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THE ZIMBABWE REPRODUCTIVE HEALTH SURVEY

INFORMATION FOR POPULATION ACTION

PN-AAZ 884 ISN 56228

INTRODUCTION

The Zimbabwe Reproductive Health Survey (ZRHS) was carried out between July and October of 1984 by the Zimbabwe National Family Planning Council (ZNFPC) with assistance from Zimbabwe's Central Statistics Office. A total of 2,574 women, aged 15-49, were interviewed regarding their 1) reproductive health behavior and attitudes and 2) knowledge and use of family planning. The survey shows that programmes which provide family planning information, motivation, supplies, and services, including those of the ZNFPC, have substantially increased levels of contraceptive knowledge and use.

At the same time, the survey shows that average fertility levels remain high in Zimbabwe. Several factors influence the number of children couples have. To continue to improve and expand family planning programmes, it is necessary to identify those factors and to obtain a deeper understanding of their impact on fertility levels, maternal and child health, and family planning practices.

The survey identifies five important determinants of population growth in Zimbabwe: 1) demographic and 2) socio-economic characteristics, 3) reproductive norms, 4) health practices, and 5) knowledge, attitudes, and practices about family planning. This booklet summarizes these factors and suggests policy implications for those working to improve the quality of life in Zimbabwe.

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Demographic Factors

Marriage Patterns—Almost all Zimbabwean women marry at some time during their reproductive years; in fact, about 80 percent are under age 20 when they first marry.[1] Although women in Zimbabwe are beginning to marry later, the change is not yet sufficient to reduce fertility levels. Consequently most women are exposed to the possibility of becoming pregnant during most of their fertile years. This pattern of early and universal marriage, in the absence of effective use of contraceptive methods, results in high fertility levels: Zimbabwean women currently at the end of their reproductive years have had an average of 7.5 births. If fertility continues at present levels, women now 15-19 years old will have an average of 6.5 births before reaching 50 years of age.

POLICY IMPLICATIONS—The Zimbabwean pattern of early and universal marriage is typical of societies where women remain in traditional roles. Raising the status of women and broadening their opportunities through education and modern-sector jobs often encourages women to marry later and reduces the number of children they would like to have. Thus, education and employment of women, important development goals in their own right, are also powerful factors in reducing fertility levels.

Socio-Economic Factors

Education—Fertility levels are higher among illiterate women and those who have not completed primary school than among those with more education. The majority of Zimbabwean women (62.8 percent) have little or no education. (See figure 1.) This factor contributes to high fertility in Zimbabwe.

POLICY IMPLICATIONS—As social and economic development continue in Zimbabwe, the proportion of urban, educated, and employed men and women will increase. With development, fertility can be expected to decline gradually as people

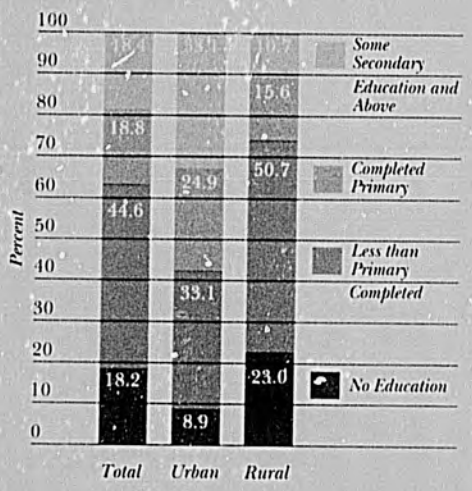
[1] *Throughout the text, whenever the term "married women" is used, it actually refers to two categories of women, those who are married, and those who are in a consensual union. The survey shows that 72 percent of Zimbabwean women aged 15-45 are married, 11 percent are in a consensual union, 5 percent are divorced or widowed, and 12 percent have never married.*

Employment—Women who do not work outside the home have more children than those who do. Further, women who perform manual labor have higher fertility than those who work in professional jobs. Since the majority of Zimbabwean women (65 percent) do not work for pay, and only a small proportion of employed women have professional, technical, managerial, or clerical jobs, most Zimbabwean women fall into categories likely to have large families.

Residence—Fertility is also higher among women who live in rural areas than among women who live in urban areas. Since the majority of Zimbabwean women (66 percent) live in rural areas, this factor also contributes to Zimbabwe's high average fertility.

Figure 1

THE EDUCATIONAL STATUS OF CURRENTLY MARRIED WOMEN, ZIMBABWE, 1984



desire smaller families. A decline in fertility can, in turn, support the development process by, for example, lowering the dependency ratio and the number of new people needing education and medical care. This is important not only for the national economy but also for couples who are faced with rising costs of feeding and educating their children. A national family planning programme should be an integral component of national development both to provide services to couples whose family size goals have changed because their individual circumstances have changed and to enhance the development process by reaching families still outside the modern sector.

Reproductive Norms

Family Size Goals—Zimbabwean women desire large families—about six children on average. If this continues as the norm, the population growth rate will remain high in Zimbabwe.

Most Zimbabwean women (75 percent) want to have more children. Consequently, there is little interest in family planning for the purpose of limiting family size. However, there is a strong interest in birthspacing which Zimbabwean women correctly believe is healthy for their children. This interest represents the primary attraction of family planning. National population growth will not decline significantly unless the births are spaced at least three years apart, thus reducing the number of children a woman could have during her reproductive years.

POLICY IMPLICATIONS—Having large families is the norm in Zimbabwe and, as such, exerts considerable pressure on couples to conform. Family planning programmes can work to change this reproductive norm through well-designed information, education, and communication programmes which inform couples of the choices open to them and the benefits of a smaller family.

Maternal and Child Health Factors

Breastfeeding—Breastfeeding is important for the health of infants and young children. In addition, breastfeeding delays the resumption of ovulation after a woman has a baby, reducing the risk of pregnancy among new mothers.

Fortunately, almost all mothers in Zimbabwe breastfeed their babies for a relatively long period of time—an average of 19 months. Among urban and educated women the breastfeeding period is shorter—about 15 months.

POLICY IMPLICATIONS—Every effort should be made to encourage the continuation of breastfeeding practices among all mothers in the country.

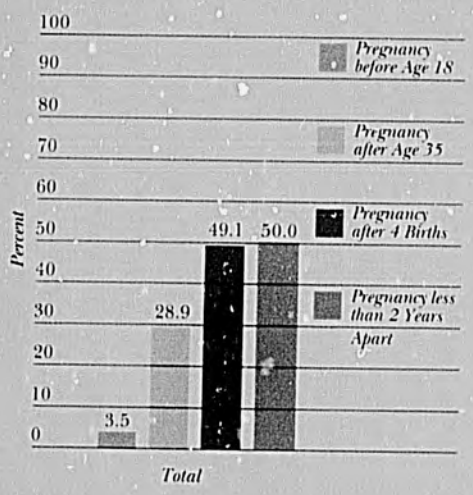
Maternal Care—Adequate medical care during pregnancy, childbirth and in the first weeks after delivery is very important for the

health of both mother and child. Almost all women in Zimbabwe receive at least some prenatal care and most (75 percent) have medically supervised deliveries. However, only 40 percent obtain postnatal care. Moreover, urban women are more likely than rural women to receive prenatal care, medical assistance at the time of delivery, and postnatal care.

Prevalence of High-Risk Pregnancies—The risks of illness and death associated with pregnancy are greatest for women under age 18 or over age 35, women with four or more births, and women whose last birth was within two years. Unfortunately, many Zimbabwean women fall into one or more of these high-risk categories, thereby increasing their risk of maternal illness or even death. (See Figure 2.)

Figure 2

PERCENT OF CURRENTLY MARRIED WOMEN IN HIGH-RISK PREGNANCY CATEGORIES, ZIMBABWE, 1984



POLICY IMPLICATIONS—It is important to improve the provision of maternal care, especially postnatal care; such services will increase the chances of good health for mothers and babies and also provide an opportunity to promote family planning. Special attention should be paid to increasing the coverage of health services, especially in rural areas.

POLICY IMPLICATIONS—Maternal illness and death can be reduced by eliminating high-risk pregnancies, providing medical care during pregnancy and normal delivery, and referring complicated deliveries to medical institutions. Women need to know that family planning is one of the most powerful ways to reduce their chances of maternal illness and death since it helps women avoid high-risk pregnancies. Family planning saves lives and should be promoted as an essential component of maternal and child health care.

High Infant Mortality Rates—Infant mortality rates in Zimbabwe are still high. About 79 out of every 1000 babies (1 out of 13) die within the first year of life. Infant mortality rates are considerably higher in rural areas than in urban areas.

High infant mortality is considered to be one of the main determinants of high fertility. Where infant mortality is high, couples have a large number of births, perhaps to ensure the survival of the number of children they want to have.

POLICY IMPLICATIONS—Every effort should be made to reduce infant mortality and ensure the survival of children. A national child survival strategy should include:

1. *breastfeeding for infant nutrition and as natural birthspacing;*
2. *immunization to protect children against deadly diseases;*
3. *oral rehydration therapy to save children who suffer from diarrheal diseases;*
4. *growth monitoring to identify children's nutritional problems;*
5. *birthspacing of at least three years through the effective use of contraception to give infants and children a healthy start in life;*
6. *family life education to help women participate in family and community decisions that affect their lives and the lives of their children.*

Family Planning Programmatic Factors

Family Planning Knowledge and Attitudes—The survey shows that most Zimbabweans are aware of family planning practices and that the efforts of the Zimbabwe National Family Planning Council and other family planning providers have had a substantial impact on attitudes toward family planning. About 90 percent of married women know of at least one contraceptive method, 84 percent approve of family planning, and 71 percent know where contraceptives can be obtained.

Male approval of family planning also appears to be widespread, although about 17 percent of currently married women report that their partners do not approve of family planning. Male attitudes are

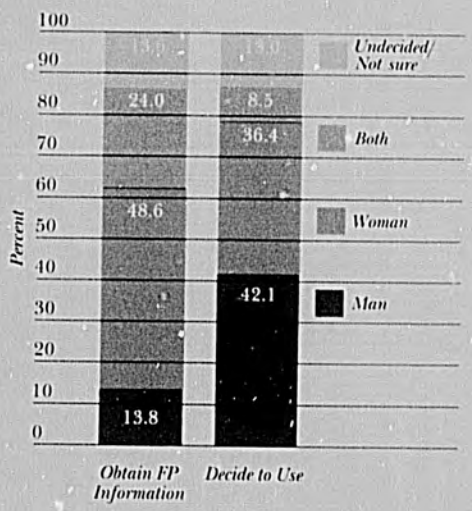
POLICY IMPLICATIONS—In general, there is widespread knowledge of and favourable attitudes toward family planning in Zimbabwe. However, some problems remain: 29 percent of women do not know of a source where contraceptives can be obtained, 16 percent do not approve of family planning, 17 percent feel that their partners do not approve of family planning, and only 8.5 percent believe that family planning decisions should be

important in determining whether a couple will adopt family planning. About 42 percent of currently married women think that the decision to adopt family planning should be the man's alone, while 36 percent think that it should be the woman's decision, and less than 10 percent say the couple should make the decision together. (See Figure 3.)

Over half the married women hear radio programmes about family planning, one-third see family planning brochures, and 15 percent watch family planning programmes on television. Over 80 percent of women indicate an interest in receiving family planning information; obtaining such information is seen primarily as a female responsibility .

Figure 3

PERCENT DISTRIBUTION OF RESPONSIBILITY FOR OBTAINING FAMILY PLANNING INFORMATION AND THE RESPONSIBILITY FOR DECIDING TO USE A METHOD, ZIMBABWE, 1984



made jointly by husband and wife. It is the responsibility of the ZNFPC and other interested parties to design information, education, and communication programmes to address these problems, particularly how to get men more involved in family planning decisions.

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Family Planning Practices—Contraceptive use is common among Zimbabwean women. Sixty-six percent of married women in Zimbabwe have used at least one family planning method, modern or traditional, at some time. However, the proportion of women currently using family planning is considerably lower. About 38 percent of currently married women are using either a modern method (27 percent) or a traditional method (11 percent). (See Figure 4.)

Among current users of modern contraceptives, 85 percent take pills. This is a direct outcome of the very limited mix of contraceptives offered by the national family planning programme. The pill is the main method provided in both the ZNFPC clinic-based and community-based strategies.

POLICY IMPLICATIONS—The contraceptive prevalence rate in Zimbabwe is relatively high compared to other sub-Saharan African countries and reflects the successful efforts of ZNFPC and other providers to promote family planning practices throughout the country. Nonetheless, fertility rates in Zimbabwe are still high. Efforts must therefore be made to:

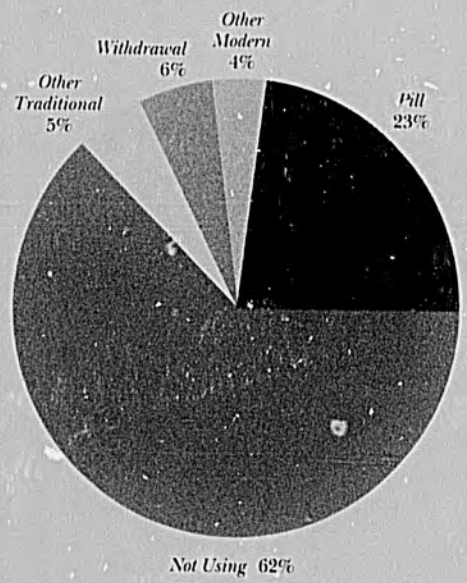
1. *Accelerate social and economic development programmes, especially in the areas of maternal and child health care, women's education, and modern sector employment for women;*

The wide gap between the percentage of women who have ever used contraception (66 percent) and those currently using it (38 percent) shows that many women who adopt family planning discontinue use. The additional gap between the women's favourable attitudes and knowledge and their current use of contraceptives shows that Zimbabwean women are not fully transforming their family planning knowledge and attitudes into practice.

The major reason women give for not using contraceptives or for discontinuing use is the desire to have another child. Other reasons for never having used contraceptives include lack of knowledge on how to obtain them and concern about the reliability and safety of methods. A

Figure 4

CURRENT USE OF FAMILY PLANNING BY METHOD (CURRENTLY MARRIED WOMEN), ZIMBABWE, 1984



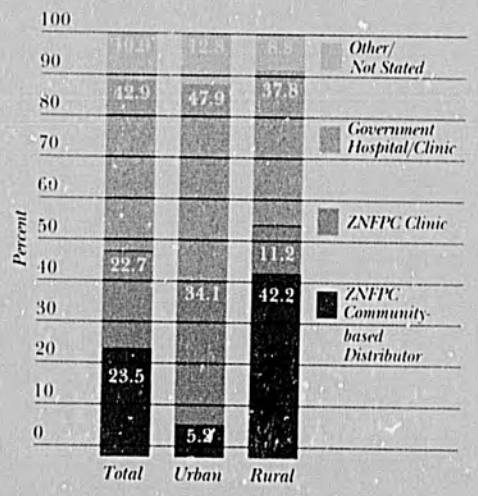
2. *Intensify family planning information, education, and communication programmes that promote gradual reduction of the high fertility norm;*
3. *Improve the accessibility of family planning services including information about where they can be obtained;*
4. *Encourage a more balanced contraceptive method mix.*

second major reason given for discontinuing use was problems with or concern about side effects.

Family Planning Services—Family planning services in Zimbabwe are provided through ZNFPC clinics, ZNFPC community-based distributors, government hospitals and clinics, private hospitals and clinics, and other private programmes. (See Figure 5.) Seventy-five percent of all family planning users either receive their contraceptive supplies at home from a community-based distributor or are within 30 minutes travel time of the source they prefer. There are, however, still women without easy access to family planning services. At the same time, some government and private hospitals and clinics are not active in providing family planning services.

Figure 5

PERCENT DISTRIBUTION OF CURRENT USERS BY SOURCE OF METHOD AND AREA OF RESIDENCE, ZIMBABWE, 1984



POLICY IMPLICATIONS—To reach all the men and women who want family planning services, hospitals and clinics which do not yet provide family planning should be encouraged to do so. Additionally, other forms of community-based distribution such as village depots and contraceptive commercial marketing should be tried on an experimental basis. Innovative approaches that combine family planning services with other community programmes, such as income-generating activities, adult literacy programmes, and women's projects, should also be tried. A diversified contraceptive method mix should be offered, especially in hospitals and clinics.

CONCLUSION

Zimbabwe's First Five-Year National Development Plan (1986-1990) states: "Programmes such as family planning, health education, etc. that are underway are intended to reduce rapid population growth and improve the quality of life of mother and child in particular."

The stated demographic, health, and welfare objectives of family planning represent a great challenge for Zimbabwe. Efforts to date, particularly those of the ZNFPC, have made a remarkable start toward the achievement of these objectives. Continuing progress will depend to a great extent on the following actions:

1. Implementation of appropriate social, economic, and health measures to affect the demographic, normative, and socio-economic factors outlined in this report.
2. Strengthening of a vigorous, well-designed family planning information, education, and communication programme to modify gradually the prevailing high fertility norms and to promote family planning practices.
3. Improvement in the quality of both clinic-based and community-based family planning services.
4. Expansion and improvement of family planning services through programmes of all kinds—governmental and private clinics, private sector health services, non-governmental organizations, and innovative types of community-based distribution.

There is no doubt that Zimbabwe is capable of meeting this challenge. The Zimbabwe Reproductive Health Survey helped to identify crucial factors in Zimbabwe's socio-economic and cultural life to guide the ZNFPC and other family planning providers in their efforts to improve their already dynamic programmes.

This booklet was prepared by IMPACT, a project of the Population Reference Bureau, Washington, D.C. It is based on the survey summary report, ZIMBABWE REPRODUCTIVE HEALTH SURVEY, 1984, *(Zimbabwe National Family Planning Council and Westinghouse Public Applied Systems, June 1985) and additional information provided by the Zimbabwe National Family Planning Council. Funding was provided by the United States Agency for International Development.*