	Statute/policy in place authorizing private practice			X Nurses Providing Private FP Services	X Clients provided A, B, and C FP services
Expatriate Physicians FP Course	Course Developed	Course Offered as Part of Contract				X Expatriate physicians trained	X FP Services provided to X clients by expatriate physicians
Nurse Practitioners in MCH/FP	Authorization of NP Cadre; Curriculum Developed for NPs-MCH/FP	Authorization of Curriculum	Course Adopted and Implementation Starts		First NP Graduates	X NP providing MCH/FP services	X Clients provided FP services by NPs

SCN Upgrading to SRN (Refresher)	Adapt Clinical Family Planning Module for Upgrading Curriculum	Introduce				More Providers with higher level of FP Training	Greater Access to more Methods, Especially LT/P Methods, Greater FP Coverage
Depo-Provera		Desk reviews of Experiences in Zimbabwe and elsewhere	Pilot test, Depo. distribution by GLs/CBDs	Studies and Pilot Activities Implemented		Expanded FP Services by Injections	Increased Prevalence of Injections
Minilaparotomy/Local Anesthesia (ML/LA)		Desk Reviews of Experiences in Zimbabwe and elsewhere	Test Various ML/LA Expansion Scenarios, Mobile Training Teams; Locums	Studies and Pilot Activities Implemented		Expanded ML/LA services being provided	Increased Prevalence of LT/P Methods
Coordination, Systems Development and Management							
Orals	Review Supplies, Orders, Reduce Proportion of POPs, Increase COCs	Disseminate Protocols to move Women off POP				Reduced Proportion of POPs in Method Mix	More Effective Contraception Protection by Pills Mix
Supervisory System and Skill Development	Adapted Curriculum Developed	First 4 Provinces Taught	Remaining Provinces Taught	All District level FP Supervisors Trained by End of Year 3		Standardized Supervision, Coordination of Supervision by MOHCW & ZNFPC	Quality services consistently being provided by sample of service providers
Family Planning Professional Bulletin	One Issue Produced with Local TA	2 Issues Produced	2 Issues Produced	2 Issues Produced	2 Issues Produced	Widespread Distribution down to the CBD Level	Well informed FP Workers through out the program

ANNEX C

PERSONS CONTACTED

USAID/Harare

Peter Benedict	Director
Carol S. Palma	Deputy Director
Roxana Rogers	Family Planning Advisor
Melissa Stephens	Project Development Officer
Mercia Davids	Health Program Specialist

GOVERNMENT OF ZIMBABWE

National Economic Planning Commission

Osias Hove	Population Planning Commission
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Ministry of Health and Child Welfare

R. Chatora	Permanent Secretary
Felicity Zawaira	Director, MCH/FP
Clara Mufuka-Rinomhota	Director, Nursing Services
Lucy Dube	Assistant Director, Nurse Education
Sylvia Mupepi	Assistant Director, Community
Nursing	
L. Masloko	Nurse, Nemamwa Rural Clinic
Chipo Mhaka	Matron, Ndaga District Hospital
Mektlida Chimedza	District Nursing Officer, Zaka
Mr. Katekate	Director, Finance Unit
Leonard Nyandoro	Chief Records Officer, Epidemiology
Ms. Chibizhe	Health Information Unit
M.T. Dhliwayo	Principal Executive Officer,
Mission and Local Grants	

Zimbabwe National Family Planning Council

Alex Zinanga	Executive Director
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J.B. Moyo	Deputy Director, Programs	
T. Nhlizio	Chief Nursing Officer	
Caroline Marangwanda	Director, ERU	
R.L.M. Zengeni	Principal Tutor	
L.B. Lunga	Assistant to Chief Nursing Officer	
F. Gwatidzo	General Stores Controller	
Mr. Kasuva	Deputy Director for Finance and Administration	
Rosemary Nhete	District Nursing Officer	
George Bungar	Deputy Stores Controller, Masvingo	Regional Store
Justin Mutongo	IEC, Masvingo Province	
R. Hore	Group Leader, Masvingo District	
C. Mushariwa	CBD, Masvingo Province	
T. Chikore	Nurse, Masvingo Booking Clinic	
F. Paraffin	Nurse Aid, Masvingo Static Clinic	

Central Statistical Office

Mr. Wakatama	National Income Accounts
Ms. Machinguru	Family Income and Expenditures Survey Unit
Mr. Mbwanda	Finance Section
Ms. Ngwengya	Price Indices Section
Mr. Matete	Revenue Section
E.Z. Mutuambizi	Senior Executive Officer, Revenue

Ministry of Public Services, Labor and Social Welfare

Mr. Mhishi	Deputy Secretary, SDF Coordination
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UNIVERSITY OF ZIMBABWE MEDICAL SCHOOL

Jonathan Kasule and Gynaecology	Chairman, Department of Obstetrics
Michael Mbizvo Coordinator	Senior Lecturer and Research

DONORS AND TECHNICAL AGENCIES

Keith Hansen Health Projects	World Bank, Task Manager, Family
Kees Kostermans	World Bank, Public Health Specialist

Hope Phillips
Yoshiko Zenda
Neil Miller
 Manager
Dorothea Luke
 Education Advisor
Christian Jorgensen
Lauchlan Munro

World Bank, Operations Analyst
UNFPA, Country Director
ODA, Health and Population Field

GTZ, Family Planning and Health

DANIDA, Senior Management Advisor
UNICEF

OTHERS

MacDonald Chaora
Clive Oliver
Robin Tonkin
 Societies
Elizabeth Gwaunza
Bokani Moyo
Carrie Crockart
M. Zulu

General Manager, Marketing
CIMAS Data Processing Manager
National Association of Medical Aid

National Coordinator, Women in Law in Southern Africa
Program Officer, Women in Law and Development in Southern Africa
Senior Product Manager, J&J
Senior Product Manager, J&J

Loice Murazvu
 Carbide
Clara Nondo
George Bicego
 International
John Herzog
Jeremy Lewis
Peter Winkler
 Pharmaceuticals
Neil Varrie
Edwin Robinson
Reed Ramlow

Health Programs Coordinator, Union

President, Zimbabwe Nurses Association
Demographic Specialist, Macro

Consultant
CEO, National Pharmaceutical Council of Zimbabwe
Marketing Manager, Zimbabwe

Marketing Director, DATLABS
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Noreen Jewel
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The Futures Group
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Morgenster Mission Hospital, Masvingo

T. Madivenga

F. Runia

S. Matingwina

Mr. Gwagwa

Deputy Matron

General Medical Officer

OPD/Family Planning Sister

Acting Administrator

ANNEX D

**EXPANDING REPRODUCTIVE HEALTH SERVICES:
INITIATIVES FOR CHANGE**

USAID WORKSHOP

MONOMATAPA HOTEL, HARARE

22 AUGUST 1994

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ANNEXES

- A. Agenda
- B. List of Participants

EXPANDING REPRODUCTIVE HEALTH SERVICES - INITIATIVES FOR CHANGE

1. WELCOME AND INTRODUCTION

Roxana Rogers, the Population Officer, USAID Harare, introduced herself and thanked the participants for attending inspite of their busy schedules and preparations for the conference in Cairo.

The programme of the day was to look at contraceptive problems. She highlighted the Ministries continuing budgetary constraints. The Workshop would look at ways of expanding family planning given these constraints.

The Workshop was deliberately limited to a small number of people, because it was felt that it is more constructive and productive to have a group that is more intimate with the issues and will discuss the issues articulately and candidly.

The Workshop was sponsored by USAID, and organised by a group of Consultants from USA doing a study on Constraints to Expanded Family Planning. Sallie Craig Huber, is the Team Leader.

Ms Rogers introduced the new USAID Deputy Director, Carol Palma.

She ended by introducing the new USAID Director - Dr Peter Benedict. Dr Benedict was previously Mission Director in Cameron. He also previously served in Niger and Mauritania. He is conversant with Africa and African family planning programmes. He has a much broader perspective, however, having been an anthropologist and having also worked in the Middle East and Asia.

2. OPENING ADDRESS BY DR BENEDICT

In his opening address Dr Benedict gave a few comments on Zimbabwe.

For the past eight years Dr Benedict has been based in West Africa. He learnt a great deal about Zimbabwe from a distance - the remarkably achievements that have been realised since the 1980s; institutional development - the establishment of an absolutely first rate institutional system for family planning; and the unique financing of family planning taking place, in particular the Government's willingness and interest to continue looking at opportunities to finance the purchasing of oral contraceptives.

Dr Benedict also pointed out some of the constraints Zimbabwe is facing such as budgetary constraints and other constraints that deal with policy. He said the participation of the private sector is necessary. The Government has to allow the private sector to take its fair share of the burden of improving coverage in the exercise of family planning services.

USAID, having been involved in population activities in Zimbabwe for a number of years, is trying to understand where to go as a donor. It is currently in the process of amending its existing Family Planning Project and will try to consolidate a number of achievements that have been attained in Zimbabwe. The amended Project will add new elements which will deepen and broaden USAID's general involvement in family planning, as an extension to what has been done for the last couple of years.

Now USAID wishes to look at the policy framework of the national family planning program with the help of the input by the workshop participants. Dr Benedict stressed that participants' contributions are very critical. A team of Zimbabwe and American consultants was put together and they are required to come up with an assessment of existing regulations and policies and possible changes that will result in even a more successful programme. There will be no attribution of comments to individuals. The report will be an assessment and will be indicative of the future direction to be taken by donors in this field. The report will also be shared with representatives of other donor organisations, to try and work out some concerted approach to the issue of policy reform.

The family planning programme and HIV/AIDS prevention activities are merged together at many different points:- institutional level, policy level, in terms of the nations that need to find financial support, in terms of the ability to get the private sector to work with government on issues regarding sexually transmitted diseases or AIDS. Participants were urged to consider corrections between family planning and HIV/AIDS.

Dr Benedict concluded by wishing the workshop great success.

3. INTRODUCTION OF ASSESSMENT TEAM AND PARTICIPANTS

Ms Sallie Craig Huber welcomed the participants and thanked Dr Benedict for his comments. She introduced the Assessment Team.

Dr Lazarus Zanamwe - Population Geographer at the University of Zimbabwe. Dr Zanamwe has worked on some very interesting AIDS modelling in terms of how AIDS may impact the situation here in Zimbabwe. He has also done an assessment of services and needs for youth in terms of STD prevention and family planning. He brings a very broad-based and a wide experience to the exercise.

Dr Susan Adamchak - She is a demographer who lived in Zimbabwe in 1987-88. She has written quite a bit from her experience in Zimbabwe. In the United States she is considered one of the Zimbabwe population experts.

Dr Jack Fiedler - a Health Economist. His experiences are primarily in Latin America He brings knowledge and experience from another continent to apply here in Zimbabwe. He has worked a little bit in Africa but this is his first visit to Zimbabwe.

Craig Naude - Private Sector Specialist involved, among many other things, with the Social Marketing Programme. He brings the private commercial sector experience to the team.

Dr Richard Sturgis - Sociologist from USAID Regional Office, Nairobi. He is focusing primarily on health and population policy activities in the region. He has a broad overview of many things that are going on in terms of policy reform, regulatory reform and other issues in neighbouring countries.

Sallie Craig Huber - third visit to Zimbabwe. First visit to Zimbabwe in 1992 heading a UNFPA Mission - a group that looked at the long term contraceptive and logistic management needs. Second visit was to do an evaluation of the outgoing USAID population project. Delighted to be back. Has learnt with every visit, more about the exciting programmes in Zimbabwe and also the potential for the future.

The participants, who included a mixture of people from Government, Private/Commercial Sector and NGO Sector introduced themselves. (See attached participant list - Annex B)

4. REVIEW OF THE AGENDA & HIGHLIGHTING PURPOSE OF DISCUSSION

Purpose

To identify and discuss the constraints and barriers impeding the Zimbabwe Family Planning Programme.

To set priorities for addressing these constraints based on:

- their potential impact on family planning and reproductive health activities;
- the feasibility of their achievement.

The objective of the day was to sit down together early in the sector assessment exercise and brainstorm about what the real constraints are and try to pinpoint those constraints that are addressable in a relatively short period of time, in a cost-effective manner that would have an impact on a large group of people or the programme as a whole. It was hoped to identify and pinpoint the priority constraints in policy, regulatory, practice areas that are really addressable in a reasonable time frame. These will then be handed over to AID, for their consideration for possible support over the next few years. The participants should come up with the barriers that the programme is facing, the constraints of moving forward in expanding and enhancing the programme.

The Agenda

- Plenary Session (brainstorming session to identify the whole universe of various constraints and issues).
- Break-out groups (to identify which of those individual barriers and constraints are truly addressable in terms of specific guidelines presented).

5. PLENARY SESSION

5.1 Identification and Categorizing Constraints

Dr - Richard Sturgis introduced the five constraints categories.

1) **Legal and Regulatory**

It is difficult at times to differentiate legal, regulatory and cultural constraints. An example was given about India which will have a population of about 1 billion in the year 2000 - India is hoping to raise the age of marriage for young men and women (men 21, women 18) so that they didn't enter into the child bearing age any earlier than that. Another example from India is that, if you had more than two or three children you couldn't work for the Government. These are regulations that India was instituting to try and curtail the growth.

2) **Administrative**

These may sometimes be thought of as regulatory; will involve either Ministry of Health or Government Organisations/Programmes altering and changing the way they perceive certain activities e.g. Zambia is looking at who can distribute oral contraceptives and how many cycles can be distributed at each visit.

3) **Political/Social/Cultural**

For example, the impact of India's policy in relation to the importance of children to assist with farming in the agricultural rural area and a cultural barrier they are facing in terms of people believing that it's extremely important to have children, especially male children.

4) **Inter-organisational**

Deals with a wide array of issues such as donor co-ordination. Multiple ministries being involved and the uncertainty about who has responsibility and nothing getting done because of these uncertainties.

5) **Economic and Commercial**

For example, the tax rebates for up to four children - that has been recently changed in Zimbabwe. Another example is that of donors and governments buying commodities for the public sector that are leaked into the private sector.

5.2 Initial Constraints Identified during Brainstorming Session

The following lists of constraints were identified by category during the plenary brainstorming session. Small breakout groups were formed to discuss each constraint listed under each category. This discussion was guided by a matrix which categorized the constraints in terms of cost and benefit; highest priority given to those constraints deemed to have the greatest (highest) potential benefit at the lowest cost - cost being related to financial as well as human, political and time costs.

Legal/Regulatory

- 1) Age of contracepting; extend to those less than 16 years
- 2) Registration/licensing procedures
- 3) Issue of termination of pregnancy; legal status
- 4) Restrictions on nurses and midwives about what they are allowed to do without a doctor's supervision
- 5) Regulations requiring GPs to pass pharmacy exams and distance to the closest pharmacy
- 6) Regulations governing midwives/nurses in providing services
- 7) Pharmacists allowed to provide injectables and pills
- 8) Lack of a clearly defined population policy
- 9) Limited distribution network for contraceptives; e.g. only 130 pharmacists in the country

BENEFITS			
COSTS	LOW HIGH	LOW	HIGH
		7	4+6
		2, 5, 9	1, 3, 8

Administrative

- 1) Who can prescribe/distribute various methods
- 2) Availability (continuous) of a variety of methods/brands (CHOICE)
- 3) Advertising--is this a problem? are there restrictions?
- 4) Dissemination of policies; e.g. pharmacists' prescription of contraceptives
- 5) Service delivery sites--access and comfort of clients
- 6) Medical barriers (access)
- 7) Quality of commodities
- 8) Lack of resources and coordination for local research
- 9) Over reliance on mini-pills
- 10) Pill distribution; number of cycles per visit

BENEFITS			
COSTS	LOW	LOW	HIGH
		3	4, 9, 1+6

	HIGH	2	8
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- 5. Don't discuss
- 7. Not an issue
- 10. Dissemination issue

Political/Social/Cultural

- 1) Mixed (contradictory) messages about family planning (church, politicians, etc.)
- 2) Level of literacy-educational opportunities for girls
- 3) Empowerment of women regarding decision-making
- 4) Male motivation
- 5) Economic status of the country
- 6) Moral undertone regarding FP and AIDS
- 7) Termination of pregnancy
- 8) Inconsistency between FP messages and AIDS messages (or attitudes)

BENEFITS				
COSTS		LOW	HIGH	
		LOW		1, 3+4, 6
		HIGH	7, 8	2, 4

Economic/Commercial

- 1) Sales tax on condoms
- 2) Introduction of user fees
- 3) Adequacy of supply of contraceptives (availability/choice)
- 4) Value of children (social and technological development)
- 5) MOHCW budget
- 6) ZNFPC budget
- 7) Training of all private doctors, midwives and nurses
- 8) Lack of rural-focused incentives
- 9) Unstandardized family planning benefits of medical aid societies
- 10) Consumer knowledge of medical aid societies' family planning benefits
- 11) Adequate financing of local research (availability and subsequent utilization)
- 12) Limited effort to expand work-based services
- 13) Fee structure and contraceptive mix
- 14) Exoneration policy (from user fee payment)

15) Retention of user fees at the service delivery point

BENEFITS				
COSTS		LOW	HIGH	
		LOW	9,10,13,14,15	1,3,7,8,11,12
		HIGH	2	4,5,6

Inter-organizational

- 1) Competition between public/private sector commodities
- 2) Discontinuity of supplies,i.e. specific product brands
- 3) Regulations governing medical aid societies/health insurance coverage both for FP and HIV/AIDS
 - A. Consumer information
 - B. Provide FP benefits
 - i. Encourage
 - ii. Mandate
- 4) Quality of commodities supplied by donors
- 5) Lack of government coordination of NOG/donor programs
- 6) Lack of financial resources for local research
- 7) Regular ZNFPC negotiations with medical aid societies
- 8) Better definition of roles between MOHCW and ZNFPC--linked to national population policy

BENEFITS			
COSTS		LOW	HIGH
		LOW	3Bii

	HIGH	3Bi	2+4, 8
--	------	-----	--------

- 1 Needs more research
- 6 Ambivalent

6. BREAKOUT SESSION

6.1 Group Selection

GROUP		LEADER	PARTICIPANTS
1.	Legal & Regulatory	Susan Adamchak	Dr Kasule Dr Parirenyatwa Ms Moyo Ms Zenda
2.	Administration	Richard Sturgis	Dr Zinhanga Ms Rogers Ms Jorgensen
3.	Political/Social/Cultural	Lazarus Zanamwe	Mr Chinamasa Dr Tawanda Dr Farag Dr Manyame
4.	Inter-organisational	Jack Fiedler	Ms Danha Mr Chaora Dr Miller Mr Muchando
5.	Economic/Commercial	Craig Naude	Ms Crochart Ms Rupare Dr Falala Dr Mbizvo

6.2 Group presentations

Each breakout group presented its top three barriers in order of priority as follows. Various points in their analysis of each barrier were shared with the larger group.

GROUP 1.	Political/Social/Cultural
-----------------	----------------------------------

Priority 1 - Lack of sensitivity to existing social/cultural, religious or moral values

The group felt that changes dealing with this barrier would affect the population in general by enhancing the credibility of the programme. At the grass roots level, the target groups in these programmes usually seem to be approached in a manner which

sidelines/denigrates what exists already in terms of traditional practices and perspectives, and attempts to force down these modernised family planning procedures. As a consequence there is a great deal of suspicion and hence resistance on the part of the users.

Sensitivity should be stressed on the part of service givers and donors. This would enhance the credibility of the programme.

Strategies - donors should be oriented into this social/cultural religious mix, on the ground in the hope that their subsequent messages and approaches would be seen to be appropriate or realistic in the eyes of the people that they are dealing with. Local leadership and Central Government, in particular, should also be included in this effort.

The results will be long term and would only be evident perhaps after the five year period that has been spoken about. The activity to conscientise the service givers and donors would be short term.

Costs to set up these group discussions would be very low.

Sources of information - as to how this conscientising process should be achieved:- the general population, the donors, proceedings of Parliamentary workshops, Organisations : Sociology Department at University of Zimbabwe, ZINATHA (Association of Traditional Healers in Zimbabwe).

Priority 2 - Lack of Accurate, Consistent and Transparent Messages

This is a condition where people would be able to make informed choices. Acceptors are not informed of possible contraindications, the likelihood and level of probability of contraceptive failure, etc. This will result in potential acceptance being influenced more by the rumours and the resistance will negatively impact the whole programme.

Consistent Messages - Across and within organisations - this would call for the need for a coordinating body and the need for a unifying policy. If this consistent message about the position on family planning existed and was sent out by chosen political and religious leaders, the general population would be affected. Results can only be anticipated in the long term.

The whole process of attempting to bring about this change must be internalised i.e. individuals, groups, organisations within Zimbabwe that need to make this a part of their organising principles.

Implementing Agencies - At the moment it is the ZNFPC which is tasked with coordinating the Family Planning Programme in Zimbabwe and the activities of the different sectors involved in family planning. The National Economic Planning Commission should be brought in to give more weight to the whole process.

Sources of Information - religious groups, community leaders, NGOs, parliamentarians, the IEC unit of the ZNFPC, print and electronic media.

Discussion - Censorship Board, Ministry of Information should be consulted.

Priority 3 - The absence/lack of equality in the decision making process

This inequality in decision making processes involves the different status between men and women. The essential method of dealing with this problem would be outside of the scope of the programme. This would involve dealing with the economic structure of the society. Informal regulations that exist against women in the job sphere should be removed.

Impact - would be amongst those who are married couples and also pre-marital phase couples. Education - in terms of male motivation study. Because this entails changing attitudes, change would occur in the long term. Another factor that would impose itself upon the barrier would be the politicians who would be a major source in facilitating this change - there are tremendous political costs involved.

Sources of information - all the learning institutions that deal with the realm of sociology, the women's organisations (e.g. Women and the Law in Zimbabwe).

GROUP 2	ADMINISTRATIVE
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Priority 1 - Restrictions of who can prescribe/distribute various contraceptive methods.

The group felt that this was equally tied up with the question of policy dissemination (see priority 2 below).

Who can distribute:-

- a) Pills - problem is more in the private sector more than in the public sector.

Strategies - there is need for some regulatory change to enable nurses in the private sector to provide pills without being under strict supervision of a medical doctor; there is also need for training and those nurses who are certified should receive certification from ZNFPC.

Implementing agencies - the College of Primary Health Care Physicians and the ZNFPC could give training for nurses providing the services in the public sector.

- b) Minilaparotomy - The group felt that for this particular contraceptive there would be limited impact to policy change because you can only train people of a certain calibre to perform sterilization. There needs to be increased training of private sector and physicians in sterilization.
- c) Norplant - the Group felt that it is important to train nurses to provide norplant. There is no reason why they can't do it now, so there is no reason for policy change. It was proposed that there should be increased training of nurses in the private and public sector for providing the method.
- d) Injectables - nurses can't provide them in the private sector. It was discussed whether or not CBDs could/should provide injectables. The impact will be high if they could. Many women would have access to injectable contraceptives. However it is a controversial issue here. There should be some operations research to test the capabilities of CBDs, find the most capable CBDs, and train them to provide on a very limited scale and after one or two years determine whether it's a feasible strategy or not. If found feasible, proceed to change the regulations. Ministry of Health endorsement would have to be sought before the operations research is done.
- e) Pharmacist - Should/could injectables be provided by pharmacists? This area would not be acceptable to the medical community in Zimbabwe. Could have some impact but it's not feasible.

In terms of removing some of those barriers, the ZNFPC in conjunction with the University of Zimbabwe have already taken the initiative of removing some of the constraints.

Priority 2 - Policy dissemination

Dissemination of policy is a high priority. The policies get changed and nobody knows when they are changed. There should be standardised procedures to notify professional bodies of any changes. The professional bodies should include: ZIMA, UZ, College of Primary Health Care Physicians, Ministry of Health, ZINA, NANGO, Population Services and all others who are involved in family planning. It would be very simple, cost effective and feasible.

Priority 3 - Over-Reliance on mini-pills

In Zimbabwe about 50% of the oral contraceptives used are progestin-only pills (mini pills). These are contraceptives which are less effective than combined oral contraceptives. There would be high impact if the type of pill that women use was changed.

Strategy - in-service and pre-service training to stress appropriate use of the mini-pill and of combined oral contraceptive.

Feasibility - it is very feasible. CBDs in particular who like to prescribe the mini pills should change their attitude. If they are told to change, they will. However, they will need written instructions.

Who should do it - ZNFPC, University of Zimbabwe, and nursing schools.

Discussion - The percentage of contraceptive failure is 25%. Harare Hospital delivers 18,000 to 20,000 per year and 40% of these are mostly unplanned pregnancies. More research needed.

GROUP 3	INTER-ORGANISATIONAL
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Priority 1 - Lack of Government coordination of NGO and donor programmes

The impact - if at all there was better coordination, more resources will be available for family planning and there will be less duplication of services; greater continuity of commodities, programmes and priorities.

Strategy - Zimbabwe National Family Planning Council should take the lead role in developing long term strategies for family planning. Developing an effective family planning coordinating policy comprising of multisectoral representation. Multisectoral institutions should avail their workplans to the Council. There should be annual reviews of the workplans.

Feasibility - highly sensible. Would be a matter of adding more structures to existing fora, e.g. ZNFPC council has various committees that address information, education, communication. There is need to increase structures around these committees to make them more effective.

Sources of information - Zimbabwe National Family Planning Council Board, IEC Sub-Committee in the ZNFPC (these are the people who are supposed to represent the multi-sectors).

Priority 2 - Consumer information about using medical aid to obtain contraceptives

Consumers are not aware that they can use their medical aid packages to obtain family planning services privately.

Impact - an increase in the number of clients obtaining services from private and public outlets using medical aid facilities.

Strategy - to encourage service providers and employers to inform users on available packages.

Processes - should be publicised through professional associations e.g. Zimbabwe Medical Association (ZIMA), College of Primary Care Physicians, employers' associations, trade unions.

Feasibility - achievable in a relatively short period of time.

There maybe financial constraints to implementing this change given the fact that financial resources are needed to get that information flowing. ZNFPC and Government could help these institutions disseminate the information, through newsletters, pamphlets etc.

Discussion - the percentage using medical aid is about 6% out of which 1% are aware of the service.

Priority 3 - Regular ZNFPC Negotiations with Medical Aid Societies

Impact - if there were regular negotiations with these societies, there would be an increase in fees for service payments to ZNFPC.

Strategies - ZNFPC should identify a committee or individuals in their structure to initiate negotiations annually (around June - medical aid societies' financial year end).

Sources of information - ZNFPC, medical aid societies and commodity suppliers.

GROUP 4.	LEGAL AND REGULATORY
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Priority 1 - Age of contraception

The age of contraception in Zimbabwe at the moment is 16 years. The group felt that this should be reduced. Impact on family planning would be high. It would lead to a decrease in teenage pregnancies, reduce illegal abortions and there would be protection from STDs and HIV/AIDS.

Strategy - Ministerial Directive for the provision of contraceptives without parental authority. Exempting contraceptives from parental consent/notification. Removing all contraceptives from prescriptions and making them over-the-counter drugs.

Process to follow - Research to substantiate this request (targeting public special interest groups); public awareness campaign in order to sensitise the public about the importance of reducing the age of contraception. Drug Control Council requirements must be addressed.

Feasibility - will be possible but quite difficult and the cost will be particularly high. Political - Cultural barriers will also be a problem as there would be parental, chiefs' and political leaders' resistance to this move.

Financial Costs - maybe low.

Sources of Information - Drug Control Council, ZNFPC, looking at other countries experiences, e.g. Thailand.

No age was agreed on - it was agreed to take note and do further research.

Priority 2 - Restrictions on nurses/midwives - what they can do without a doctor's supervision

Impact - improve services in the rural areas, improve access, and stability of service provided.

Strategies - amending legislation by lobbying MPs, Ministry of Health and conduct research of the current situation, international comparisons.

Process to be followed - addressing the people involved in the Ministry of Health, Parliament, Health Professions Council and Zimbabwe Nurses Associations. Lobbying Ministry of Health Permanent Secretary, Minister, ZINA, Women's Groups and MPs. Organise briefing meetings, doctors in the Health Professions Council.

Research - National Planning Council, NGOs, Medical School, Blair Research and international comparisons.

Feasibility - 2-3 years. There would be low data costs. Costs for GPs maybe high as far as competition goes. Limited but consistent human costs; should have follow-up on programme. Might encounter problems with doctors and HPC members who are against family planning.

Sources of information - ZINA, HPC, Ministry of Health, and the School of Nursing.

Priority 3 - Lack of National Population Policy

Will have a high impact. A possible strategy is already underway (National Economic Planning Commission).

Process to be followed - research, consensus building, public debate, lobbying - inclusive of technical ministries.

Feasibility - quite feasible but very costly especially in light of political costs.

Sources of Information - NEPC.

GROUP 5.	ECONOMIC AND COMMERCIAL
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Priority 1 - Getting rid of Sales Tax on condoms and dispensing fees on oral contraceptives

Immediate Impact - reduce contraceptive cost which would encourage the use of private sector products. It would also enhance the perception of contraceptives as priority products.

Strategy - policy change and information dissemination.

Feasibility - would be an easy process - a ministerial directive. It wouldn't take a long time to initiate this directive but would have a lot of financial implications.

Sources of Information - Ministry of Health, Ministry of Finance, Ministry of Industry & Commerce, retail pharmacies, and private sector.

Priority 2 - Train all doctors, nurses and midwives in family planning

Provision for legislative change for increasing dispensation; midwives and nurses would be allowed to dispense oral contraceptives. If doctors, nurses and midwives were given training in family planning, the impact would facilitate better distribution of family planning products. It would also increase the convenience and reduce opportunity cost to the end user.

Strategies to bring about this change - firstly, motivate Ministry of Health to change legislation on dispensation; create an update of the current medical training module and facilitate training.

Feasibility - very feasible. Changing the legislation could take time but updating and changing the current training module would not be difficult.

Cost of training might be high, in terms of a number of current practitioners that would have to be brought in and trained.

Priority 3 - Limited efforts to expand work-based services

Could have a significant impact to the high dependency ratio.

Strategies - sensitise the private sector to get involved; e.g. proportion of tax incentives, to establish essential coordinating bodies.

Feasibility - would need donor support to initiate and the coordination could be time consuming. It is a very politically attractive scheme.

7. VOTING

Fifteen different constraints were identified as priorities by the breakout groups. The delegates voted to identify which of the 15 constraints should be given priority attention by the sector assessment team.

7.1 Constraints Identified by number of Votes

<u>Total Number of Votes Cast</u>	<u>Constraint</u>
5	Routine negotiation of tariff between ZNFPC and medical aid societies
9	Over reliance on mini-pills
10	Lack of equality in decision making (male/female); male role motivation
11	Lack of accurate, consistent, transparent messages about FP and AIDS
13	Lack of consumer information regarding medical aid coverage for FP
17	Provide contraception to youth
17	(Improve) Policy dissemination
18	Train all doctors, midwives and nurses in FP
20	Lack of a national population policy
22	Restrictions on nurses and midwives regarding service provision without doctor's supervision
24	Who can distribute or provide contraceptives
28	Limited efforts to expand work-based FP
28	Lack of government coordination of NGO and donor programs
30	Remove sales tax on condoms and dispensing fees on other contraceptives

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Lack of sensitivity to existing values

7.2 Constraints Identified in Priority Order *(please note items 3 and 8 received an equal number of votes).*

1. Lack of sensitivity to existing values
2. Remove sales tax on condoms and dispensing fees on other contraceptives
3. Limited efforts to expand work-based FP
3. Lack of government coordination of NGO and donor programs
4. Who can distribute or provide contraceptives
5. Restrictions on nurses and midwives regarding service provision without doctor's supervision
6. Lack of a national population policy
7. Train all doctors, midwives and nurses in FP
8. Provide contraception to youth
8. (Improve) Policy dissemination
9. Lack of consumer information regarding medical aid coverage for FP
10. Lack of accurate, consistent, transparent messages about FP (and AIDS)?
11. Lack of equality in decision making (male/female); male role/ motivation
12. Over reliance on mini-pills
13. Routine negotiation of tariff between ZNFPC and medical aid societies

8. CONCLUSION

Dr Farag expressed his concern on the importing of western ideas and methods which would cause tragedies in the Zimbabwean cultural setting.

It was suggested that Dr Farag should give suggestions on what process to follow to USAID.

Ms Huber concluded by thanking the participants for attending the Workshop.

ANNEX A

EXPANDING REPRODUCTIVE HEALTH SERVICES: INITIATIVES FOR CHANGE

USAID WORKSHOP

*MONOMATAPA HOTEL, HARARE
22 AUGUST 1994*

PURPOSE:

- 1) To identify and discuss the constraints and barriers impeding the Zimbabwe Family Planning Program.
- 2) To set priorities for addressing these constraints based on:
 - Their potential impact on family planning and reproductive health activities;
 - The feasibility of their achievement.

AGENDA

- | | |
|---------------|---|
| 08:00 - 08:15 | Tea and registration |
| 08:15 - 09:00 | Welcome and introduction of USAID Director
Opening address by Mission Director
Introduction of participants and review of the remainder of the agenda |

09:00 - 10:00	Plenary session-Identification and categorization of constraints to sustainable expansion of family planning and reproductive health activities in Zimbabwe
10:00 - 10:30	Tea break
10:30 - 12:30	Breakout session-Small group discussion of constraints
12:30 - 13:30	Lunch
13:30 - 14:30	Breakout session (continued)
14:30 - 14:45	Tea break
14:45 - 16:30	Plenary-Review and discussion of small group reports

EXPANDING REPRODUCTIVE HEALTH SERVICES : INITIATIVES FOR CHANGE
MONOMATAPA HOTEL - 22 AUGUST 1994
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ANNEX E

THE RECENT EVOLUTION OF ZIMBABWE'S FAMILY PLANNING SECTOR

A. INTRODUCTION: URBAN VERSUS RURAL IMPEDIMENTS TO EXPANDING FAMILY PLANNING SERVICES

The contraceptive market structure of Zimbabwe consists of two overlapping but distinct sub-markets. The larger of these sub-markets consists of the rural population, 70 percent of Zimbabweans. This sub-market is serviced primarily by the nearly 800 CBDs employed by ZNFPC and the relatively large rural public health facilities infrastructure. The meager number of private physicians and pharmacies and, more generally, the small size of the private commercial sector severely circumscribes the private sector's potential for soon becoming an important source of contraceptives in this sub-market. The limited potential of the private sector in rural areas is underscored by the population's generally low and erratic income levels. At least partially in response to this situation, the laws, administrative rules and regulations governing who can provide contraceptives have been developed in a somewhat dichotomous manner in Zimbabwe; the rules in rural areas are different from those applied in urban areas. For example one important such difference is that CBDs are allowed to distribute OCs using a screening checklist in rural areas, whereas in urban areas even relatively highly trained health professionals, such as SRNs, are not allowed to do so.

The other contraceptive sub-market in Zimbabwe consists of the urban population, which is serviced chiefly by public health facilities. There are a number of distinguishing characteristics of the urban sub-market. First, different organizational actors play much more important roles in the urban areas. Most notably, the 12 Municipal Health Departments play an important role, with the three largest Departments accounting for 13 percent of total CYPs provided in the entire country in the past seven years. Available data for the MOHCW and ZNFPC do not permit isolating the three major cities from their provinces. However, if we look at the entire province of Mashonaland East, where Harare and Chitungwiza are located, and Matabeleland North, where Bulawayo is, the Municipal Health Departments account for 32.2 and 24.5 percent of new acceptors, 30.7 and 25.8 percent of repeat visits, and 34.1 and 31.1 percent of total CYPs in their respective provinces.

The shortages of physicians in the rural areas means that the availability of clinical contraceptives is very limited. Most rural health facilities are staffed by expatriate physicians who have been contracted by the MOHCW for two or three years. In 1993, 350 of the 1551 registered physicians (23 percent) in Zimbabwe were expatriates, the vast majority of whom practice in relatively isolated and understaffed rural health clinics and hospitals (MOHCW, Health Statistics Quarterly Report, Second Quarter, 1993). Furthermore, the number of

physicians practicing in rural areas is not the only impediment to expanding contraceptive prevalence rates, particularly clinical methods. Most of expatriate physicians practicing in rural Zimbabwe have not had specialized training in family planning, specifically as it is delivered in Zimbabwe.

The shortage of physicians and particularly physicians trained in Family planning is a longstanding supply side constraint and a major explanatory factor for the low rural prevalence rates of long-term and permanent (LT/P) methods, such as VSC, Norplant and injectables. Training expatriate physicians in family planning will help to overcome some of the problem. Even if all of physicians are trained, however, the shortage of physicians will persist. Moreover, given that 70 percent of the population is located in this sub-market, unless reforms are made in the rules and regulations concerning who can provide/distribute these methods, the physician bottleneck will continue to act as a major drag on Zimbabwe's efforts to change its method mix. Accordingly, short term resupply methods will continue to dominate Zimbabwe's family planning program and will do so independent of women's--and particularly rural women's--contraceptive preferences.

The physician bottleneck, however, is not exclusively a rural problem. Efforts to expand available contraceptive choices and to alter the method mix in urban areas also are restricted by it, albeit to a lesser degree.

B. THE PUBLIC SUB-SECTOR

1. Sources of Contraceptive Supplies

In this analysis, the term public sector refers collectively to family planning activities of the MOHCW, the ZNFPC, mission hospitals and clinics, municipal health departments, and rural and district council clinics. The family planning sector of Zimbabwe is dominated by public sector organizations. Four factors--the low income level of the vast majority of the population, the Government's continued commitment to providing free or nominally priced health services to the entire population, the small numbers of private sector agents (physicians and pharmacies, as well as other commercial entities such as consumer product retail outlets which require a distribution channel), and the vast quantities of free or nominally priced contraceptives that have long flooded the national market--have discouraged the development of private sector family planning activities in Zimbabwe.

Historically, the most prominent public sector organization providing family planning services has been the ZNFPC. According to the 1984 Zimbabwe Reproductive Health Survey (ZRHS), ZNFPC was the source of family planning services for 46 percent of all contracepting women throughout the country. In 1988, the Zimbabwe Demographic Health Survey (ZDHS) found that ZNFPC's share

of the national market had slipped to 39 percent, while the role and significance of MOHCW, municipal, local and rural council clinics had expanded by nearly 9 percentage points, slightly more than the relative contraction of the Council.

Unfortunately, there are no more recent data available that are directly comparable. The best that can be done is to compare the number of couple years of protection (CYPs) provided by public sub-sector with DHS information on regular source of supply for contracepting women. The CYP data, assembled from ZNFPC, MOHCW and City Health sources, are presented in Table E-1. It appears as though the trend of the growing relative importance of public sector organizations vis-a-vis ZNFPC has continued.

In 1989, the Council accounted for 51 percent of all public sector CYPs. Throughout the course of the next four years, this share fell on average by 3.3 percentage points per annum, to reach 38 percent in 1993. The three major municipal health systems--Harare, Chitungwiza and Bulawayo, with 68 percent of the clinics and 77 percent of the 12 municipal health system's employees--accounted for a relatively stable proportion of approximately 13 percent of national CYPs. The MOHCW facilities, together with mission hospitals and clinics, and rural and district council clinics accounted for a growing share of CYPs, roughly equivalent to the proportion lost by ZNFPC. By 1993, this set of public facilities accounted for 50 percent of the total CYPs provided by public sector entities.

The data in Table E-1 do not include CYPs resulting from VSC because this information was incomplete. For the years 1992 and 1993, however, these three sources combined produced only 17,876 and 16,364 CYPs from VSC, respectively. If each VSC provides 12.5 CYPs, this means that about 1430 VSC procedures were done in all these facilities in 1992 and about 1310 in 1993.

2. Causes of the Changes in the Source of Contraceptives

There are a number of factors that influenced the demand for and supply of family planning services between 1987 and 1993. Zimbabwe experienced a major recession in 1992, with the real gross domestic product (GDP) falling by 6.2 percent. The recession reduced disposable income and left many people unemployed or less than fully employed. Consumption slipped in 1992 and remained depressed in 1993. According to the Central Statistical Office's (CSO) National Income Accounts Office, although a general recovery was underway in 1992, it was very uneven across different sectors of the economy. While the general economy picked up 2.1 percent in real terms in 1993, the CSO estimates that total real health care expenditures (i.e., public and private), continued to fall in both absolute and relative terms. Real health care expenditures fell by 1.6 percent in 1993, and fell from 2.84 percent of GDP to 2.74 percent.

A confounding causal factor in this decline in health care expenditures was that, as part of the Economic Structural Adjustment Program (ESAP), the MOHCW embarked on an initiative to intensify its cost recovery efforts in 1991. While user fees for public services were established 1985, collections prior to 1991 were relatively modest, increasing only nominally each year (see Table E-2). In 1991 the Ministry made a deliberate effort to increase its cost recovery by more consistently enforcing the established fee schedule and more carefully monitoring who would be exempted from user fee payments. As part of this effort the MOHCW published a detailed manual on user fee systems. The results of the initiative are evident in the jump in user fee collections posted in 1992 and 1993 noted in Table E-2.

Without additional information, it is impossible to determine the extent to which increasing prices as distinct from declining average incomes and cautious consumer behavior due to economic uncertainties resulted in the declining utilization rates posted by MOHCW facilities in 1991. Along with the initiative to more uniformly enforce the levying of user fees, there was a large increase in the general level of fees charged the following year in November 1992. In the area of family planning, this general price hike resulted in the introduction of increased prices for contraceptives of four-fold for most orals and, for the first time, a fee (Z\$.10) was charged for condoms. Compelling, anecdotal evidence suggested that the demand for contraceptives fell dramatically--particularly in the case of condoms--in response to these price increases.

The price elasticity of the demand for contraceptives has not been estimated in any country. There have, however, been a number of studies of the price elasticity of demand for health care in general and for outpatient care in particular. In nearly all of these studies, whether in more or less developed countries, the demand for health care has been found to be inelastic, and generally highly inelastic. That is, a percentage increase (decrease) in the price of care results in a less than proportionate decrease (increase) in the quantity demanded. Thus, a price hike of 10 percent results in a reduction in the quantity of the good or service demanded of less, and generally substantially less, than 10 percent.

Economic theory also tells us that items that are inexpensive, such that their purchase would require an outlay equivalent to a small proportion of the individual's annual income, generally have a price elasticity that is less than 1.0; i.e., they are price inelastic. Other things being equal, goods and services which entail smaller outlays, relative to annual income, are generally found to be relatively more price inelastic.

On the basis of both of these theoretical considerations, one would predict that the introduction of fees for condoms and of increased prices for other contraceptives would not have had much of an impact on the quantity of these items demanded. Apparently that was not

the case with the November 1992 contraceptive price changes, however, especially the introduction of a fee for condoms.

There is some evidence that with the MOHCW's introduction of the fee for condoms that there was, at least initially, a substitution of Municipal Health Department condoms for the now relatively higher priced MOHCW product. The MOHCW fee was introduced in the middle of the fourth quarter of 1992 and ostensibly caused the number of condoms distributed by the MOHCW to fall that quarter by 44 percent (see Table E-3). That same quarter, the three largest Municipal Health Departments experienced a 90 percent increase in their condom distribution. In the first quarter of 1993, however, while the MOHCW's distributions fell yet another 43 percent before stabilizing, the three Municipal Systems distributed nearly two-thirds less than they had the previous quarter. Moreover, they declined an additional 25 percent in the second quarter of 1993. It is not certain if the MOHCW forced these municipal systems to adopt similar price hikes, which could be one explanation for the trends.

Another partial explanation for the decline in condom distribution is that with the introduction of the fees, ZNFPC started charging the other public health organizations it was supplying with condoms. Many of these organizations, such as the district health units, were experiencing severe financing difficulties in recent years and had not anticipated having to pay for condoms and had not budgeted funds for this purpose. They might not have been able to raise the necessary monies, or may have felt that condoms were a relatively low priority and had chosen not to purchase them. As a result, the condom distribution figures declined, not due to a reduction in the quantity demanded attributable to the price hike, but due to a supply constraint.

A number of other intervening influences and alternative interpretations may have accounted for the marked reduction in demand for contraceptives for condoms in particular. Other points can be made about the expected duration of the change in demand.

First, it is likely that after at least a decade of free condom distributions some people had stockpiled them. With the introduction of the fee, many people chose to postpone purchasing condoms, and instead drew down their stockpiles. Following through the logic of this interpretation, one would anticipate that over time, as consumers' stockpiles were expended they would eventually return to the market where they would again purchase condoms.

A second partial and possibly complementary explanation comes from empirical observations of consumer reactions to price increases. Frequently, a consumer's initial reaction to a price hike is to immediately cut back on his/her purchases of the product in question. Over the course of a few weeks or a few months, however, consumers tend to return to their previous

behavioral patterns and again purchase the product, resulting in a slow, although sometimes only partial, restoration in the level of sales.

Unfortunately, examination of the accuracy of these two hypotheses is limited to monthly data on condom distributions for 1993 for ZNFPC's CBDs only. Those data suggest that while the initial dramatic impact of the price changes was tempered over time, the restoration of demand for these products was in most cases only partial by the end of 1993 (see Graph E-1). In the case of OCs distributed by CBDs, it appears as though the restoration was more rapid and proportionately greater, but still not complete, as indicated in Graph E-2. However, the November 1992 change in fees for OCs was an increase in the existing fee rather than the introduction of a fee for a product that was previously provided free of charge as in the case of condoms.

A third, partial explanation is that the new MOHCW statistical reporting forms were introduced during this same period. Initially it was reported that there were substantial problems with the new forms which may have resulted in undercounting condoms and other contraceptives that were distributed.

A fourth explanation is that after having distributed condoms free of charge for so many years, there may have been considerable wastage. The lack of studies about the actual use of condoms obtained free of charge (a study called for repeatedly in various evaluations in Zimbabwe over the last six years) impedes the full exploration of this possibility. Some analysts contend that the wastage was considerable and that the lower level of condom use that subsequently developed may have been a more accurate depiction of actual use. In early 1994, the fee for condoms was rescinded; condoms are once again supplied free of charge.

Contrary to what theory and common sense would seem to dictate, the seemingly price elastic demand for condoms constitutes a constraint on being able to charge for this contraceptive without seriously reducing its use and increasing the risk of pregnancy, as well as STD and AIDS transmission.

The contraceptive prevalence rate (CPR) and the contraceptive method mix and market structure are all heavily influenced by laws, rules and regulations governing who can provide contraceptives and where. There have been changes in these areas in the past few years which have made the contraceptive market more commercially attractive. First, import duties on condoms have been eliminated. This has reduced the cost of condoms to importers by 20 percent, enabling retail price cuts and/or increased profit margins, thereby increasing the quantity of condoms demanded and/or encouraging more wholesalers and possibly retailers to enter the market or to increase supply and sales. How much of an impact this change actually had is not known. Much of the potential impact may have been thwarted by the large quantities of free or very

low priced condoms that are in the public sector, some of which have been reported to have leaked into the private sector.

Second, the import duty on OCs was reduced from 45 to 20 percent in 1993. One would anticipate that this change would have the same potential effects on the sales of orals as the elimination of duties on condoms might have on condom sales.

Third, in 1992, the Drugs Control Council reclassified OCs from an "ethical" product (obtainable only by prescription) to a "pharmacist-initiated-drug". By eliminating the need to visit a physician to obtain the prescription and to have to pay the monetary and non-monetary costs of obtaining a medical consultation and making it possible to simply go directly to a pharmacy to obtain OCs, this change made OCs more accessible and effectively reduced their price to the consumer. However, there is some evidence that many pharmacists and a considerable number of potential consumers do not know about this change in availability of OCs.

The fourth recent method-related change was the reintroduction of Depo-Provera in 1992. This method, which was very popular before it was banned more than a decade ago, is expected to rapidly become one of the most prevalent in Zimbabwe. The expeditious and largely unanticipated reintroduction caught nearly everyone off-guard. As a result, it was a year before adequate supplies of this method were imported. It is reported to be gaining rapidly in the public sector where most supplies have been brought in by UNFPA, as part of a three year grant agreement. A large portion of the women selecting Depo are reported to be switching from orals, another substantial fraction are reportedly first-time contraceptors. Private commercial sales of Depo-Provera grew from 500 units in 1992 to 11,400 in 1994 (see Table 3 in Section IV).

Fifth, Norplant has undergone recently concluded clinical trials in the country and is expected to be registered in the near future. Although this method is expected to be popular with some segments of the population, its relatively high cost will probably restrict its use.

The sixth, and final recent change in Zimbabwe's contraceptive market parameters is of a more general nature involving the demand for children. Early in 1994, the pronatalist tax policy of providing tax deductions for up to six children was revised down to four children. This change will probably increase the demand for contraceptives in both the public and the private sector.

All six of these recent changes in the laws, rules and regulations governing the demand for, and use and cost of contraceptives will improve the general family planning climate in Zimbabwe and should improve the CPR. Although these recent changes will benefit the entire market, it is likely that most of them will benefit the private sector relatively more than public sector.

It should be noted, however, that several of the changes have already been in effect for some

time, but have not yet had much of an impact. This is telling as it reflects the relatively unattractive nature of the commercial contraceptive market in Zimbabwe.

In terms of the impact of these changes on the public sector, with USAID having supplied ZNFPC with all of its condoms until 1993, and with the ODA importing and supplying 344 million condoms throughout the next five years, the elimination of the sales tax on condoms will have little effect on the public sector. As ZNFPC moves toward purchasing larger proportions of the commodities it supplies, the reduction in the duty on OCs will benefit the public sector, as well. The reintroduction of Depo-Provera will undoubtedly be the one change that will have the greatest impact on the public sector family planning programs. Between 1992 and 1993, the number of injections given at ZNFPC clinics increased from 9,940 to 24,810, and it appears that uptake of the method is continuing at a brisk pace.

3. The Recent Evolution of ZNFPC

Although the proportion of CYPs produced by ZNFPC has generally been falling since the mid-1980s, the absolute number of CYPs produced by the Council increased each year from 1987 through 1990 before becoming erratic. The highest number of CYPs produced by the Council was in 1992, when it reached 346,028. The following year, however, there was a precipitous fall of 37 percent to 253,622 CYPs--the lowest point during the seven year period under analysis (see Graph E-3). The causes of these wide fluctuations in the past few years are not readily evident, although a better understanding of the recent performance of the Council suggests some partial explanations.

As seen in Graph E-4, ZNFPC experienced a pronounced and steady decline in the number of new acceptors enrolled in the program each year throughout the 1987-1993 era to a low of 55,499 new acceptors in 1993. This was less than half the number of new acceptors that were brought into the program in 1987. At the same time, after posting a dramatic drop of one-third in 1988, the total number of revisits made to ZNFPC increased for three consecutive years before falling off and reaching its period-long nadir in 1993 (see Graph E-5).

(a) Falling Productivity of the CBD Program

Table E-4 presents the number of new acceptors, revisits, CYPs and revisits per CYP for the entire ZNFPC organization, as well as for the two service delivery constellations--the CBD system and the clinics. As the table shows, the CBDs new acceptors fell by 53 percent over these seven years and the CBDs accounted for 93 percent of the total reduction in new acceptors experienced by ZNFPC between 1987 and 1993. This may be an indicator of saturation of the CBD catchment areas, which cannot be expanded further due to transportation constraints.

According to ZNFPC staff, there was very little turnover in the CBDs during the period and their numbers edged up slightly over the first six of these seven years, annually averaging roughly 700. In 1993, 80 additional CBD positions were created with funding from UNFPA. To the extent that women discontinued using contraceptives and dropped out of the ZNFPC Program, the number of CYPs declined. One can infer that with the passage of time, client attrition (drop outs) coupled with ever-declining numbers of new acceptors would produce an increasingly stable population. It would appear, therefore, that since 1987 the CBD system has been servicing an increasingly stable population of contracepting women and, as suggested by increasing revisit rates, has been servicing them more intensively over these years, particularly from 1988 through 1991.

Evidence supportive of this interpretation was obtained in a field trip visit with a CBD and Group Leader in Masvingo. According to the 1987 ZNFPC Annual Report, CBDs then worked on a 12 week cycle of visits; generally distributing 3 cycles of OCs to their clients and making a scheduled return visit just as the clients' stock of pills was exhausted. According to the Masvingo GL, the CBDs under her supervision are on a 3-week visitation cycle. While they distribute three cycles of pills to their clients, providing them with a three-month supply, the CBDs visit each client once every three weeks. Although there have not been any studies to cast light on this hypothesis, it is likely that the high frequency of revisits should result in substantially lower rates of contraceptive failures and drop-outs.

The high a level of scheduled revisits has its costs however. It results in CBDs--at least those of this particular district-- being able to serve only one-quarter of the theoretical maximum number they could reach if they were on a 12-week cycle of visits. This in turn translates into the CBDs having smaller numbers of new acceptors and/or lower numbers of CYPs and a higher average cost per CYP. To the extent that the three-week cycle is the norm, this vitiates the coverage and efficiency of ZNFPC operations.

Table E-5 presents several simple indicators of the productivity of CBDs over the 1987-1993 era. The average number of new acceptors per CBD declines monotonically from 1987 through 1993. In 1993, the average CBD has 42 percent of the number of new acceptors that she had in 1987. The average number of revisits per CBD follows a similar course, but there was a sizeable temporary increase in 1991. The 1987-1989 annual average number of revisits is more than 11 percent greater than the 1991-1993 level. The average number of CYPs per CBD follows a still more ambivalent, but still generally declining trajectory. It ended the period with its lowest level, 264 CYPs per CBD. During the first 3 years of the study period, CBDs annually averaged 342 CYPs. In the last 3 years, this figure slipped nearly 10 percent to 310 CYPs per CBD.

The bottom portion of Table E-5 contains three indices of changing average CBD productivity. Each index uses 1987 as the base year, setting the average number new acceptors, revisits and CYPs equal to 100 percent in that year, and measuring subsequent levels relative to the 1987 levels in percentage terms. The resultant index makes it easier to assess the evolution of each of the three output indicators, and clearly reveals the faltering levels of CBD service provision by all three of the indicators.

With the highly underdeveloped private sector in rural areas, rural women who are not presently contracepting and who are not located close to a health facility have an access problem. The way in which the CBD Program has come to operate in the past few years, with ever-declining new acceptors, has resulted in reduced access to family planning services and now constitutes a supply bottleneck to expanding coverage.

(b) The Faltering Efficiency of the CBD Program

The productivity of the inputs used to produce a particular good or service is inversely related to the cost of producing that good or service. Faltering CBD productivity has resulted in increases in the cost of CBD service provision, as measured by the cost of providing a client contact/consultation for either a new acceptor and revisit or the cost of producing a CYP.

Estimating the cost of a CBD client contact/consultation or a CBD-produced CYP is not a straightforward undertaking. The ZNFPC accounting system contains 13 cost centers which are primarily activity or programmatically based. One of these cost centers--education and fieldwork expenses--is dedicated to the costs of the CBD Program. Education and fieldwork expenses, however, includes only direct costs of operating the CBD Program and only a portion, although most, of the direct costs. The various indirect costs, e.g., any CBD training/retraining or administrative costs, are not included. In addition, some of the direct costs such as the cost of the contraceptives, are not included. Assigning the CYP-prorated share of the total value of contraceptives provided by the CBD program and adding to these the program's direct costs yields an estimate of the direct unit costs ZNFPC incurs in providing a CBD client contact of Z\$6.03 and a CBD CYP of Z\$29.83 in 1993 (see Table E-6).

Application of the same methodology to annual data from 1989 through 1993 reveals that the CBD Program has indeed been becoming more expensive. Since 1989 the cost of providing one CBD contact or one CBD CYP has been increasing annually by an average of 23 percent. Over this same period CBD's wages increased annually by an average of 14 percent. Wages constitute 75 percent of the total costs of the CBD program. Assuming the rate of inflation effecting the remaining 25 percent of the costs of the program were the equivalent of the GDP deflator, and constructing a simple two component (wage versus everything else) price index for the CBD

program during this era, it is estimated that the real unit cost of the CBD Program annually increased by just under 5 percent per year. The rising real cost of the CBD Program is a reflection of the declining productivity of the average CBD.

(c) A Simple Cost-Effectiveness Analysis of ZNFPC'S CBD versus Clinics Programs

Applying the same simple costing methodology to ZNFPC'S Clinics Program yields (nominal) unit cost estimates of Z\$ 17.07 per contact and Z\$ 61.85 per CYP. Comparing the relative efficiency of ZNFPC'S two means of providing family planning services is a type of cost-effectiveness analysis (CEA). While the settings and operations of these two different modes of service delivery are distinct and they have very different methods mixes and different target populations, CEA can provide a useful first approximation of the relative magnitude of the impacts that might be produced by a given amount of resources devoted to one of the service delivery modes versus the other.

The clinic modality is 2.4 times more expensive than the CBD in providing a contact and 1.8 times more expensive in producing a CYP. The primary reason for this significant difference is personnel costs. Recall, however, that this methodology is highly simplified, based on highly aggregative data, and makes several heroic assumptions, thereby missing some potentially important costs that might vary systematically across the two programs. Perhaps the most glaring of the missing elements is depreciation, which is a much more important factor in the clinic program with its more extensive equipment requirements and physical infrastructure. The crude manner of assigning contraceptive costs, however, errs in the opposite direction, assigning less than the actual costs of contraceptives to the clinics. Moreover, the methodology does not even deal with indirect costs which constitute 35 percent of total costs.

They were ignored in this analysis because time did not permit determining how their various components--administration, training, IEC and the ERU units--should be distributed between the CBD and clinic activities. In the absence of such information, it would be necessary to develop some simple method for assigning a portion of these costs to each of the two service delivery components. The application of the most common such rule, however, (viz., assigning costs to programs in proportion to their ratio of direct costs) would not have altered the findings, as it would have resulted in simply proportionately increasing the costs of each program.

The same methodology was applied for each year from 1989 through 1993 in order to examine whether there had been any changes in the relative cost-effectiveness of the CBD program over the past five years. That analysis, presented in Table E-6, reveals that CBDs were even more cost-effective in 1989, using either output measure. Over the course of the five years of analysis, the relative cost-effectiveness of the CBD program was slowly eroded; CBD program

costs per contact and per CYP both increased by about 11 percent more than did the costs of the Clinic program.

(d) A Simple Cost-Effectiveness Analysis of the ZNFPC Clinics and MOHCW Clinic-Based Family Planning Services

How do the costs of ZNFPC services compare to the costs of other providers of family planning services in Zimbabwe? The only other provider of such services for which a cost analysis has been done is the MOHCW. In late 1993 and early 1994, UNICEF conducted cost studies in two districts, Shurugwi and Gutu (MOHCW and UNICEF, December 1993 and May 1994). The districts selected were intended to provide a representative sample of MOHCW facilities. Thus the cost estimates developed in the studies can be regarded as being fairly representative of MOHCW facilities more generally.

The methodology employed in those studies was more precise than the desktop approach that time and resource constraints forced us to adopt in the analysis of ZNFPC. Also, the scope of the analysis was broader in the UNICEF studies; the analysis included the indirect costs of administering the district facilities. These indirect costs were distributed and assigned to the individual MOHCW facilities in the district on a prorated basis. We can revise the methodological approach of the analysis of ZNFPC costs in order to make the findings more comparable. This change entails including all of ZNFPC's indirect costs (none of which were included in the just discussed estimates, for reasons noted above) and re-estimating the costs.

A decision was made to take into account the national coordination and leadership role of ZNFPC since this entails incurring additional costs that are not directly attributable to service delivery. The method used recognized that a portion of ZNFPC's training, IEC, and evaluation and research activities, as well as the costs of administering these activities, are undertaken not for the direct benefit of only ZNFPC's CBD and Clinic Programs, but for all family planning programs in Zimbabwe, we assign only a portion of these costs to ZNFPC. The convention adopted to quantify the ZNFPC service delivery programs' share of these costs was to assume that this share was directly proportional to the ZNFPC share of total CYPs produced throughout the country (in just the public sector, since we have no data on the private sector). In 1993, the year for which the analysis was done, ZNFPC's share of total CYPs was 38 percent.

Finally, the ZNFPC service delivery programs' share of the indirect costs of training, youth services, IEC, evaluation and research, and administration were incorporated into the analysis by assigning them to the CBD and Clinics Programs in direct proportion to the Programs' share of total costs. The resulting estimates for ZNFPC are presented in Table E-7. The CBD unit cost of a client contact was estimated to be Z\$8.79, compared to the Clinic Program's cost of

Z\$21.05, and the CBD unit cost of producing a CYP was Z\$42.11, compared to Z\$73.96 for ZNFPC clinics.

The MOHCW-UNICEF study estimated costs for different types of facilities, district hospitals, rural hospitals, mission hospitals, mission clinics and rural health centers. Since none of these types of MOHCW facility is directly comparable to ZNFPC's clinics it was thought best to take a weighted average of providing family planning services in these facilities. This was done by weighting each facility's estimated cost of a family planning consultation by the number of such services provided. Forty-one percent of all MOHCW family planning consultations were provided in a mission clinic, mission hospital, rural hospital or district hospital, with the remainder in rural health centers. In Shurugwi, the cost of providing a family planning consultation was Z\$6.79. In Gutu District, it was Z\$7.05. Taking the arithmetic mean yields Z\$6.92, the single best point estimate of the MOHCW cost of providing family planning.

A ZNFPC CBD-provided family planning consultation costs 27 percent more than an MOHCW facility-based family planning consultation. A ZNFPC Clinic-provided family planning consultation costs three times more than an MOHCW facility-based family planning consultation. The average cost of providing a ZNFPC family planning consultation, weighted by type of facility/provider, is Z\$10.86, more than half again (54 percent) as expensive than the MOHCW.

While ZNFPC appears to be a substantially less efficient producer of family planning services vis-a-vis the MOHCW, we hasten to caution against concluding that ZNFPC should be eliminated and/or integrated more fully into the MOHCW. The cost-effectiveness analysis conducted here has been based on a very crude methodology in the case of ZNFPC. Furthermore, we have not been able to examine any systematic variation in the quality of services provided by the two organizations. Even if these estimates accurately reflect variation in the relative efficiencies of these two organizations, one must be cognizant of the potential impact on service delivery and on the contraceptive prevalence rate that any radical restructuring of ZNFPC might produce. It is important to recall that ZNFPC, with its cadre of less than 800 CBDs and its 24 clinics, provided 38 percent of the CYPs provided in the public sector in 1993.

On the other hand, the assumptions made in developing the cost estimates have been relatively generous to ZNFPC, and one could reasonably argue that a much larger share of the administrative, IEC, ERU and training costs should be attributed to ZNFPC. The magnitude of the difference in the cost of the MOHCW and ZNFPC providing family planning services, however, suggests that ZNFPC has considerable managerial slack and that it could and should attempt to improve the efficiency of its operations. Improving the productivity of the CBDs by changing their regularly scheduled three week cycle of visits constitutes an important first step.

Another area in which it appears some efficiency gains or cost savings could be generated is administration. ZNFPC's administrative and head office expenses constituted 29 percent of its recurrent costs in 1993. Relative to other health care organizations in other countries this appears to be excessive and should be scrutinized.

Another avenue for enhancing the efficiency and effectiveness of ZNFPC operations is through the development of more routinized performance reviews. The Council has not produced an annual report since 1991. Although it has continued to produce quarterly reports, such short term reviews do not lend themselves to providing an adequate, overall assessment of how the organization is performing. With only three month snapshots, more significant structural changes cannot be disentangled from short term oscillations due to either seasonal variations or other less meaningful fluctuations. Longer term trends, such as some of those discussed in other sections of this report, are not as evident. The result is the organization continues without adequate appreciation for changes in the demand for contraceptives, faltering productivity of a portion of its program, or the impact of changing market conditions or market structure, which have important implications for the role and operations of the organization.

Another related shortcoming is that ZNFPC has not used the information systems it has developed and operates to their full advantage. The level of detailed data collected on the quantity and mix of contraceptives by geographic area could be analyzed to enable much more effective use of the Council's resources by identifying specific areas and populations which are underserved and targeting more resources to these areas and populations.

Although the MOHCW and Municipal and other health systems also have good information systems which could be combined with that of the ZNFPC to obtain a countrywide understanding of the coverage of the sector, ZNFPC has not integrated these databases. There would be relatively little work involved in developing such an integrated database, and the potential benefits are likely to be great. Such a database would be a useful tool for coordinating with other family planning service providers. It could be a useful tool to avoid duplication and overlap, and to maximize family planning coverage.

Rather than networking with other service organizations and working to coordinate the sector, ZNFPC appears to have been content with simply continuing to do what it has long done. This is not to say there have not been initiatives in the past few years; there have been new developments. The organizational restructuring the Council is currently undergoing, the decentralization process that has been unfolding, and the depot holders pilot project are important examples. Still, most of these initiatives have been undertaken at the recommendation of outside agencies. Moreover, throughout the course of the past five or six years there have been a number of important reviews and analyses, undertaken by ZNFPC itself and by the World Bank, UNFPA and USAID, that have made important recommendations for improving

the effectiveness and efficiency of ZNFPC, but the vast majority of which have not been acted upon. Indeed one is struck by how often one reads the same recommendation--yet to be responded to--in various documents.

The MOHCW-UNICEF cost studies produced two additional noteworthy findings. First, it was learned that the EPI mobile team of Gutu provides a large number and a large proportion of total new acceptors. Second, each facility in Gutu District sets aside one day of the week for EPI outreach, which is distinct from the non-facility-based EPI mobile team. Each month a team from each facility visits an average of three or four regular, fixed sites which are located from five to ten kilometers from their base facility. A substantial number and proportion of all of the family planning services reported by these facilities were provided during these outreach efforts.

Time constraints precluded an assessment of how common the practice of outreach activities by facilities is in the MOHCW system. Nor was it possible to determine the composition of these activities more generally. The practices in Gutu District, however, run counter to the frequently heard lament that MOHCW facilities often "wash their hands" of family planning activities, arguing that they already have too much to do and maintaining that family planning is the domain of the relatively resource rich ZNFPC. An effort should be made to assess how much family planning services--particularly recruitment of new acceptors--is currently done via MOHCW outreach efforts. In addition, the possibility of expanding the family planning element of outreach should be investigated.

(e) Method Mix and Efficiency

In most countries, progestin-only pills (POP) constitute 15-20 percent of all OCs used. In Zimbabwe, the percentage has long been in the 40 to 50 percent range--a disproportionately large amount of POP compared to the amount of combined oral contraceptives (COC) distributed. According to one Zimbabwean family planning expert, a recent survey found that 25 percent of women had experienced an unwanted pregnancy and, of those, 90 percent had a method failure involving the use of the POP.

Over-reliance on the POP, therefore, constitutes an effectiveness and efficiency problem. When queried about explanations for the over-reliance on POPs, several physicians stated that women preferred the POP because it had fewer side effects. This quiescent position of physicians is uncharacteristic and unacceptable. It is imperative that efforts be undertaken as expeditiously as possible to educate physicians, CBDs and the general public about when the POP is to be used and when it is more advisable to rely on COCs. A simple analysis of the distribution of POP and other OCs by health care sub-system and geography was undertaken to

identify targets most in need of such interventions. Table E-8 contains the results of that analysis.

(f) Promoting Change in the Contraceptive Method Mix and ZNFPC'S Organizational Priorities: Is There a Conflict?

Table E-9 provides information on the distribution of commodities of ZNFPC's two service delivery modes and the entire organization from 1987-1989 and for 1992-1993. Data for 1990 and 1991 were not available. One particularly striking fact in Table E-9 is that the CBDs use only two, short-term resupply methods. As such, the size and cost of the CBD system limits the extent to which ZNFPC as an organization can change its method mix to longer term or permanent methods which are generally more effective. Parts B and C of Table E-9 contain the CYPs generated by the commodity distribution reported on Part A and the percentage distribution of the CBDs, clinics and the entire ZNFPC organization, respectively.

At the clinic level, the method mix is beginning to shift in favor of long term methods. As may be seen in Table E-9 (C), in 1993 injectables surpassed condoms and IUDs tied condoms in terms of the proportion of total ZNFPC clinic-produced CYPs. For the most part this was due to a huge reduction in ZNFPC clinics' distribution of condoms in 1993 relative to 1992 (when their numbers fell by 80 percent) and by the momentum gained after the reintroduction of injectables in 1992.

In the CBD Program, however, reductions in condoms simply result in increasing proportions (though not absolute increases) in CYPs attributable to orals and declining absolute numbers of CYPs. Although injectables increased from three to 12 percent of all CYPs in 1993, the domination of the CBD Program means that for ZNFPC as a whole injectables account for only two percent of overall method mix. A critical question is whether ZNFPC's domination by the mostly OCs and, to a lesser extent, condom-tied CBD Program--which directly costs 35 percent of ZNFPC's annual expenditures--does not slow the organization's reorientation toward and leadership in promoting LT/P methods.

(g) ZNFPC Financing and Sustainability Issues

A detailed financial analysis was conducted as part of the USAID Zimbabwe Family Planning Project Amendment in June 1994. Rather than duplicate that material, the discussion here will be confined to elaborating on a few specific points. In addition, data on ZNFPC income by source (1987-1992) and expenditures by program/activity type (1987-1993), which are distinct from those presented in the Project Amendment analysis are presented in Appendix 1 to this Annex.

For many years, USAID provided ZNFPC with all the contraceptives it distributed through its own clinics and CBDs. Also, ZNFPC provided commodities to other public sector organizations, including the MOHCW and Municipal Health Systems, that distributed them to their own family planning clients. As part of the current USAID Project, this arrangement is being altered. In the interest of promoting the financial sustainability of ZNFPC and the Zimbabwe's national family planning effort, the Council is suppose to take responsibility for purchasing orals and condoms over the course of the current Project. There has been one change in these plans. The British ODA will supply about 344 million condoms over the next five years. In 1994, the Council purchased Z\$3 million worth of commodities, primarily OCs. It is expected that this figure will quadruple in 1995.

USAID's efforts to wean ZNFPC from its dependence on donor funding have not been without problems. First, the significant increase in commodity prices in November 1992, which had such an unanticipated depressing effect on the demand for contraceptive commodities in general and condoms in particular, produced a backlash and reintroduction of free condoms. Second, UNFPA has been moving in the opposite direction. In 1993 it provided funding to hire 80 additional CBDs, an increase of more than 10 percent. The plan is for ZNFPC to phase in the financing of these positions over the next 3 years. In terms of CBD personnel costs alone, exclusive of the derivative materials, training, transportation and supervision costs, this represents an additional Z\$700,000 in annual ZNFPC costs.

Third, there is an inherent conflict between ZNFPC's need to generate revenues in order to be able to purchase an ever-increasing proportion of OCs and generally becoming more financially independent and the goal of encouraging the development of the private sector. ZNFPC sells contraceptives to private businesses with work-site family planning and STD/AIDS prevention initiatives, as well as to private physicians and even pharmacies. The very low selling prices undermine commercial viability of these products.

Despite these partial and/or temporary setbacks, the Council's progress in the area of cost recovery has been impressive. Although CBDs have always been directed to collect fees for selling contraceptives, the system was very lax for many years. Since 1992, however, there has been increased pressure to collect fees for contraceptive sales by the CBDs and ZNFPC clinics.

As a result of these revitalized efforts, the highest levels of revenues ever generated from contraceptive sales were posted in the first two quarters of 1994 when CBDs collected Z\$349,000 and clinics Z\$523,000.

The cost recovery experience of the Council is depicted in Table E-10. The increases in 1992 and 1993 of 62 and 197 percent, respectively, distinctly identify a new era in ZNFPC cost recovery. Still, there is room for additional progress. We provide two examples. First, after negotiating a reimbursement schedule with the National Association of Medical Aid

Societies (NAMAS) in 1991 and garnering rapidly increasing, though still relatively limited, reimbursements totaling Z\$90,895 in FY93, the Council failed to renegotiate reimbursement rates with NAMAS for the two years that followed.

A second example relates to training fees. The estimated costs of ZNFPC training which serve as the basis for determining fees to charge trainees were developed five years ago, in 1989. Although SEATS Project personnel developed revised cost estimates in 1993, Council personnel felt the estimates were inaccurate and refused to adopt them. In the meantime, since the Council has not developed the capacity to undertake its own cost estimates--a recommendation made to it first by the World Bank in 1989--the old prices continue to be used, and potential training revenues are not being generated.

TABLE E-1

Public Sector FP Services-Total CYPs* and Percent Distribution by Source (in '000)					
Sub-Sector	1989	1990	1991	1992	1993
ZNFPC	320.3	335.8	277.2	346.0	253.6
MOHCW**	224.7	284.5	329.6	365.5	326.9
City Health	78.6	83.2	107.2	102.8	77.3
Total	623.6	703.4	714.0	814.4	657.9
Sub-Sector	1989	1990	1991	1992	1993
ZNFPC	51%	48%	39%	42%	38%
MOHCW**	36%	40%	46%	45%	50%
City Health	13%	12%	15%	13%	12%
Total	100%	100%	100%	100%	100%

* Statistics are exclusive of sterilizations

** MOHCW includes missions, district council and rural council facilities.

SOURCES: ZNFPC Annual Reports 1988-1991 and unpublished data from the Evaluation and Research Unit for 1992-1993 for ZNFPC data; MOHCW Annual Statistics Reports for MOHCW and City data.

TABLE E-2

MINISTRY OF HEALTH USER-FEE REVENUES

Fiscal Year	Revenues (Z\$)
1985	2,169,727
1986	2,835,823
1987	3,821,090
1988	4,565,919
1989	4,630,588
1990	5,166,760
1991	6,979,789
1992	14,198,706

1993	14,937,376
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SOURCE: Government of Zimbabwe, "Report of the Comptroller and Auditor-General (various years); unpublished data of NOHCW Revenue Section.

TABLE E-3

**IMPACT OF THE INTRODUCTION OF
A 10 CENT FEE*
ON CONDOMS IN NOVEMBER 1992**

	NEW ACCEPTORS	REPEAT VISITS	CONDOMS
BULAWAYO CITY			
Q2 1992	3,069	18,176	115,710
Q3 1992	1,395	17,976	87,142
Q4 1992	1,217	18,235	83,840
Q1 1993	1,034	15,545	41,665
Q2 1993	966	15,653	20,904
HARARE CITY			
Q2 1992	1,236	21,401	150,810
Q3 1992	487	17,204	34,530
Q4 1992	5,276	38,721	163,280
Q1 1993	2,495	23,919	62,893
Q2 1993	2,154	32,506	55,981
CHITUNGWIZA			
Q2 1992	735	16,196	18,825
Q3 1992	487	17,204	34,530
Q4 1992	511	1,706	65,696
Q1 1993	512	12,803	3,685
Q2 1993	522	11,169	4,396
3 CITY TOTAL			
Q2 1992	5,040	55,773	285,345
Q3 1992	2,369	52,384	156,202
Q4 1992	7,004	58,662	312,816
Q1 1993	4,041	52,267	108,243
Q2 1993	3,642	59,328	81,281

MOH			
Q2 1992	30,023	282,165	1,173,205
Q3 1992	31,338	288,320	1,319,120
Q4 1992	21,397	194,119	741,261
Q1 1993	18,181	186,499	418,906
Q2 1993	21,662	224,346	435,930

	NEW ACCEPTORS	REPEAT VISITS	CONDOMS
NATIONAL			
Q2 1992	35,063	337,938	1,458,550
Q3 1992		340,704	1,475,322
	33,707		
Q4 1992	28,401	252,781	1,054,077
Q1 1993	22,222	238,766	527,149
Q2 1993	25,304	283,674	517,211

* Fee was Z\$0.10/condom

SOURCE: MOHCW Quarterly Reports

TABLE E-4

ZNFPC SERVICE PROVISION:
 NEW ACCEPTORS, REVISITS AND CYPs*
 BY SOURCE

	1987	1988	1989	1990	1991	1992	1993
NEW ACCEPTORS							
1. CBDs	99,988	85,015	79,082	67,594	59,745	52,410	47,053
2. CLINIC	12,458	13,391	14,493	13,075	11,022	10,475	8,396
3. TOTAL	112,446		93,575	80,669	70,767	62,885	55,449
		98,406					
REVISITS							
1. CBDs	1,614,915	1,070,107	1,134,146	1,164,461	1,265,032	1,149,295	1,071,893
2. CLINIC		215,824	211,559	223,863	255,659	248,898	205,528
3. TOTAL	206,162	1,821,077	1,345,705	1,388,324	1,520,691	1,398,193	1,277,421
	1,821,077	1,285,931	1,345,705	1,388,324	1,520,691	1,398,193	1,277,421
CYPs							
1. CBDs	231,600	233,583	251,865	259,664	200,023	268,274	200,771
2. CLINIC	60,200						
		59,856	68,415	76,095	77,166	77,754	52,851
3. TOTAL	291,800	293,439	320,280	335,759	277,189	346,028	253,622
REVISITS/ CYP							

1. CBDs	7.0						
		4.6	4.5	4.5	6.3	4.3	5.3
2. CLINIC	3.4						
		3.6	3.1	2.9	3.3	3.2	3.9
3. TOTAL	6.2						
		4.4	4.2	4.1	5.5	4.0	5.0
4. CBD/CL	204%						
		127%	146%	152%	191%	134%	137%

* All exclusive of sterilizations

SOURCES: ZNFPC Annual reports for 1987-1991; unpublished data from ZNFPC Evaluation and Research Unit for 1992-1992.

TABLE E-5

ZNFPC Service Provision: New Acceptors,
Revisits and CYPs* by CBDs

Category	Year						
	1987	1988	1989	1990	1991	1992	1993
Number of Clients, CYPs, and CBDs							
New Acceptors	99,988	85,015	79,082	67,594	59,745	52,410	47,053
Revisits	1,614,915	1,070,107	1,134,146	1,164,461	1,265,032	1,149,295	1,071,893
CYPs	231,600	233,583	251,865	259,664	200,023	268,274	200,771
Number of CBDs	670	728	704	737	680	720	760
Averages per CBD							
New Acceptors	149	117	112	92	88	73	62
Revisits	2410	1470	1611	1580	1860	1596	1410
CYPs	346	321	358	352	294	373	264
		Avg. 342			Avg. 310		
Averages per CBD, Relative to 1987							

New Acceptors	100%	78%	75%	62%	59%	49%	42%
Revisits	100%	61%	67%	66%	77%	66%	59%
CYPs	100%	93%	103%	102%	85%	108%	76%

* All exclusive of sterilizations

SOURCES: ZNFPC Annual Reports for 1987-1991; unpublished data from ZNFPC Evaluation and Research Unit for 1992-1993.

TABLE E-6

DIRECT UNIT COST OF ZNFPC CBD AND
CLINIC PROVIDED SERVICES
(in Z\$)

Unit Cost of Contacts and CYPs				Unit Costs Relative to 1989 Levels	
Fiscal Year*	Unit	CBD	Clinic	CBD	Clinic
1989	Contact	2.69	7.34	100%	100%
	CYP	13.13	26.04	100%	100%
1990	Contact	3.58	9.15	133%	125%
	CYP	17.13	29.32	130%	113%
1991	Contact	4.35	10.21	162%	139%
	CYP	24.17	33.54	184%	129%
1992	Contact	5.05	11.26	188%	153%
	CYP	27.27	38.24	208%	147%
1993	Contact	6.03	14.57	224%	199%
	CYP	29.83	52.81	227%	203%

* Financial data for this table are for the fiscal year (July 1-June 30); service data available were for the calendar year so they were averaged with data for the previous year to make them more closely conform with fiscal year financial data.

SOURCE: ZNFPC Annual Reports for 1989-1991; unpublished data from ZNFPC Evaluation and Research Unit for 1992-1993

TABLE E-7

**1993 COST-EFFECTIVENESS ANALYSIS -
ASSIGNING A PORTION OF ALL
INDIRECT COSTS TO OTHER THAN ZNFP CONTACTS AND CYP**

Costs	CBD	Clinic	Total
Direct Cost of Service Delivery (Z\$)	6,996,286	3,448,361	10,444,647
Percentage	67%	33%	100%
Training	78,892	37,125	305,308
Youth Advisory Services	323,838	152,394	1,253,242
IEC	116,297	54,728	450,065
ERU	90,956	42,803	351,998
Administration/HQ	1,394,604	656,284	5,397,073
Contraception			1,788,601
ZNFP Share = 38%	1,198,084	590,517	1,788,601
Total	10,198,957	4,982,213	19,990,935
Outputs	CBD	Clinic	
New Acceptors	49,732	9,436	
Revisits	1,110,594	227,213	
Total Contacts	1,160,326	236,649	
CYP	234,523	65,303	

Unit Cost of Output	CBD	Clinic
1. Direct Cost Only	\$6.03	\$14.57
A. Per Contact	\$29.83	\$52.81
B. Per CYP		
2. Direct Cost + % of (TRG+IEC+ERU+YAS)		
A. Per Contact	\$6.50	\$15.78
B. Per CYP	\$32.43	\$57.20
3. Direct Cost + % (TRG+IEC+ERU+YAS+ADM/HQ)		
A. Per Contact	\$7.76	\$18.56
B. Per CYP	\$38.38	\$67.25
4. Direct Cost + % (TRG+IEC+ERU+YAS+ADM/HQ+Contraceptives)		
A. Per Contact	\$8.79	\$21.05
B. Per CYP	\$43.49	\$76.29

SOURCE: ZNFPC Evaluation and Research Unit, unpublished data; ANFPC Annual Audit.

TABLE E-8

PROGESTIN ONLY PILL DISTRIBUTION AS
A PROPORTION OF ALL OCs DISTRIBUTED

Year	Municipal Facilities		MOHCW Facilities	
	Harare	Chitungwiza	Mashonaland Central	Mashonaland East
1988		63%	53%	57%
1989	61%	63%	51%	54%
1990	58%	68%	55%	52%
1991	60%	60%	52%	49%
1992	65%	66%	50%	52%
1993	64%		49%	

SOURCE: MOHCW Annual Reports for municipal data; ZNFPC Annual Reports and unpublished data for provincial data.

TABLE E-9 (A)
ZNFPC COMMODITY DISTRIBUTION

ZNFPC CLINICS COMMODITIES DISTRIBUTED

METHOD	1987	1988	1989	1992	1993
ORALS	398,200	425,369	462,496	535,932	406,223
CONDOMS	764,600	1,370,861	1,759,047	2,570,710	543,674
INJECTION		14,309			
S	12,900		16,098	9,940	24,810
IUD	2,500	2,883	3,554	2,553	2,173
IMPLANT				460	
BARRIERS					109
	49,800	84,341	61,038	35,988	12,562

ZNFPC CBD COMMODITIES DISTRIBUTED

METHOD	1987	1988	1989	1992	1993
ORALS	2,727,600	2,721,999	2,890,825	2,750,003	2,373,685
CONDOMS	2,178,100	2,420,782	2,949,479	5,673,657	1,836,302
INJECTION		0	0	0	0
S	0				
IUD	0	0	0	0	0
IMPLANT	0	0	0		0
BARRIERS	0	0	0	0	0

TOTAL ZNFPC COMMODITIES DISTRIBUTION (INCLUDES CBDs AND CLINICS)

METHOD	1987	1988	1989	1992	1993
ORALS	3,125,800	3,147,368	3,353,321	3,285,935	2,779,908
CONDOMS	2,942,700	3,791,643	4,708,526	8,244,367	2,379,976
INJECTION	12,900	14,309	16,098	9,940	24,810
S					
IUD	2,500	2,883	3,554	2,553	2,173
IMPLANT	0	0	0	460	109
BARRIERS	49,800	84,341	61,038	35,988	12,562

SOURCE: ZNFPC Annual Reports and unpublished data.

TABLE E-9 (B)
ZNFPC-PROVIDED CYPs BY METHOD

ZNFPC CLINICS CYPs BY METHOD

METHOD	1987	1988	1989	1992	1993
ORALS	30,631	32,721	35,577	41,226	31,248
CONDOMS			17,590	25,707	5,437
INJECTION	7,646	13,709			
S	3,225	3,577	4,025	2,485	6,203
IUD		7,208	8,885	6,383	5,433
IMPLANTS	6,250				
BARRIERS	0	0	0	2,300	545
		16,868	15,258	7,268	2,582
	9,960				
TOTAL	57,712	74,082	81,335	85,368	51,447

ZNFPC CBD CYPs BY METHOD

METHOD	1987	1988	1989	1992	1993
ORALS	209,815	209,385	222,371	211,539	182,591
CONDOMS		24,208	29,495	56,737	18,363
INJECTION	21,781				
S	0	0	0	0	0
IUD	0	0	0	0	0
IMPLANT	0	0	0		0
				0	

BARRIERS	0	0	0	0	0
TOTAL	231,596	233,592	251,866	268,275	200,954

ZNFPC TOTAL CYPS BY METHOD (INCLUDES BOTH CBD AND CLINICS)

METHOD	1987	1988	1989	1992	1993
ORALS	240,446	242,105	257,948	252,764	213,839
CONDOMS	29,427	37,916	47,085	82,444	23,800
INJECTION S	3,225	3,577	4,025	2,485	6,203
IUD			8,885		
	6,250	7,208		6,383	5,433
IMPLANT	0	0	0	2,300	545
BARRIERS		16,868	15,258		2,582
	9,960			7,268	
TOTAL	289,308	307,675	333,201	353,643	252,401

SOURCE: ZNFPC Annual Reports and unpublished data.

TABLE E-9 (C)
ZNFPC-PROVIDED CYPs BY METHOD

ZNFPC CLINICS' CYPs

METHOD	1987	1988	1989	1992	1993
ORALS	53%	44%	44%	48%	61%
CONDOMS	13%	19%	22%	30%	11%
INJECTION S	6%	5%	5%	3%	12%
IUD	11%	10%	11%	7%	11%
IMPLANT	0%	0%	0%	3%	1%
BARRIERS	17%	23%	19%	9%	5%
TOTAL	100%	100%	100%	100%	100%

ZNFPC CBD CYPs BY METHOD

METHOD	1987	1988	1989	1992	1993
ORALS	91%	90%	88%	79%	91%
CONDOMS	9%	10%	12%	21%	9%
INJECTION S	0%	0%	0%	0%	0%
IUD	0%	0%	0%	0%	0%
IMPLANT	0%	0%	0%	0%	0%

BARRIERS			0%		
	0%	0%		0%	0%
TOTAL	100%	100%	100%	100%	100%

ZNFPC TOTAL CYPS BY METHOD (INCLUDES BOTH CBD AND CLINICS)

METHOD	1987	1988	1989	1992	1993
ORALS	83%	79%	77%	71%	85%
CONDOMS	10%	12%	14%	23%	9%
INJECTION	1%	1%	1%	1%	2%
S					
IUD	2%	2%	3%	2%	2%
IMPLANT	0%	0%	0%		0%
BARRIERS	3%	5%	5%	1%	1%
TOTAL	100%	100%	100%	100%	100%

SOURCE: ZNFPC Annual Reports and unpublished data.

TABLE E-10

**ZNFPC COST RECOVERY
BY SOURCE OF INCOME (in Z\$)**

Year	Contraceptive Sales	Medical Consultation Fees	Sundry Income(a)	Total	As A % of Recurren t Expend s	Annual Growth in Revenue s
1987	383,543	33,441	35,047	452,031	6.6%	
1988	523,314	35,319	51,583	610,216	7.2%	35%
1989	458,218	40,472	13,391	602,081	6.0%	1%

1990	503,721	46,116	157,054	706,891	5.9%	17%
1991	590,283	52,879	248,208	891,370	5.9%	26%
1992	882,672	58,632	505,729	1,447,033	8.0%	62%
1993	2,676,508	52,596	1,466,794	4,295,898	21.7%	197%

ANNUAL DISTRIBUTION BY SOURCE

Year	Contraceptive Sales	Medical Consultation Fees	Sundry Income (a)	Total
1987	85%	7%	8%	100%
1988		6%	8%	100%
1989	86%	7%	17%	100%
1990	76%	7%	22%	100%
1991	71%	6%	28%	100%
1992	66%	4%	35%	100%
1993	61%	4%	34%	100%
	62%			

ANNUAL RATES OF GROWTH BY SOURCE

Year	Contraceptive Sales	Medical Consultation Fees	Sundry Income (a)	Total
1987	--	--	--	--
1988		6%	47%	35%
1989	36%	15%	100%	-1%
1990	12%	14%	52%	17%
1991	10%	15%	58%	26%
1992	17%	11%	104%	
1993	50%	160%	190%	62%
	203%			197%

(a) Sundry income includes revenues from training fees and sales of audiovisual goods and services

SOURCES: ANFPC Annual Reports 1987-1991; ZNFPC unpublished data for 1992-1993.