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UNITED NATIONS POPULATION FUND
PROPOSED PROJECTS AND PROGRAMMES

Recommendation by the Executive Director
Assistance to the Government of Zimbabwe

Proposed UNFPA assistance: $8.9 million, $6.4 million from regular resources and $2.5 million from multi-bilateral and/or regular resources

Programme period: 4 years (1996-1999)

Cycle of assistance: Third

Category per decision 96/15: B

Proposed assistance by core programme areas (in millions of $):

	Regular resources	Other	*Total*
Reproductive health	4.5	2.4	6.9
Population & development strategies	1.1	.1	1.2
Advocacy	.8	-	.8
Total	6.4	2.5	8.9

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ZIMBABWE

Demographic Facts

Population (000) in 1995	11,261
Population in year 2000 (000)	12,514
Sex Ratio (/100 females)	98.4
Per cent urban	32.1
Age distribution (%)	
Ages 0-14	44.1
Youth (15-24)	20.2
Ages 60+	4.3
Percentage of women aged 15-49	47.4
Median age (years)	17.8
Population density (/sq.km.)	29
Annual population growth rate (%)	2.11
Urban	4.4
Rural	0.9
Crude birth rate (/1000)	36.0
Crude death rate (/1000	13.2
Net migration rate (/1000)	- 1.7
Total fertility rate (woman)	4.53
Life expectancy at birth (years)	
Males	49.8
Females	51.8
Both sexes	50.89
GNP per capita (U.S. dollars, 1994)	490

Sources: Data are from the Population Division, Department of Economic and Social Information and Policy Analysis of the United Nations, World Population Prospects: the 1994 Revision. GNP per capita is from UNDP. Two dashes (--) indicate that data are not available.

INDICATORS RELATED TO ICPD GOALS*

		(Thresholds)*
Births attended by health professional (%)	70.0	≥60
Contraceptive prevalence rate (15-44) (%)[2]	43.0	≥55
Access to basic health services (%)[3]	85.0	≥60
Infant mortality rate (/1000)[4]	67.0	≤50
Maternal mortality rate (/100,000)[5]	285.0	≤100
Gross female enrolment rate at primary level (/100)[6]	84.0	≥75
Adult female literacy rate (%)[7]	77.9	≥50

*** AS CONTAINED IN DOCUMENT DP/FPA/1996/15 AND APPROVED BY EXECUTIVE BOARD DECISION 96/15.**

[1] *WHO, Coverage of Maternal Care, 3rd ed., 1993. Data cover the period 1983-1993.*
[2] *United Nations Population Division, World Contraceptive Use 1994, ST ESA SER.A 143. Data cover the period 1986-1993.*
[3] *UNICEF, The State of the World's Children, 1995. Data cover the period 1985-1993.*
[4] *United Nations Population Division, World Population Prospects Database 1950-2050, 1994 Revision. Data are for 1992.*
[5] *UNICEF, The State of the World's Children 1995, which is based on data compiled by WHO. Data cover the period 1980-1992.*
[6] *United Nations Statistical Division, Women's Indicators and Statistics Database, Version 3 (CD-ROM), 1994, which is based on data compiled by UNESCO.*
[7] *UNESCO, Education for All - Status and Trends, 1994.*

1. The United Nations Population Fund (UNFPA) proposes to support a comprehensive population programme over the period 1996-1999 to assist the Government of Zimbabwe achieve its population and development objectives. UNFPA proposes to fund the programme in the amount of $8.9 million, $6.4 million of which would be committed from UNFPA's regular resources to the extent such resources are available. UNFPA would seek to provide the balance of $2.5 million from multi-bilateral and/or regular resources to the extent possible, consistent with Executive Board decision 96/15 on the allocation of UNFPA resources. This would be UNFPA's third programme of assistance to Zimbabwe.

2. The proposed programme is based on the findings of an extended programming process in which the UNFPA field office and a group of national consultants conferred frequently with key government officials, especially in the Ministry of Finance, the Ministry of Health and Child Welfare, the National Economic Planning Commission and the Zimbabwe National Family Planning Council (ZNFPC), as well as with leading non-governmental organizations (NGOs). The UNFPA Country Support Team based in Harare provided guidance and feedback during this exercise. The proposed programme takes into account the Government's population priorities, the relatively advanced state of Zimbabwe's population programme, and inputs from other donors, including United Nations agencies.

3. In spite of the impressive achievements of Zimbabwe's national population programme, the country's reproductive health situation is being jeopardized by difficult economic conditions and by the HIV/AIDS epidemic. The overall objective of UNFPA assistance is to enable the Government to better address five of its priority population concerns: adolescent reproductive health, maternal mortality, the quality of reproductive care, the HIV epidemic, and the status of women. Given the significant efforts of the Government and the presence of a large number of other donors, the most effective use of UNFPA resources will be for meeting important needs left unfinanced by the Government and other donors. This is especially true in reproductive health, where other donors are concentrating their efforts. UNFPA assistance will be tailored to complement the considerable inputs of Government, local NGOs and other donors.

4. All activities under the proposed programme, as in all UNFPA-assisted activities, would be undertaken in accordance with the principles and objectives of the Programme of Action of the International Conference on Population and Development (ICPD), which was endorsed by the General Assembly through its resolution 49/128.

Background

5. Zimbabwe has been classified as a group "B" country in terms of UNFPA resource distribution, having met the threshold level for four of the seven selected indicators. It does not, however, meet the criteria for three of the indicators relating specifically to reproductive health -- contraceptive prevalence rate, maternal mortality rate and infant mortality rate. The maternal and infant mortality rates have, in fact, been worsening in recent years. The per capita gross national product (GNP) of $490 is well below the norm for group "B" countries.

5. Zimbabwe is characterized by a high rate of population growth caused by relatively high fertility and declining mortality rates (although these now seem to be climbing after years of decline), a relatively high level of contraceptive prevalence, increasing HIV prevalence, rural residence, and extreme youthfulness. The population was 11.3 million in 1995, up from 7.6 million in 1982, representing an average annual growth rate of 3.1 per cent. The Government projects that the population size will increase to 16.5 million by the year 2007, although this projection does not take into consideration the potential demographic impact of the increasing prevalence of HIV/AIDS. The population is very young with 45 per cent under 15 years of age while only 3 per cent is 65 years and above. About two thirds of the population lives in rural areas, but there is substantial rural-to-urban migration and the country's urban centres are growing at the rate of 3.6 per cent a year. The proportion of households headed by females, 33.2 per cent, is high.

6. The transition to lower fertility rates has started in Zimbabwe, but it is too early yet to know whether this constitutes a continuing trend. The crude birth rate decreased from 44 per 1,000 in 1982 to 34.5 per 1,000 in 1992. Similarly the total fertility rate declined from 6.4 in 1984 to 4.3 in 1994 and is projected to decline to 3.7 by the year 2002. Fertility rates, however, remain high among particular groups, especially uneducated and rural women. The level of teenage pregnancies is relatively high: in 1994 about 20 per cent of women aged 15-19 were either pregnant or had borne at least one child. Knowledge of family planning is almost universal, and use of contraceptives is high and increasing. The contraceptive prevalence rate among married women is 48 per cent, up from 38 per cent in 1984. Fully 42 per cent of women use modern methods (78 per cent of whom rely on oral contraceptives). However, services are not available to adolescents under 16, and for those over 16 the attitudes of service providers are a significant barrier to use of family planning and other services.

7. The HIV prevalence rate is estimated at 17 per cent of the adult population and reaches more than 30 per cent among pregnant women. The potential demographic consequences of the HIV/AIDS pandemic are not routinely taken into account in population projections or in efforts to incorporate population into development planning. Awareness of AIDS is almost universal, but it has not led to behavioural changes, especially among females, sufficient enough to slow the spread of HIV infection.

8. In addition to the achievements mentioned above, Zimbabwe has been able to improve on many other indicators of human development since Independence. For example, adult literacy increased from 62.3 per cent in 1982 to 80.4 per cent in 1992. Primary school enrolment had risen to 83 per cent in 1994. About 85 per cent of the population has access to modern health facilities. The 1994 demographic and health survey showed that 93 per cent of pregnant women received some form of pre-natal care during pregnancy, and 69 per cent of deliveries took place in health facilities.

9. Zimbabwe's economy has experienced a down-turn since 1983; the rate of economic growth averaged 2.2 per cent a year from 1982 to 1992 while the population was growing at 3.1 per cent a year, with a consequent decline in incomes. By some estimates, unemployment was 40 per cent in 1994. The Government adopted a five-year Economic Structural Adjustment Programme (ESAP) in 1991 that has reduced the traditionally large portions of the budget that are available for health and education, thereby threatening, at least in the short term, social gains achieved so far. The

Government has instituted programmes to cushion the impact of ESAP on the poorest segments of the population, but considerable donor support is needed to complement these efforts.

11. There are considerable gender disparities in most of the country's human development indicators, reflecting the lower social and economic status of women in the country. The female literacy rate is lower than that of males. Females are over-represented in the informal sector of the economy and in low-wage jobs in the formal sector but under-represented in higher management positions. However, the Government is ahead of schedule in meeting its targets for recruiting more female civil servants. Gender disparity is underpinned by a cultural system that prefers sons over daughters and places heavy emphasis on the role of women as mothers and housewives, thereby emphasizing their reproductive over their productive and community management roles.

12. Political commitment to population and human development (including gender concerns) has been high in Zimbabwe. The Government acknowledges that the country's population situation, especially its high rate of growth and young age structure, constitute obstacles to accelerated socio-economic and human development, especially with respect to the provision of social services. No explicit population policy has yet been formulated, but the Government has decided to do so and has set in motion the necessary processes.

Previous UNFPA assistance

13. The focus of UNFPA's second country programme (1989-1995) was on capacity-building and reproductive health, including the provision of contraceptives. During the programme period, the objective of reducing the total fertility rate to 4.5 was achieved in 1994, more than two years ahead of schedule. The programme was approved for a total of $10 million, but expenditures were low in the first years of the programme, which was eventually extended through 1995. Expenditures reached $10.4 million by the end of 1995. Development of in-school population education and formulation of a population policy lagged behind schedule and only began to gather steam at the end of the programme.

14. Several key lessons, of an essentially pragmatic and bureaucratic nature, have been extracted from the previous two UNFPA programmes. Support at both the political and technical levels of Government, including properly identifying appropriate agencies with which to work, is essential in Zimbabwe. For example, lack of support from the national counterpart ministry hampered implementation of activities in the area of maternal and child health and family planning (MCH/FP), and the population policy project was hindered because the proper counterpart agency was not identified until 1994. As elsewhere in the world, work in Zimbabwe has shown that increasing cooperation with NGOs increased both the flexibility and effectiveness of programme activities.

15. Progress in programme implementation has been hampered by the national economic crisis, implementation of the structural adjustment policy, a reorganization of government ministries in 1992, the restructuring of the Zimbabwe National Family Planning Council (ZNFPC), and an overstretched bureaucracy and low motivation of personnel due to deteriorating conditions of services. On the UNFPA side, funding constraints and vacancies in the Country Director post slowed implementation. Since mid-1993, performance has improved, and annual expenditures have exceeded $2 million.

Other external assistance

16. The country receives considerable assistance from both multilateral and bilateral donors in the implementation of its population programme, especially in the areas of reproductive health, where there are over ten major donors. The multi-donor-funded Family Health Project 1 ($52 million for 1987-1993) and 2 ($101 million for 1992-1997), under the leadership of the World Bank, have helped support the Ministry of Health and Child Welfare, including the ZNFPC, to reduce fertility, infant and maternal mortality rates, increase the financial sustainability of family planning programmes, improve health education, and strengthen detection and care of sexually transmitted diseases (STDs). Partners include Norway, Sweden, the European Union, Germany, the Netherlands, Denmark, the United Kingdom and UNFPA.

17. The United States Agency for International Development (USAID) provides $5.5 million a year for family planning activities. In addition to its support for the Family Health Project, the Swedish International Development Cooperation Authority (SIDA) supports AIDS prevention, demographic statistics and population education activities. Japan provided $13.4 million between 1992 and 1994 for the construction and equipping of maternity and paediatrics hospitals. Among United Nations agencies, UNICEF, UNAIDS and WHO have programmes in the country. UNFPA's comparative advantage among these donors, in spite of its low funding level, lies in its neutrality as the multinational population agency, in its flexibility and quick response time, in its technical credibility, and in its ability to coordinate activities among donors and the Government.

18. The coordination of donor inputs for the national population programme is an area that requires strengthening. In the health sector, the Ministry of Health and Child Welfare has a unit designated to coordinate all external assistance, but the substantive units often have more say in approving individual activities, leading to a lack of coordination among them. The Ministry calls quarterly briefing meetings for donors. ZNFPC also holds such quarterly meetings, for which UNFPA acts as the secretariat. The Resident Coordinator's office started in 1994 to act as the secretariat to all donor assistance in health area at the request of the donors and the Ministry. The National Economic Planning Commission (NEPC) is the coordinating ministry for population matters, although the delineation of responsibilities between the Ministry of Finance and the NEPC is not well defined.

Proposed programme, 1996-1999

19. Reproductive health. In the area of reproductive health, including family planning and sexual health, UNFPA will contribute to meeting the national objectives of reducing the maternal mortality rate to 200 or less per 100,000 live births by the year 2000 and to significantly reducing maternal morbidity; reducing the proportion of adolescents having children from the current 20 per cent to 10 per cent by the year 2000; reducing the rate at which HIV spreads, particularly among adolescents; and increasing the utilization of integrated reproductive health services and improving their quality.

20. UNFPA's support in achieving these goals will be limited to certain specific activities not now being undertaken by the Government or other donors. This would include, for example, setting up on a pilot basis, and expanding if successful, a scheme to provide family planning counselling in health facilities for women who have had abortions. In focusing on the needs of adolescents, the Fund would help set up pilot adolescent reproductive health centres and would support peer education

among adolescents by NGOs as well as starting an experimental activity to encourage parent-child discussion of reproductive health issues through NGOs, including church groups.

21. Other IEC activities in support of reproductive health will include campaigns by the Ministry of Health to inform health workers about reproductive health issues beyond those covered in traditional MCH/FP programmes and the introduction of family life education in the country's teacher training schools. The Fund would also help the Ministry of Information promote reproductive health through the popular media and would help the Zimbabwe National Family Planning Council (ZNFPC) build up its IEC capacity in advocating for smaller families, the use of contraception for family planning and practices to prevent STDs, including HIV/AIDS.

22. In helping the country deal with the AIDS pandemic, which has hit Zimbabwe especially hard, UNFPA will contribute to the UNAIDS programme, will provide technical expertise to the National AIDS Coordination Programme (NACP), and, together with UNICEF, support peer education among commercial sex workers. UNFPA will help in meeting the country's contraceptive needs, in cooperation with other donors and the Government, which has tripled its funding for contraceptives in the last three years. The Fund will focus on expanding the contraceptive mix in the country, especially in trying to reduce over-reliance on oral contraceptives and to increase usage of condoms, important for HIV prevention efforts. UNFPA will help in analysing bottlenecks in the logistics of contraceptive supply and in improving the system as well as working to maintain the successful community based distribution programme and to expand a pilot test of a depot holder system.

23. In helping to build national capacity, the Fund will carry out situation analyses on improving quality of care and integrating the concept of reproductive health into MCH/FP programmes. This will include strengthening the capacity for reproductive health research and dissemination of findings of the Medical School of the University of Zimbabwe and other relevant institutions. It will also mean helping national NGOs, like Zimbabwe Population Services, increase the reproductive health services they are able to provide.

24. Population and development strategies. The Government has expressed the need for a comprehensive population policy and attendant action plans, and it recognizes the need to increase the use of population dimensions in development planning, especially at the sub-national level. The aim of the proposed programme is to achieve an agreed-upon population policy by 1998 and to work to integrate population factors into development planning at all levels, with specific attention to mainstreaming gender concerns. UNFPA will be the lead donor in providing support to enhance the technical capacities for population and development planning of the Ministry of Finance, NEPC and of planning units in other relevant ministries and institutions. This will include expanding and improving national population and gender databases and carrying out needed policy-oriented research. It will be very important to review HIV infection rates in order to update the mortality assumptions used in population projections. This will be crucial for assuring that future population policy and efforts to incorporate population into development planning have a realistic basis.

25. Advocacy. Advocacy is still required in the Zimbabwean context to achieve the removal of legal barriers to reproductive health services and information for all sexually active persons, including adolescents. Work also needs to be done in removing the remaining cultural, social and legal barriers to gender equity and quality; greater and more open attention to the escalating problem of HIV/AIDS and other STDs; and greater participation of leadership groups in combating its spread. UNFPA will consequently provide support for workshops with parliamentarians and other leadership groups to engage them in advocacy relating to the above issues. The Fund will also help develop advocacy campaigns through the mass media on issues concerning gender, adolescence and HIV/AIDS.

Implementation, monitoring and evaluation

26. A number of steps have been taken to remove many of the obstacles that impeded implementation of the previous UNFPA country programme. These include filling the UNFPA Representative post; conducting a highly consultative programming process that assured national involvement and ownership; and ensuring better UNFPA coordination with other donors to avoid duplication. Additionally, UNFPA has been asked to support training in project development, planning, management and administration in order to bolster the capacity for national execution of population activities. Issues of motivation of personnel stemming from their conditions of service are the responsibility of the Government, which may require outside assistance as well. UNFPA will, in the meantime, attempt to address the problem in its areas of concern through the use of such incentives as training opportunities and improved working environments.

27. All projects to be designed and implemented within the context of this programme will have built-in monitoring and evaluation components, and some of them will also be subject to scheduled independent evaluations. In some cases, production of baseline data and/or needs assessments will be undertaken at the beginning of the programme. In addition, all projects would be subject to standard progress reports, monitoring field visits and annual review meetings, in conformity with UNFPA guidelines and government regulations. A mid-term review of the programme will be conducted at the end of 1997 and a final evaluation in 1999. At the field level, the resident UNFPA Representative will be responsible for implementation of the programme. UNFPA will continue to play a key role in assisting the Government coordinate multi-bilateral population assistance.

Recommendation

28. The Executive Director recommends that the Executive Board approve the programme of assistance for Zimbabwe, as outlined above, in the amount of $8.9 million over the period 1996-1999, $6.4 million of which would be programmed from UNFPA's regular resources, to the extent such resources are available, and the balance of $2.5 million would be sought from multi-bilateral and/or regular resources to the extent possible, consistent with Executive Board decision 96/15 on the allocation of UNFPA resources.

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