POPULATION AND FAMILY PLANNING

IN ZIMBABWE

BACKGROUND PAPER

FY1987 CDSS
USAID/ZIMBABWE

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BACKGROUND PAPER

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Abbreviations

CBD Community-based distribution or distributors
CBR Crude birth rate
CMR Crude mortality rate
CPR Contraceptive Prevelence Rate
CS Child Spacing
CSFA Child Spacing and Fertility Association
CSFPC Child Spacing and Family Planning Council
CSO Central Statistical Offic
ED Educator/distributor
FAO Food and Agricultural Organization
FLE Family life education
FP Family Planning
FPA Family Planning Association
GNP Gross National Product
HA Health Assistant
IEC Information Education
IMR Infant mortality rate
IUCD Intra-uterine contraceptive device
JHPIEGO Johns Hopkins Program for International Education in gynecology and obstetrics
MA Medical assistant
MCH Maternal and child health
MCDWA Ministry of Community Development and Women's Affairs
MOA Ministry of Agriculture
MOE Ministry of Education
MOH Ministry of Health
NGO Non-governmental organization
NRR Net reproduction rate
Non-Cs Non-child spacing (other than child spacing)
PCS Population Communication Services
PHC Public Health Care
PID Pelvic inflammatory disease
PMD Provincial medical director
REU Research and Evaluation Unit
RHC Rural health center
STD Sexually transmitted disease
SRN State registered nurse
UN United Nations
UNICEF United Nations Children's Fund
UofZ University of Zimbabwe
USAID United States Agency for International Development
VHW Village Health Worker
YAS Youth Advisory Services
I. INTRODUCTION

This background paper on Population and Child Spacing Strategy considerations for Zimbabwe is part of the preparation for the FY87 Country Development Strategy Statement (CDSS).

Section II of this paper reviews the demographic situation in Zimbabwe (to the extent made possible by the limited data available) and discusses certain population projections within the context of the assumptions on which they are based. The consequences of Zimbabwe's rapid population growth rate are then examined relative to education, health, employment and the labor force. Particular attention is given to the availability of skilled and qualified labor and to the perceived farm labor shortage in communal lands. This review strongly suggests that population growth in Zimbabwe should be reduced by a vigorous child spacing program if the socio-economic development objectives of the Government are to be attained.

Section III examines in detail the Government's population policy and, in particular, the strengths and weaknesses of the child spacing program. In addition, the implications of the Government's policies of integrating child spacing with maternal and child health services are examined and broad strategy recommendations are presented.

Section IV reviews the population and child spacing related programs of other donors.
Finally, the conclusion of this background paper identifies the major areas in need of assistance, presents various strategies for consideration by USAID and sets a research agenda.

II. DEMOGRAPHIC SITUATION IN ZIMBABWE AND ITS IMPLICATIONS

1. General Setting

   Demographic data for Zimbabwe are generally unsatisfactory. This is true because they are based mostly on a series of censuses, since only a few small scale surveys, unrepresentative of the nation as a whole, have been conducted. Moreover, the vital registration system includes only a small fraction of vital events. For instance, in 1980, there were an estimated 370,000 births, of which only 13,861 (3.7%) were registered, and an estimated 116,000 deaths, of which 22,431 (19.3%) were registered (USAID, 1982, p.2). In addition, while the figures for the non-African population have been fairly complete, those for the African majority are incomplete at best and often inaccurate. An attempt to enumerate the non-European population was carried out on a sample basis for the first time in 1948, and again in 1953-55. In both cases, age was classified only in broad categories, making it impossible to calculate precise mortality and fertility rates. Only in the 1969 Census, the second to include the African population (the first was carried out in 1962), was a full enumeration carried out that included precise ages, making it possible to calculate reliable estimates of fertility and mortality rates.
A new census was taken in August 1982, but to date only preliminary results, including total population by provinces, municipalities and other administrative divisions, are officially published and available. These figures permit only rough estimates of growth rates. The analysis of a 10 percent sample should be published shortly but are available only unofficially. Unofficial figures, resulting from the analysis of the 10 percent sample, give some incomplete and tentative indications of the present situation. The available figures will be compared to the 1969 Census figures and to the 1980 estimates and discussed below. These data are presented in Table 1.

Table 1

Zimbabwe Population and Fertility and Mortality Indicators
1969, 1980 and 1982

<table>
<thead>
<tr>
<th></th>
<th>1969</th>
<th>1980</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude birth rate (per 1000 pop.)</td>
<td>53-58</td>
<td>48</td>
<td>47-49</td>
</tr>
<tr>
<td>Crude death rate (per 1000 pop.)</td>
<td>11-14</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>8.0</td>
<td>7.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Infant mortality (per 1000 live births)</td>
<td>100</td>
<td>n.a.</td>
<td>84-102</td>
</tr>
<tr>
<td>Total population</td>
<td>5,099,340</td>
<td>7,360,000</td>
<td>7,546,071</td>
</tr>
<tr>
<td>Percent African</td>
<td>95.05</td>
<td>96.5</td>
<td>n.a.</td>
</tr>
<tr>
<td>Percent non-African</td>
<td>4.95</td>
<td>3.5</td>
<td>n.a.</td>
</tr>
<tr>
<td>Annual population growth</td>
<td>4.1</td>
<td>3.3</td>
<td>3.1</td>
</tr>
<tr>
<td>Percent of population under 15</td>
<td>n.a.</td>
<td>50.8</td>
<td>46.54</td>
</tr>
<tr>
<td>Females 15-49(% of total pop.)</td>
<td>n.a.</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Children under 5(% of total pop.)</td>
<td>n.a.</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>53-58</td>
<td>n.a.</td>
<td>56</td>
</tr>
</tbody>
</table>

Source: 1969: Based on the 1969 census; 1980 estimates are calculated on the basis of the Zimbabwe fact sheet (GOZ/CSO 1981) or quoted in USAID 1982 (p.3); 1982 estimates are based on preliminary unpublished census results, based on informal discussions, and are therefore only tentative and should not be quoted; they are used only to tentatively examine the trends.
A contraceptive prevalence survey, initiated in 1984 and still being conducted, will also provide useful data. It includes information on contraceptive knowledge, use, and availability as well as about attitudes towards child spacing and family size. These results should be incorporated in this background paper when they are available later this year.

a. Crude birth rate and crude death rate

In 1980, CSO estimated the birth rate at 48 per 1000 population, a rate substantially lower than the 1969 estimate of 53-58. The preliminary results of the 1982 Census seems to be in agreement with the 1980 CSO estimate.

The crude death rate was estimated at 11-14 per 1000 population in 1969. The 1980 estimate (15) was slightly higher than in 1969. The preliminary results of the 1982 Census seem to confirm the 1980 estimate. It is expected that these rates will vary by ethnic groups (European have had a low birth rate for a long time) and by geographic areas (e.g. urban/rural; communal/commercial farm areas, etc.).

b. Infant and child mortality rates

In the past, infant mortality rate estimates have varied considerably. UNDP has given an estimate as high as 140 per 1000 live births for the whole country and UNICEF suggested 120 per 1000 in 1982 (UNICEF, 1982).
Health with Equity, A Sectorial Review and Policy Statement

issued by the MOH (GOZ/MOH, c.1982) provided infant mortality rate (IMR) estimates which varied from 14 for the white population (in 1979), to 30-50 for Harare the black population, 50-90 for the black population in other towns, and 140 for the population in rural areas. Considerable regional variations among rural areas have also been noted by Saunders in "A Study of Health Services in Zimbabwe", ranging from 300 per 1000 in Binga District, Matabeleland, to 68 per 1000 in Bikita communal lands, Masvingo Province (David Saunders, 1980).

A preliminary analysis of the 1982 Census data, based on a 10% sample, suggests an IMR between 84 to 102. This estimate suggests that infant mortality has not decreased significantly in the last 15 years. This could be explained by the War and the lack - until recently - of child and maternal care in rural areas where infant mortality is highest.

With regard to child mortality (i.e. for children less than 5 years old), there is a dearth of reliable estimates. Some estimates have been suggested, but they have not been based on reliable data. For information, the World Bank estimate for 1982 is 14 per 1000 (based on a variety of sources including the UN Demographic Year Book, UN Population and Vital Statistics Report, United Nations "Infant Mortality: World Estimates and Projections, 1950-2025", Population Bulletin of the United Nations and from the World Bank).
c. Life Expectancy at Birth

Zimbabwe has one of the highest life expectancies at birth among sub-Saharan countries, close behind or equal to Kenya and Congo (World Bank, 1984). However, it should be noted that if the estimates based on the preliminary analysis of the census data are accurate, life expectancy at birth has not risen in the last 13 years. This would be consistent with the observation that child mortality probably has declined little if at all.

d. Total fertility rate

The total fertility rate (the number of children that would be born to a woman if she were to live to the end of her childbearing years and were to bear children at each age at prevailing age-specific fertility rates) was estimated in the 1969 Census at 8.0 children. Preliminary census results suggest that a slow downward trend – from 8.0 in 1969 to 7.5 in 1980 and to 7.0 in 1982 – is taking place. This, however, can be confirmed only when 1982 census data are available.

e. Contraceptive Prevalence

There have not been, prior to the ongoing CPS, any national surveys which provided estimates of contraceptive prevalence rates in Zimbabwe. In 1981, the World Bank estimated, based on service statistics, that 15 percent of married 15-49 year old women or their husbands practiced contraception. Although service statistics seem to suggest that this percentage has risen significantly since then, it is difficult to ascertain the present prevalence rate because the records that are kept are incomplete
and inconsistent. Such a determination will be possible when the contraceptive prevalence survey, carried out by the Child Spacing and Family Planning Council (with the technical assistance of Westinghouse Public Applied Systems), is completed.

f. Adolescent Fertility

As in many countries throughout the world, Zimbabweans are concerned with adolescent fertility. Data, however, are difficult to obtain. The Ministry of Education has recently started to keep pregnancy statistics with regard to school-aged girls but these data had not been released at the time this draft was prepared. In response to this concern, CSFPC has opened some youth clinics and is providing, at the invitation of the school headmasters, courses on family life education.

g. Population Composition

As of 1969, 95 percent of the population was African. Of the non-African population, 90 percent were of European descent. Given a substantial net emigration of non-Africans, especially since the late 70's, and lower fertility among non-Africans, the percentage of non-Africans (3.5%) as estimated by CSO in 1980, is probably fairly accurate. Immigration of Africans from neighboring countries, mostly from Malawi and Mozambique, has been significant. Most of the African immigrants (about 7% of the African population) lived on European-owned farm lands and in the urban areas.
h. Annual Population Growth Rate

According to the preliminary results of the 1982 Census, the annual rate of natural growth of the population was 3.1 percent (GOZ/CSO 1984c). As pointed out by the World Bank (World Bank 1983), this rate seems low compared to the 4.1 percent annual growth rate observed between 1962 and 1969 (GOZ/CSO 1984c, p.5). It will not be possible to reconcile these two rates until full information from the census is available. The relatively low 1969-1982 intercensal average could be explained by various combinations of:

"(i) reduced fertility; (ii) increased mortality; (iii) net migration; and possibly (iv) a larger percent undercount in 1982 than in 1969". (World Bank, 1983)

The World Bank has estimated (based on the 1969 Census data) the population growth rate at 3.25 per cent (World Bank, 1984). In association with this higher growth rate, the World Bank has used the birth rate (54 per 1000) and the death rate (11 per 1000) estimated by the United Nations (UN World Population Prospects as Assessed in 1982. The preliminary 1982 Census data, however, suggest that fertility might be lower than these estimates might indicate (birth rate: 47-49 and TFR: 7.0) and that mortality might be higher (CMR:15). Until the census results become available, it will not be possible to ascertain which estimates are correct. However, even at a 3.1 percent growth rate, Zimbabwe's population would double in less than 23 years, exceeding 13 million by the year 2000.
Population Density. In 1982, the overall population density was 19.5 persons per square kilometer, somewhat higher than the sub-Saharan average of 16. As Table 2 indicates, however, this density was not evenly distributed across areas of the nation.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Density (pop/Km²)</td>
<td>19.5</td>
</tr>
<tr>
<td>Population Distribution  (per cent)</td>
<td></td>
</tr>
<tr>
<td>Percent of total land area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25.7</td>
</tr>
</tbody>
</table>

Table 2

Population Density and Distribution According to Type of Area (1982)

<table>
<thead>
<tr>
<th></th>
<th>Communal Lands</th>
<th>Large Scale Farming</th>
<th>Urban Town of 10000 pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Density (pop/Km²)</td>
<td>26</td>
<td>8</td>
<td>870.9</td>
</tr>
<tr>
<td>Population Distribution  (per cent)</td>
<td>55.7</td>
<td>15.8</td>
<td>23.2</td>
</tr>
<tr>
<td>Percent of total land area</td>
<td>42</td>
<td>44</td>
<td>1</td>
</tr>
</tbody>
</table>

1/ "Other" includes small scale farming, mines, parks.

Source: GOZ/CSO, 1984c.

As shown in Table 2, 55.7 percent of the 1982 population, approximately 700,000 households (UNICEF/GOZ, 1984), lived in the communal lands, formerly called Tribal Trust Lands, where the land is communally owned¹. These communal areas cover roughly 42 percent of the country. The average population density in these areas was approximately 26 persons per square kilometer, while in the areas of large scale farming, the density was approximately 8 inhabitants per square kilometer. Urban areas, which have increased by 17 percent since 1969, had an average population density of 870.9 inhabitants per square kilometer (GOZ/COS, 1984c p.13). Harare and Bulawayo account for almost half of the urban population.
Population Pressure in Communal Areas. In the communal areas, the soil is often poor - sandy and acid - and is not appropriate for intensive cropping. Farming plots allocated to individual families average three hectares. Livestock graze on communal areas. Farming is largely carried out by women, old men and school age children with organic power. Able bodied men are generally in employment or seeking employment in the urban centers or, less frequently, on commercial farms, and return only on vacations and some weekends when they may help with ploughing, weeding or harvesting. In other words, the bulk of the farming responsibility in the communal farming areas falls, along with household chores, on women.²

Compared to peasant farming in other African countries, crop farming in communal areas in Zimbabwe has achieved sophisticated levels of production techniques and diversification. However, compared to production on commercial farms, yields in communal areas is low and has not kept pace with the population growth rate. According to FAO, the average annual quantity of food produced per capita in 1980-82 was only 87 percent of what was produced in 1969-71. (World Bank, 1984, p.228).

Population pressure is already evident in the communal areas. A study which looked at soil production potential as it related to existing food requirements on four such areas found that, in three of the four, there were deficits of 38 to 60 percent of the land necessary to provide adequate food supply. (UNICEF/GOZ, 1984).
Meanwhile, because of erosion, soil impoverishment, and attempts to get higher production from the land without benefit of fertilizer and other inputs which are difficult to obtain, land degradation is said to be increasing at a rapid pace. (Bratton, 1981).

As will be discussed later, the low yields are not simply due to poor soil and lack of fertilizers and mechanized tools, but also to the lack of adaptive research, the weakness of the infrastructure, and to a lesser extent, a shortage of labor.

2. Population Projections

As mentioned above, Zimbabwe already has a density higher than the average density in sub-Saharan countries. Population pressures are beginning to be felt, especially in the communal lands. As was also mentioned earlier, at the present growth rate of 3.1 percent suggested by the preliminary census results, the population of Zimbabwe would double in less than 23 years.

Population projections for Zimbabwe are difficult because of the absence of reliable fertility and mortality data. In spite of these limitations, the UNDP and the World Bank have calculated some population projections to the year 2010 based on the 1969 census. These 2010 estimates, presented in Table 3, vary from 15,200,000 (UNDP low prediction) to nearly 29,000,000 (World Bank Standard projection).
Table 3 presents three sets of population projections (for 1980, 1985 and 2010) derived from the 1969 Census data. Each projection is based on a different set of assumptions:

- Projection A assumes no decline in fertility since the 1969 Census and during the projection period. This is not a likely scenario, since contraceptive use has increased during the 1970s and is likely to have had a negative impact on fertility.

- Projection B assumes no decline in fertility from 1969 until 1995, when it will begin to decline until a net reproduction rate (NRR) equal to one is reached by 2035 (Standard World Bank assumption for sub-Saharan African countries).

- Projection C assumes fertility started to decline from 1975 onwards and will decrease steadily until NRR-1 is achieved by 2015.

### Table 3

**Zimbabwe Population Projections 1980-2010**

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>1985</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td><strong>Total pop</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(000's)</td>
<td>7,502</td>
<td>7,502</td>
<td>7,421</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>1,633</td>
<td>1,633</td>
<td>1,552</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-12 (Primary School pop)</td>
<td>1,562</td>
<td>1,562</td>
<td>1,562</td>
</tr>
<tr>
<td><strong>Working age pop</strong> (Adult 15-64)</td>
<td>3,521</td>
<td>3,521</td>
<td>3,521</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>1985</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td><strong>Total pop</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(000's)</td>
<td>14,393</td>
<td>14,393</td>
<td>12,545</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>3,225</td>
<td>3,225</td>
<td>2,136</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-12 (Primary School pop)</td>
<td>3,166</td>
<td>3,166</td>
<td>2,693</td>
</tr>
<tr>
<td><strong>Working age pop</strong> (Adult 15-64)</td>
<td>6,466</td>
<td>6,466</td>
<td>6,390</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>1985</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td><strong>Total pop</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(000's)</td>
<td>28,992</td>
<td>25,388</td>
<td>17,708</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>6,588</td>
<td>4,392</td>
<td>2,103</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-12 (Primary School pop)</td>
<td>6,482</td>
<td>5,398</td>
<td>2,790</td>
</tr>
<tr>
<td><strong>Working age pop</strong> (Adult 15-64)</td>
<td>12,747</td>
<td>12,747</td>
<td>10,965</td>
</tr>
</tbody>
</table>


It should be noted that these projections do not take into account the preliminary results of the August 1982 Census. If the Census population count is accurate, however, each of these projections overestimates total population in 1980, since even the lowest projection (C) yields a higher 1980 total population figure than implied by the 1982 Census preliminary count. This
table, however, is presented for illustrative purposes to show the impact of a

decline in fertility on the population growth rate. A comparison between

projections B and C shows that mortality has less of an influence on population

size than does fertility. By 2010, total population would be 43 percent higher

under projection B than under projection C. The difference is even more

striking regarding children aged 0-4 (109%) and 6-12 (93%). These differences

illustrate the differential burden on public services of different population

growth patterns; the specific age groups 0-4 and 6-12 are especially important

in this regard in view of the Government's commitment to give top priority to

MCH and primary education.

The difference in working age population between projections B and C is less

pronounced because of the 15 year lag between the onset of fertility decline and

the corresponding impact on this population group. However, the ratio of

working age population to total population, which is only about 2:1 under

projection B, would reach almost 3:2 under Projection C. This difference is of

great importance for long term development prospects. Projection B implies a

CBR of about 39 per 1000 by 2010 compared to 26 per 1000 under projection C.

Experience elsewhere suggests that achievement of this level of fertility would

necessitate a large increase in the rate of contraceptive use. This would

require the continuation of the Government's strong support of the Child Spacing

Program, combined with a significant increase in the resources - financial and

human - allocated to the program.
3. Consequences of Rapid Population Growth

In recent years, African countries have come to recognize that, although some population growth may be necessary, rapid population growth - at rates above 2 percent - acts as a brake on development. This concern was expressed for the first time in a public forum at the Second African Population Conference held in Arusha, Tanzania in January 1984. The final conference document, the Kilimanjaro Declaration, calls for "achievement of population growth rates which are compatible with the desired economic growth and social development goals."

In this section, some of the consequences of rapid population growth for Zimbabwe are examined.

a. Education

The Government of Zimbabwe has expressed a strong commitment to education, which it views as "a means by which the Government expects to influence attitudes, values and skills, enhance opportunities for individual advancement, and redistribute the nation's resources and wealth" (Whitsun, 1983, p.85). In consequence, the Government has instituted a policy of free primary education designed:

"to eventually introduce universal compulsory and free primary education and to extend this to secondary education so that most children can have at least nine years of schooling" (GOZ, 1982, para. 18.14, p.90).
As Table 4 indicates, this policy has resulted in an enormous increase in school enrollment following independence.

Table 4

Total Primary School Enrollment 1979-1983

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total primary school enrollment</td>
<td>819,128</td>
<td>1,235,994</td>
<td>1,680,143</td>
<td>1,934,614</td>
<td>2,044,847*</td>
</tr>
<tr>
<td>Annual increase (%)</td>
<td>-</td>
<td>50.9</td>
<td>35.9</td>
<td>15.1</td>
<td>5.7*</td>
</tr>
<tr>
<td>Grade 1 enrollment</td>
<td>173,050</td>
<td>376,392</td>
<td>455,536</td>
<td>410,453</td>
<td>368,328*</td>
</tr>
<tr>
<td>Grade 1 as percent of total primary school enrollment</td>
<td>21.1</td>
<td>30.5</td>
<td>27.1</td>
<td>21.2</td>
<td>18.0*</td>
</tr>
</tbody>
</table>

* Preliminary figures

Source: GOZ/CSO, 1984c, p.5.

As a consequence of these increases in enrollment, the Government has been confronted by three major challenges: 1) to rebuild the educational system that was damaged during the war; 2) to find financial and human resources to expand and maintain the educational system; and 3) to deal with the long range consequences of rapid population growth. The additional number of students entering the system every year and the consequent pressures produced by these numbers, would need to be taken into account and reflected in Government policy and planning.

In response to the first two challenges, the Government has instituted an accelerated school construction program and has been hiring increasing numbers of personnel to teach at the primary school level. It still has to address the third challenge.
The post-independence period has also witnessed a very substantial increase in secondary education enrollment (see Table 5) and in the provision of secondary school facilities.

Table 5

Total in Secondary School Enrollment 1979 - 1983

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total secondary school enrollment</td>
<td>73,540</td>
<td>74,966</td>
<td>145,363</td>
<td>224,609</td>
<td>316,438*</td>
</tr>
<tr>
<td>Annual increase (%)</td>
<td>-</td>
<td>1.9</td>
<td>93.9</td>
<td>54.5</td>
<td>40.8</td>
</tr>
<tr>
<td>Form I enrollment</td>
<td>19,962</td>
<td>22,201</td>
<td>82,262</td>
<td>94,841</td>
<td>110,725</td>
</tr>
<tr>
<td>Form I as percent of total enrollment</td>
<td>27.1</td>
<td>29.6</td>
<td>43.4</td>
<td>57.8</td>
<td>65.0</td>
</tr>
</tbody>
</table>

* Preliminary figures.

Source: GOZ/CSO, 1984c, p.5.

Enrollment in secondary school soared in 1981 and is still increasing at a high rate. This increase is due to the fact that so few African children were enrolled prior to independence and to rising expectations of African children and parents stimulated by the Government's educational policy.

These increases, both in primary and secondary enrollment, have caused Government expenditures related to education to increase enormously. For example, total educational expenditures increased by 32 percent from 1980 to 1981, by 40 percent from 1981 to 1982, and by another 26 percent from 1982 to 1983 (UNICEF, 1983b). In order to meet this high rate of increase, the Government allocated to the Ministry of Education the largest of all ministerial budgets, 80 percent of which was required to be spent for teachers' salaries (UNICEF, 1982, p.10).
Increases in educational expenditures have occurred in both recurrent and capital investment costs. For 1981, it was estimated that recurrent expenditures on education and training would account for 20 percent of the total Government recurrent outlays, or 6.5 percent of the 1980 GNP; if private contributions for education and training are included, this would constitute almost 7.5 percent of the GNP.

The school age population (5-19 years of age), even assuming a considerable reduction in the fertility rate (see Table 6), is likely to increase by 170 percent from 1980 to 2010 (45 percent from 1980 to 1990; 42 percent from 1990 to 2000; and 32 percent from 2000 to 2010). It will continue to constitute 38.5 percent of the population during this period and the majority will continue to live in rural areas.

One can expect the primary school population to more than double by the year 2000 - assuming universal attendance by all children of primary school age - and the number of teachers who will be needed to be approximately 90,000 if the classroom size remains about 40 students per teacher. Secondary education population would increase at a slower rate, doubling only around 2010.
Table 6
Total and School-Age Population 1980-2010

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total pop. of Zimbabwe (000s)</td>
<td>7,396</td>
<td>10,489</td>
<td>14,726</td>
<td>19,962</td>
</tr>
<tr>
<td>School age pop. (15-19 yrs)(000s)</td>
<td>2,831</td>
<td>4,094</td>
<td>5,803</td>
<td>7,644</td>
</tr>
<tr>
<td>Percent increase in school age population</td>
<td>-</td>
<td>45</td>
<td>42</td>
<td>32</td>
</tr>
<tr>
<td>School age pop. as percent of total population</td>
<td>38</td>
<td>39</td>
<td>39</td>
<td>38</td>
</tr>
<tr>
<td>Rural school age pop. 5-17 yrs.</td>
<td>2,180</td>
<td>2,866</td>
<td>3,598</td>
<td>4,128</td>
</tr>
</tbody>
</table>


NOTE: These figures are slightly overestimated, since the 1982 census suggests that the 1982 population was about 4% smaller than what was estimated; based on the Census, the growth rate assumed here is also probably somewhat high. Nevertheless, these figures are useful for illustrative purpose.

These estimates make it clear that, because of the high and continued population growth rate, if there is to be equal opportunity in education, growth of the education budget must continue to outstrip the economic growth rate of the country and the recurrent costs must constitute a rapidly increasing percentage of the GNP. It should also be emphasized that, even if fertility rapidly and drastically decreased, the population would continue to grow for several decades. The later the fertility rate decline is initiated, the more severe the problem will be, as the decline will start from a larger, younger population.

Despite this need for a rapid increase in the education budget, during the school year 1982-83, the Government, as a result of an overall budget review, reduced the planned budget for
primary and secondary education by 8.5 percent to Z$375 million. This cut has certainly had repercussions on the quality of education, the number and quality of teachers and on the construction of new schools.

In other words, Government planners and policy makers are already faced with painful choices. However, the Government will face even more such choices through the end of this century, as it is forced to cope with the continued high rate of population growth projected for this period, the youthful age structure and high fertility of the population.

b. Health

Zimbabwe, though it has better health services than many developing countries, shares many basic health problems common to the developing world. The main problems are as follows:

- Considerable disparity in both access to and quality of medical care in urban and rural areas. (This disparity was increased during the War when many rural clinics and hospitals were destroyed);

- Chronic shortages of physicians, nurses and other trained para-medical personnel required for the necessary expansion of health care services. (The shortage became even more acute as the white emigration increased during the War); and

- A high rate of preventable deaths, especially among infants and children and, to a lesser, extent among mothers.

Since independence, the Government of Zimbabwe has been rebuilding and restructuring a national health care system which before 1980, was 1) based upon a curative, rather than a
preventive, approach and 2) was strongly biased in favor of the urban population. In response to these conditions, the Government has placed a greater emphasis on primary health care and has established (and is in the process of establishing more) several rural health centers to serve as primary health care and screening referral facilities. It is planned that, when all of the rural health centers are completed, they will each serve a population of no more than 10,000 people, living in a radius of about 8 km. The staff of each of these centers will have the task of supervising the village health workers who are to be chosen by their communities to be trained and to deliver primary health care at the grassroots level.

At the secondary level, care will be provided by district hospitals, the main functions of which will be:

"to support, supervise and upgrade the primary health care activities in the center district, and to provide district hospital care mainly for patients referred from the rural health centers". (Chidede, 1983).

To support this goal, the Government has started a construction program designed to build 105 new hospitals (Whitsun, 1983) and expects to have a total of 165 hospitals nationwide by 1990.

These activities reflect the basic policy statement on health included in Zimbabwe's Transitional National Development Plan (GOZ, 1982). Section 19.1 of that Development Plan states that:

"Government regards access to adequate health facilities as a basic human right and is conscious of the importance of a
healthy nation in the socio-economic development of the country [...] A high proportion of the health problems affecting the majority of the population arise from poor nutrition, lack of adequate sanitation and safe water, poor hygiene, substandard housing and ignorance of preventive health measures. In general, these preventive problems are closely associated with poverty, health and development."

It is important, however, to recognize that Zimbabwe will need to address the problems generated by rapid population growth and the increasing health care demands of a large, young and highly fertile population. As stated earlier, the preliminary results of the 1982 Census estimate that almost half of the population is under 15 years of age, that females of child bearing age (15-49 years) comprise more than 20 percent of the population and that the total fertility rate is about 7 children. The maternal and child health (MCH) care requirements and resource inputs necessary for a population of this nature are far greater than those needed for an older and less fertile population. By encouraging mothers to have fewer, spaced, children - thereby reducing the fertility rate - the demands on the health care system would inevitably be reduced, first by the improvement in the health conditions of both mothers and their children, and, in the longer term, by reducing the proportion of women of childbearing age and children under five. However, during the coming decades, the number of children under 5 and of women in Zimbabwe will continue to increase enormously and they will still constitute approximately 40 percent of the total population in 2000. From a budgetary standpoint, MCH care, which is only one aspect of health care, will require an enormous increase in the health budget. Such a budget will require a very significant, and much greater, proportion of Zimbabwe's national budget. The re-
the Zimbabwe health care system, the emphasis on preventive care and the implementation of the primary health care model will make it possible to deliver health care to a greater number of people at a lower per capita cost. However, it must be emphasized that the competing health and development priorities and increasing demands for health services produced by a growing population will still require costly inputs to (a) build and maintain the planned infrastructure and network of health service centers required to provide appropriate access to health care in rural areas and (b) to recruit and train staff in sufficient numbers to operate these facilities and cope with the increasing demands.

Primary health care requires a different way of approaching health and health care than does the curative approach. Although the availability of resources is important in the primary health care approach, even more important are the proper and effective management and use of human and financial resources and the participation of the population which is being served by the primary health care program. Because women (as women and as mothers) are the principal consumers and decision makers concerning family health, much more attention needs to be given to their needs and informed participation. This means that serious attention should be given to the status of women, women's rights, and the issue of child spacing and fertility control.

In summary, higher population growth will mean that a greater share of the national resources will have to be invested in the health sector, claiming a larger proportion of Zimbabwe's constrained budget resources.
c. Employment and the Labor Force

The Government of Zimbabwe has acknowledged that "the creation of productive employment is the key element in the strategy to achieve the objective of equity and social stability" (GOZ, 1981a, p11). The size and structure of the population have a direct impact on the nature and extent of employment at any given time and place and will also influence the possibilities for job creation and the performance of the economy. It should also be noted that unlike the school age population, whose rate of growth starts to slow five or six years after a decline in fertility, the growth of the working-age population is more or less fixed for 15 to 20 years. People born in 1980-84 will be entering the labor force in 2000 and will be there almost until half way through the twenty-first century.

Like other high fertility countries, Zimbabwe faces increases in its labor force. Over the past two decades, the high rate of population growth has created an annual expansion of the labor force far in excess of the GNP growth and the capacity of the economy to absorb the large numbers of new job seekers. This has created a situation of large scale unemployment and underemployment.

According to the World Bank (1984, p.258), 50 percent of the population of Zimbabwe was of working age (15-64 years of age) in 1982. It is estimated that the labor force, which grew at a rate
of 2.3 percent a year between 1970 and 1982, will grow at a rate of 4.5 percent from 1982 to 2000. The Government of Zimbabwe is cognizant of the fact that not enough jobs are being generated to meet the net growth in the labor force and recognizes that many of its citizens are unemployed or join the informal sector, the resettlement schemes or the large number of underemployed in the rural peasant sector.

In order to demonstrate the appreciable effects of continued population growth and the expanding labor force on employment in Zimbabwe, both at present and in the future, the specific effects of these factors on various sectors of the economy are summarized below.

Industry. Between 1971 and 1981, employment in manufacturing increased by about 20 percent, accounting for nearly 30,000 new jobs. Significant increases in employment have also occurred in mining, distribution and construction. The Government expects a net annual economic increase in this section resulting in a 3.3 percent increase in new jobs, the largest increases coming in manufacturing and construction. Transport, communications and distribution are also expected to create new jobs and it is anticipated that cumulative new employment in industry will amount to 77,000 jobs over the period 1982 - 1985 (GOZ, 1982, pp.30-31). However, a number of economic factors, such as the increase in building costs, higher inflation than expected and reduced mining exports may impact negatively on these projections.
Service Sector. Between 1979 and 1981, there have been significant increases in employment in this sector, particularly in education (accounting for 80% of the rise in employment during this period), public administration and health (Whitsun, 1983, p.113). The Government's target for mid-1982 to mid-1985 for this sector calls for a cumulative employment of about 32,600 new jobs.

Modern Agricultural Sector. Although this sector contributes an average of 40 percent of merchandise exports, it presently accounts for less than one third of all formal wage employment (26% in 1982). It has been in continuous decline since 1970, despite the significant real increases in agricultural production witnessed in 1980 (13.9% of GNP) and in 1981 (17.1% of GNP) (Whitsun, 1983, p.111).

Communal Agriculture. Fifty-six percent of the Zimbabwean population, according to the 1982 Census, are residents of communal farming areas (GOZ/COS, 1984c). They represent approximately 75 percent of the rural population and occupy about 42 percent of the country's land area. As stated earlier, a large proportion of these areas possess soil of poor quality. Many factors in recent years - not the least of which was the War - have contributed to the difficulties facing residents of the communal areas. However, the fundamental problem has been created by the high population growth, which means that too many people are now trying to live off far too small an area of land, much of which is only marginally productive.
One Government study (GOZ, 1981b, p. 147) strongly suggests that, with the present infrastructure and technology, communal land areas have a maximum carrying capacity of 325,000 families; estimates based on the 1982 Census indicate that at least twice that number are now living in the communal areas. This has the unavoidable result that the population density in the communal areas is far in excess of the carrying capacity of the land base, a situation which is bound to become worse in the years ahead as the population continues to grow and the land base shrinks even further.

Frequently, one or more members of the families living in communal areas are forced to seek employment elsewhere in order to supplement the family subsistence income. It is estimated that 1/3 to 1/2 of communal area households presently have a member in the formal sector. In order to alleviate some of the population pressure on the communal lands, the Government has initiated a resettlement program. However, this solution will only accommodate - at a very high cost - a small number of households; with the population growth in rural areas continuing at the present rate, all unutilized and underutilized lands are likely to be used prior to 1990. In other words, the fact remains that the land base is finite and continued high population growth will not be accommodated merely by resettlement. Thus:

"In the long term, the cost of providing infrastructure and services, while at the same time endangering the national well-being by undermining commercial farming productivity, will likely cancel out many political commitments for resettlement with equity by virtue of the sheer weight of human numbers" (Whitsun, 1983, p.110).
In the three year period from mid-1979 to mid-1982, taking into account both agricultural and non-agricultural employment, it is estimated that employment increased by some 57,000 jobs, while over the same period it is estimated that there were at least 300,000 new entrants in the labor market. As a result, in the past several years, neither the modern agricultural/industrial sector nor the communal farming sector has been able to generate increased employment capacity at a rate near the annual increase in the labor force. The present estimated annual number of new entrants varies, according to various studies, from 75,000 per year (UNDP) to 125,000 (Futures Groups). In either case, the prospect of creating employment of this magnitude seems remote. This is particularly problematic in view of the present and projected high population growth rate for Zimbabwe, a rate which virtually assures - because of the age structure of the population - uninterrupted annual growth in the labor force for the next 15 to 20 years at a level probably close to 4 percent per year (World Bank, 1984, p.258). As a result, as stated earlier, even if the present high level of fertility were to decrease immediately, the impact of such a decrease would not be felt before the end of the century. In the meantime, the increasing demand for new jobs will only stimulate the employment-related rural to urban migration, which is already producing stress upon the urban infrastructure.

It cannot be expected that the informal sector will be able to provide employment and a living wage to anywhere near the large and growing number who at present are and in the future will be unable to find jobs in other sectors.
In the light of the above, one cannot avoid stressing that, even if a fertility decline started immediately, its impact on the labor force will not be felt before the turn of the century.

The Zimbabwean Paradoxes. There are two paradoxes in the Zimbabwean labor situation. First, despite a chronic shortfall in new employment creation, a serious labor shortage of skilled or qualified personnel exists. Second, farmers complain of a shortage of farm labor on the labor-intensive, non-mechanized communal lands, although there are too many people there compared to the numbers the land can support.

The skilled and qualified personnel shortage is due to the emigration of many such personnel and to the lack of trained Zimbabweans. Although training programs have been established, it will take some time for the students to graduate and to acquire the experience to assume the vacant positions. There is no doubt that the situation will become increasingly difficult as the economy expands and the public sector, including parastatals, compete even harder for the limited number of openings for well-trained, qualified and experienced managers and other technically competent personnel.

However, it should be pointed out that this shortage will be relatively short-term as the labor force continues to expand at a rate significantly greater than the demand for both the public and the private sector. In other words, the needed skilled and
qualified workers are already born: they need only to be educated. The policy of the government concerning primary and secondary education, along with the expansion of technical training facilities and higher education, point to a time in the not too distant future when educational opportunities will far outstrip the capacity of the country to generate new jobs. Thus, over the next few years, it can be expected that the present shortage of skilled personnel will become a thing of the past. This present shortage would, under no circumstances, justify postponing a reduction of the population growth rate.

Labor constraints in the communal areas are even more of a paradox. Although there has not been a national study of labor problems in these areas, several small, geographically limited, studies have been carried out. All acknowledge the population pressure in the communal lands (e.g. Rukuni 1984), where available supplies of land are not growing as fast as the population. Paradoxically, all studies also mention that farmers cite the shortage of labor as the most important constraint on farming production (Callear, 1983), the second being draught power. These labor constraints have increased since independence. Most children are now attending schools and cannot help as much as they used to help. In addition, minimum wages for hired labor, which is available, may be too expensive for many families to be able to afford such labor as frequently as required. These labor constraints are compounded by a weak infrastructure (lack of markets, roads, means of transport) as well as by a lack of equipment, fertilizer and herbicides (Prescott, n.d.).
No study has yet been carried out to investigate whether the peasants think that having a large family will help them to be better off because such a family would provide either additional income or free labor. There is some indication, however, that rural families expect their children to migrate in order to find wage employment and thus be able to remit and contribute to the family income. This, it is suggested, might encourage families to have more children (Weinrich, 1983). With regard to whether larger families are, in fact, better off, some studies seem to indicate that total income increases with family size (de Swardt, 1984). On the other hand, the same study shows that, in certain areas, per capita income was lower for families with more than seven members than for those with 4 to 7 members; in other areas, per capita income of larger families was lower than for all smaller families. Several studies seem to indicate that the relationship between cattle ownership and income is more important than that of family size and income (Jackson et al, n.d.).

The picture which emerges, from reviewing these studies and from talking with their authors, is that young families starting out will have more problems than older families. The young families are more likely to be paying the brideswealth (lobolo), restricting their ability to acquire farm capital. They tend to have less land and fewer or no cattle. The younger families are also likely to have to support the husband while he seeks employment in urban areas or on commercial farms, for all or part of the year (Callear, 1983). In contrast, older families
generally have more cattle, more equipment, more land, a higher family income, often enhanced by migrant children who remit. With this higher cash income, these older families are better able to hire labor to assist them.

The cost of education may discourage families from having many children. Although most families want their children (especially the males) to be educated, they cannot afford to pay for a large number of such children to go to school. In addition, the fact that children often need to leave home to attend secondary school means that they will not be able to help with farming activities and that they will, therefore, become a financial burden to the family for many years before they can migrate and contribute to the family income (Callear, 1983). A family with many closely spaced children will then not be able to afford education for all its children. This economic reality, together with the strong belief that children should receive an education, may encourage peasant families to have fewer children and to look for new ways of cultivating their land that would reduce the demand for labor.

In spite of the traditional positive attitude toward large families in Zimbabwe, there is evidence that when economic pressures exist, couples will have smaller families. For example, couples living on commercial farms (where income is low) have smaller families on an average than do families living on the communal land (Weinrich 1983). It is therefore possible that, with the spreading of education, more families will perceive children as a financial burden.
From the data available, it is difficult to reach any definite conclusion regarding the strength of the relationship between income and family size among communal families. There is no evidence as to whether farm families consciously associate a large family with having a higher income. However, the studies reviewed suggest that larger families are better off because they are also older, established families who have had more time both to accumulate capital (cattle, equipment and, often land) and to have more children. In the future, it is likely that the cost of education will limit the number of children a family can educate. Many families are likely to want fewer children and to look for farming practices less dependent on child labor. Labor-saving agricultural methods and equipment, a better infrastructure (i.e. better roads, transportation and market outlets), the use of herbicides and fertilizers will also help diminish the demand for more labor.

d. Conclusion

Population and development are interwined in many ways, not all of them fully understood. However, after reviewing the population statistics available, it is clear that with a population of approximately 7.6 million and an annual growth rate of 3.1 percent, Zimbabwe will face increasing problems in the coming years. Some of these problems will include providing educational facilities and teachers for the school age population which will double in less than 20 years, making available to mothers and children adequate health services (mothers and children under five represent nearly half of the population), and in generating jobs for the thousands of new labor force entrants.
There is no doubt that the issues of high fertility and population growth present serious problems to be considered by the Government in relation to future investment and development priorities. One of the options the Government has is to develop a strong population policy and to support it by a nation-wide, Government-sponsored family planning program. This is an expensive option, but one whose potential benefits would exceed the direct and indirect cost of the program. As one study has concluded:

"Since the major benefit from a family planning program is the reduced level of expenditures on consumption and social service expenditures and the costs are the direct cost of the program plus the indirect cost in terms of foregone production resulting from a lower potential labor force, it is almost antological that cost/benefit analysis of family planning programs will inevitably result in the present value of benefits exceeding the present value of cost" (USAID, 1982)

Aside from these demographic and economic reasons, there are other reasons why a family planning program can provide useful benefits to Zimbabwe. Such a program could:

- improve the health of mothers and children.

- allow parents to have the number of children for whom they know they can provide adequate food, health care and education.

- enlarge the choices available to people, (especially women) a central purpose of economic and social development.

- offer the greatest potential benefits for the poorest people, whose mortality and fertility rates are usually the highest of any group.
Other factors which have been demonstrated to reduce the population growth rate are:

- Provide more years of education
- Raise per capita income
- Increase employment for women
- Reduce infant mortality rate

Each of these factors is discussed briefly below.

**Provide More Years of Education.** Fertility has been shown to be negatively associated with the level of educational attainment. However, in some African countries, this impact seems to occur only after ten to twelve years of education (World Bank, 1984), requiring a considerable investment in education to achieve an effect. Thus, even if the impact of one dollar invested in education were the same as one invested in family planning, the dollar invested in education would take longer to have its effect simply because most clients of the educational system are below the age of puberty and it could not start to reduce their fertility for several years.

**Raise per Capita Income.** Raising per capita income has been demonstrated to have two effects on the demand for children: As the level of a family's income rises, the family has a tendency to increase its expenditures on all goods and services and, to a point, to want more children, partially because they can better afford and provide for them. In contrast, there is also a tendency for higher income families to want more and better education and health care for their children. This tends to
impact negatively on the demand for children. Although the exact nature of the relationship between per capita income and population growth has not yet been determined in Zimbabwe, whatever that relationship, any potential decline in fertility resulting from rising income would require a long time to take effect, given the current 3.1 percent growth rate and the large number of youth in the present population base.

Increase Employment Opportunities for Women. The provision of employment opportunities for women has also been demonstrated to negatively impact on fertility in many countries. The underlying reasons for this effect are 1) the reduced time that working women have to care for children and 2) the reluctance, or inability, of such women to incur the earning losses resulting from leaving their jobs to have children. However, in Zimbabwe, where both unemployment and the cost of creating a job in the formal sector are high, it is not likely that employment for women will increase rapidly.

Reduce Infant Mortality. A reduction in infant mortality has also been shown to lead, over time, to a decline in the birth rate in several nations. Parents who expect some of their children to die must have more babies to insure that the number they want will survive. In addition, high infant mortality can cause high fertility for biological reasons: if a baby dies, the mother will stop breastfeeding, thus hastening the return of ovulation and reducing the interval between births.
In the short term, reducing infant mortality will lead to an increase in the population growth if there is no decline in fertility, as more babies survive. In addition, it will take time for beliefs to change and for parents to realize that they need not have a large number of children so that a few will survive. Consequently, this factor will not have an immediate impact on population growth.

Summary. As educational levels increase, per capita income rises, employment opportunities for women become available and infant mortality decreases, attitudes towards family size will change towards a smaller family. But in order to help translate attitude change into behavior, the means of reducing fertility i.e., contraceptives, are necessary. In other words, a child spacing/family planning program which can make contraceptives available to all who want them is necessary in order to increase the impact of the other socio-economic factors. As stated above, a child spacing program can have an impact in the short run but it is also necessary in the long run when other factors will be affecting fertility.

III. ZIMBABWE POLICIES AND PROGRAMS

1. Background

African fertility has been a controversial issue in Zimbabwe, especially under the previous government. The Africans saw a high fertility rate as the basis for their survival and a value deeply
imbedded in their past, but the white-controlled government saw it as a threat to white survival and therefore tried, through both persuasion and pressure, to reduce the African birth rate.

Africans still regard children as valuable, both because they guarantee the continuity of their tribal, ethnic and family groups and because such children can help the group members to produce their food supply. One indication of the importance attached to children is the fact that under the African Marriages Act "barreness" is still cause for divorce for Shonas. (May, 1983 p.81)

In early Zimbabwean societies, children helped in food production from early childhood; the older they became, the greater became their economic contribution. Hence, the more children a family had, the greater was its economic security. In the late seventies, 56 percent of all couples would still have liked to have as many children as possible (Weinrich. 1982 p.110). This desire was particularly strong in communal rural areas (62 percent versus 48 percent in urban areas and 54 percent in commercial farms and mines).

Children in rural areas are not yet seen as much as consumers (and therefore economic burdens) as they are as "producers". This attitude may be starting to change now that education is becoming available more widely; as children spend more time in school, they have less time available to help grow food. This has reduced the economic value of children as producers, especially for parents who must pay for secondary school attendance. Children who must leave home to attend school are an even greater burden.
Smaller families in urban areas, and even more so in commercial farming and mining areas, are already being observed, indicating that economic and other pressures are affecting family size. In the urban environment, children are an economic liability rather than a benefit. Moreover, the good health facilities found in urban areas have greatly reduced the urban infant mortality rate over that found in the rural areas; as more children survive, the economic burden they pose increases. A study carried out in the late 1970s, shows that the smallest African families were those living on European-owned farms and mines; this was partly due to a high divorce rate and partly to the fact that on mines and farms, where people lived below subsistence level, children posed many problems. The relatively low infant mortality rate on farms and mines was due to access to maternity aid provided by the employer's wife. (Weinrich, 1983).

As mentioned earlier, family planning was viewed negatively by the African population during the UDI government. During the struggle for independence, nationalists openly opposed such planning. This was due not only to traditional values, but as one author observed, due to:

"the very fact that Africans were being asked to limit their families at the same time as the Prime Minister, Ian Smith appealed to white parents to give more children to the nation and the government launched an intensive white immigration campaign, was interpreted by Africans as a desperate move by Europeans to reverse the racial imbalance in their favour". (Weinrich, 1983 p. 130).
In addition, the past regime's family planning campaign coincided with the publication of the papal encyclical Humanae Vitae that condemned artificial birth control. The Catholic Church in Zimbabwe, which was often perceived as supporting the independence movement, then intensified its opposition to contraception. This position won much vocal support from the nationalists.

The stage for conflict about family planning was therefore set. On one side, traditional values, Catholic moral teachings and nationalist politics opposed such planning. On the other side, economic conditions as well as health considerations by the African families in urban areas, commercial farms and mining areas, lent support to the need for family planning. These conflicting considerations explain the complex reaction of the Zimbabweans toward family planning. It is in this context that the present Government came to power, which explains some of the Government's caution in advocating family planning and, in addition its emphasis on "child spacing" and on the benefits to the mother's and child's health resulting from it.

2. Official Position of the Government

In the Transitional National Development Plan 1982 -83/1984-85 (GOZ, 1982) the need for child spacing is mentioned as being necessary but there is no policy statement concerning it. In Health with Equity (GOZ/MOH, c.1982), child spacing is never mentioned, although there is a great emphasis on mother and child
health and on the preventive approach. In contrast, the Government has been supporting the Child Spacing Program financially and through public statements since 1981. Since September 1982, the Government has provided \( \frac{2}{3} \) of the funds needed by the Child Spacing and Family Planning Council, the parastatal organization which has succeeded the private Family Planning Association; the balance is provided by USAID.

At a 1983 workshop on Maternal and Child Health in Nyanga, the Minister of Health, in his opening address, explained the Government's health policy:

"Access to health services for all became a human right as everyone has a right to be healthy (....) This can be achieved in utilising all resources made available to the Ministry of Health in the most cost effective manner. To ensure this there is no better strategy than to adopt the Primary Health Care approach which has been recommended globally as the only way all countries throughout the world can cope and attain the global goal of Health for All by the year 2000. As we all know, the Primary Health Care approach demands that we develop appropriately and effectively the following components or programs that make up Primary Health Care:

1. Health education.

2. The development of effective and appropriate nutrition programs.

3. The development and provision of appropriate, cost effective Maternal and Child Health Service including Child Spacing (emphasis added). (....)

Of the eight components listed, the development and provision of appropriate cost-effective MCH programs is the one most critical cornerstone toward ensuring the success of primary health care". (Cde. O. M. Munyaradzi, Minister of Health, quoted in GOZ/MOH, 1983. pp 4-5).

During the same workshop, the policy regarding the proposed MCH services was outlined by the Deputy Secretary for Rural Health Care, Dr. Makuto, who identified the promotion and the delivery of
child spacing services as one of those to be delivered in the context of MCH (Makuto, 1983).

In other words, although the Government does not have a population policy as such, it has endorsed child spacing as one service necessary for the well being of the people. In June 1984, a seminar on Population and Development was organized by the Ministry of Health and the Central Statistical Office, the purpose of which was to inform and educate senior Government officials on matters relating to population and their impact on development. Among the recommendations emanating from the workshop were several concerning child spacing in particular. Among those recommendations was this one:

4. Child Spacing should be seen primarily as a means of allowing the mother and child to benefit from better health conditions and career opportunities. A possible consequence might be a subsequent decline in fertility [...]. The advantage of child spacing for mother and child health should be promoted via

i. mass media [...]

ii. appropriate family life education in schools

iii. community development workers in the field (GOZ, 1984:1)

Later recommendations stated:

We recommend the following programmes aimed at raising the standard of living:

i. Primary health care which includes the following:

(....) maternal and child care, including family planning (....)" (GOZ, 1984:2)

These recommendations reflect the cautious official attitude of the Government towards family planning. This caution is further demonstrated by the official "Zimbabwean Views on
Population" (GOZ, 1984) presented in Mexico City at the UN Conference on Population, which stated only that "Zimbabwe's socio-economic development plans seek to harmonize population growth with overall development", and mentioned "population problems" but never specified neither the nature, nor the seriousness, of those problems.

In summary, although the Government does n-t, as yet, have a population policy, it has fully endorsed the concept of child spacing, is in the process of educating both government officials and the public as to why child spacing is necessary and is providing significant financial assistance to the Child Spacing and Family Planning Council. Finally, the Government is planning to establish, with the assistance of UNFPA, a Population and Development Planning Unit as an integral part of the central planning process.

3. Child Spacing Service Delivery System

a. Organizations Delivering the Services

Child spacing services were introduced on a voluntary basis to Zimbabwe in 1953. In 1965, various uncoordinated family planning activities were consolidated with the inauguration of the Family Planning Association (FPA) of Rhodesia, which was registered as a welfare organization. In 1967, the Government announced its support for the FPA and started to provide it with a yearly grant. The Permanent Secretary for Health was also designated as
an ex-officio member of the Executive Committee of the FPA.

During the 1970's, the FPA was accused of trying to limit the African population. During this period, it relied mostly on Depo-Provera as a method of contraception. In 1981, a year after independence, the Association was instructed to discontinue the use of injectables and a major confrontation ensued. As a result, the Government took control of the FPA. Soon thereafter, most of the administrative staff at headquarters and some of the provincial administrators left; a compromise was then reached to phase out injectables except for a few special types of acceptors (mental patients, women over 35 and women who want to be sterilized).

Although this confrontation caused considerable disruption, the FPA maintained its role as a leading institution in the child spacing field. However, the Government changed the policy orientation of the Association from one of population control to one of family welfare and planned national development. In order to reflect this change in policy, the Association's name was changed to the Child Spacing and Fertility Association (CSFA).

In November 1983, the CSFA became a parastatal organization, the Child Spacing and Family Planning Council (CSFPC), to be supervised by the Ministry of Health. An executive committee, chaired by the Permanent Secretary of Health, is now in the process of being established. Up until September 1982, the CSFPC program was financed by the Government. Since then, USAID has
co-,tributed approximately a third of the CSFPC budget under the Child Spacing and Fertility Project, which was developed by MOH with USAID technical assistance. The objectives of the project were to:

- "systematically promote child spacing practices by offering information and services to the entire population with special emphasis on youth, semi-urban and rural population, thereby increasing their social well being, especially in the area of family health."

- Extend coverage of child spacing information and services through increasing the management, technical and training capacity of the council" (for a more detailed description of the project see USAID Project Paper, 1982)

Child spacing services are also provided in the health facilities of MOH, local government, mission health facilities and in commercial and industrial enterprises.

In 1981, the distribution of child spacing clients by type provided was roughly as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSFPC (then CSFA)</td>
<td>40 percent</td>
</tr>
<tr>
<td>MOH</td>
<td>10 percent</td>
</tr>
<tr>
<td>Local Government</td>
<td>40 percent</td>
</tr>
<tr>
<td>Missions and Other</td>
<td>10 percent</td>
</tr>
</tbody>
</table>

In the next section, the types of services provided by the various organizations involved in providing child spacing services will be described.

b. Types of Services

**Services Delivered by CSFPC.** The CSFPC delivers services through five operational units supported by an Administrative Unit and a Research and Evaluation Unit. The five operational units are the:

- Medical/Clinical Unit
- Community Based Distribution (CBD) Program Unit
The Training Unit
- Youth Advisory Service (YAS) Unit
- Information, Education and Communication (IEC) Unit

The Council headquarters are located in Harare at the Spillhaus Center. The Medical/Clinical Unit supervises 22 child spacing clinics located throughout the country (mostly in urban areas). These clinics are staffed by nursing officers, state registered nurses (SRN) and medical assistants (who have received additional midwifery training). All of these personnel have been trained by CSFPC in child spacing management skills. In addition, all the clinics provide education, motivation, counselling, physical examinations and contraceptives (oral contraceptive (oc), injectables on a restricted basis, intra-uterine contraceptive device (IUCD) and condoms). The two largest clinics, in Bulawayo and Spillhaus, also provide subfertility services. Voluntary sterilization and laparoscopy services are available only at Spillhaus.

The Community-based Distribution (CBD) program unit, the principal outreach mechanism of the CSFPC, started in 1968. Under this program, 423 community-based distributors (CBDs) provide education, motivation, screening services and child spacing supplies (oral contraceptives and condoms). CBDs are selected by the members of the community in which they live. They must be literate and able to speak English as well as at least one of the two major indigenous languages (Shona and Ndebele). They receive four weeks of training in child spacing and interpersonal communication and two weeks of in-the-field training. While in the field, the CBDs are organized into groups of 8 to 12,
The group leaders are supervised, in turn, by a senior educator who is based at the CSFPC provincial office and is supervised by the Provincial Nursing Officer. Group leaders and senior educators are promoted from the ranks, as demonstrated by the fact the head of the CBD Unit started as a community-based distributor.

The Training Unit has two centres, one in Harare, the other in Bulawayo. The eleven tutors provide three types of courses:

- A four-week course for medically trained personnel. It teaches doctors and nurses delivery of all contraceptive methods, side effect management, maternal and child health and population education.

- A six-week course for midwives (practical IUCD insertion)

- A six-week course for the CBD's who have no health training. It includes communication skills, contraceptive screening and methods and population education.

The Youth Advisory Service (YAS) Unit was initiated in 1978 at the request of the Ministry of Education. The principal function of this unit is to provide family life education (FLE) in the primary and secondary schools upon invitation of the headmaster of each individual school. The youth advisors also deliver family life education in the University and to the Youth Brigades as well as make presentations to parents. The YAS also runs a youth clinic in Harare which provides contraception and counselling to adolescents.
The Information, Education and Communication (IEC) Unit was created in 1983. So far, its responsibilities consist primarily in the broadcasting of three radio programs per week. The Unit also has plans to expand mass media promotion of child spacing and is in the process of developing various manuals and audio-visual aids to facilitate child spacing education.

The Administrative Unit coordinates all the activities of the Council and provides executive leadership to the program. The Research and Evaluation Unit (REU) is only now being established. A long term resident advisor will assist CSPFC to develop data collection systems and operational research.

Other Organizations. Family planning services are also provided in some MOH, local government, mission, commercial and industrial health facilities. The Rural Health Department of MOH is responsible for MCH and child spacing activities in MOH facilities and for the coordination with CSFPC, local government and other providers of MCH and child spacing services. In spite of the Government policy, many health facilities do not provide child spacing services either because no staff is qualified to deliver these services or because the staff members are too busy with curative care or because the staff feels that it is extra work for which they are not paid. These obstacles reflect the lack of emphasis on child spacing in the training of medical personnel. Fortunately, this lack of emphasis is changing, however, as shown by the fact that the curricula for nurses and midwives have been revised to include comprehensive child spacing training starting...
in September 1984 and, furthermore, by the fact that the curriculum for medical students is being reviewed. The type of services provided vary across clinics, ranging from physical examinations, to contraceptive screening and supply to counselling. It is difficult to assess the quality and the impact of these services, since only about 1/3 of the clinics report to CSFPC (CSFPC, 1984) on their activities.

c. Strengths and Weaknesses of the Program

The Zimbabwe Child Spacing Program, as mentioned in the mid-project evaluation (USAID, 1983), is widely recognized as one of the best in Africa. The Child Spacing and Family Planning Council has contributed greatly to the success of the program and, although it is generally perceived as the main provider of child spacing services, it is in fact providing only 40 percent of the services. Consequently, in this section, the Zimbabwe Child Spacing Service delivery system at the national level will be examined as a whole. In addition, general policy issues will be discussed and the strengths and weaknesses of the delivery system will be assessed.

The first question to be addressed concerns the dependence of the national child spacing program on funding from USAID, which presently underwrites approximately one third of the budget for the CSFPC, which provides most of the contraceptive supplies presently used by CSFPC, MOH and other health facilities. This means that if USAID were to withdraw its support, the child spacing program would not be able to obtain supplies unless the
Government of Zimbabwe was willing to make available sufficient foreign exchange for contraceptive procurement.

In this context, the long term problem of contraceptive procurement must be examined as soon as possible. Will the Government of Zimbabwe be committed enough to the child spacing program to commit sufficient foreign exchange for the quantity of contraceptives necessary for the program to continue to be effectively? Further, contraceptives should, like other drugs, be in the highest priority category for foreign exchange. Regardless of how this long term problem is resolved, what other source of support does the Government propose to tap in order to make the procurement of contraceptive supplies less dependant on USAID funding? In the short term, the following issues need attention:

- Supply
- Availability
- Method Mix
- Reporting
- Training
- Public Education
- Equipment
- Distribution System

Each of these issues is discussed below.

**Supply.** In the past, there have been critical shortages of contraceptives. As a result, it has often been difficult to fill all the orders of the various health facilities. This has also made it impossible for community-based distributors to give more than one cycle of contraceptives to users, forcing them to come back every month instead of every three months. Switching among the contraceptive brands because the same brands are not always available has also contributed to discouragement among some users.
If the program is to be successful, a system of maintaining adequate supplies at all levels needs to be established. To maintain such a system will require regular periodical reporting, from all health facilities, of contraceptive distribution to users and balance on hand by method and brand. In addition, these data would be useful in determining months of supply on hand for all program levels, information which in turn would help in identifying supply imbalances. The inventory presently being compiled by the Research and Evaluation Unit to determine which health facilities are obtaining contraceptives from CSFPC can be the first step in the creation of such a report system. When the REU inventory is completed, some mechanisms should be instituted which would require all health facilities to report regularly what they have used and what they have on hand. Ideally, any facilities which did not report should not be eligible to obtain more supplies until they are in compliance.

A clear indication of the need for a better forecasting system is provided by the fact that CSFPC recently requested from USAID larger quantities of contraceptives than were included in the original bilateral agreement. This shortage is, of course, evidence that the program has generated higher demand than expected - a clear measure of success. Nevertheless, much of this excess demand could have been anticipated with good forecasting methods. However, if health facilities do not regularly report their inventories to CSFPC, they make it impossible to predict - and therefore to meet - their needs.
In order to supply adequate quantities of contraceptives at all levels, an initial large order will be necessary and smaller quantities will be needed yearly thereafter. However, the combination of this initial order and of the additional quantities needed for the following two years would cost approximately six million dollars (preliminary evaluation report of the CBD program, Monteith & Johnson, 1984), an amount in excess of that anticipated in the amended bilateral agreement. This raises the question of whether AID is willing and capable of increasing its supply of centrally funded commodities and whether it is willing to redirect some bilateral funds from other activities to contraceptive procurement. Only if the supply of contraceptives is adequate will the program be able to expand as public demand increases. This demand is likely to increase in response to several factors: (1) IEC activities, which are going to be intensified, (2) word of mouth, as the number of satisfied users increases, (3) economic pressure, and (4) the increased motivating activities of the CBDs, who will no longer be distributors almost exclusively, but who will have more time to motivate and recruit new acceptors. A shortage of supply can frustrate both clients and workers who have difficulties in responding to the need they generate and can, therefore, seriously interfere with the expansion of the program.

Another issue related to the question of supply is whether or not CSFPC should order supplies for the nation as a whole. It can be argued that, for planning and administrative purposes, it is easier to have a single agency ordering contraceptives for the
whole country. The use of the newly acquired computer to keep stock and distribution records will facilitate this process. However, as mentioned before, forecasting the quantities of contraceptives necessary to keep an adequate supply at all levels of the system will be possible only when all child spacing and non-child spacing health facilities report the quantities of contraceptives they have distributed to users by method and by brand as well as their balance at hand on a regular basis. CSFPC should consider giving technical assistance to health facilities which have problems setting up their recording and reporting system.

Finally, the use of the mini-pill is widespread in Zimbabwe because many women breastfeed their children. The present CSFPC policy is to give the mini-pill to breastfeeding mothers until their child is six months old (one year old in drought affected areas) and then to switch them to a combined oral contraceptive. However, the health workers who distribute the progesterone-only mini-pills have indicated that this policy is difficult to enforce. Frequently the mini-pill is given for considerably longer periods of time in order to insure that the mother continues to have an adequate supply of breast milk. This practice, however, seems to result in a frequent shortage of progesterone-only oral contraceptives. Relaxing somewhat the currently very restricted criteria guiding the use of Depo-provera would partially alleviate this shortage. Such a relaxation would also probably affect the general patterns of use and have an impact on the need for other contraceptives and, therefore, should be taken into account when doing supply forecasting.
Availability. Child Spacing clinics and other static health facilities are concentrated in urban areas where they are easily accessible. In rural areas, however, many rural health centers (RHCs) do not provide child spacing services and access to those that do is difficult. In addition, there are not enough community-based distributors in rural areas to service such large areas. In order to improve this coverage, all health facilities should be encouraged to provide child spacing activities. At present it would be difficult to enforce such a policy because all facilities do not have trained staff. A four-week in-service training program is currently provided by CSFPC, but it instructs only 40-50 people approximately four times a year. There are about 4000 maternity assistants and 5000 SRNs to be trained. At the present rate, it would take close to 45 years to train the existing staff.

The Ministry of Health is currently developing a project proposal for the World Bank which would include training in child spacing for health facility staff at the provincial level; this instruction would be provided by trainers who would be taught by CSFPC. If this project were to be implemented, it could greatly improve the situation in non-CS clinics.

Staff who will be hired in the future should not need to be retrained as the curriculum for nurses and mid-wives has been revised to include four weeks of child spacing. This training, which will start with the next academic year, will include both
theoretical and practical components. The physicians' curriculum is also currently being revised by the medical school, in consultation with the CSFPC, with the financial assistance of JHPIEGO.

Private hospitals and missions should also be encouraged to train some of their health workers to provide child spacing services on a routine basis. (Some countries make it a requirement for private hospitals and missions to provide primary health care - including child spacing - in order to be allowed to operate in the country.)

When a CBD recruits a new acceptor of oral contraceptive, the CBD gives her one cycle of pills and refers her to the closest health facility, a CS clinic or another type of facility. There are still instances when the staff of the health facilities refuse to examine the new acceptor, either because the staff member (1) does not know what to do or what to check, (2) does not have time (curative care is considered more important) or (3) feels it is extra work for which they are not paid. When such an incident is known to occur, it is supposed to be reported to the provincial office by the CBD. The Nursing Officer then pays a "motivation visit" to this health facility. Although such a visit generally prevents future incidents, it involves only minimal training - e.g. going through the CO check list - and it does not replace the four-week training course which is given by CSFPC to health personnel.
The Community-based Distribution (CBD) program operated by CSFPC enjoys a well deserved reputation. The task of the educator/distributors (or community based distributors - CBDs) are comprehensively defined. The supervisory staff, promoted after years of experience, provide a supportive style of supervision. Nevertheless, the program could be more cost effective. Partially because of the shortage of contraceptives, CBDs have been giving the users only one cycle of pills per visit and have had to visit all their clients every three weeks. This arrangement seriously limits the number of clients that can be served by each CBD. In other words, the CBDs spend most of their time visiting well established users and doing little motivation and recruiting. This practice makes the CBD program very expensive, without providing any additional health benefits.

Already a move has been initiated to increase the stock of available contraceptives to CBDs (Boohene's memo to CSFPC Provincial Managers, 1984) with the instruction to increase the number of pill cycles, or of condoms, dispersed to established users. This change can be expected to have both immediate and long term beneficial implications for the program:

- CBDs will be able to meet the demand that their efforts have stimulated without running out of contraceptives.
- By dispensing more supplies to established patients who need not be visited every three weeks, the CBDs will have more time for motivating, educating and recruiting new acceptors and for visiting "old users", thus extending the coverage without increasing the cost. This would also allow CBDs to spend more time in currently under-served areas and to visit non-CS clinics to motivate the staff. All of these changes would be congruent with the government policy of moving toward integrated MCH/CS services.
One of the concerns expressed at the provincial level was the difficulty they experienced in covering the territory of the CBDs who are on vacation, sick or who have resigned. In some instances, the group leader (GL) will try to substitute, but it is difficult for a GL to supervise his/her whole territory while covering one CBD's clients. This problem will be reduced somewhat when CBDs can give a three month supply to all the established users. In order to cope with this problem, as well as with the problem of users who are away at the time of the CBD's visit, it is suggested that a "satisfied user" who is well known and respected by the community be identified. This person would keep contraceptive supplies -- for re-supply only -- and women whose appointment with the CBD was missed could go to her and obtain new supplies. This woman would have to be literate enough to be able to read the names of the users and of the contraceptives she would be dispensing; however, she would not be a motivator nor a recruiter: she would supply only women who had already been using the OCs (Monteith & Johnson, preliminary report, 1984, discuss such an approach).

As the program matures and more women are well motivated to use contraception, a shift in the role of the CBDs may be envisaged. It will never be possible, for cost reasons, to have enough CBDs to cover all the rural areas in Zimbabwe. However, almost universal coverage could be attained if more and more static depots are established. Motivated users could go there to get their supplies without waiting for a CBD to visit. Each
"passive distributor" would need a minimum of training to be able to remind the user that she is due for a check up and to answer basic questions about contraceptives.

Village health workers (VHW) could also carry contraceptives and re-supply established users. These workers should not, however, recruit new users, although they should refer women who are interested to a CBD or to a clinic. If most of the re-supplying were done by VHW and passive distributors, the CBDs could then concentrate on motivation, by visiting women at home, attending village meetings and educating health facility staff. Such a system would be much more cost-effective than the present one, since the expertise of the CBD would be fully utilized and the tasks for which their expertise is not needed could be accomplished at a much lower cost. Such a revised system would require less training, no bicycles, no per diem and no salaries for either the "passive distributors," or for the VHW who would distribute contraceptives in the course of their duties. In the case of "passive distributors," it might be a good idea to give them a small profit on the contraceptives distributed to give them an incentive and to prevent turnover.

Some of the provincial territories are very large. The Mashonaland provincial office, for example, covers three provinces while the Matabeleland office covers two. This makes it difficult for the provincial office personnel to supervise effectively and provide support to the CBDs and their group leaders.
Finally, some concern has been expressed by the CSFPC Administrative Unit with regard to the turnover rate of the CBDs. The UER is presently conducting an evaluation of each of the CBDs and soon hopes to be able to select more effectively new recruits so as to reduce the costly turnover rate. In addition, consideration should be given to improving, as much as possible, the working conditions and compensation rates of the CBDs.

Financial accessibility is also a matter of concern. At present, the policy is to provide condoms free of charge and pills at a nominal charge for those who earn less than $150 a month. There are no data which indicate whether the charge for oral contraceptives is an obstacle to the use of contraception but it is worthy of investigation.

Method Mix. Since 1981, when injectables became restricted, the child spacing program has been mostly pill-based. Condoms, IUCDs, injectables, sterilization, vaginal foams and suppositories, and natural family planning are used on a limited, and mostly temporary basis, e.g., when starting to use the pill, when forgetting a pill, etc. The condom is also used as a prophylactic measure against STD. This mix is likely to change only if the stringent criteria restricting the use of Depo-provera are relaxed. Although the IUCD does not have great potential for extended use because the prevalence of STD and of PID is high, its use cannot increase even modestly if it is not available. To accomplish this, more CS nurses could be trained to insert such devices. Sterilizations, for males and females, are performed at
Spillhaus. The demand for such operations has been increasing slowly and, although it does not seem that sterilization will become the most popular method in the near future, it can be assumed that with better availability it would become more used. This operation should be made available to all provincial hospitals and many more gynecologists/obstetricians should be trained to perform sterilizations; this training could be provided by the medical/clinical unit at Spillhaus. In the distant future, it is also possible that a long-term hormonal method could be tested and used in Zimbabwe, if found satisfactory by the Drug Council and acceptable by the users.

In the past, many types of oral contraceptives have been available, some of them for only a short time. Although such contraceptives are often comparable, users resent having to change pills. Furthermore, the question of side-effects is raised anew each time a user is given a new brand. The CSFPC should therefore identify a limited number of brands which are acceptable to the Drug Council and can be expected to remain readily available and restrict distribution to that set. Finally, the distribution of brands should be regionalized so that in a region only one type of combined pills and one type of mini-pills are distributed consistently through time.

Reporting. Four issues are important with regard to reporting:

- Does the program systematically collect the data necessary for monitoring?
- Are the reports regularly sent to the people who need them for planning and evaluative feedback?

- Is there any unnecessary amount of information collected of little or no use, making the recording and the reporting process more complicated and less efficient than it needs to be?

- Do all the facilities obtaining contraceptives from CSFPC report regularly to CSFPC?

The first projects REU plans to undertake address these questions. There seems to be a consensus on the need to update and redesign recording and reporting forms to satisfy current data requirements and to streamline the system. Particular attention should be given to ensuring that supervisors, decision makers, and planners have access to the data they need, but also, to ensuring that they understand how to interpret and use the data they receive. To accomplish this goal, further training will be necessary.

**Training.** The CSFPC currently has the singular responsibility for providing child spacing training. As part of the government directive to integrate services, it has been given the added responsibility of organizing and standardizing child spacing training programs throughout the country. This includes providing assistance for curriculum review and development as well as, in the future, the training of trainers. However, the training staff has a very busy schedule and cannot satisfy the demand for in-service training.
Two steps should be taken to improve the CSFPC training program:

- CSFPC should train trainers for other ministries which frequently require CSFPC services (MOH and MOE for example).

- CSFPC should help these ministries to develop a training program (for in-service medical personnel for MOH and for youth advisors for MOE) which would be carried out by the trainers. Although trainers would be supervised within their ministries, they would keep in contact with CSFPC and occasionally attend refresher seminars.

This approach is in agreement with the policy of integration of MOH; it would permit the training of more people more rapidly and it would utilize the high degree of staff expertise at CSFPC more effectively.

In order to maintain the high quality of the present child spacing staff, the training unit should not become larger. Instead, it should concentrate, as an expert resource, on training its own personnel and trainers for other organizations such as MOH, MOE and private health facilities.

Public Education. Public education in the field of child spacing is carried out exclusively by the CSFPC, through its CBDs in rural areas, its youth advisors in schools, in clinics, and in various other organizations dealing with adolescents and young adults, and above all, through the IEC Unit. The IEC Unit strategy and plan of action were developed with assistance from the centrally-funded Johns Hopkins Population Communication Services Program (PCS). The plan has been approved by CSFPC, MOH and AID. The plan, which is now being implemented, outlines objectives and the schedule of activities which are to take place in the next four years.
The program will concentrate in three areas:

- Print materials: design, testing, production, and use of print materials. Some manuals and pamphlets are being tested at present.
- Mass media: radio, film and television programs (including three weekly radio programs at the present time and cooperation with all the radio channels when they wish to do a show on child spacing).
- Public relations: these include organizing seminars for government officials, women’s groups, etc., as well as all the other public relation activities.

The IEC strategy and four-year implementation plan are well-conceived and commendable. However, the IEC Unit will probably need some additional technical assistance and project support from PCS in order to carry them out successfully. The timing of the implementation plan may also have to be revised. It would be useless and a waste of resources to fund IEC activities at a time when the supply shortage would make it impossible to meet the newly created demand. Such inopportune timing would only result in frustration, both for clients and CS workers.

Equipment. In order to carry out CS activities, various types of equipment, some of it quite specialized, is necessary. Some child spacing clinics have this equipment but other clinics do not. In Masvingo, for example, the Provincial Health Officer mentioned that there was an acute shortage of specula. There is only one
laparoscope in the country (at Spillhaus) and were it to break down, tubal ligation would be impossible. The CSFPC laboratory has a microscope but it is on loan from the University of Zimbabwe and they may have to return it. There are no colposcopes in the entire country. At a more mundane level, road-worthy vehicles are in short supply, making the supervision of CBDs and CS clinic staff difficult. CSFPC and ROH should plan to obtain this equipment, in particular the vehicles, in the near future in order for the program to function well.

Distribution System. At present, CSFPC sends mostly small quantities of contraceptives (one or two month supplies) only when requested to do so. Instead, CSFPC should develop a strategy which will decrease its work load by reducing the number of supply transactions between its provincial offices, the Provincial Medical Offices and other responsible organizations, such as the Harare City Health Department. To do this, CSFPC could provide these organizations with a supply sufficient to last six months (or a year if the stocks permit) plus enough additional supplies to provide for unanticipated demand. The organizations would then receive new shipments every six months (or year) provided they account for the distribution of the preceding allotments. The quantity sent in each shipment would be adjusted based upon the quantity used as indicated in the reports which would be submitted on a quarterly basis. In turn, provincial offices would supply health facilities in their province.
4. Integration of Child Spacing and Maternal and Child Health

a. Definitions of Integration

The word "integration" has several meanings. We will here make the distinction between administrative integration and functional integration. Administrative integration implies that one program becomes part of a larger bureaucracy. Administrative integration of Child Spacing and Maternal Child Health, therefore, would mean that CSFPC would cease to be a semi-autonomous organization and would become part of the Ministry of Health. In theory, the child spacing program could remain a vertical program within the Ministry. Administrative integration does not necessarily mean that services are integrated. For instance, in the past the various maternal and child health services were not integrated although they were all administrated by MOH.

This type of integration, whether or not functional integration of the services took place, has generally had negative repercussions on family planning programs in other countries and it is not recommended that it be carried out in Zimbabwe.

Functional integration implies that functions previously delivered separately, would be provided together. In this case, for example, functional integration would mean that a client could receive child spacing services and MCH services at the same place, at the same time. The degree of integration can vary: services can be delivered in the same physical facilities by different
persons or by one person. In the latter case, the health worker
would be a multi-purpose worker for whom child spacing would be
only one of many responsibilities. Evidence in other countries
has shown that when health workers are multi-purpose workers, they
do not emphasize, nor promote systematically, one service or
another but rather address the issues raised by the clients. This
suggests that functional integration of child spacing services
would mean that child spacing will not be given much attention
except with those clients who are already motivated enough to ask
about it. In the case where several specialized workers provide
various services in the same physical facility, a client can
obtain during one visit all the services she needs and receive
specialized services.

b. Position of the Government

Although there does not seem to be a consensus in the Ministry
as a whole, nor at the various levels of CSFPC, as to what the
Government policy of integration means, senior MOH and CSFPC
officials seem to agree that such integration should be functional
and that CSFPC should remain a semi-autonomous specialist
organization. This position was reflected in the fact that CSFA
was made a para-statalt organization in November 1982, even after
MOH had announced its policy of integration.

c. Guidelines for the Integration of Child Spacing and Maternal
and Child Health Services

All health workers should receive some training in family
planning so that they can understand it, be able to answer the
question of clients/patients about it, and, if necessary, make
references to the appropriate facility. Workers specializing in child spacing should have such basic training in MCH as how to mix an ORT solution, where to refer mothers if their children are malnourished, when to encourage mothers to have their children vaccinated and how to breastfeed. However, child spacing workers should deliver primarily child spacing services; they should not become multi-purpose workers. As mentioned above, if this multi-purpose worker approach were adopted, past experience suggests child spacing would not be emphasized except for those clients who request it and would place little emphasis on their roles as motivators and as recruiters. Child spacing workers in Zimbabwe currently do perform their tasks very well, following specific procedures to motivate, recruit and screen new acceptors; it is not clear, however, how many more tasks they can be taught and can do well in addition to their present tasks. Thus, when, as was done recently, new health tasks are added to the tasks the CBDs must perform, the performance of the CBDs should be closely monitored. In fact, it is recommended that any such restructuring of roles be done on a pilot project basis to ensure that undesirable effects do not outnumber desirable ones.

In summary, it is recommended that while MCH/CS should be integrated functionally only to a limited degree at the level of the health workers, facilities should have integrated services. If, for example, a mother takes her sick child to the health center, she should be able to get contraceptive counselling and supplies at the same time. Health center staff should handle simple child spacing cases and refer other cases to the district
where a CS specialist could work next to the MCH personnel (See Figure I). This integration of services within a facility has been taking place in Masvingo where the provincial CSFPC clinic has been moved onto the premises of the provincial hospital. Having CS personnel at the district level would in fact mean having a CS clinic in each of the district health facilities. It might then be desirable, for supervision purposes, that the CS personnel be employed by CSFPC and asked to report to CSFPC through their provincial offices. All CS personnel would receive additional training as it is currently provided.

CSFPC should remain the organization specialist in child spacing. As such they would be responsible for (1) training CS workers, (2) assisting in the development and revision of the medical personnel curricula, (3) assisting MOH and other organizations (police, army, MOE, private health facilities, industry) to develop training programs for their personnel, (4) training the trainers who will do the training for such organizations, (5) providing technical assistance in CS program development and management, (6) procuring and distributing contraceptives, (7) conducting research related to child spacing, and (8) providing specialized services such as laparoscopy, andrology, subfertility and sterilization. All of these CSFPC responsibilities, of course, would be in addition to that of actively promoting child spacing nation-wide through the IEC Unit.
FIGURE I
MCH/CS Service Delivery System
Functional Integration - A Model

CHILD SPACING AND FAMILY PLANNING COUNCIL
- Specialized services
- Training of CS Personnel
- Training of Trainers
- Procure and distribute Contraceptives
- IEC
- Research and Evaluation
- Supervision of CS Personnel

CSFPC PROVINCIAL OFFICE
Supply contraceptives to CS clinics/personnel including CBDs

CS reporting

MOH PROVINCIAL OFFICE
Supply contraceptives to non CS-health facilities

CS reporting

OTHER MOH HEALTH FACILITIES
CS personnel (clinic on MOH premises)
- Some specialized services
- Counselling
- Physical examination
- All methods except sterilization
- Subfertility and CS referral

PROVINCIAL HOSPITAL
- Sterilization
- IUCD
- CS and subfertility referral
- Physical examination
- Supply methods

HEALTH CENTERS
- MCH care
- CS counselling
- Physical examination
- Screening
- Supply OCs, condoms, vaginals, injectables (in some centers, IUCD)

GROUP LEADERS
COMMUNITY-BASED DISTRIBUTORS
- Motivation
- Recruiting new acceptors
- Screening
- Supply of OCs, condoms, vaginals
- Blood pressure
- Census of eligible women
- CS referral
- CS counselling
- ORT
- Hand washing

VILLAGE HEALTH WORKERS
IV. PROGRAMS OF OTHER DONOR

In this section, the assistance the other international donors give to Zimbabwe in the field of population and family planning will be examined briefly. None of these agencies provide as much assistance as AID but they offer assistance in areas where AID has been involved only in a limited way or not at all.

The United Nations Fund for Population Activities (UNFPA). In January 1983 the Government of Zimbabwe signed an agreement with the UNFPA which committed the latter to spend $3.45 million through the end of 1985. These monies were to be spent to provide advisory services to the Central Statistics Office for its work on the Census. Until now they have paid for a contographer and a demographer is to arrive in Harare in the near future to help with the analysis of the Census.

UNFPA will also help with training Zimbabweans in demography by paying for the salary of a demography professor at the University of Zimbabwe. In the Fall of 1984, this professor will replace the Fulbright fellow who started the program. The UNFPA will also assist Zimbabwe to develop capacities in MOH/MCH-FP by offering two fellowships for study abroad. WHO has been given the responsibility to execute this component of the UNFPA assistance program.

In another area of assistance, the UNFPA is providing $200,000 worth of contraceptive supplies which are to be distributed free of charge to users who cannot afford contraceptives.
The UNFPA has further committed itself to help the Government of Zimbabwe to set up a Population and Development Planning Unit which would become part of the central mechanism for planning by providing the demographic data necessary for such planning. This endeavor was delayed until March 1985 when Zimbabweans, presently involved in the analysis of the Census, will become available to be trained and to participate in the development of the Unit. The UNFPA has committed assistance to this Unit for one year and if it is assessed as a useful Government planning tool at the end of this year, UNFPA will consider supporting it for two more years.

The UNFPA is also financing a project which is designed to increase MCH-FP care in Zimbabwe. This project is to be implemented by WHO which until now has had problems with finding appropriate staff. At the time of this writing, the program was just starting and the project director was expected to arrive shortly. A longer description of this project is presented below.

Two projects which the UNFPA plans to fund are presently at the preliminary stage:

- The Communication and Family Life Project is a project designed to provide family education to workers in the workplace. Working together with CSFPC, UNFPA will establish relationships with the trade Union, the employees associations and the Government in order to initiate a program whereby "Family Life Education" could be provided in the workplace.
The Law and Population Project is a project to examine the relationship of law to population issues. As it has done in other countries, the UNFPA will fund a review of existing laws affecting population issues (in particular, laws related to child custody, labor laws and maternity leave, women status, etc....). This review is planned to start in mid-1985.

The UNFPA has been considering requests from women's organizations to develop a program in the area of women in Development but has not yet developed such a program. As is apparent from the above discussion, the UNFPA is committed to assisting the Government of Zimbabwe to develop the capacity to produce and analyze the demographic data necessary for socio-economic planning. Its strategy is to help the Government start a program but after a short time - 1 to 3 years - to allow the government to take these programs over.

World Health Organization (WHO). The WHO does not contribute any financial assistance but executes programs which are funded by UNFPA, such as the fellowship program mentioned above and the MCH/FP programs described briefly below.

The main objectives of the MCH/FP program are to strengthen MCH/FP services in Zimbabwe, (2) formulate new projects, (3) evaluate existing projects and (4) emphasize the need to address the problem of adolescent pregnancies. This project, which is now
starting after a 9-month delay due to recruiting problems, will last for four years.

An inter-country MCH/FP project - which is to cover 17 English speaking and two Portuguese countries - has the same objectives as the Zimbabwe MCH/FP project and is based in Harare. Zimbabwe may also be able to receive some assistance under this project.

United Nations Children's Funds (UNICEF). UNICEF assistance in the population field in Zimbabwe is indirect. It provides primary health care assistance in the areas of immunization, diarrhoeal disease control and nutrition education (See UNICEF, 1983a). These activities contribute to lowering infant mortality and will have an influence in the long term on family size. UNICEF is also involved, somewhat more directly, in providing population assistance by supporting the training of the village health workers (VHW) and of the traditional birth attendants (TBA). This training includes family planning training.

World Bank. The World Bank at present is not providing any assistance in the population field to Zimbabwe. However, a new project is being developed which would have three components (1) health and hospital management; (2) pharmaceuticals management and quality control and (3) maternal and child health/family planning services. The third component would include the retraining of the staff of the MOH, the Ministry of Community Development and Women's Affairs, CSPFC and local authorities (urban and rural)
through support for tutor training, retraining courses, orientation courses, materials and equipment, contraceptives and necessary additional training facilities. The World Bank proposes to support monitoring and evaluation activities, including a mid-censal demographic survey and would also provide fellowships, study tours and logistical and program support to the CSFPC. It is hoped that this project will proceed but at present it is only in the preliminary stages and it is difficult to assess what its impact will be.

International Planned Parenthood Federation (IPPF). Although it strongly backs the CSFPC, the IPPF provides little more than moral support at present. In 1983, it provided only support for a small regional project, the Manicaland Child Spacing Project

Overseas Development Assistance. This international donor is also interested in assisting Zimbabwe in dealing with its population problems but until now has not contributed any financial help.

Summary. In summary, several international donors - besides the USAID - provide, at present, limited assistance to Zimbabwe in the field of population. Most of the present or planned assistance programs i.e. training and retraining, and presently do not duplicate USAID efforts. However, when the USAID phases out its program, these donors, it is hoped, will expand their assistance, in particular in the area of providing contraceptive supplies.
V. CONCLUSION: STRATEGY IMPLICATIONS

The child spacing program in Zimbabwe is one of the most advanced in Africa. Services are delivered through clinics, local government health departments, health centers, and a well-organized network of community-based distributors. At present only part of the rural areas are covered in spite of the efforts of the CBDs. Referral services are not easily available to a large portion of the rural population. Therefore, the program has an enormous potential for growth. In the last few years the program has been expanding rapidly and is now at the crossroads, where the government policy of integration requires that the program be reexamined. It is in this context that the following general recommendations are presented.

**Cost effectiveness.** The program is a good one and delivers services of high quality; it is, however, very expensive, and could be made more efficient. For example, CBDs could supply more cycles per visit and "passive distributors" for established users could be identified. These two steps alone would increase the coverage of the program without increasing its cost significantly. Each component of the program should be reviewed with cost-effectiveness in mind. In particular, distribution should become, in the long term, more passive and the CBDs should concentrate on counselling, motivating, and recruiting rather than on re-supply.
Development of potential. Medical personnel delivering MCH services should be trained in child spacing so that all of the approximately 500 clinics located throughout the nation can deliver basic child spacing services. The curricula for all medical personnel should be reviewed and revised to include extensive theoretical and practical child spacing training.

Research. The contraceptive prevalence survey will provide much data concerning knowledge, use and availability of contraceptives as well as about attitudes towards CS and family size. These data will be very useful for the child spacing program and will permit the development of strategies for public education.

The REU has developed a research plan as described above. Further research will also be necessary to monitor the implications of changes in the program. For instance, the performance of the CBDs is presently being evaluated by the REU. Such evaluations should be conducted again after the CBDs have received their training for the four new components which were added to their tasks: blood pressure, ORT, hand washing and enumeration of eligible women in their area. These pre- and post-evaluations would allow the determination of whether their performance as child spacing workers has been affected by the new tasks.

As a follow up to the CPS, an in-depth survey of attitudes of peasants towards child spacing and family size would also be very useful. Funding of this type of survey should be investigated in
more depth with Westinghouse Public Applied Systems, which, under
the Family Health and Demographic Survey (FHDS) program recently
awarded to them, has a mandate to carry out such in-depth surveys.

Labor Constraints in Communal Areas. USAID should recognize that
labor constraints exist in communal areas and encourage
agricultural programs which aim at reducing the labor demands on
the farmers there. For example, the use of herbicides, which
would reduce the labor-intensive task of manual weeding, should be
supported. The use of equipment or cattle which can be used for
draught power to reduce the need for labor should also be
encouraged. In addition, farmers should be supported in their
efforts to join together to purchase goods which they could not
afford individually or which could be bought less expensively in
large quantities or would not be cost-effective on small
individual farms.

Integration of Child Spacing and Mother and Child Health. USAID
should support the Government position with regard to the
functional integration of MCH and CS care in health facilities.
This integration will permit more efficient service delivery to
mothers and children and, with time, will help increase child
spacing coverage. However, USAID should recommend that any change
in the task of CS workers be monitored closely by the REU in order
to insure that child spacing remains their main and most important
activity and that they continue to perform it well. The CSPPC
should remain a semi-autonomous specialist organization.
Encourage a Greater Method Mix. At the moment, the child spacing program is mostly pill-based, which means that a significant group of women may be excluded. Although other methods may never become as popular as OCs, their availability should be increased in order to provide options for women who cannot take the pill. The IUCD is available only in CS clinics and a handful of other clinics, and should be more widely available, as should vaginal methods. The relaxation of the criteria which restrict the use of Depo-provera should also be encouraged, especially for breastfeeding mothers. Finally, sterilization, which currently is only available in Harare, should be made available at least at the provincial level.

Areas Where the Program Needs Assistance. As discussed above, there are at least three areas where the program needs assistance:

1. Training of existing health personnel. It is hoped that the World Bank project will provide assistance to MOH, but there are many health workers who need training and the GOZ may not be able to borrow enough funds to train them all.

2. Supply of contraceptives. The success of the Child Spacing program depends largely on the continued and regular availability of contraceptives. If there are frequent shortages of supplies, this will discourage users and cause great frustration and morale problems among the CS workers who will not be able to respond to the demand generated by their efforts.
3. Equipment/vehicles. As the program expands, more equipment, including laparoscopes, specula, etc., will be necessary. In addition, more road-worthy vehicles will be necessary to ensure the quality of the supervision.

Dependency of the Child Spacing Program on USAID. In the unlikely but possible event that USAID withdraws its support to Zimbabwe, the child spacing program would be in great danger of collapsing. At the moment, USAID provides most of the contraceptives necessary to the program as well as some salaries and other recurrent costs. In the short term, the GOZ should be encouraged to tap other donors to help them support their recurring costs, in particular the cost of procuring contraceptives. Gradually, USAID should decrease the portion of its support covering recurring costs and provide more funding for capital (construction, equipment and vehicles) and human development costs, so that the program can become less dependent on USAID and does not suffer when USAID withdrew its support.
Footnotes

1. In the communal areas, the land is owned communally; however, the right to cultivate a plot is passed from father to son and the land can be sold or exchanged. Finally, it is very rare that a family loses the right to the land which has been allocated to them.

2. The women's workload is probably increased further by the more demanding crop schedules required for improved seeds. One of the side effects of this increased workload is a greater pressure to skimp on domestic chores (Cailear, 1983, p9): Eating cold or wheated maize meal and being less careful about obtaining water from purer, more distant sources, both contribute to malnutrition and gastroenteritis, and have an impact on children's health.

3. The analysis is complicated by the fact that no data on household composition are available: it is therefore difficult to estimate the role the children play, the extent of their contribution, and to determine whether their role is changing.

4. Widows and families where migrants do not remit also have problems accumulating capital.

5. The relatively low infant mortality rate on farms and miners due to access to maternity aid provided by the employer's wife (Weinrich, 1983). This lower rate may also have contributed to the lower birth rate.

6. The UNFPA will provide $200,000 worth of contraceptives a year for the next three years.

7. How the high demand for contraceptives should be resolved: is it planned or anticipated to meet all or part of the quantities necessary through centrally funded commodities or through an amendment to the bilateral agreement.
Government of Zimbabwe


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PERSONS INTERVIEWED

(by organization and in alphabetical order)

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- Elias Hluyo, Trainer, CBD program, Central Office
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- Dr. Norbert Augwagwa, Director
- Dr. Aureli Paruch, Acting Chief, Medical and Clinical Unit, Central Office
- Mrs. Sibindi, Administrator, Mashonaland Provincial Office
- Mr. E. Zimwara, Senior Educator, Masvingo Provincial Office
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- Mr. Gregory J. Moffat, Demographer
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