Country Assessment: Zimbabwe

Family Planning Needs in the Context of the HIV/AIDS Epidemic

November 2004

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral therapy
CPR	Contraceptive prevalence rate
FHI	Family Health International
HIV	Human immunodeficiency virus
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Nongovernmental organization
PMTCT	Prevention of mother-to-child transmission
TFR	Total fertility rate
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
ZNFPC	Zimbabwe National Family Planning Council

Key Findings

- **Zimbabwe's strong family planning program is being threatened as resources become scarce, numbers of skilled health care workers decline, and attention and funding focus more on HIV/AIDS.**

- **In the context of HIV/AIDS, demand for family planning may be increasing, but the quality of family planning services is deteriorating.**

- **Integrating family planning and HIV/AIDS services offers an opportunity to maximize limited resources and provide comprehensive service delivery to meet all the reproductive health needs of clients.**

Introduction

Family planning services can prevent mother-to-child transmission of HIV by helping HIV-infected women avoid unwanted pregnancies. Contraceptive barrier methods, such as male and female condoms, protect against sexual transmission of the virus. Yet, despite the potential contribution of family planning to preventing HIV/AIDS, most HIV/AIDS prevention and care efforts are evolving as separate, vertical programs that do not provide traditional reproductive health services.

Responding to concerns that HIV/AIDS programs are diverting attention and resources from comprehensive reproductive health services, the U.S. Agency for International Development (USAID) asked Family Health International (FHI) to assess how the epidemic has affected family planning needs and services in three African countries: Kenya, South Africa, and Zimbabwe.

In all three countries, FHI, in collaboration with the Commonwealth Regional Health Community Secretariat, reviewed published and unpublished literature on family planning and HIV/AIDS epidemiology, policies, and programs, and assembled a team of experts to conduct a field assessment. FHI formed a local steering committee in each country to provide technical oversight and ensure that the assessment produced information that was locally relevant. The steering committees were composed of representatives from in-country governmental and nongovernmental institutions working in family planning and HIV/AIDS. In Zimbabwe, the country's Integration Working Committee served as the steering committee, which was chaired by the Ministry of Health and Child Welfare (MOHCW).

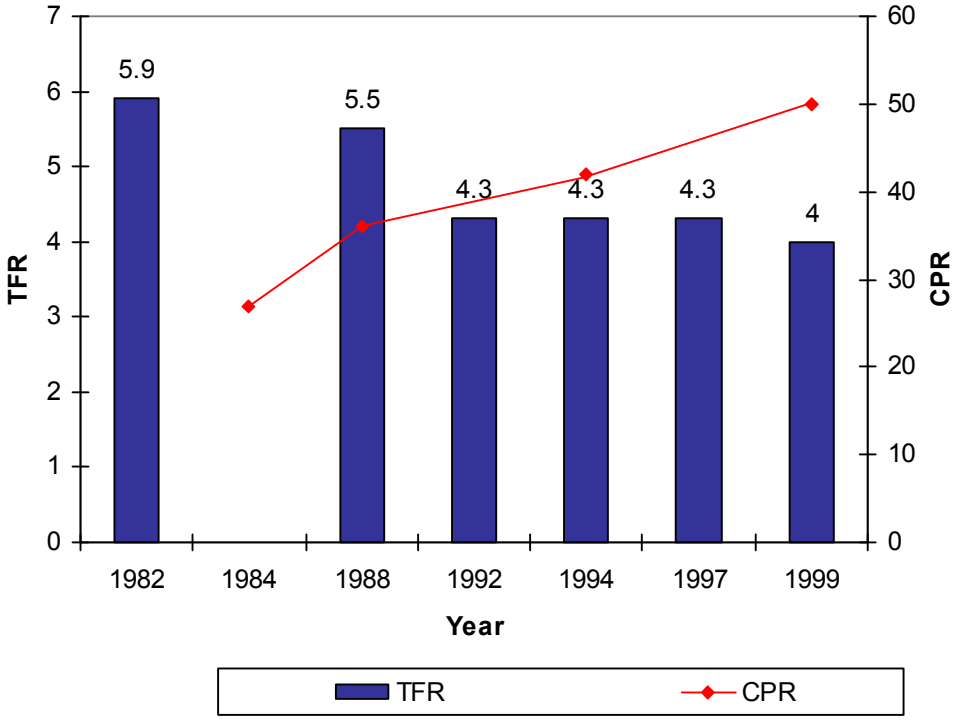
The Zimbabwe field assessment was conducted in May and June 2004, both in Harare and in urban and rural districts of four additional provinces. The assessment team members conducted 205 interviews with members of the Zimbabwe National Family Planning Council (ZNFPC) and the National AIDS Council (NAC), provincial medical directors, provincial and district health

executives, policy-makers, donors, service providers, opinion leaders, and representatives of community-based, faith-based, and nongovernmental organizations. They also held 18 focus group discussions with health executives and local health facility staff, and they administered an "expert views" survey to 31 key informants for their opinions on family planning and HIV/AIDS programs and services in Zimbabwe. A summary of findings from the desk review and field assessment are presented here. A more detailed report is available from FHI.

Family Planning and HIV/AIDS in Zimbabwe

The 1999 Zimbabwe Demographic and Health Survey showed that between 1984 and 1999, all contraceptive use among married women more than doubled and modern contraceptive use nearly doubled, from 27 percent to 50 percent. Between 1982 and 1992, the total fertility rate, or mean number of births per woman, dropped from 5.9 to 4.3. However, this rate remained steady at 4.3 throughout most of the 1990s, declining only slightly to 4.0 in 1999 (Figure 1).

Figure 1: Trends in total fertility rate (TFR) and contraceptive prevalence rate (CPR): 1982 to 1999



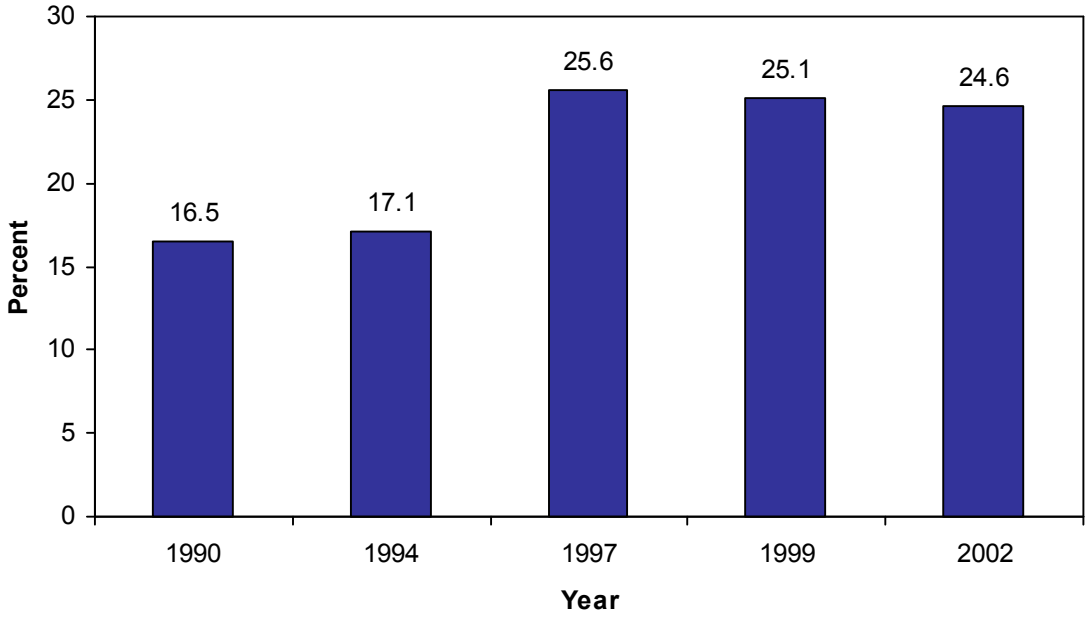
The most common contraceptive method used in Zimbabwe is oral contraceptives, which account for 35.5 percent of the method mix. However, use of injectables is on the rise, as rates of use increased from 1 percent in 1988 to 8 percent in 1999. Reported use of condoms is just 2 percent among married women, compared with 14 percent among married men.

Contraceptive discontinuation rates, however, remained high between 1994 and 1999, when one in five contraceptive users stopped using a contraceptive method within one month of starting use. Unmet need for contraception (for both limiting and spacing births) is also high in Zimbabwe, at 13 percent among married women and 12 percent among youth ages 15 to 19 years.

Fertility rates in Zimbabwe differ according to HIV status. A retrospective survey in rural Zimbabwe and a multivariate logistic regression model showed that recent birth rates and current pregnancy rates are lower among HIV-infected women than among HIV-negative women. Total fertility rates are estimated to be 8 percent lower among the HIV-infected women, and subfertility associated with HIV may account for as much as 25 percent of the fertility decline seen in Zimbabwe since the 1980s.

Throughout Zimbabwe, an estimated 1,820,000 people—57 percent of them women—are living with HIV/AIDS. Of all the countries in the world, Zimbabwe has the third highest HIV/AIDS prevalence, estimated in 2003 by the MOHCW AIDS and Tuberculosis Programme and others to be 24.6 percent among adults ages 15 to 49 years (Figure 2). According to the Young Adult Survey conducted in Zimbabwe between September 2002 and February 2003, HIV prevalence was 22 percent among young women ages 15 to 29 years and 11 percent among young men ages 15 to 29 years. And, national HIV/AIDS estimates from the MOHCW and colleagues in 2003 predicted that 761,000 children were orphaned because of AIDS by the end of that year.

Figure 2: Trends in HIV prevalence: 1990 to 2002



Policies and Guidelines

Zimbabwe has a national HIV/AIDS policy and reproductive health and population policies. No separate policy for family planning is in place, but family planning is incorporated into the reproductive health policy as one of its key components. This same policy also calls for the integration of family planning and sexually transmitted infection management. In addition, representatives of ZNFPC revealed that the country's Family Planning Act of 1985 is being revised to integrate reproductive health programs and activities, including those focused on HIV/AIDS.

Results of the field assessment suggested a high awareness of the national HIV/AIDS policy but lower awareness of reproductive health policies among key informants. They also indicated that family planning guidelines have not been updated since 1994 and are considered by service providers to be outdated.

A range of stakeholders, including service providers, help formulate reproductive health and HIV/AIDS policies and guidelines in Zimbabwe. However, results of the field assessment suggested that at times, only those in senior positions are consulted for this purpose. The major strategy for disseminating policies is to hold training workshops. Meetings, circulars, journals, newsletters, and the MOHCW Web site are among other means of dissemination.

Implementation of policies is difficult, in part because ZNFPC and the MOHCW are hampered by high staff turnover and inadequate funding. Other barriers to implementation, especially of family planning guidelines, mentioned by key informants include outdated guidelines; limited commitment to family planning; differences in access to services in rural versus urban areas; stigma and discrimination by health care workers aimed toward subgroups of clients such as youth; and a feeling of exclusion among nongovernmental organizations.

Policy Gaps

Through interviews and focus group discussions, several critical gaps in policy were revealed. At least in part, said respondents, the gaps exist because the HIV/AIDS and reproductive health policies were designed for vertical programs. Several of these gaps are highlighted below.

Policy structure: Zimbabwe has a national HIV/AIDS policy, reproductive health policies, and family planning guidelines, but services are not coordinated under a single-policy framework.

Information on youth: Specific issues addressing the reproductive health and sexuality of youth, such as the implications of youth having sex and clear guidelines for service provision for this age group, are not adequately addressed in any of the policies.

Content: Both HIV/AIDS and reproductive health policies focus on women and lack important information about men. Furthermore, the national HIV/AIDS policy does not provide adequate information on the family planning needs of people living with HIV/AIDS and may lack updated information on HIV treatment.

Urban versus rural needs: Policies focus on improving health services in rural areas, which has caused the quality of public health services to decline in urban settings. Also, policies do not differentiate the needs of urban versus rural populations and are not simplified and translated into languages that can be well understood in rural areas.

Research to practice: Translating policy into practice is difficult. For example, health professionals in Zimbabwe would like to see a policy that will allow routine HIV testing on all pregnant women, and data from the national prevention of mother-to-child transmission (PMTCT) program suggest that this would be acceptable to the women. However, initiatives to determine the best ways to implement routine HIV testing and evaluate its impact are lacking.

Resources for Family Planning and HIV/AIDS Programs

The Zimbabwe government, through the MOHCW, funds both family planning and HIV/AIDS programs in the country. But as the current major public health problem in Zimbabwe, HIV/AIDS has undermined the government's ability and capacity to fund all programs—including family planning programs—at both micro and macro levels. Public sector institutions charge minimal user fees to complement government support, and international donors also contribute by procuring and distributing family planning commodities.

Overall, donor assistance to the MOHCW has decreased from US$71 million in 1997 to US$7 million in 2002. This decline has substantially affected family planning programs, where 54 percent of resources required to run ZNFPC technical programs are provided by donors and 44 percent are provided from the sale of family planning products and services. Government officials reported that ZNFPC continues to receive government support at requested levels, but data show that government funding for ZNFPC—in real terms—decreased from Z$7.4 million in 1994 to Z$2.95 million in 2002. Funding from international donors, especially within the United States, has been unpredictable but has also decreased in recent years (Table 1).

Table 1: Trends in donor assistance to ZNFPC in $US: 1998 to 2003

Donor	1998	1999	2000	2001	2002	2003
AVSC	15,704	----	----	----	----	----
IPPF	9,655	----	----	----	168,261	11,231
JHPIEGO	25,531	33,806	24,483	72,094	----	----
Pop. Council	66,461	37,728	14,923	59,768	----	----
JHU/PCS	111,721	50,516	70,473	----	----	----
Advance Africa	----	----	----	151,863	800,111	311,917
Rockefeller	52,236	160,728	----	----	927,332	366,638
CDC	----	----	----	658,198	7,273	----
UNFPA	144,052	231,222	12,149	290,429	188,959	205,427
South-South	----	5,267	608	14,375	50,000	45,000
DFID	----	----	----	----	----	145,631
Other	4,825	13,987	3,214	----	30,817	----
Total	430,185	533,271	125,8509	1,246,726	2,172,753	1,085,845

Source: Environmental Assessment Study

In contrast, HIV/AIDS programs have a much broader funding base, as donors that have pulled out of other sectors have continued to support HIV/AIDS programs. At least in some provinces, funding for these programs appears to be increasing. In 1999, an AIDS levy was introduced to supplement the MOHCW's budget for HIV/AIDS. The levy has already provided Z$23 billion to the government, and the NAC has disbursed more than Z$5 billion to communities, sector ministries, and nongovernmental organizations providing HIV/AIDS prevention, care, and support.

In line with these findings, the MOHCW's 2003 budget for HIV/AIDS, sexually transmitted infections, and tuberculosis field operations was more than five times higher than that for reproductive health field operations, which include elements of both family planning and HIV/AIDS. Projected government support for HIV/AIDS in 2004 is almost three times that provided to ZNFPC for family planning (Table 2).

Table 2: MOHCW budget for family planning and HIV/AIDS: 2003 to 2004

	2003 Estimate ($Z)	2004 Estimate ($Z)
ZNFPC	**1,166,000,000**	**5,229,063,000**
ARVs	2,500,000	10,000,000,000
HIV/AIDS/STI/TB	160,000,000	3,000,000,000
HIV test kits	50,000,000	600,000,000
HIV/AIDS research	60,000,000	368,000,000
Total HIV/AIDS Expenses	**272,500,000**	**13, 968,000,000**
Reproductive Health Expenses	**50,000,000**	**500,000,000**

Source: GOZ Ministry of Finance, 2003

Current Status of Family Planning and HIV/AIDS Services

Family Planning Services

The MOHCW provides family planning and HIV/AIDS services through a network of more than 1,335 health facilities. Family planning services have been provided since 1953, and the public sector is the main provider. Available services include a range of contraceptive methods; counseling; information, education, and communication; management of side effects and complications of methods; youth-friendly clinics; training of service providers; and a very strong national community-based distribution program that is considered the backbone of ZNFPC. The private sector, nongovernmental organizations, and community-based organizations operate facilities offering comparable services, though more than 77 percent of clients obtain contraceptives from the public sector. Urban areas offer a broader range of services than do rural areas.

Challenges in providing family planning

Results of the assessment revealed several challenges for providing family planning in Zimbabwe. Respondents highlighted the fact that more attention is being paid to HIV/AIDS programs than to family planning programs. As a result, limited training and refresher courses are available, especially for new service providers with no formal training in family planning. Furthermore, high staff turnover has caused remaining staff to become demoralized and overburdened by large workloads, and many are moving elsewhere for better-paying jobs.

National-level program managers reported that the large numbers of people living with HIV present a challenge because their emerging family planning needs must be addressed with limited resources. In addition, many service providers are not confident addressing the contraceptive needs of HIV-infected clients.

Another challenge highlighted was lack of services for underserved populations. Representatives of ZNFPC acknowledged that their services target women of reproductive age, leaving youth and men in need. Other underserved groups include gold panners, disabled individuals, apostolic women who need approval from their church before receiving services, populations who live in border towns or are nomadic, and those who have moved because of land reform.

Additional challenges to family planning that were mentioned by key informants were variations in fees charged by different service providers, a skewed method mix because of a lack of trained providers, an absence of discussions with clients on cultural issues that can affect family planning, and opposition—even among service providers—to reproductive health services for youth.

HIV/AIDS Services

The NAC, nongovernmental organizations, community-based organizations, and government sectors all collaborate with the MOHCW to provide HIV/AIDS services in Zimbabwe. Voluntary counseling and testing (VCT), PMTCT, and antiretroviral (ARV) therapy programs have been established. Zimbabwe currently has 26 VCT centers, 13 of which are integrated into existing health service institutions such as public-sector clinics and hospitals, facilities of nongovernmental and community-based organizations, and private health clinics. Four of the VCT centers have integrated family planning and sexually transmitted infection management services. HIV testing is also offered in public- and private-sector health services as part of routine diagnostic services. The PMTCT program is offered at 205 sites in 43 of the 57 districts in Zimbabwe. As of January 2004, 6,000 to 10,000 people had been receiving ARV therapy provided by all sectors in Zimbabwe.

Additional HIV/AIDS activities funded by agencies besides the government include informative media programming, social marketing of condoms, home-based care for people living with HIV/AIDS, programs for orphans and vulnerable children, and advocacy for effective HIV/AIDS policies and their implementation. In addition, the country's strong community-based family planning distribution program now trains distributors to provide HIV/AIDS services, but only 16 of 57 districts are receiving these services.

Challenges to providing HIV/AIDS services

Respondents agreed that HIV/AIDS services are being overwhelmed by the large numbers of people living with HIV/AIDS in the country. Many people are embarrassed to seek VCT services because of stigma or discrimination, so even more people may be in need of services but are not utilizing them.

As was the case for family planning, lack of training, high staff turnover, and loss of trained staff to other jobs were cited as obstacles for providing HIV/AIDS services. Lack of services for underserved populations such as men, disabled individuals, and populations who live in hard-to-reach areas or are nomadic was also noted.

Additional challenges cited by interviewees were the perception that VCT is a dead end unless testing is supported with access to ARV drugs; low coverage for VCT services in rural areas; lack of programs that directly target couples; and the need for health facilities to be refurbished to create quiet and confidential environments where clients can be counseled.

Family Planning in the Era of HIV/AIDS

Impact of HIV/AIDS on Family Planning Practice

Behavior change

Most respondents noted that Zimbabweans are adopting safer sexual habits, which may help explain the recent stabilization of HIV prevalence among pregnant women and young women ages 15 to 19 years. The primary behavior change cited was an increase in the uptake of condoms. The number of condoms distributed through the public sector increased from 14 million in 1997 to 40 million in 2003. Condom use was also reported to have increased among youth, though no data are available on consistency of such use.

Some assessment results were less encouraging. Reports from all five provinces indicated that some people are still engaging in high-risk behaviors that expose them to HIV, often because of lack of knowledge, socio-cultural beliefs, and misconceptions about illness and death. In addition, premarital sex remains common and fertility appears to be increasing among young women ages 15 to 19 years. Also, concerns still exist about promoting condoms among youth, condoms are often not encouraged for use in marriage and with regular sexual partners, and negative perceptions about condoms distributed in the public sector—such as that they are substandard or are laced with HIV—are still prevalent.

Demand for family planning

General consensus among respondents was that demand for family planning has increased in recent years, and representatives of both the MOHCW and ZNFPC believed that rates of contraceptive use could be as high as 60 percent by 2005. This increase has necessitated the introduction of depot holders to re-supply contraceptives for continuing clients, the integration of family planning and

HIV/AIDS services at some facilities, and the renovation of farmhouses to clinics in two provinces so that family planning and other health services can be offered to more clients.

Most respondents believed that HIV is the cause for the increase in demand as couples seek contraception to limit childbearing, avoid pregnancy, avoid infection, or possibly gain weight if they have lost weight from HIV. It is important to note, however, that this is difficult to confirm and that not all respondents agreed that HIV is the cause for the increase. For instance, according to service providers, HIV does not seem to have affected the desire for children among populations living in remote areas, where children are considered to be wealth and are necessary for working in the fields. Overall, a substantive conclusion on the impact of HIV/AIDS on desire for children cannot be drawn from this study without complementary information from the communities.

Decline in service quality

The shift in focus and funding from family planning to HIV/AIDS has been blamed for deterioration in the quality of family planning services, especially within the public sector. Specific factors affecting quality of services included inadequate training, resources, and facilities; separate, vertical programs for family planning and HIV/AIDS; lack of standardized family planning services; and widespread stigma and discrimination among health care workers toward clients suspected of being infected with HIV. Unmotivated and overwhelmed staff, resulting in high staff turnover, also affect quality of services. As of January 2003, vacancy rates in the public health sector were 40 percent for nurses, 55 percent for doctors, and 91 percent for pharmacists.

Family Planning Needs of HIV-infected Individuals and Couples

Most health professionals acknowledged that the family planning needs of HIV-infected clients are different than those of HIV-negative clients and that HIV-infected clients should receive more counseling and support on their contraceptive methods of choice. However, societal norms and stigma are contributing to the perception that people living with HIV/AIDS should avoid pregnancy. Many do not realize that they still have the choice to have healthy sexual relationships with both HIV-infected and HIV-negative partners and to have children.

Dual protection was recommended by respondents as a contraceptive approach for HIV-infected clients. Despite all available evidence showing that intra-uterine device use is safe for HIV-infected women, most health professionals were of the opinion that HIV-infected individuals should be discouraged from using this method due to fears of increased risk of reproductive tract infections. Concerns were also raised about the safety and appropriateness of use of hormonal contraceptives among HIV-infected clients and about possible interactions between ARV drugs and hormonal contraceptives. Because not all interactions are known, many health professionals reported that they would instead encourage HIV-infected clients or those suspected to be HIV-infected to use condoms.

Linkage of HIV/AIDS and Family Planning Services

Respondents viewed integrating services as the best way to maximize limited resources and meet the reproductive health needs of clients. Family planning programs are already integrating HIV/AIDS

services at the provider level in the public sector and at pilot sites served by the national community-based distribution program. Also, family planning has been integrated into VCT services in at least four sites. Yet, key informants regard current integration efforts as weak and in need of enhancement. They rated the efforts of family planning programs to integrate HIV/AIDS services as average and the efforts of HIV/AIDS programs to integrate family planning services as poor. Programs that can integrate family planning and all HIV services—including VCT and PMTCT services—to provide a "one-stop shop" were thought to have the greatest potential to benefit clients.

Integration Opportunities

Although family planning and HIV/AIDS services are beginning to be integrated in Zimbabwe, improvement in and enhancement of efforts is needed. Responses from the field assessment revealed several factors that may facilitate further integration:

- ZNFPC, the NAC, and the District AIDS Action Committee offer complementary, specialized training that can be used to create a comprehensive, integrated reproductive health program.
- ZNFPC offers a good base for the development of information, education, and communication materials on prevention, which respondents believed should play a key role in integration.
- The already-established national community-based distribution program could be key for integration in rural areas because distributors are in contact with people at the grassroots level and are in the best position to deliver messages on both family planning and HIV/AIDS.
- Appropriate infrastructure is already available in some clinics to provide integrated services, and many service providers have counseling skills and are familiar with referral systems.
- Youth attendance at VCT centers is increasing, presenting an opportunity for integration within adolescent sexual and reproductive health programs.
- Research by ZNFPC showed that it is feasible to involve men in family planning, so efforts to integrate family planning into male HIV and gender programs may present opportunities to reach men with family planning services.

Respondents also identified multiple challenges to integration, many of which have already been highlighted in this report. These challenges included limited resources, inadequate training, overburdening of existing staff, erratic supplies of family planning commodities, negative perceptions about male condoms, lack of policies that adequately address integration, and the fact that HIV/AIDS is receiving more attention and funding than family planning.

Recommendations

Stakeholder commitment

- All stakeholders need to be involved in decision-making about integration, and a coordinator of the integration process—perhaps a coordination body to monitor integration efforts and programs—should be established.
- Parliamentarians need to be well informed on family planning issues and policy needs if they are to mobilize political support and oversee programs once more policies are in place.
- Donors are encouraged to review the programs they are supporting and to fund integration so that all reproductive health programs are linked and no component lags behind.

Advocacy and education

- Renewed advocacy for family planning is needed at both national and provincial levels so that family planning will be viewed as a priority by all opinion leaders.
- Increased advocacy and community mobilization are needed to reduce stigma associated with HIV/AIDS and to inform people about VCT and PMTCT programs so they can make more informed choices about their reproductive health.

Policy issues

- No national family planning policy exists, so family planning sections from different policy documents should be consolidated into one document to facilitate standardization of service provision.
- Policies that infringe on reproductive health rights should be reviewed and revised as necessary. A need also exists to review and revise policies in an effort to reduce stigma and discrimination (e.g., to ensure that AIDS is treated like any other infection).
- To facilitate the integration of family planning and HIV services, guidelines for providing integrated services should be developed.
- Service delivery guidelines on the provision of contraceptive services for HIV-infected clients, including clients on ARV therapy, should be updated and disseminated.
- Correct and updated information on what factors influence policy development needs to be made available to programmers, service providers, activists, and other family planning stakeholders to enhance the policy-development process.

Organizational restructuring

- The MOHCW should encourage interaction between reproductive health and HIV/AIDS departments and improve current human resource management to address salary issues for health workers.
- ZNFPC and the NAC should be working together because ZNFPC's strong programmatic capacity can complement the NAC's availability of resources.

Service delivery

- The concept of dual protection needs to be emphasized among both service providers and clients, as some providers are not fully conversant on the concept and there is low acceptance of condoms for dual protection among clients.
- Intense capacity building is needed to empower HIV/AIDS counselors to discuss and dispense contraceptives, and for family planning providers to discuss HIV-related issues.
- An effective referral system needs to be established so that clients can be referred to more specialized services when needed or when full integration of family planning and HIV/AIDS services is not possible.
- The ARV therapy program should be expanded so that affordable drugs are available to clients in more districts and that demand for VCT increases.
- ZNFPC's integrated community-based distribution program should be expanded to all districts.
- More mobile clinics should be established to reach underserved populations.

- A balance should be established for resource allocation between urban and rural areas so that service provision is comparable in all settings.

Training

- More demand is being placed on community-based distributors, so village workers and traditional birth attendants should be trained to complement their service provision.
- Nurses should receive more training in insertion of intrauterine devices and implantable contraceptives, and in the management of sexually transmitted infections.
- The post of medical officer of health services, who was responsible for training doctors and other health workers in both family planning and maternal and child health, should be revived and should include a responsibility to train these providers on HIV/AIDS as well.
- A training needs assessment should be conducted to reform training curricula for both family planning and HIV/AIDS. Family planning certificates should expire, and service providers who complete refresher courses should receive revised certificates.

Research to practice

- More operational research is needed in Zimbabwe to guide policy and help clients make more informed choices about their reproductive health. Specifically, more research is needed to determine effective behavior change communication strategies, identify safe and effective contraceptive methods for people living with HIV/AIDS and using ARV therapy, better understand how the HIV/AIDS epidemic is affecting fertility desires and family planning practices, and identify effective models for the delivery of integrated family planning and HIV/AIDS services.
- More support should be given to research institutions within the MOHCW and ZNFPC to strengthen research to practice and to support integration efforts.