

Findings from the Sub-Saharan Africa Urban Family Planning Study

BULAWAYO City Report

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List of abbreviations

AIDS	-	Acquired Immuno-Deficiency Syndrome
BCH	-	Bulawayo City Health
CAFS	-	Centre for African Family Studies
CBD	-	Community-based distribution
CPFH	-	Center for Population and Family Health
COC	-	Combined oral contraceptives
ERU	-	Evaluation and Research Unit
FP	-	Family planning
FPPMES	-	Family Planning Program Monitoring and Evaluation System
GGD	-	Guided group discussions
GOZ	-	Government of Zimbabwe
HHRAA	-	Health and Human Resources Research and Analysis for Africa
HIV	-	Human-immunodeficiency virus
IEC	-	Information, education and communication
IUD	-	Intra-uterine device
JHPIEGO	-	Johns Hopkins Program for International Education in Reproductive Health
KAP	-	Knowledge, attitudes, and practice
LAP	-	Lower abdominal pain
MCH	-	Maternal and child health
MOH	-	Ministry of Health
MWRA	-	Married women of reproductive age
NGO	-	Non-governmental organization
NFP	-	Natural family planning
PNO	-	Provincial Nursing Officer
POP	-	Progestogen only pill
SDP	-	Service delivery point
STD	-	Sexually transmitted disease
TFR	-	Total fertility rate
SEATS	-	Service Expansion and Technical Support
VSC	-	Voluntary surgical contraception
WRA	-	Women of reproductive age
ZNFPC	-	Zimbabwe National Family Planning Council

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Introduction

The SEATS project of John Snow, Inc., in collaboration with the Centre for African Family Studies, Columbia University's Center for Population and Family Health, and the Population Council, with funding from the USAID Bureau for Africa, recently completed a major study to determine how family planning service delivery programs in Sub-Saharan African cities can be made more efficient and effective. The working hypothesis is that many/most urban family planning programs are overwhelmed by the recent rapid growth of urban populations and are not equipped to satisfy potential demand for contraceptive services. In part, past decades of focussing development assistance on unserved and underserved rural areas has contributed to the inability of urban infrastructure to keep pace with rapid urbanization. Three cities are included in the study: Mombasa, Kenya; Blantyre, Malawi; and Bulawayo, Zimbabwe.

This report covers the work done in Bulawayo, Zimbabwe, during the period January through November 1994, using new situation analysis data, service statistics, geographical data, and an assessment of the capacity required for future family planning services.

Summary of findings and conclusions

Overall, family planning service delivery in Bulawayo has the potential to expand and reconfigure itself in response to changing demand

- Estimates of the future family planning service load in Bulawayo suggest that the current system must be substantially expanded to maintain and to raise the contraceptive prevalence rate. This service burden is increased in light of post-Cairo Conference mandates for greater integration of family planning and other reproductive health services.
- The available method mix in Bulawayo is mainly comprised of resupply methods, which increases the future client load dramatically. However, this study finds evidence that the demand for long term methods in Bulawayo is larger than the current supply, so in order to reduce the future service burden, eligible women should be responsibly encouraged to adopt long term methods.
- Most public SDPs are located in residential areas, and most private SDPs and pharmacies are located in the city center. In the outer residential areas, there is a service vacuum in the evening hours, which could be filled by private SDPs moving there or by a change in the hours of public SDPs.
- Pharmacies exhibit a strong foundation on which to expand family planning services. Improvements can take the form of increased pharmacist training in contraceptive technology, increased range of methods available, and more widespread use of IEC materials.
- The CBD program is running quite efficiently, and could be expanded to the less densely populated wards of the city.

- The public charges for FP are modest, and women generally seem to have the means to pay for them, although they feel examination charges are too high. If SDPs find they are not self-sustaining, there may be room to increase fees without losing many clients.
- The status of service delivery statistics in Bulawayo varies greatly between the public and private sectors. In the public sector, recordkeeping is admirable, and reporting is consistent. However, in the private sector data on family planning services is kept in a different format than the public sector, making it difficult to access.
- In the public sector, supervision takes place irregularly and supervisory guidelines are lacking. In the private sector, supervision does not take place because most private clinics are run by private physicians, who do not have direct supervisors.

Although it is excellent in some respects, the quality of services in Bulawayo is in need of improvement

- The basic physical infrastructure in both public and private clinics in Bulawayo is highly commendable.
- Overall, both nurses and physicians are in need of increased training in family planning methods (especially long-term methods) as well as in STD/HIV management.
- IEC materials are very effective in client motivation and education, but they are generally scarce in Bulawayo.

- Although FP services are provided at many SDPs, the availability of these services is not well advertised.
- During the client/provider interactions, the medical history obtained from new clients was limited. These data reveal room for improvement in examination protocols.
- Information about the various methods was given selectively to clients. The majority of new acceptors are receiving methods without adequate counseling.
- Only about half of new clients were given sufficient follow-up information by the providers.
- The majority of clients are satisfied with the services they receive.

Non-family planning services are available at many SDPs, but the level of integration of these services with family planning varies across SDPs.

- Over 85% of SDPs in both sectors offer STD/HIV management along with FP services. Information on AIDS in particular is offered at 96% of public and 78% of private SDPs.
- However, during the client interactions, STDs and AIDS were only mentioned with 14% of the clients. This shows that although policies may favor integration, very little if any has actually taken place.
- Staff display generally poor awareness of STDs/HIV. Although training attendance has been high, knowledge appears low. Improved staff training in

STD/HIV counselling, diagnosis and management is necessary for full integration of FP and STD services.

- Psychological barriers to integration among staff include fear of cross-infection of clients, increased workload, staff shortage, and the loss of FP clients through stigma and congestion. These concerns can be alleviated with staff training, combined FP and STD appointments for clients, and public education to remove the stigma associated with STD clinics.

Background

Zimbabwe

Urbanization

Southern Africa, like the rest of Sub-Saharan Africa, is urbanizing at a rapid pace¹ (Figure 1). By 2025, fully 66% of the Southern African population is expected to reside in urban areas, up from 44% in 1990.

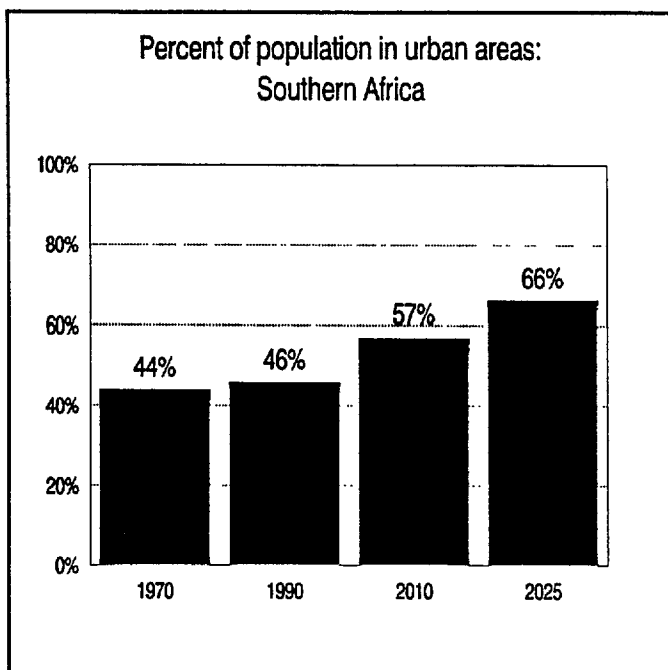


Figure 1

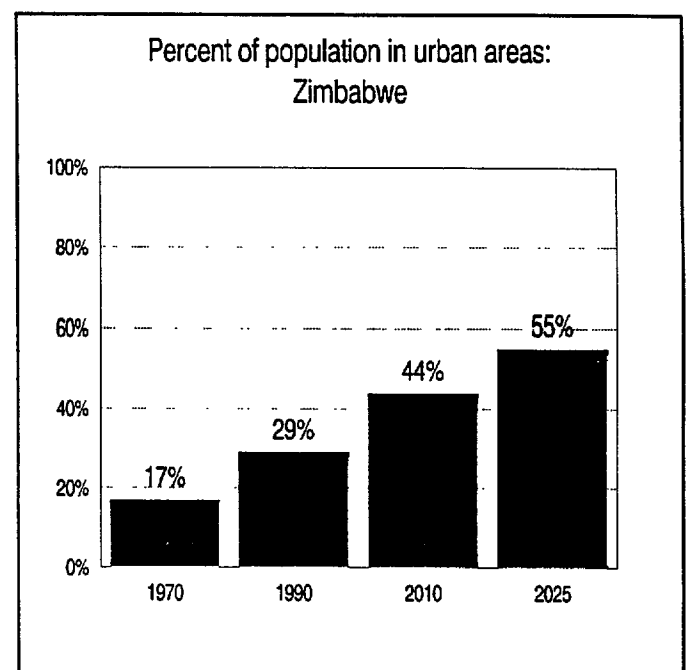


Figure 2

Source: World Urbanization Prospects: The 1992 Revision, United Nations Department of Economic and Social Information and Policy Analysis, ST/ERA/SER.A/136, New York, 1993

¹ The United Nations definition of 'Southern Africa' includes Botswana, Lesotho, Namibia, South Africa, and Swaziland. The UN considers Zimbabwe to be an East African country. For the purposes of this report, however, Zimbabwe will be compared to the Southern African region.

Figure 2 shows that Zimbabwe is less urban than the Southern African region as a whole. Nonetheless, urbanization is having a significant demographic impact in Zimbabwe; in 1990 the proportion of its population in urban areas was 29%, and by 2025 it is projected to be 55%.

Family planning and fertility

Family planning services were first introduced in Zimbabwe in 1953. In 1984, the Zimbabwe National Family Planning Council (ZNFPC) was established as a parastatal organization under the MOH, to coordinate FP services. The ZNFPC has a comprehensive national FP strategy for 1991-1996.

Preliminary findings from the 1994 Demographic and Health Survey (DHS) show that there has been an increase in modern contraceptive use in Zimbabwe, with an accompanying drop in the total fertility rate (TFR). The CPR for modern methods among married women rose from 36.1% in 1988 to 42.2% in 1994². The national TFR observed by the 1994 DHS is 4.4, down from 5.5 in 1988.

The increase in CPR is a significant achievement, based largely on increased FP services. In the future, this continuing demand for services as well as the rapid urbanization in Zimbabwe will place an extraordinary burden on urban family planning systems. This calls for a close examination of current service capacity and the development of innovative service delivery systems for the future.

² The CPR for modern methods among *all* women of reproductive age also rose in the same period. In 1988 this CPR was recorded as 27.2% and in 1994 it was 31.1%.

Bulawayo

Geography and population

Bulawayo is the second largest city in Zimbabwe, after Harare. Map 1 in appendix 5 shows the city's boundaries and its 24 wards. The total area of the city is 479 square kilometres, and according to the 1992 Census, the population is 621,742. This gives a population density of 1,298 people per square kilometre.

The population of the city is young: 36% of the residents is under 15. Women of reproductive age (WRA) constitute 56% of all women and about 28% of the provincial³ population. Map 2 in appendix 5 gives the density of WRA by ward, and shows that the regions northeast and southeast of the city center are some of the most densely populated with WRA (data from the 1992 Bulawayo census). Ward 6 is also densely populated near the city center, but averages to fewer WRA per km² because of its large size.

Family planning and fertility

The national increase in CPR and decrease in TFR over the past few years has not been strongly reflected in Bulawayo. The 1988 DHS found that the urban TFR for 1983-1988 was 4.13, and the 1992 Census recorded a Bulawayo TFR of 4.35. The preliminary results from the 1994 DHS confirm this finding. The TFR varies within social categories to as high as 5.5, for example, among Bulawayo women with no education. In 1988, the CPR for modern methods among MWRA in Bulawayo was 41.2%. The 1994 DHS preliminary results show this figure to be 44.8%, so there has been an increase in contraceptive use in the city, but not as large as for the country as

³ Bulawayo is treated as a province for Census purposes.

Population and demographic indicators, Bulawayo

Population, 1992	621,742
WRA, 1992	173,841
TFR, 1992	4.35
CPR for modern methods among married WRA, 1994	45%

Sources: 1) Zimbabwe Population Census, 1992, Provincial Profile, Bulawayo, Central Statistical Office, Harare, Zimbabwe, and 2) 1994 Zimbabwe DHS

Table 1

a whole. Table 1 gives a summary of population and demographic indicators for Bulawayo.

The FPPMES shows that the public sector (both municipal and

central government clinics) accounts for 64% of contraceptive use, the ZNFPC clinics account for 27%, and the private sector (pharmacies only) account for 10%. This does not take private clinics into account, as they are not required to submit service statistics, so the private sector contribution is probably larger. (For comparison, the 1994 DHS found that 85% of all clients in Zimbabwe are served by the public sector.)

Although over half of the service providers interviewed for this study report that they have seen clients for abortion services or for treatment of complications, this study did not seek to expand on the issue of abortion in detail.

In-depth interviews were held with three Bulawayo politicians, all of whom are quite knowledgeable about and supportive of FP services. The main reason for their vigorous support is economic -- that every family ought to be able to meet the basic needs of its children, and that runaway population growth impacts negatively on development.

The politicians were asked about barriers to FP use in Bulawayo, and cited cultural resistance, ignorance, and general lack of education as the major factors, especially among people over 30. Education through the media and schools, programs with commercial sex workers, and the use of tax incentives were cited as efforts that could increase contraceptive use in Bulawayo.

Methodology

Following a series of planning meetings between the USAID Africa Bureau HHRAA project staff, the John Snow Inc. SEATS project staff, USAID Zimbabwe Mission staff, Population Council Operations Research project staff and the Centre for African Family Studies staff, a methodology to be used for the study was developed and agreed upon. CAFS was then given the responsibility for developing the data collection instruments and the necessary field logistics. The Centre was also responsible for the data collection, analysis, preliminary preparation of city reports and coordination of the in-country dissemination workshops. The Center for Population and Family Health and SEATS staff were responsible for the FPPMES service statistics analysis, mapping reports, and editing of the city reports, as well as for the logistical arrangements for the final conference in Blantyre in March 1995.

In all, the study in Bulawayo included the following activities.

Reconnaissance activities

After the USAID Mission in Zimbabwe granted concurrence, suggestions and assistance were solicited from the Zimbabwe National Family Planning Council (ZNFPC), which coordinates all family planning activities in Zimbabwe. ZNFPC recommended that Bulawayo be selected as a study site. Discussions were then held with the Bulawayo City Health (BCH) Department to familiarize city health officials with the objectives of the study and to define the various roles of CAFS, SEATS, ZNFPC and BCH.

A complete listing of SDPs in Bulawayo was subsequently prepared by the ZNFPC office in Bulawayo, CAFS staff, SEATS staff, and a private sector representative.

Because ZNFPC works closely with both the private and municipal sectors, the list is quite comprehensive and includes pharmacies, community-based distributors (CBDs) and private doctors. It is included as Appendix 2.

Recruitment and training of data collection assistants

During the reconnaissance visits, the ZNFPC and Bulawayo City Health Department agreed to collaborate with CAFS in the proposed study. The ZNFPC approached BCH, Matabeleland North and Matabeleland South PMDs and requested them to assign FP-trained staff to participate in the study. The ZNFPC Provincial Nursing Officer (PNO) for Matabeleland North province, the Evaluation and Research Unit Computer Programmer (ZNFPC) and the PNO Bulawayo City Health were seconded to the project.

These contact people identified potential data collection assistants. Following interviews conducted jointly by CAFS staff and the collaborating agencies in Bulawayo, a total of twenty-six nurses and six other assistants were recruited. A ten-day residential training of these assistants involved a theoretical and practical training on the study objectives, methodology and instruments. The assistants also participated in translating the questionnaires into Ndebele and Shona, which are the two languages spoken in the city.

At the end of the training, both the data collection assistants and the customized data collection instruments were pretested in two of the clinics in the municipality.

Data collection

Situation Analysis data

Using a modified Situation Analysis methodology (based on the approach developed by the Population Council), data were collected on the status of SDPs, management systems, human resources, client/service provider interactions, non-clinic-based and other FP service delivery systems, and integration of FP services with other reproductive health services, especially STDs and HIV. Information was also collected on the feasibility of cost sharing in the FP programs and on pharmacy family planning activities. (This was an expansion of the areas usually covered by the Population Council Situation Analysis methodology, which does not usually include STD/HIV management, cost sharing, pharmacy, or private sector modules.)

The client/provider interactions were observed by trained nurses. The data were collected with as much objectivity as possible (a standard checklist was used), but the consultations were probably affected by the presence of observers. Over the course of the data collection, however, it became clear that behavior modification on the part of providers decreased with each client. Nonetheless, these results should be viewed with this potential bias in mind.

Qualitative data

In order to flesh out the quantitative data, four guided group discussions with contraceptive users and non-users were carried out, as well as three in-depth interviews with Bulawayo politicians. Topics for discussion included family planning knowledge, attitudes, and practices, fertility decisions, quality of services, STDs/HIV/AIDS, and cost issues. A detailed discussion of this methodology, as well as a report on the results, is included as Appendix 4.

Service statistics

Using the available records at SDPs, service statistics covering the longest continuous period of up to at most twelve months in the past 24 months were collected. These data cover the number of new clients, number of revisits, and contraceptives dispensed by type. These data were then processed with the FPPMES (Family Planning Program Monitoring and Evaluation System) methodology to generate estimates of contraceptive prevalence, method mix, and service delivery capacities.

Mapping data

Geographical data on SDP location and district population data were collected in Bulawayo by SEATS and ZNFPC. CPFH then translated these data into computerized maps showing the geographical distribution of SDPs by type along with demographic data. The maps generated in this analysis are included as Appendix 5.

Data management and processing

The Situation Analysis data were entered at ZNFPC, and preliminary analysis was carried out jointly by ZNFPC and CAFS, using EPIINFO. Qualitative discussions and their preliminary analysis were conducted by CAFS. The service statistics were entered and analyzed at CPFH using FPPMES (Lotus). Geographical data were collected by SEATS staff, and were entered and analyzed at CPFH using AutoCAD and MapInfo software packages.

Dissemination workshop

After data entry, a preliminary analysis was undertaken and the findings presented at a one day dissemination workshop in Bulawayo. The objectives of the workshop were to interpret preliminary findings and to generate practical recommendations for program

improvement.

The workshop was attended by a cross-section of individuals involved or interested in FP services in Bulawayo, who would appreciate the findings and enhance the output of the workshop. The majority of the 40 participants was invited by the ZNFPC from within and outside Bulawayo, and included representatives of the various types of SDPs and of the provincial, district and municipal administration, as well as community opinion leaders. In addition to the Bulawayo residents, representatives from the USAID Zimbabwe Mission, Ministry of Health headquarters, SEATS, UNFPA, and CAFS attended the workshop.

The workshop consisted of plenary and group work sessions. At the start of the workshop, presentations of the study objectives, methodology and preliminary findings were made. The participants were then divided into four working groups to interpret study findings and generate practical recommendations. Each group was assigned an area of the study to review in detail: status of SDPs and management systems, status of human resources, client/provider interactions, and service delivery modes. The group discussions were facilitated by CAFS and ZNFPC staff, who were familiar with the study and the data.

The dissemination workshop yielded useful comments and recommendations that are discussed together with the results. A report of the Bulawayo dissemination workshop is included as Appendix 3.

Principal findings and conclusions

Future capacity requirements

The magnitude of the task facing family planning programs in Bulawayo in the coming decades is formidable. Estimating this magnitude into the first quarter of the next century requires several assumptions and invokes numerous unknowns. This study's assumptions include continued high rates of urban growth, increasing urban demand for family planning services, and differing proportions of use of longer term and more effective methods. Among the important unknowns are social and economic changes in the coming decades, changes in reproductive behavior and contraceptive technology, whether new urban service delivery strategies will evolve, the impact of stronger links between family planning and other reproductive health services, and the role of the private sector.

Nevertheless, it is important to develop estimates of future workloads to illustrate the capacities required. The first assessment is of the current Bulawayo services, and the second is of the magnitude of services needed in coming decades.

For the first task, the FPPMES was used to estimate contraceptive prevalence for Bulawayo. Data on all distributed methods for the 12 months prior to the study generated an estimate of 31% CPR for Bulawayo⁴. Thus, the current family planning

⁴ As noted above, the 1994 DHS found that the national CPR for modern methods among all WRA is 31.1% (as of this writing, an urban CPR for all WRA is not available). This is in clear agreement with the FPPMES estimate derived here for Bulawayo. Note that the DHS estimate of CPR for married women is much higher: 42.2%. However, the FPPMES does not distinguish between married and unmarried FP clients, since it measures only commodities dispensed, not characteristics of users. For this reason, the FPPMES estimate can only be compared to the DHS estimate for *all* women, not for *married* women.

system is capable of sustaining at least 31% CPR given the current population⁵.

For the second task (estimating future service delivery needs), our model was developed as follows. First, the current CPR and method mix are used to construct a baseline of client contacts. Next, the population of WRA is projected through 2025 from the current population estimate, using United Nations urban growth rates.

Two additional parameters are introduced at this point. The first considers maintaining or doubling the current CPR of about 30%, and the second introduces various levels of use of longer term methods.⁶ The results are then expressed as the number of client contacts⁷ required in a future year under various combinations of these assumptions.

⁵ With the given data, more detailed estimates of Bulawayo's potential capacity are not possible. (This analysis is carried out for Mombasa; see "Family Planning Services in Mombasa, Kenya: Findings from the Sub-Saharan Africa Urban Family Planning Study".)

⁶ These levels are set at 0%, 20%, 40%, and 60% users of IUD's, sterilizations, and Norplant®. Note that these figures do *not* refer to the percent of all WRA using long-term methods. Instead, they refer to the percentage of the overall CPR attributable to long-term methods. For example, if the CPR is 20%, and half of those users are practicing long-term methods, then for our purposes the "level of use of long-term methods" is 50%.

⁷ Standard numbers of client contacts are estimated as follows. These values may vary for individual programs, so the projections should be evaluated in light of these defaults.

oral contraceptives	4 visits per year
injectables	4 visits per year
sterilization	2 visits/current year acceptor (with 10% of total sterilization users assumed to have accepted in the current year)
IUD	2 visits/current year acceptor (with 33% of total IUD users assumed to have accepted in the current year)
Norplant®	2 visits/current year acceptor (with 33% of total Norplant users assumed to have accepted in the current year)

Condoms are not included in this analysis. Assuming that a condom user requires 12 visits per year, this resulted in astronomical numbers of client contacts. These results were judged to be fairly misleading, since a condom resupply visit normally takes very little staff time as compared to other methods.

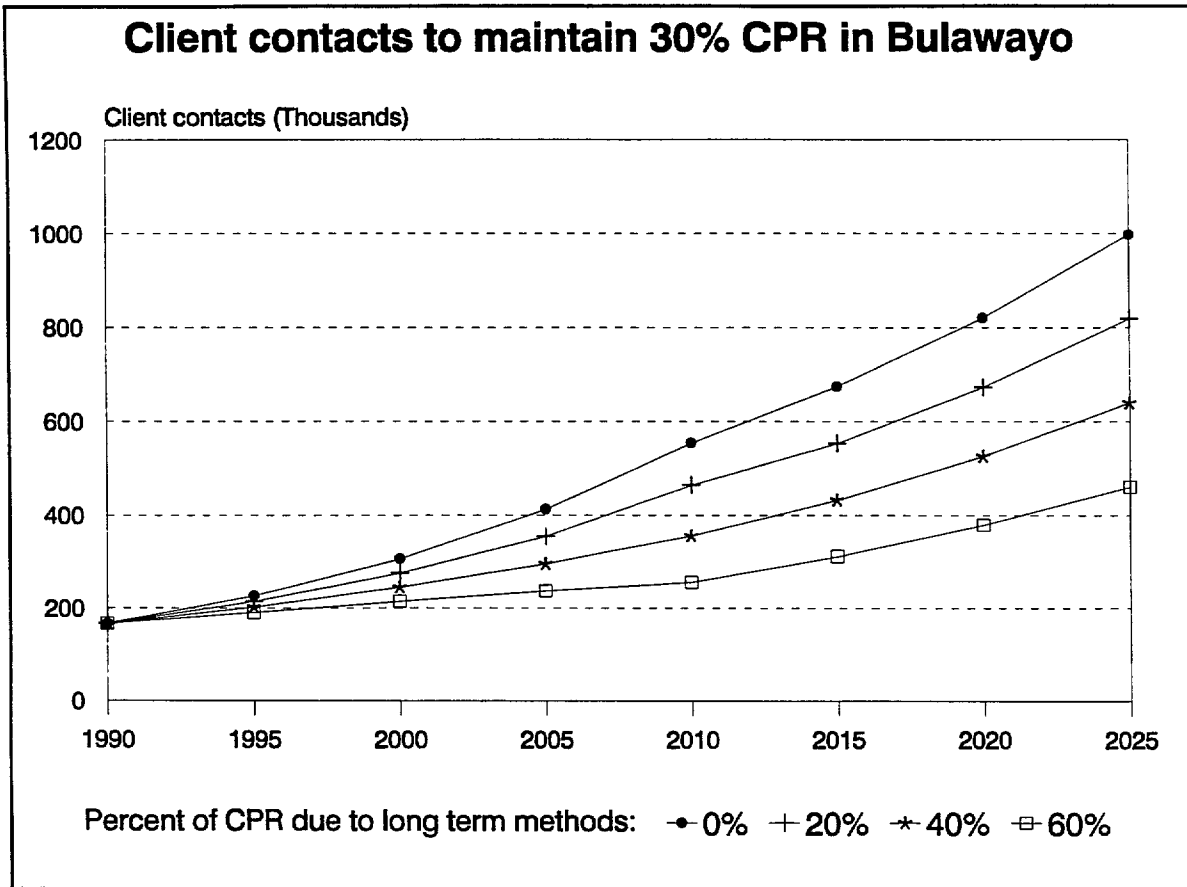


Figure 3

Figure 3 shows the estimated number of client contacts to maintain the 30% CPR, assuming 0%, 20%, 40%, or 60% of that CPR is comprised of long term methods. In the most extreme scenario, in which no women use long term methods, Bulawayo would face a million client contacts in the year 2025, up from about 170,000 in 1990. Currently about 21% of all contraceptive users in Bulawayo use long term methods; continuing with this mix would result in roughly 800,000 client contacts by 2025. Figure 4 shows a similar estimate of future client contacts given a doubled CPR of 60%, and predicts over a million contacts in most circumstances, and about 1.6 million if 21% of all users continue to practice long term methods.

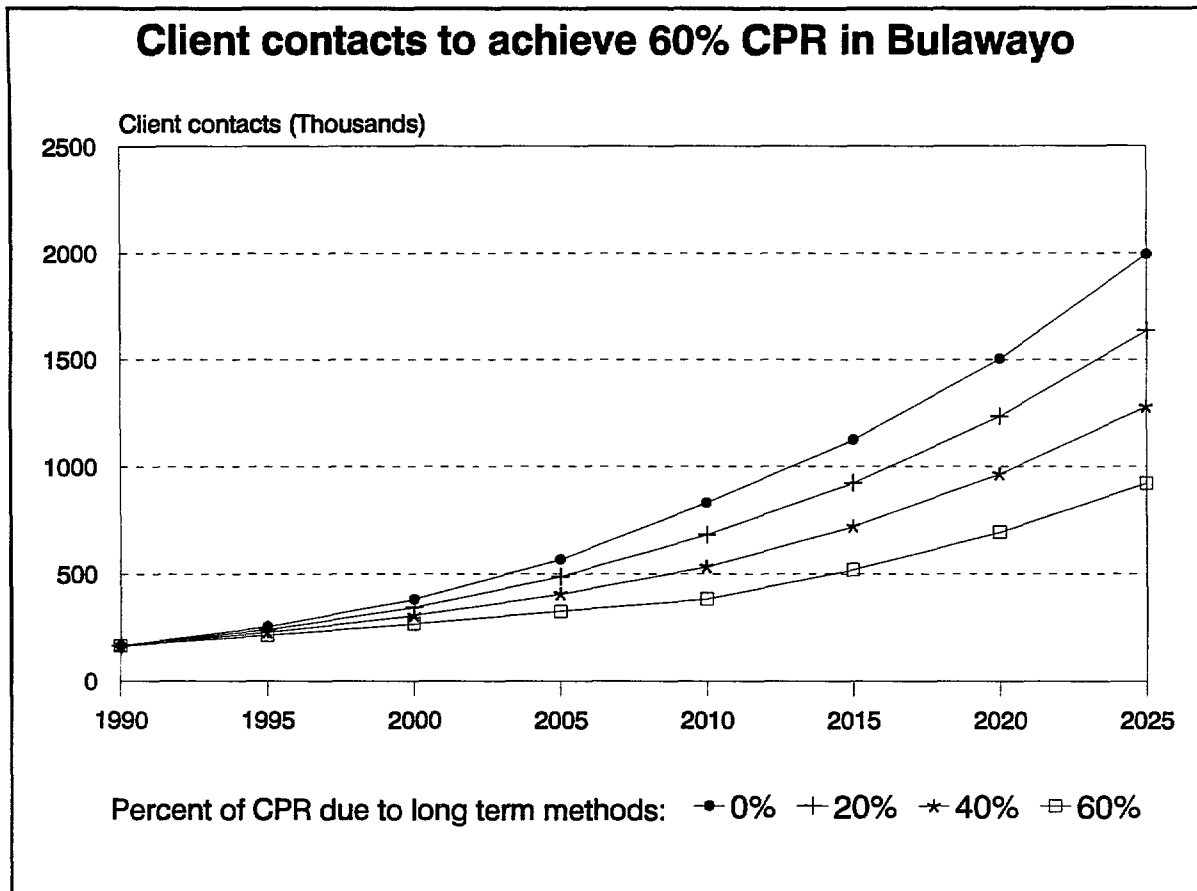


Figure 4

Clearly, the service delivery "burden" of maintaining clients on resupply methods is dramatically lessened by increasing the proportion who choose longer term methods. Nevertheless, this "burden" requires substantial expansion of services if contraceptive prevalence rates are to be doubled by 2025. This client load is further increased in the light of post-Cairo Conference mandates for greater integration of family planning and other reproductive health services.

SDPs by type

A total of 67 SDPs, 134 service providers, 17 CBDs, 23 pharmacies, 125 FP clients and 145 non-FP clients participated in the study. Following are the detailed findings from the study components.

Geographical distribution and hours of operation

Map 3 in Appendix 5 shows the distribution of all SDPs in Bulawayo. Many are clustered in the downtown area, and others are scattered throughout the outer wards. The next eight maps in the appendix show the distribution of SDP by sector: municipal (map 4), central government (map 5), private (map 6), pharmacy (map 7), ZNFPC, NGO and mission (map 8), and industry and army (map 9).

Municipal clinics are well distributed throughout the city. They are located in the city center as well as in the most and least densely populated wards -- in fact, all five SDPs serving the most densely populated wards are municipal. The five government clinics are hospitals that are distributed throughout the outer wards but not in the most densely populated areas. ZNFPC, NGO, mission, industry, and army clinics are also distributed evenly throughout the less densely populated areas. Although not indicated on these maps, the CBDs cover the most densely populated areas: downtown and to the northeast and southeast (see discussion of CBDs, below).

Private clinics and pharmacies are largely centralized: only two private clinics and three pharmacies lie outside the city center. Map 10 gives a detailed view of clinics in the downtown area, which is dominated by private SDPs and pharmacies.

These maps show that the distribution of SDPs varies largely between the public and private sector. Roughly speaking, public SDPs are evenly distributed throughout the city, whereas private ones operate largely in the center.

During the day, many working women commute to the city center, so the density of WRA probably increases in ward 1. This justifies the clustering of SDPs downtown. In the evening, however, women can probably be found at home, and the density of WRA resembles that shown in the series of maps.

Since the majority of FP clients seek care from the SDP closest to their homes (see 'Factors considered in selecting a clinic', below), it would be important for the clinics near women's homes to be open evenings. Map 11 shows the locations of the fourteen SDPs in Bulawayo that are open past 17:00. Aside from the National Breweries Clinic (attached to a factory) and one private provider named Dr. Mbengegwi, all the clinics with evening hours are located in the center. Working women might visit these downtown clinics after their workdays without inconvenience, but it would clearly also be advantageous for more of the outer SDPs to be open on non-working hours as well.

The municipal clinics in the most densely populated areas are the primary targets for this recommendation, but since they are staffed by civil servants, their working day officially ends at 16:45. This creates an evening service vacuum in the outer wards that could be filled either by private SDPs or by a change in the official workday of public servants.

Pharmacies

Virtually all of the 23 pharmacies visited in this study have appropriate facilities and operating hours. Over 90% of the pharmacies have drinking water, electricity,

telephone, and refrigerator, and over 80% have acceptable storage conditions. All the pharmacies are open for services Monday through Saturday (eight are also open Sundays) and a pharmacist is always present during open hours. The one observed equipment shortfall is in IEC materials, which were present in almost no pharmacies.

Methods available at the pharmacies are largely appropriate. All pharmacies stock condoms, 91% offer Nordette pills, and 91% offer Depo-Provera injectables. Other methods are not as available: only 17% offer spermicide cream and 13% or fewer offer various types of IUDs. However, these methods are not generally solicited from pharmacies.

In general, Bulawayo pharmacists count contraceptive sales as remarkably important to their businesses. About 65% rated these sales as 'important' or 'very important', and none referred to them as 'not important'.

Percent of Bulawayo pharmacists aware of pill-related information

Point	%
Client should start pill in first 1-5 days of menstrual cycle	43.5
POP clients can start at any point in cycle	30.4
Clients should take pills daily	69.6
Clients should take pills at the same time each day	21.7
If client forgets pill, she should take it immediately on remembering, then continue as usual	56.5

Table 2

The area of largest concern in Bulawayo pharmacies is the training status of the pharmacists themselves. Although fully 91% have attended some training in family planning (largely through the University or ZNFPC), these courses took place an average of seven years ago. A series of questions on several methods revealed that method-specific knowledge among pharmacists is not as detailed as might be required by customers. Table 2 shows the responses for the oral contraceptive questions -- this area of knowledge is particularly important since 30% of pharmacists report that clients ask them questions about pills. 78% of the pharmacists interviewed expressed interest in attending updated refresher courses on family planning methods.

In all, this evidence on pharmacies reveals a strong foundation on which to improve family planning service delivery in Bulawayo. The pharmacists themselves consider family planning sales of paramount importance, and are eager for further training.

Improvements could take the form of a larger range of methods available (spermicide, Norplant®, etc.), increased method-specific knowledge among pharmacists, or widespread use of IEC materials.

Community-Based Distribution (CBD)

There are seventeen community-based distributors (CBDs) working in the city of Bulawayo, and all but one has been in operation for over ten years. Their main functions are to motivate users, to resupply pills and condoms to current users, and to recruit and refer new acceptors to the static clinics. The CBDs are each attached to specific clinics for referrals. All the CBDs were individually interviewed for this study, and nine were observed interacting with clients (five resupply, two new acceptors, and two discontinuers). All nine clients were well satisfied with the services they had received.

The CBDs all received a basic six-week training course before they started working, and 29% had attended refresher courses within one year prior to the study. Nevertheless, dissemination workshop participants concluded that CBD's counseling skills are in need of improvement.

CBDs are adequately supervised by their group leaders: all had received supervisory visits in the three months prior to the study. About 88% report that the frequency of supervision is just right, and the remaining 12% feel that supervision should take place less often.

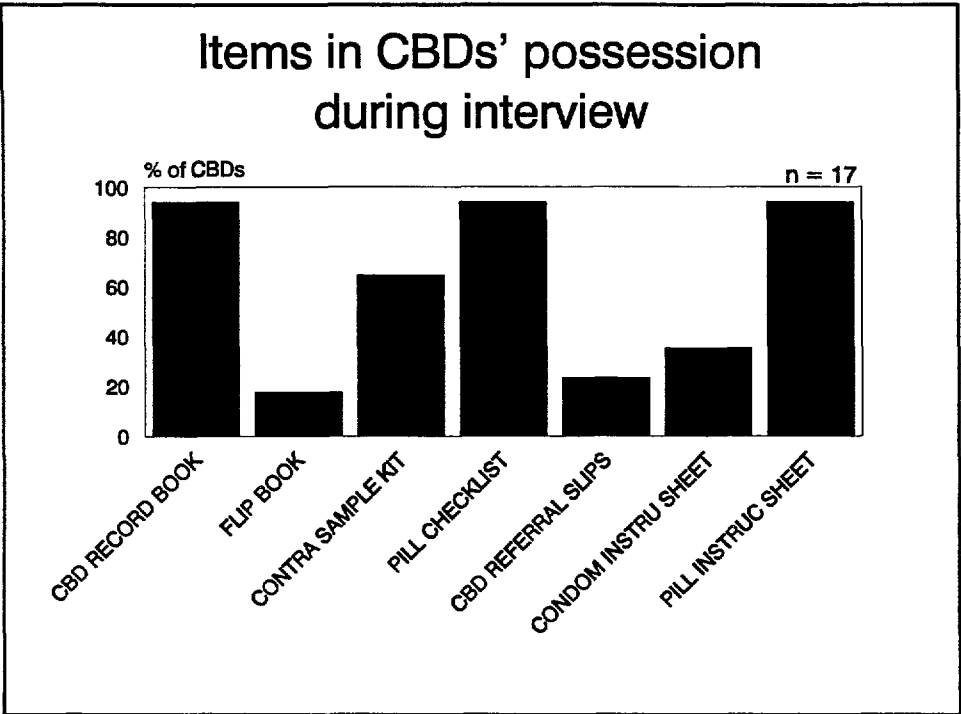


Figure 5

CBDs are expected to carry some equipment and materials to facilitate their work. Figure 5 shows the items that the CBDs had with them at the time of the interview. In general they are well-equipped with record

books, sample kits, checklists and pill instruction sheets. However, flip books, condom instruction sheets, and referral slips are generally in short supply. The shortage of referral slips is a particular concern, since a major function of the CBDs is to motivate and refer clients, but the other shortages are not critical.

Basic infrastructure working on day of visit

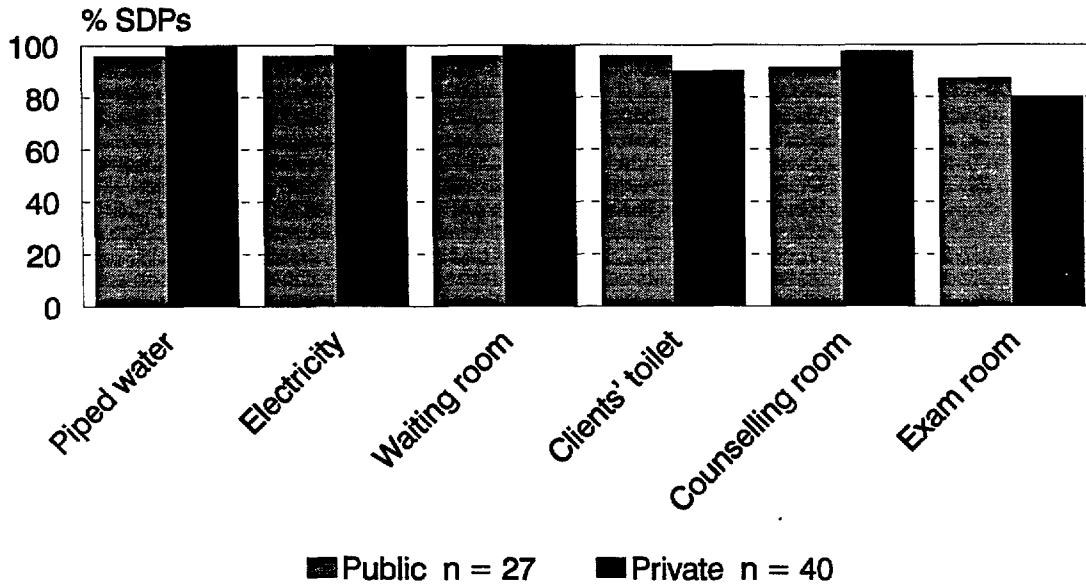


Figure 7

Separate examination rooms are present in 80% of private sector and 87% of public sector SDPs. In general these examination facilities in both sectors are in exceptionally good condition, with adequate lighting and water, and sufficient visual privacy. Auditory privacy is found in 100% of private clinics and 67% of public clinics; this reveals some room for improvement in public sector SDPs. Half of private sector and 74% of public sector SDPs have separate rooms for breast/pelvic examinations. This does not imply any shortcoming, however, since separate rooms for these particular examinations are not strictly necessary.

More advanced facilities such as sluice rooms and laboratories are less common. Sluice rooms (storage areas for soiled laundry and other materials) are crucial to preventing cross-infections in clients and are a necessity for quality health care. They are found in 70% of public sector SDPs in Bulawayo, but only 28% of private SDPs.

Laboratories are scarce. In the private sector, 18% of SDPs have laboratories, and only 4% of public SDPs have them. Since laboratories are costly to maintain, however, some SDPs probably have access to centralized laboratories. In general, although laboratory tests are not strictly required for prescribing pills, injectables, and condoms, general reproductive health care does require laboratory work in the form of testing for STDs, conducting pap smears, etc. If one goal of the system is to integrate family planning with other reproductive health services, then access to laboratory services, via whatever mechanisms, will be paramount.

As discussed below, a small number of SDPs provide surgical methods in Bulawayo, which is consistent with the lack of laboratories and sluice rooms. This reveals an area of potential expansion for Bulawayo SDPs; increased access to laboratory services and availability of sluice rooms would facilitate the provision of long term methods, which would in turn decrease the city's future service delivery burden.

Method mix

The available method mix in Bulawayo is mainly comprised of resupply methods. The public sector is particularly well-stocked for these methods: Figure 8 shows that well over 80% of public SDPs provide pills, condoms, and injectables. Among private SDPs, between 25% and 33% have these supplies on hand. However, many private physicians prescribe for resupply methods without providing the supplies themselves, mainly because Drug Council regulations prohibit doctors within five km of a pharmacy to stock drugs. These doctors are not represented in Figure 8, so the number of private SDPs actually offering these methods is higher.

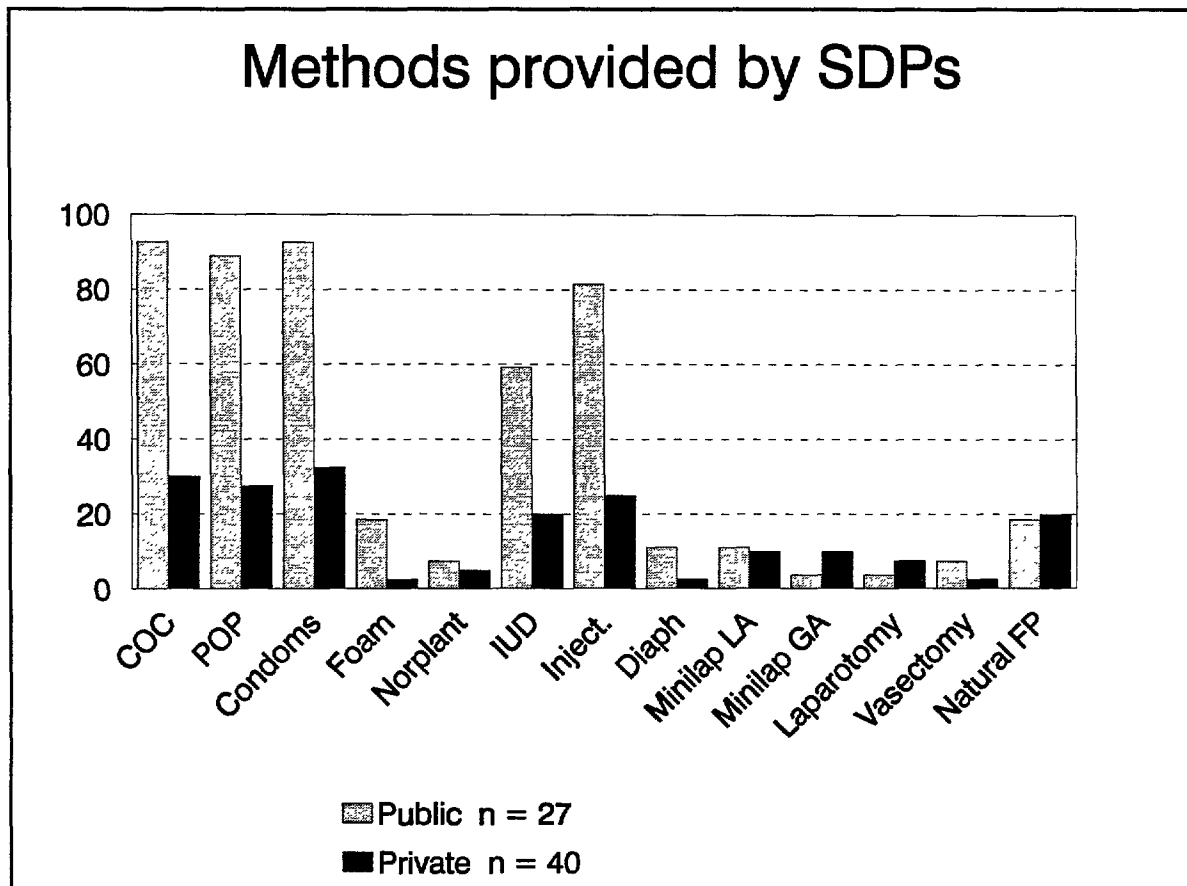


Figure 8

Long term methods are more rare. Only 7% of public and 5% of private SDPs offer Norplant®⁸ and about 10% or fewer SDPs in both sectors offer female or male sterilization. IUDs are a bit more common, especially in the public sector, where they are available in 60% of SDPs. In the private sector, IUDs are available in 20% of SDPs.

According to the 1994 DHS, about 21% of the CPR in Bulawayo is comprised of long term methods. The analysis of the future service delivery burden presented in Figures 3 and 4 suggests that this proportion ought to be raised by responsibly encouraging women to adopt long term methods. In order to achieve this, however, more SDPs will have to offer long term methods in both sectors.

Publicity

Only about 30% of public sector SDPs and 5% of private SDPs have a sign announcing the availability of FP services either inside or outside the facility. Moreover, those signs that do exist are all in English, even though 39% of clients cannot read that language. This circumstance surely inhibits clients' knowledge about FP services, but it may reflect a reluctance to promote 'vertical' FP services where other MCH services are available.

IEC materials

IEC materials are very effective in client motivation and education, but they are generally scarce in Bulawayo. In the public sector, almost 90% of SDPs have FP posters on the walls, but only about half have flip charts, brochures, information sheets,

⁸ The scarcity of Norplant® is because it is not registered by the Drug Control Council, although some providers are permitted to maintain low stocks in limited trials. Its high cost is probably also a factor.

promotional materials, or contraceptive samples. About 15% have audio-visual equipment or anatomical models.

Availability of IEC materials is lower in the private sector: 25% of private SDPs have posters on the walls, and between 5% and 23% have flip charts, brochures, information sheets, promotional materials, or contraceptive samples. Only 3% have anatomical models, and none have audio-visual equipment. An increase in IEC materials in both sectors is highly recommended.

Recordkeeping and supervision

Generally, both the public and private sectors use multiple visit record cards that are stored alphabetically (or occasionally by method, in the public sector). In the public sector, 74% of SDPs were observed to keep records in a systematic manner, and 52% of private SDPs were observed to do so. The vast majority (85%) of public SDPs keep a daily register, virtually all of which are complete and up-to-date. Daily registers are not generally used in the private sector; only 3% of private SDPs have one.

Service statistics reporting is undertaken only in the public sector in Bulawayo⁹. Fully 93% of public SDPs prepare monthly reports, and they are variously sent to ZNFPC, the Provincial Medical Department's Health Information Officer, MOH's Provincial Nursing Officer, and other places. However, none of the SDPs received any feedback on their last two service statistics reports.

Supervision in Bulawayo appears to be inadequate. Only 37% of public SDPs report a supervisory visit within the previous six months, and 15% received a visit more than six

⁹ ZNFPC is considering allowing private sector providers in work-based settings to purchase FP supplies directly, in return for service statistics reporting.

months previous. Fully 49% have never had or cannot remember a visit. Almost no supervision takes place in the private sector, and dissemination workshop participants confirmed that "as far as the private sector practitioners are concerned, the supervisory issue is not relevant" (see Appendix 3).

Moreover, there seem to be no standard supervision procedures or guidelines in the public sector. Only 30% of supervisors observed FP service delivery, 41% inquired about problems, and 15% suggested improvements. None offered praise for good work.

Overall, the status of recordkeeping and supervision in Bulawayo varies greatly between the public and private sectors. In the public sector, recordkeeping is quite commendable, and reporting is consistent. However, supervision takes place irregularly, and supervisory guidelines are lacking. Moreover, the private SDPs are not now inclined to report service statistics or be subject to supervision. If the quality of care is to be improved in Bulawayo, this lack of statistics or regulation in the private sector is a topic for further consideration.

Commodities and logistics

The commodity and logistics systems in the public sector in Bulawayo appear to be working reasonably well. No public SDPs were found to be currently out of pills, condoms, IUCDs, or injectables, and only two SDPs were found to have expired stock of any kind on hand. In the six months previous to the study, 4% of public SDPs had experienced a stockout of COC, 12% had stocked out of injectables, and 24% had stocked out of IUCDs. None had stocked out of condoms or POP.

In the private sector, these systems do not seem to be functioning as well. At the time of the study, several SDPs were stocked out of POP (9% of SDPs), condoms (23%), IUCDs (25%), and injectables (10%). Moreover, large proportions of SDPs reported stockouts in the six months previous to the study: about a quarter had run out of POP or IUCDs, about a third had run out of injectables, and over half had stocked out of condoms at some time in the previous six months. Although no private SDPs were found to have expired stock on hand, these data nevertheless show significant room for improvement in the commodity and logistics systems of private sector SDPs in Bulawayo.

Staff characteristics

In all, 134 staff members were interviewed for this study, 83 from the public sector and 51 from private SDPs. About 27% of this sample are physicians, 63% are nurses of various types, and 10% are non-clinical staff.

Nurse training in family planning services

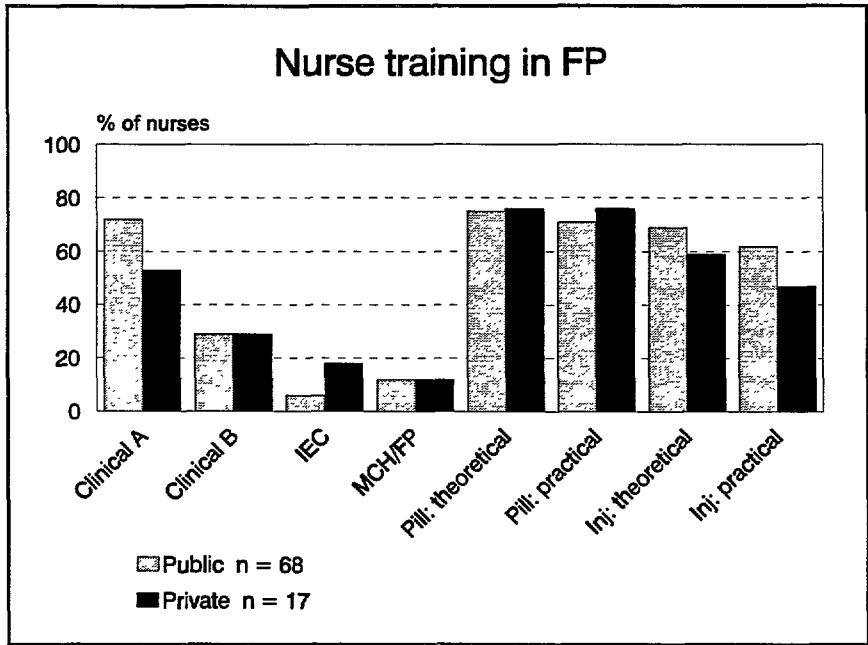


Figure 9

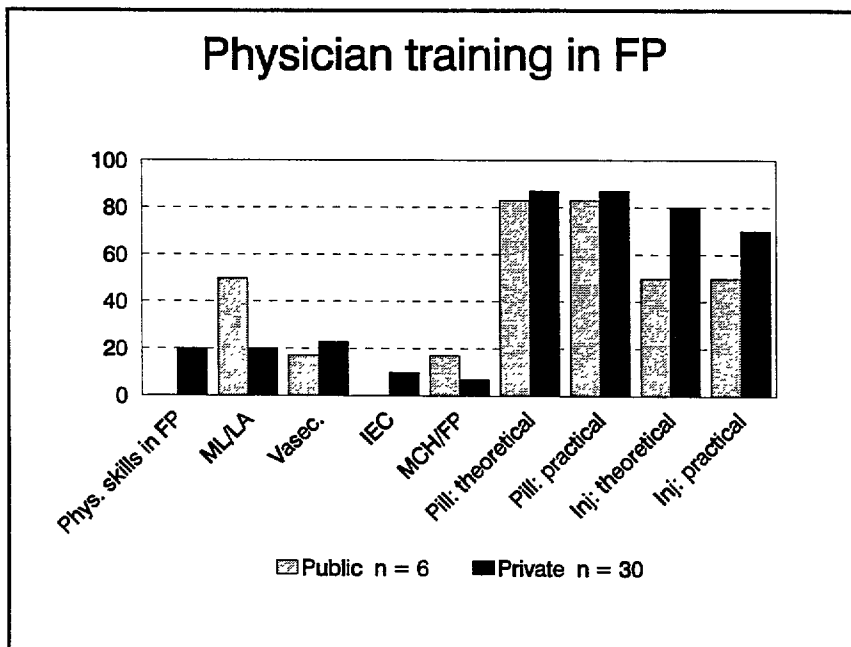
Two general clinical courses are offered to nurses, labeled A and B. Figure 9 shows that in both sectors, the majority of nurses have taken course A (more in the public sector), and about a third have completed course B. Training is relatively high in theoretical and practical aspects of two

common methods - pill and injectable - and is about equal across the public and private sectors. Related issues such as IEC and MCH/FP have not been emphasized in nurse training.

These findings indicate that there is room for improvement in nurse training in Bulawayo. In 1984-5, the government of Zimbabwe established FP requirements for all nursing and midwife students, and embarked on a program to increase the competency

of FP instructors. A 1993 assessment of this program¹⁰ found distinct progress made in pre-service training, but also revealed persistent gaps in nurses' competency-based knowledge. A joint program with ZNFPC, JHPIEGO, and the MOH/World Bank is currently addressing this training need.

Physician training in family planning services



The data on physician training in the public sector are not entirely reliable because only six doctors were interviewed (30 were interviewed in the private sector).

Nonetheless, Figure 10 gives the available data, and shows that the majority of doctors have attended theoretical and practical training in pills and injectables.

Figure 10

and injectables. As for related courses in physician's skills in FP, female and male sterilization, IEC, and MCH/FP, training is quite low.

These data reveal a compelling need for increased physician training in FP. The lack of training in surgical methods is especially critical, since the proportion of long-term method users must rise if the future service delivery burden is to be eased.

¹⁰ Gaffikin, McKenzie, McGrath, and Husman, Pre-service Family Planning Training in Zimbabwe, JHPIEGO Technical Report Number FCA-12, Johns Hopkins University, Baltimore, MD, August 1994.

Staff knowledge of FP

General FP knowledge among staff		
Percent of staff answering correctly		
Question	Public	Private
When should a client start taking COC pills?	75%	68%
When should a client start taking POP pills?	42%	27%
How often should a client take the pill?	96%	92%
If a client forgets to take a pill for one day, what should she do?	83%	65%
When should a client return after an initial injection?	86%	84%
When should a client have a follow-up visit after sterilization?	34%	52%
How can a client check if an IUD is in place?	95%	94%
When should an IUD client return for the first checkup?	71%	73%

Table 3

The moderate levels of staff training are reflected in the general knowledge of methods among staff. All staff were asked a series of questions on various methods, and Table 3 gives the percent answering correctly in both sectors. Although the providers are quite knowledgeable on some points, the overall level of knowledge can clearly be improved.

Staff were also asked about methods they would recommend for clients who wanted to space or limit their births. In both sectors, about 80% of staff mentioned the pill as a

spacing method, about 75% mentioned the injectable, and just under half mentioned Norplant®. Upwards of 90% of staff in both sectors recommended female or male sterilization for limiters. Generally, these recommendations are appropriate, but some responses were unusual: among private providers, 20% would recommend NFP for limiters, and 8% would never recommend Norplant®. Although the present study does not investigate the reasons behind these attitudes, at a recent conference on quality of care in East and Southern Africa¹¹, provider bias was identified as a major barrier to contraceptive use. This conference resulted in a work plan for ZNFPC that includes activities to reduce provider bias.

¹¹ Davis, Improving Quality of Care and Access to Contraception: Reducing Medical Barriers, Proceedings of East and Southern Africa Regional Workshop, JHPIEGO, Johns Hopkins University, Baltimore, MD, January 1994.

Client/service provider interaction

Of the 124 interactions observed, 95 were in public and 29 were in private SDPs. Because the private sample is so small, this section will not disaggregate the data by sector. The vast majority of observed clients (81%) were revisits, either for resupply, regular follow-up, discontinuation, or method difficulties. The remaining 19% of the observed clients were new acceptors.

Client characteristics

The mean age of FP clients in this study is 27.2, and 60% had completed secondary school or higher. This is quite similar to the overall Zimbabwe WRA population as reported in the 1988 DHS, which found the average age to be 28.4 and the level of higher schooling in Bulawayo to be 55%.

Over half of FP clients in this study desire more children, and are interested in spacing methods. Fully 35% do *not* desire more children, a surprisingly high proportion given that long term methods account for only 21% of current contraceptive use in Bulawayo. In the qualitative discussions, women were found to understand FP as child spacing only. This finding suggests that latent demand for long term methods is high, and this demand could be harnessed through client education and responsible promotion of sterilization and IUDs.

Mean parity among these FP clients is 2.4, and all of them have at least one child. This may indicate that women in Bulawayo prefer to demonstrate their fertility before initiating contraception.

About 12% of the FP acceptors are single/never married. This is a reflection of the current policy to offer services to unmarried young adults.

Some women in this sample report strong communication with their partners regarding FP: fully 83% of the FP clients had ever discussed FP with their partners, and 87% of their partners were aware of their contraceptive use. A different picture emerged from the qualitative discussions, however, during which a large proportion of current users reported that their husbands were not aware of their FP use. The groups generally agreed that broaching the subject of contraception is very difficult, and that if a husband disapproves, the woman should adopt FP without his knowledge. Although these results are somewhat contradictory, they clearly reveal some degree of difficulty with spousal communication, and indicate the need for increased male involvement in FP.

Factors considered in selecting an SDP

Women in Bulawayo tend to visit SDPs nearest their homes: 69% of the clients report this to be their main concern in selecting a SDP, a finding that was repeated in the qualitative discussions. Of those who visited clinics further from their homes, about a third simply had other reasons to visit the area. Other motivating factors in this group are the friendliness and trustworthiness of providers and the convenience of services. Very few (9%) are mainly motivated by quality of services. This reveals that proximity to women's residences is paramount in creating convenient services (see 'Geographical distribution and hours of operation' above).

Medical history and examination

The type of medical history taken and examinations performed on clients should clearly differ depending on the client's medical status, reproductive intentions, and method of choice. For this reason, it is difficult to establish a standard set of procedures that should be followed in every case, particularly for revisit clients. A woman does not require a pelvic examination, for example, every time she refills her oral contraceptives prescription. However, for the purposes of this study, the procedures listed in Figure 11 are taken to be a basic standard for new acceptors. For revisits, the 'optimum' level for each procedure is debatable, but some information about quality of care is nevertheless discernable from these data.

The medical history obtained from new clients in Bulawayo is limited. Only 18% were asked about previous experience with FP, and only half were asked if they had concerns about using any method. More were asked about spacing vs. limiting births (72%), breastfeeding status (61%), and method preference (64%). This type of information is particularly important to obtain from every new client. The pattern of other examinations performed on clients is displayed in Figure 11, and it reveals clear room for improvement in examination protocols, particularly for new clients.

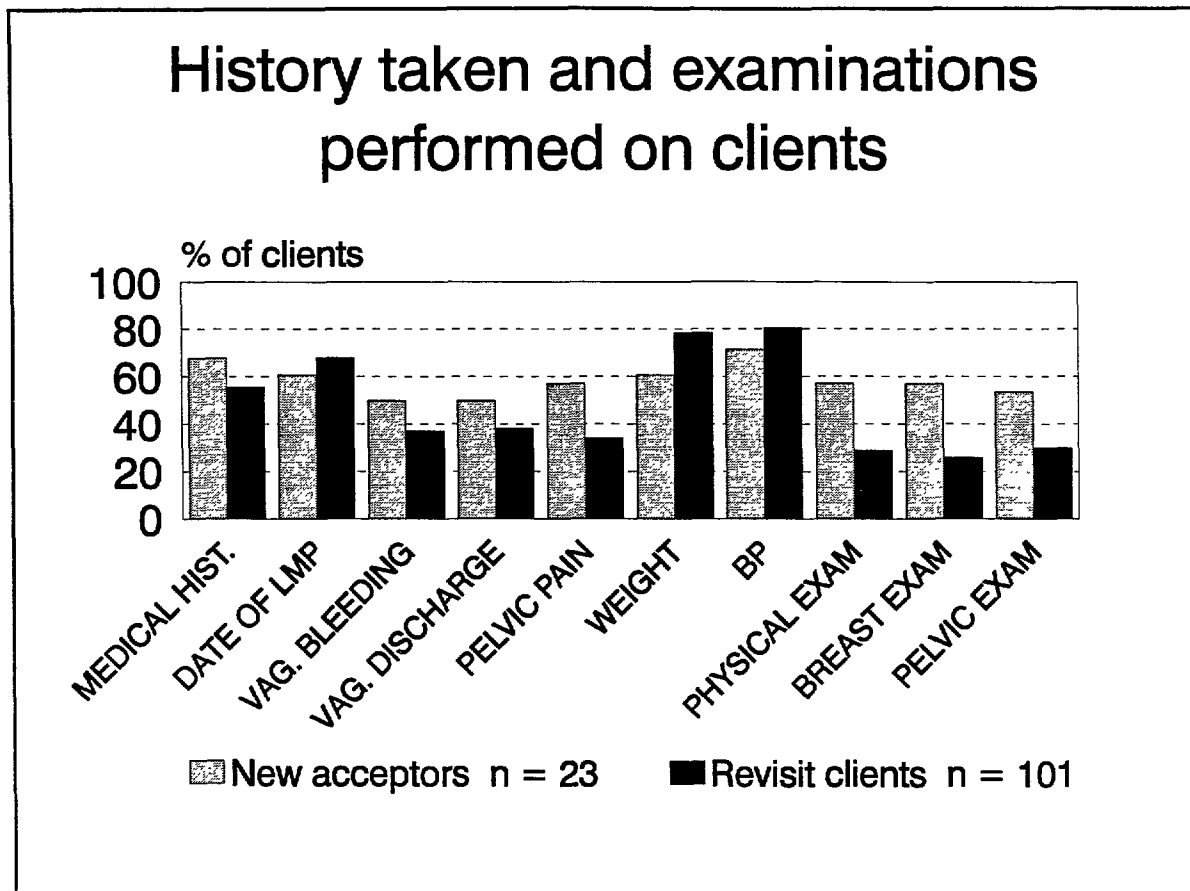


Figure 11

Information about contraceptive methods

The majority of new acceptors receive inadequate counseling on methods. Information about the various contraceptive methods was given selectively; although 75% of providers mentioned the pill, only about half mentioned IUDs, condoms, or injectables¹². Providers gave particularly scanty information to new acceptors: only 33% explained the method clearly, 38% demonstrated its use, and 25% described side effects (at the

¹² This study did not investigate providers' decision-making strategies, but the selection of methods to discuss with a client may reflect the providers' knowledge and preferences as well as the availability of methods at that SDP.

dissemination seminar, participants noted that some providers may be particularly uncomfortable discussing the side effects of some methods). Moreover, only 34% of clients reported to have asked questions about FP, even though the qualitative discussions revealed very limited knowledge among clients about the various methods. These discussions also revealed that women are unnecessarily fearful of FP side effects, and that providers are often condescending or unresponsive to women who report problems or wish to switch methods. All of these findings add up to a lack of support and information given to clients, who are in particular need of just such services.

Follow-up

Only about half of new clients were told when to come for resupply, and 30% were informed about the possibility of switching methods at that time.

Client satisfaction

Despite the shortfalls noted during the observation of the client/service provider interactions, over 90% of clients reported that they had received the information and services they had desired. Fully 90% said the service provider was easy to understand, and 82% were comfortable with the amount of privacy they experienced during the consultation.

Cost sharing

In October of 1992, Zimbabwe officially introduced charges for FP services. Exit interviews with FP clients show that most women seem to accept these charges now, although many view them as too high.

The public sector has standard fees: Z\$1.10 for pills, Z\$0.10 for condoms, Z\$4.00 for Depo-Provera, Z\$42.50 for sterilization, Z\$100 for Norplant®, and between Z\$6.50 and Z\$10.00 for IUDs. Since most of the interviewed FP clients visited the public sector, these are the fees most paid. Private clients generally paid higher fees: up to Z\$2.20 for pills, Z\$1.00 for condoms, Z\$20.00 for IUDs, and Z\$128 for Norplant®.

Most women seem to accept these charges, and will not discontinue their method because of cost. When asked what motivates their choice of SDP, almost no women listed service fees as an important factor. Moreover, 40% generate their own income, which averages Z\$800 per month, and 78% of these working women have complete or partial control over their salaries. Of those who do not generate their own income, 78% rely on their husbands for support. In addition, 71% of the entire sample report that their partners already pay for FP services or would be willing to pay should the need arise. In this light, the public charges for FP are quite modest, and women generally seem to have the means to pay for them.

However, 47% of clients feel that the fees are too high in public clinics, 38% feel they are reasonable, and the rest had no response. Women at the qualitative discussions clarified that the examination fees in particular are high, not necessarily the fees for supplies. They recommended that the examination and supply fees for a FP visit not exceed Z\$10, and that women who are unable to pay should be offered credit or an installment plan.

In general, then, cost does not seem to present a large barrier to services, but the pricing schemes might be altered to accommodate clients. If SDPs find they are not self-sustaining, there may be room to increase supply fees without losing many clients.

Integration of STD/HIV management with FP service programs

Over 85% of SDPs in both sectors offer STD/HIV management along with FP services. Information on AIDS in particular is offered at 96% of public and 78% of private SDPs. However, during the client interactions, STDs and AIDS were only mentioned with 14% of the clients, even though the qualitative discussions revealed quite limited knowledge of STDs among clients. This shows that although policies may favor integration, very little if any has actually taken place.

Staff training in STD/HIV management

Staff attendance at STD management courses is fairly high in Bulawayo. About 89% of providers report that STD/HIV management was included in their basic training, but 31% felt that the time allotted was not adequate. About half of the providers have recently attended an inservice training on STD/HIV counselling or management -- 67% of counselling courses and 45% of management courses took place after 1992.

Staff knowledge of signs and symptoms of STDs

Nevertheless, staff knowledge of STDs is in need of improvement. All staff were asked to list all the STDs they know, and were prompted on some common STDs if not mentioned. Figure 12 gives the results. Although more than three-quarters of providers are aware of gonorrhoea, syphilis, and chancroid without prompting, under

Staff awareness of STDs

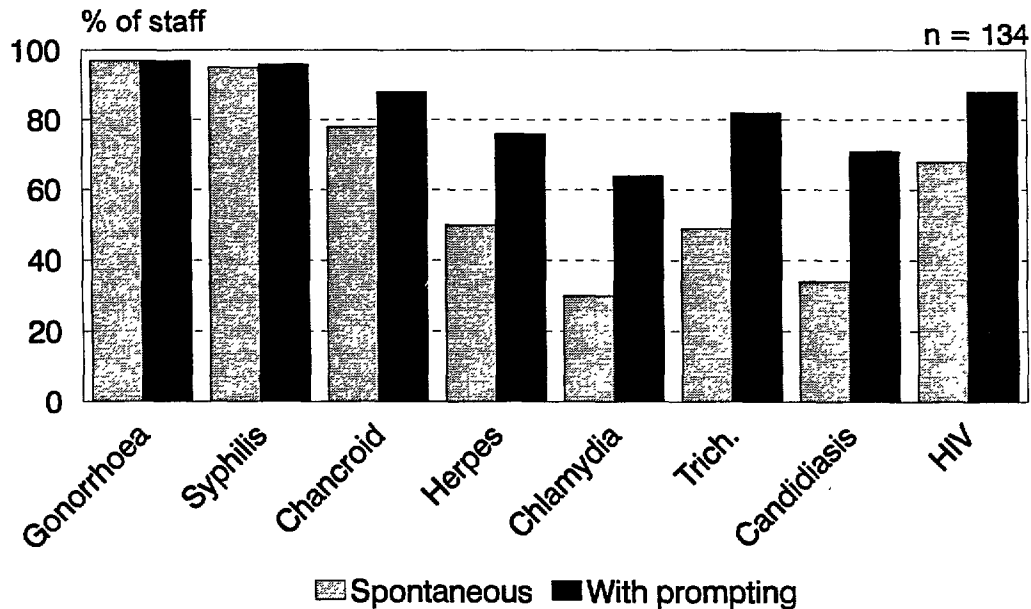


Figure 12

half mentioned herpes, chlamydia, trichomoniasis, or candidiasis. For this latter group of STDs, provider awareness increased with prompting, but did not exceed 82% (trichomoniasis).

The HIV figures are of particular note. Only 68% of providers mentioned HIV spontaneously, and with prompting 88% recognized it as an STD. However, awareness may be significantly higher than recorded here because of the language of the survey question. The interviewers asked providers specifically about STDs, but many providers are trained about HIV separately from other STDs. That is, they may be aware of HIV, but do not immediately classify it as a traditional STD. Since counseling

on AIDS/HIV is offered at 85% of SDPs, it is reasonable to assume that more than 68% of providers are actively familiar with HIV.

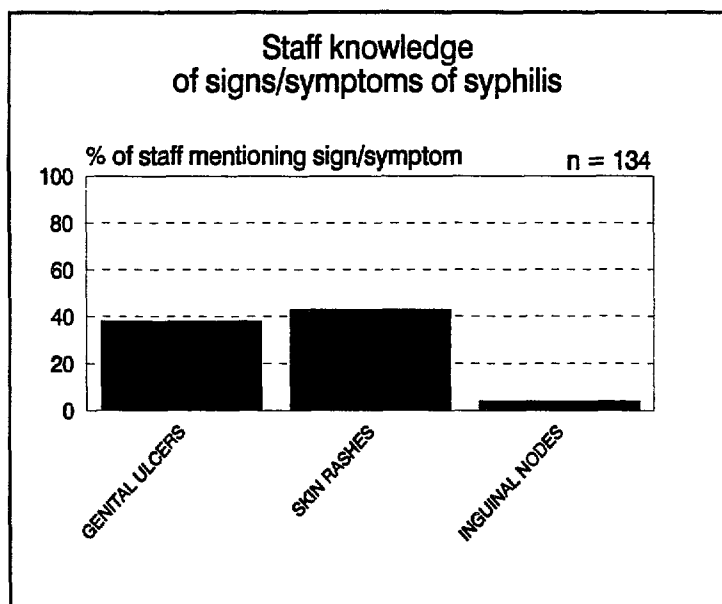


Figure 13

In addition, staff were asked to name the signs and symptoms of certain STDs. Although 96% of the staff are aware that syphilis is an STD, only about half are able to name genital ulcers or skin rashes as symptoms. Enlarged inguinal nodes were mentioned by only 4% of providers (Figure 13). The awareness of signs and symptoms of other common STDs is similarly low.

Psychological barriers to integration

About 75% of providers at SDPs that treat STDs/HIV report that they agree with the policy and practice of treating these clients. However, only half are themselves willing to provide FP to an STD patient, and only 41% are willing to provide FP to an HIV patient. When asked about arguments against integration, 56% offered none, revealing a sizeable base of providers who are not actively against integration. Among those who listed arguments against integration, the most common were cross-infection of clients, increased workload, staff shortage, and the loss of FP clients through stigma and congestion.

These results identify three areas for improvement. First, with increased staff training in STDs, the quality of care will rise, and staff will be more confident in their ability to prevent cross-infections with sanitary measures. Second, client appointments for FP and STDs can be combined so that the workload is not increased substantially. (In fact, many providers argued in favor of integration because it would *decrease* the number of client contacts.) Lastly, public education is recommended to remove the stigma associated with STD clinics.

Appendices

Appendix 1: Distribution of FP clients by selected background characteristics

Background characteristic	Number	Percent
<u>Age</u>		
15 - 19	5	4.0
20 - 24	41	32.8
25 - 29	35	28.0
30 - 34	24	19.2
35 - 39	13	10.4
40 - 44	2	1.6
Missing	5	4.0
<u>Marital status</u>		
Single/never married	15	12.0
Married/monogamous	88	70.4
Married/polygamous	3	2.4
Cohabiting	9	7.2
<u>Number of living children</u>		
1	37	29.6
2	66	26.4
3	51	13.6
4	60	12.0
5	30	4.8
6	30	4.0
Missing		9.6
<u>Reproductive intentions</u>		
Do not desire any more children	44	35.2
Desire more children	72	57.6
Depends on husband	3	2.4
Depends on God	1	0.8
<u>FP discussions with spouses</u>		
Discussed	91	79.1
Husband knows that she is using	96	83.5
<u>Education</u>		
No education	2	1.6
Primary	43	34.4
Secondary+	75	60.0

Background characteristic	Number	Percent
<u>Literacy</u>		
Can read letter in English easily	77	61.6
Can read letter in Ndebele/Shona easily	109	87.2
<u>Religion</u>		
Protestant	21	16.8
Other Christians	43	34.4
Catholic	25	20.0
Traditional	2	1.6
Other	23	18.4

Appendix 2: Inventory of service delivery points in Bulawayo

Municipal (18 SDPs)

Central Clinic
Dugmore*
Emakhandeni
Entumbane
Khami Road Clinic
Luveve clinic
Magwegwe clinic
Mzilikazi
Njube clinic
Nketa clinic
Nkulumane clinic
Northern Suburbs clinic
Pelandaba clinic
Princess Margaret Rose clinic
Pumula clinic
Shennah, Dr., clinic
Tshabalala clinic
Watson, E. F., clinic

Ministry of Health (5 SDPs)

Central Maternity (Lady Rodwell)
Ingutseni Hospital
Mpilo Hospital*
Thorngrove Infectious
United Bulawayo Hospital

ZNFPC (3 SDPs)

Bulawayo Booking
Mpilo
Youth Advisory Centre

Industrial (6 SDPs)

Contton Printers
Merlin Industrial
National Breweries
Supersonic
Workers' Compensation (parastatal)
Zimbabwe Grain Bag

NGO (1 SDP)

Orap clinic

Army (1 SDP)

Headquarters 1 Brigade Hospital

Mission (1 SDP)

Mater Dei Hospital

Private (34 SDPs)

Bashir, Dr.
Bulle, P., Dr.
Celenstel Flats
Chaibva, Dr.
Dhhannbhai, Dr.
Chiwora, Dr.
Dube and Moyo, Drs.
Ferguson, Dr.
Gaibie, B., Dr.
Gazi, Dr.

Gordon, P. R. G., Dr.
Hodges, Dr.
Kalsheker, Dr.
Kings Polyclinic
Manolakakis, J. J., Dr.
Maphasa, Dr.
Maternal Child Health
Mbengegwe, Dr.
McNair, Dr.
McNally, Dr.
Mkwanzani, Dr.
Msimanga, G. M., Dr.
Mthupha, G., Dr.
Mugabe, Dr.
Munyoro, Dr.
Museta, Dr.
N, Dr.
Naik, Dr.
Ndlovu, A., Dr.
Patel, H. A., Dr.
Phiri, Dr.
Qamar, Dr.
Queens Park Surgery
Tatz, Dr.

Pharmacies
(25 SDPs)

Atlas
Bradfield
City Pharmacy - 1
City Pharmacy - 2
Dae & Nite
Emergency
Family
Geddes*
Highfield
Hillside
Justin Smith
Lancaster
Medlink
Northend*

Plus 2
Plus Care
QV - 6th & Fort
QV - Fife Street
QV - Selbourne
R. J.
Standard
Sunnyside - 1
Sunnyside - 2
Tees - 1
Tees - 2

CBDs
(16 SDPs)

Bepete, F.
Bulle, J.
Gumede, S.
Jemma, J.
Katapa, M.
Lungu, E.
Mpokosa
Mudara
Muhomba, A.
Mutsasa
Ndlukula, L.
Nkhomo, M.
Pfende
Sibanda, C.
Sibanda, N.
Tasara, P.

Appendix 3: Report of the Bulawayo dissemination workshop

Note: Table references in this appendix do not match table numbers in the main text.

Zimbabwe National Family Planning Council one-day dissemination workshop on the Bulawayo Urban Family Planning Study, 27th September, 1994, Bulawayo Sun Hotel, Bulawayo, Zimbabwe

Officially opening the workshop, Dr. Dlodlo, (Deputy Medical Director) welcomed workshop participants and thanked ZNFPC and its partners for having selected Bulawayo as a study site. She highlighted the importance of periodically measuring program performance and the duty of technical staff to provide the society at large, press and politicians with the correct information and guidelines on the family planning program. She said this was essential especially in view of the fact that FP also touches on intimate issues such as reproductive rights and is, from time to time, subjected to agitation, emotional turmoil and press headlines which are in most cases, misleading.

The morning session was chaired by the ZNFPC's Provincial Manager, (Matabeleland North) Mr. H. Soganile.

Mr. David O'Brien (SEATS), briefly outlined the purpose of the workshop. Specifically, the objectives of the workshop are:

- (i) To disseminate the study findings to Bulawayo health officials and ZNFPC management;
- (ii) To discuss the findings with an aim of providing meaningful interpretations of the data; and
- (iii) To generate practical recommendations from the data and discussions for intervention purposes.

He went on to explain that Bulawayo City is one of the four cities in Africa where such studies have been conducted by the Centre for African Family Studies (CAFS) in conjunction with respective family planning organisations. Other cities participating in similar studies are; Dakar, in Senegal, Mombasa, in Kenya and Blantyre, in Malawi. These studies were carried out to assess the impact of the rural-urban migration on family planning services in urban areas. The rationale for urban FP Situation Analysis studies is that, without efficient and effective family planning programs, cities experiencing increased urban migration rates will be severely strained in terms of family planning service provision.

Mr. O'Brien's presentation consisted of the following graphs:

- Urban population growth by region
- Percentage of total population in urban areas in sub-Saharan Africa
- Contraceptive users by the urban population in sub-Saharan Africa
- Contraceptive users urban population in sub-Saharan Africa compared to urban areas in other countries.

Next to present was Mr. L. Ndlovu of the Population Council, who explained that the Bulawayo FP study adopted the Situation Analysis methodology. This methodology has been in use since 1989 and is widely accredited to the Population Council. The methodological approach investigates the problem of why people are not using family planning services not only from the demand side but by also assessing the supply side, that is, assessing the availability, functioning and quality of family planning services at a representative sample of Service Delivery Points (SDPs).

Ms. Ojermark (SEATS, Harare) explained the trends from the Bulawayo family planning service statistics. The data showed that while oral contraceptives were still dominating, the program was improving in terms of the use of injectables and other long term and permanent methods.

Mr. B. Dlodlo (ZNFPC) described the training of six teams of interviewers which lasted 10 days. The following instruments were administered during the data collection.

- SDP inventory
- Staff interviews
- Observation guide
- Exit interviews
- Female MCH clients
- Pharmacy module

Field work lasted for 10 days. Three teams covered hospitals and clinics, and one team each covered private doctors, pharmacies and CBDs. For quality control assurance, there were field visits by survey supervisors throughout the data collection period and also there were daily meetings by survey teams and their supervisors. Altogether the following activities were carried out:

- 23 pharmacies were visited
- 67 service delivery points were visited
- 160 female MCH clients were interviewed
- 125 observations carried out
- 134 staff were interviewed

The following are comments made by participants during presentation of findings:

Status of facilities and management systems

Table 1: Distribution of Service Delivery Points (SDPs) visited by type

The conclusion that 60% of the health care services are provided by the private sector in Bulawayo should be revisited since the number of private sector medical practitioners may not necessarily reflect the magnitude of family planning services offered, i.e. there maybe comparatively fewer public sector family planning facilities which attend to the majority of the people.

Table 7: Availability and Status of Medical Examination Facilities

The statistics on "privacy" was said to be worrying and needed revisiting. Also participants were not convinced by the data on the separate room for breast/pelvic examinations since, in reality, there are no separate rooms for these examinations. The provider/consultant examines their clients in the same room. There was, therefore, need to explain this category or revisit the data.

Tables 14 and 15: Frequency of Reported FP Supervisory visits and What Supervisor does during Visits

Participants suggested that the FP supervision issue should be restricted to the public sector since, as far as the private sector practitioners are concerned, the supervisory issue is not relevant.

CBD component

It was apparent that CBDs counselling skills needed improvement. However, participants suggested further analysis, if possible, of the socio-economic characteristics of the CBD clients so as to get some further insight on the type of clients who prefer CBDs' services.

Pharmacy component

Participants felt that it would be of importance to have information on the qualifications of the pharmacy staff interviewed/visited. Presenters were also asked to verify whether pharmacy staff inject clients with Depo at these outlets or they only dispense injectables to clients for doctors to administer. This information would assist in implementing some interventions.

Service provider/client interactions

Table 3A: History taken by Service Providers to Revisits

The analysis portrayed in this table is not clear. Also it would be necessary to include the number of observations for the public and private sector separately.

Table 5: IEC Materials used during consultation

On IEC materials, participants suggested that there is need to revisit the base in order to enable meaningful recommendations. It would be better to separate those facilities with IEC materials from those SDPs without in order to analyse the use of these materials accurately.

Profiles of staff interviewed

Table 6: Service Providers Recommending Different FP Methods for Clients with Different Contraceptive Needs

Although the findings of the study indicate that the majority of staff interviewed were trained in family planning, there appears to be need to increase follow-ups and supervision of staff in order to make sure that staff put into practice what they were trained in and to update them on new family planning technologies. This need was evidenced from study findings of significant percentages of staff who were not adequately counselling clients. For example, some of the service providers interviewed said they recommended IUDs for limiting births while others were not making use of available IEC materials, some were not asking new acceptors all the necessary questions during their first visits, etc..

The afternoon session was chaired by the Deputy Director, Administration and Finance (ZNFPC) Mr. N.C. Kazuva and it started off with group discussions. Participants were divided into 4 groups.

The following were group presentations which followed thereafter:

Group 1: The status of SDPs and management systems

1. Mapping information is required to better assess the distance travelled by clients to the SDPs, access the SDPs, proximity of SDPs and the distribution of FP services within the City.

2. Comparisons of these findings with the 1992 Bulawayo subset of the Situation Analysis is required. Table 2, weekend service coverage or evening coverage is poor for employed women in the public sector. Table 3 is not clear.
3. A working group composed of Bulawayo City Health, Ministry of Health and Child Welfare, ZNFPC and the private sector could be constituted to review findings and recommendations from the study. However, participants felt that this can be considered only after findings have been disseminated to the Bulawayo City Health Directorate.
4. It is not clear what is referred to as "family planning promotional materials". The use of sample contraceptives and promotional information (brochures, flipcharts) is low. IEC materials should also be distributed to the private sector SDPs. The distribution of IEC materials to public facilities should be intensified.
5. There is no need of separate rooms for breasts/pelvic examinations. Sites with curtains and room dividers should be looked into for improvement so as to insure auditory privacy.
6. Location for examining clients' BP is not an important factor for quality.
7. Basic equipment lacking/not adequate e.g. BP machines. It is necessary to distribute basic equipment required as a corrective measure.
8. Family planning methods provided: the figures for condoms and pills (POP) provided by the private sector is not convincing - suggests a revisit. Depo Provera should be made available in all public sector SDPs. More information is needed on private sector prescription and administration of Depo Provera. All column headings should indicate the number of interviews/observations carried out.
9. According to the Drug Council regulations, doctors within 5 kms of a pharmacy are not allowed to stock drugs. ZNFPC facilities should explore the possibility to honour prescriptions of clients from private doctors.
10. Record Keeping: table on record keeping should be revisited since the private sector does not keep clients' FP records as separate record from other medical records, that is, the private sector has generic records.

11. ZNFPC should explore ways of obtaining/collecting service statistics from the private sector.
12. Table 16: Other Reported Services Available at the SDPs, should be disaggregated further into hospitals and clinics.

Group 2: Human resources available to service family planning programs

1. There is need to increase the proportion of service providers trained in the full range of contraceptive methods (training should be relevant to concerned SDPs selected according to need).
2. There is need for updating service providers on changes in FP technology.
3. Service providers need in-service training in matching reproductive intentions with appropriate contraceptive methods.
4. The data in Table 8, of the staff component seem to indicate that there is need for post-abortal services in Bulawayo. In view of the above, there is need to investigate the underlying factors and institute appropriate interventions from these findings. It is however, not possible to get the actual number of women requiring post-abortal medical treatment from these findings.

Group 3: Client/service provider interactions

1. There is need to standardize the definition what a "new acceptor" was because it seems new acceptors were not those clients who have never used family planning methods.
2. Service providers need refresher courses, follow-up and supervision in order to update and strengthen their counselling skills. This is due to the fact that all questions listed in Table 3 are very important issues to be addressed with new acceptors yet a significant number of providers did not address these issues. It is recommended that the use of checklists be emphasized. Perhaps, there is need to design chart/poster which should put on the wall to guide service providers as they interact with clients. Maybe Table 3A could be more meaningful if the denominators of both the private and public sectors were stated and utilised for analysis.

3. **Table 4: Client - provider information exchange**

Most of the information exchange was on the pill. Side effects, generally, are seldom mentioned - this could be attributed to the fact that service providers are not comfortable to talk about side effects of some methods. This could be an indication of need for further family planning training.

4. **Table 5: IEC Materials used during Consultation**

The lack of use of IEC materials could have been due to:

- IEC materials unavailability
- Service providers were so busy that they could not use IEC materials.

5. **Table 6: Medical History and Examination**

The conclusion for Table 6 is not convincing since the table shows that a significant number of service providers do not perform all the examination they are expected to do.

6. **Table 7 and 8: Contraceptive Methods given to New Acceptors and Client Follow-up Information Provided to Clients during Consultation**

Short term methods are still being promoted and information given to new clients is insufficient.

7. **Table 9: Distribution of any other Health Issues Discussed during Interaction**

There is need to work out when the distribution of any other health information can be done because not all clients may be willing to listen to other issues which are not related to the purpose of their visit to the SDP.

Group 4: Other FP service delivery approaches

1. **Cost sharing and cost recovery issues:**

Charging of the pills gives value to the commodity. However, contraceptives should be offered free of charge to those who cannot afford.

Encourage medical insurance companies to pay for FP services. (This is already in place).

Private sector involved in work - based FP services can buy FP methods for their employees. ZNFPC is considering allowing direct purchases by the private sector whose medical staff is trained in family planning on the condition that, in turn, the private sector agrees to provide ZNFPC with service statistics.

2. Integration of HIV/AIDS/STDs management in FP programs

Training of peer educators dealing with smokers and people in industry (this has been going on in Bulawayo for 4-5 years).

Program involving school teacher approach to children about sexuality should be instituted.

ZNFPC is conducting an operational research to find ways of providing reproductive health services to the youth.

In her closing remarks, Dr. Moyo, Deputy Director, Programmes (ZNFPC), thanked participants for their attentive and fruitful discussion throughout the day. She also pointed that it was gratifying to note that private sector involvement in the provision of FP services in Bulawayo is high.

List of participants

Compiled by: MS. H.M.B. DUBE (ZNFPC - Research Officer)

Dr. A.F. Zinanga, Executive Director, ZNFPC
Dr. J.B. Moyo, Deputy Director, Programmes, ZNFPC
Mr. N.C. Kazuva, Deputy Director, Admin. & Finance, ZNFPC
Mrs. C.S. Marangwanda, Head of ERU, ZNFPC
Mrs. T. Nhliziyo, Chief Nursing Officer, ZNFPC
Mr. A. Phiri, Research Officer, ZNFPC, Rapporteur
Ms. H.M.B. Dube, Research Officer, ZNFPC, Rapporteur
Mr. B.H. Dlodlo, Computer Programmer, ZNFPC
Ms. Bopoto, Mass Media Manager, ZNFPC
Mr. H. Soganile, Provincial Manager, Mat. North
Mrs. G.N. Dube, Training Officer, ZNFPC, Mat. North
Ms. I. Tawodzera, Sister In-charge, ZNFPC, Mat. North

Mr. Zwambila, Regional Education Officer, ZNFPC, Southern Region
Mr. W. Ngulube, IEC Officer, Mat. North
Dr. Dloido, Deputy Medical Director, Bulawayo City Health
Dr. F. Ndlovu, Asst. Director, Bulawayo City Health
Dr. C.Y. Saunders, Venereologist, Bulawayo City Health
Mrs. V.P. Easton, Chief Nursing Officer, Bulawayo City Health
Mrs. G.R. Dube, Deputy Chief Nursing Officer, Bulawayo City Health
Dr. Hodges, Private Doctors Representative, BYO
Mrs. D. Dlamini, Nursing Sister, Posts & Telecomm., BYO
Mrs. S. Maseko, Community Nursing Officer, Clay Products Bulawayo
Mrs. Nyoni, Nursing Sister, TD Holdings
Ms. T. Nheta, Programme Officer, UNFPA, Harare
Mr. L. Ndlovu, Associate, Population Council, Nairobi
Mr. I. Muvandi, Programme Officer, CAFS, Nairobi
Ms. M. Mujomba, Asst. Progr. Officer, CAFS, Nairobi
Mr. D. O'Brien, SEATS, Washington D.C.
Mrs. M. Ojermark, Acting Regional Director, SEATS, Harare
Mr. L.W. Kangas, Resident Technical Advisor, Africa Bureau USAID,
Washington, D.C.
Ms. R. Rogers, Family Planning Officer, USAID, Harare
Mrs. I. Moyo, Provincial Nursing Officer, MOH

Appendix 4: Report of the Bulawayo guided group discussions

Methodology

Four guided group discussions (GGD) with current contraceptive users and non-users and three individual interviews with politicians were conducted and this constituted the qualitative component of the Bulawayo Urban Situation Analysis study. In all, 38 females aged between 16 and 45 years participated in the group discussions. The themes for the GGDs included family planning knowledge, attitudes and practices, fertility decisions, quality of services, STDs/HIV/AIDS and cost sharing.

Data collection

The Centre for African Family Studies' researcher spent one afternoon training two of the study supervisors on the techniques of moderating guided group discussions. Each of these two supervisors was accompanied by two note takers. The four note takers were selected among the best research assistants recruited for the study. Before the guided group discussions were conducted, the note takers were briefed on their role and the importance of taking notes verbatim.

The individual in-depth interviews were conducted by the CAFS researcher and the Zimbabwe National Family Planning Council's (ZNFPC) Evaluation and Research Unit (ERU) staff member seconded to the project.

Recruitment of guided group discussion participants

The teams which conducted guided group discussions liaised with service providers at three service delivery points namely Pumula, Mpopoma and Mpilo to recruit participants for the group discussions. The group discussions were conducted at these clinics. The clinic staff were given selection criteria for the participants which included contraceptive use status (current users and non-users), age and educational background. In all, there were four guided group discussions, two with non-contraceptive users and the other two with current contraceptive users. The table below shows the composition of guided group discussion participants.

Composition of guided group discussion participants

Venue	Contraceptive use status		Age	Number
	Users	Non-users		
Mpilo O.P.D		X	16 - 38	10
Mpilo Maternity		X	18 - 24	8
Pumula	X		22 - 45	9
Mpopoma	X		22 - 37	11
Total				38

As is observed from the this table, the age ranges of the participants is quite large with a possibility of militating against open and free interaction among the participants. However, the supervisors who were the moderators convinced the researchers that discussions normally proceed well within such age ranges. Most of the discussions took between one and one and half hours.

Selection of individual in-depth interviewees

The ZNFPC Bulawayo's provincial manager made all the appointments with the local politicians to schedule interviews. Unfortunately, most of the politicians did not meet the appointments. In all, we interviewed four politicians, all of them councilors.

Discussion topics for guided group discussions

Of major interest was to find out why the non-users are not using any form of contraception and for the current contraceptive users, we wanted to find the motivations for contraception. The other reason for conducting the GGDs was to try and find some explanations to the quantitative component of the study. The GGD guide was centred around the following topics:

- Family Planning Knowledge, Attitudes and Practices (KAP)
- Fertility Decisions
- Quality of Services
- STDs/HIV/AIDS
- Perceived Characteristics of a Good Place/Clinic to Receive FP Services
- Cost Sharing

Findings

Family planning knowledge, attitude and practices

Group discussion participants were asked what they understand by the concept of family planning. Family planning was defined in various ways but it came out clearly that contraceptive users and non-users understand family planning to mean child spacing. However, some participants perceive family planning to be a way to prevent or avoid having children. Both current contraceptive users and non-users know the majority of family planning methods available on the market. In all the four groups, participants mentioned the pill, injectable, the loop, condom, female and male sterilization, Norplant, traditional methods and natural family planning. However, the methods cited by the majority of group participants were the pill and the injectable. Sterilization was less known among the non-users. For those who had heard about sterilization among the non-users, they did not know under what circumstances sterilization could be performed as a method of family planning.

Some of the participants among the current contraceptive users mentioned the injectable as a method of contraception but they did not know the specific name of the injectable neither did they know its duration of effectiveness. The loop was mentioned but some participants among the current users reported that this method is not satisfying because they have heard (rumours) that it can come/fall out anytime.

Participants from all the four groups approved use of family planning by women in Bulawayo. The major reasons cited for approving use of family planning by women in the community were:

- The woman will be able to look after the children so that they grow well;
- To give mothers a rest in between pregnancies; and
- There is population explosion in Zimbabwe.

Non-contraceptive users were asked whether they approve use of family planning by themselves and/or their partners. Participants in both groups approved use of family planning by themselves and/or their husbands. Non-users were also asked about the reasons for non-use. One woman reported that she was previously on contraception but she experienced side-effects with the injectable. A majority of the non-users reported that they were not contracepting because they had young babies. The encouraging observation was that most of the current non-users intend to use contraception in the future. The participants were asked what contraceptive methods they would use if they choose to contracept in the future. The responses were mixed with some reporting that they will use the pill while others reported that they are not sure of the method they will use.

Some women reported that they are not contracepting because contraceptives are associated with side-effects. Some of the side-effects cited were that:

- Family planning causes high blood pressure;
- FP causes infertility;
- FP causes excessive weight gain;
- FP causes abnormal babies;
- The loop can remain inside the womb or vagina since it is a rubber, it will float inside and cause diseases;
- The loop causes big stomach and abnormal pain; and
- Condoms sometimes burst and a woman gets pregnant.

Fertility decisions

Both current contraceptive users and non-users were asked whether their partners approve their use of family planning. Among current users, almost equal numbers reported that their partners approve and do not approve their use of family planning respectively. The ultimate decision on the use of family planning, the number of children and the timing of births all rest with the male partner. Among the current users, one of them had had a tubal ligation without the husband's knowledge. The women felt that although it is the male partner who makes ultimate reproductive decisions, the women themselves should take the initiative to discuss reproductive issues including family planning and then seek approval/permission from their partners. Still some women felt strongly that women should make the final decision vis-a-vis use of family planning because they are the ones who carry the pregnancy.

Participants were also asked if they ever have discussions on family planning issues with their spouses. Some women said that they do not discuss family planning issues with their partners may be due to the fact that they do not know how the partners would react. Other participants felt that if a woman feels that there is need for her to use family planning, she should initiate the discussion with the male partner until he agrees. However, the women who shared this opinion reported that in order to initiate such a discussion, women have to be very brave. There was a feeling among participants that if the male partner does not agree, then the woman should adopt contraception without the spouse's knowledge. Only a few participants reported that they make joint reproductive decisions with their spouses.

Women were also asked if there was sex preference for children in the communities in which they live in Bulawayo. Generally, participants agreed that these days there is not much of sex preference for children. It was observed that this can happen when there are only sons in the family that mothers pressure for daughters and vice versa. This observation cuts across users and non-users.. However, there were still some women

who felt that there was still some sex preference due to adherence to traditional values. It came out that traditionally, first borns should be boys otherwise the woman would be divorced. A number of marriages have been dissolved due to this sex preference for children especially sons.

Quality of services

Non-contraceptive users were asked what their preferred source of family planning services would be if they decide to contracept in the future. The sources cited were local clinics, private doctors and community based distributors (CBDs). Women seem to prefer their local clinics because of their nearness to their homes.

With regards to the perceived quality of family planning services offered at the local clinics, current contraceptive users reported that generally family planning services are of good quality. However, it was pointed out that there was need for improvement of the attitudes of some service providers particularly when clients come back with problems when they are contracepting. Because of the negative attitudes towards family planning by some service providers, they accuse clients of not saying that the problems are caused by the contraceptive being used¹³.

Some service providers were reported not to be keen on switching clients from one method to another. The participants who reported this felt that interactions in such situations are more of interrogation than consultations.

To enhance the quality of services, women cited the following areas as needing improvements:

- Clients wishing to change method should be respected without interrogation;
- If a client has a problem, the problem should be thoroughly addressed without being unnecessarily brushed aside; and
- Counselling should be done as necessary.

Some current contraceptive users complained of long queues hence long waiting times. Most of the users were satisfied with the quality of service because they had never experienced any problems related to contraceptive use.

Women were asked what they would want to see improved in the clinics from where they get health services. Some of the women reported that clients should be free to change methods,

¹³ The example cited were clients complaining of problems like headaches and bleeding while on the pill.

Clients' problems should be thoroughly attended to and examination fees should be reduced. A number of women also reported that there should be separate queues for family planning in order to cut on waiting time.

STDs/HIV/AIDS

This was very unstructured in the moderators guide to the extend that it was only discussed in three of the four groups. The discussion was basically intended to get the extend to which women know about the different types of sexually transmitted diseases, their signs and symptoms and their modes of transmission.

Very few women know the different types of STDs. Those who could mention some STDs mostly mentioned gonorrhoea, syphilis and HIV/AIDS. Otherwise any STD is referred to as "Siki". Only a few women know the signs and symptoms of the different diseases that they mentioned. It was observed that women generally know the signs and symptoms associated with HIV/AIDS. The mostly cited mode of transmission for the different types of siki was sexual intercourse.

Perceived characteristics of a good place/clinic to receive FP services

Guided group discussion participants were asked what they consider to be the characteristics of an ideal clinic/place for them to receive family planning services. Over and above nearness to their homes, participants cited the following as the characteristics of an ideal clinic/place to receive family planning services:

- If there is a contraceptive method of choice, clients should be given what they want;
- Nurses should be kind, patient and be able to give advise; and
- Nurses should learn to give instructions without being harsh and facilitate discussions with clients.

Cost sharing

All contraceptive users for contraceptives in Zimbabwe. However, any person who cannot afford is not supposed to be denied the services. Generally, users are willing to pay for the contraceptives they are using. However, women reported that they should not be refused contraceptives when they are unable to pay..rather they feel they should be asked to pay over a period of time.

Most of the non users also reported that they would be willing to pay for family planning services as long as they are affordable. Current users reported that the examination fees should be reduced and clients should be allowed to have credits on these fees.

Most of the women felt that the examination fee plus the cost of the method should not exceed Z\$10 because it would not be affordable especially given the high cost of living in the urban areas.

Individual in-depth interviews with politicians

The politicians interviewed were quite mature with the youngest of them being aged 47 years. By virtue of their ages, these politicians had achieved their desired family sizes. The politicians interviewed had 2, 3 and 6 children respectively. When asked what they perceive to be the ideal family size in Bulawayo, the three politicians reported exactly the number of children that they had themselves. The reasons cited for the number of children reported to be ideal included the following:

- Some children may die;
- Parents need company;
- That number of children is manageable;
- Children themselves need company of their siblings; and
- Economics of child rearing.

The politicians defined family planning as planning one's family so that one lives without worries. All the respondents reported that they approve of the whole idea of family planning. The major reason cited by politicians for approving use of family planning was for every individual family to be able to provide basic needs to their children.

Interestingly enough, the politicians are very conversant with all the different family planning methods. One of them even went on to cite the female condom and breastfeeding as contraceptive methods. One of the politicians recommended use of the condom especially by young people because of AIDS. Although the contraceptive pill is the most widely used contraceptive in Bulawayo, one politician reported that she will never recommend it because it causes some problems in the long-run.

All the politicians agreed that family planning is a priority in Bulawayo and that the City of Bulawayo allocates resources to the family planning program activities. In the majority of cases, the resources are from donors but they are controlled by the local authority which then allocates some of these to family planning activities.

The politicians were asked what they perceive to be the factors that affect the use of family planning in Bulawayo. Cultural resistance, ignorance and general lack of education were cited as the major factors militating against use of contraception. Cultural hold and ignorance were reported to be the major factors for the older generation especially those aged 30 years and above.

Education through the media, family planning education in school, programs with commercial sex workers and the use of tax incentives were cited as issues which can potentially increase the utilization of family planning services in Bulawayo. With regards family planning education in schools, one politician recommended that it should start at the age of 12 years.

Of interest to note was that all the politicians were fully aware of the negative consequences of large and growing populations on development. Another important issue is that the population variable is fully integrated into all aspects of development planning in Bulawayo.

Major conclusions and recommendations

The following are the major conclusions and recommendations emanating from the qualitative component of the research:

- Women in Bulawayo understand family planning mainly to mean child spacing. However, with the early age at marriage, child spacing alone would have a limited demographic impact. It is therefore recommended that programs be designed which encourage the adoption of a small family size norm in Bulawayo.
- Women in Bulawayo (including current users) are generally aware of family planning methods especially the pill but, the quality of the information/knowledge pertaining to these methods is very limited. We therefore recommend that during consultations, service providers discuss all contraceptive methods detailing their advantages, disadvantages and side-effects. This will facilitate informed choice on the part of new acceptors and possible method switching for continuing users.
- Some women do not use contraception because of fear of perceived side-effects associated with contraceptive use. There should be information, education and communication (IEC) programs to counter some of the myths and misconceptions associated with contraceptive use.
- In Bulawayo, like the rest of Zimbabwe, male partners are the ultimate decision makers vis-a-vis reproductive issues. At the same time, limited number of sexual partners ever discuss family planning issues. It is therefore recommended that family planning programs be developed which increase the involvement of men in family planning issues.
- The major consideration in choosing an SDP for family planning service is the distance from the SDP to the client's home. Given that CBDs bring the services

to the door-step of the clients, it is recommended that the ZNFPC together with Bulawayo city health department review the CBD activities in Bulawayo with a view to enhancing its effectiveness.

- The quality of services offered at the SDPs in Bulawayo is generally acceptable but there is still room for improvement especially the attitudes of some service providers towards contraceptive method switchers and those with problems.
- Generally, women in Bulawayo are willing to pay for contraceptive services as long as the prices are affordable. Current contraceptive users feel that the cost of examination is too high. Users feel that the examination fees plus the cost of the method should not exceed Z\$10.¹⁴
- Knowledge of STDs/HIV/AIDS among some Bulawayo women is quite limited. Knowledge levels of the signs and symptoms of the STDs (known as Siki in Ndebele and Shona) are even lower. To facilitate integration of these services into family planning services, more information pertaining to sexually transmitted diseases should be provided to clients during group talks at clinics and any other possible fora.
- Some politicians in Bulawayo recognize the importance of family planning and they could be effective supporters of family planning activities if they are genuinely mobilized.

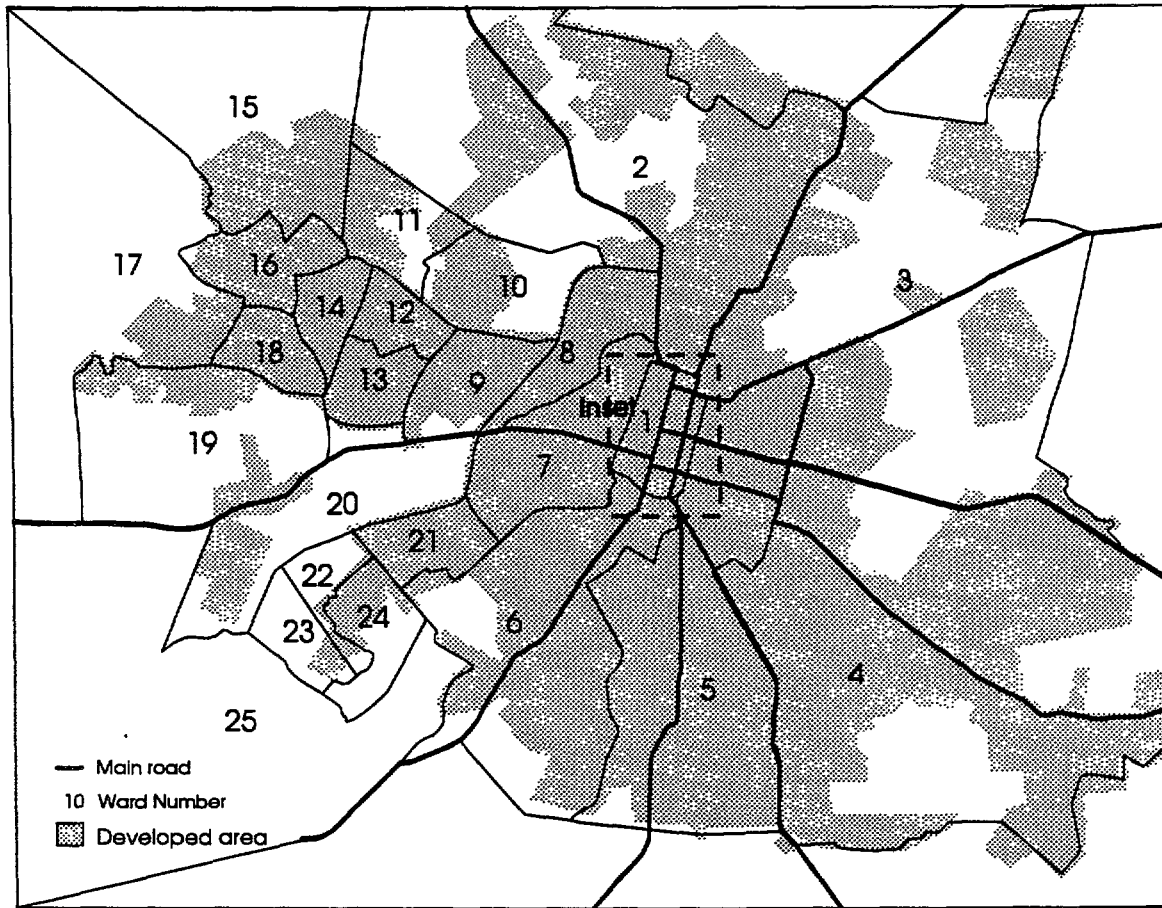
Addressing the above gaps, it is hoped, would get a long way in improving the quality of family planning services, increased contraceptive prevalence and ultimately fertility reduction in Bulawayo.

¹⁴ The exchange rate at the time of the study was 1USD = Z\$8.

Appendix 5: Maps of Bulawayo

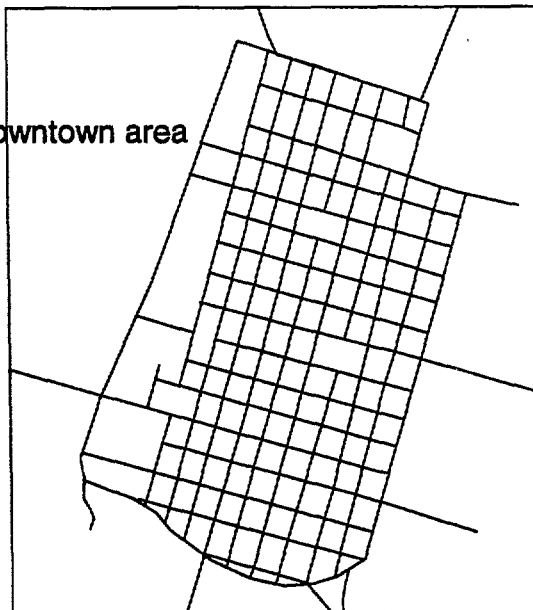
- Map 1: Ward boundaries in Bulawayo, Zimbabwe**
- Map 2: Density of women of reproductive age in Bulawayo, Zimbabwe**
- Map 3: SDP location and WRA density in Bulawayo, Zimbabwe**
- Map 4: Municipal clinic location and WRA density in Bulawayo, Zimbabwe**
- Map 5: Federal clinic location and WRA density in Bulawayo, Zimbabwe**
- Map 6: Private clinic location and WRA density in Bulawayo, Zimbabwe**
- Map 7: Pharmacy location and WRA density in Bulawayo, Zimbabwe**
- Map 8: ZNFPC, NGO, and Mission clinic location and WRA density in Bulawayo, Zimbabwe**
- Map 9: Industry and army clinic location and WRA density in Bulawayo, Zimbabwe**
- Map 10: SDPs of all types in the downtown area, Bulawayo, Zimbabwe**
- Map 11: SDPs open after 5pm and WRA density in Bulawayo, Zimbabwe**

Map 1: Ward boundaries in Bulawayo, Zimbabwe

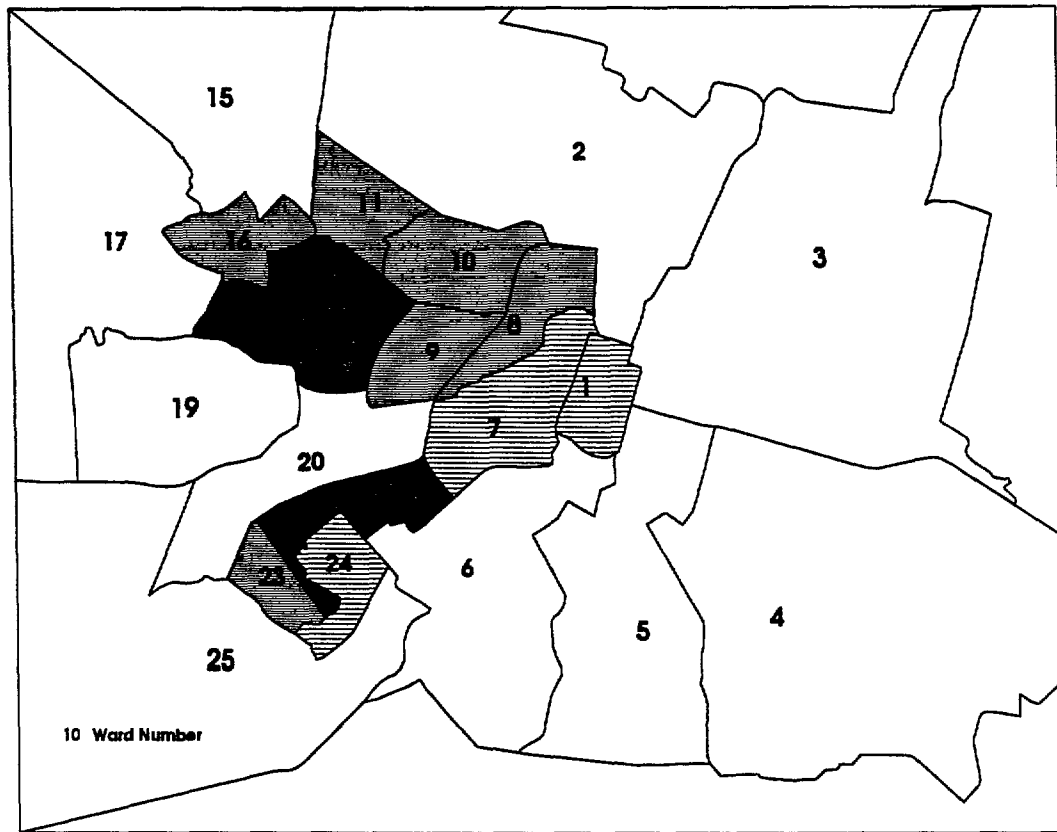


Scale: 1 in = 7.100 km

Inset: Downtown area



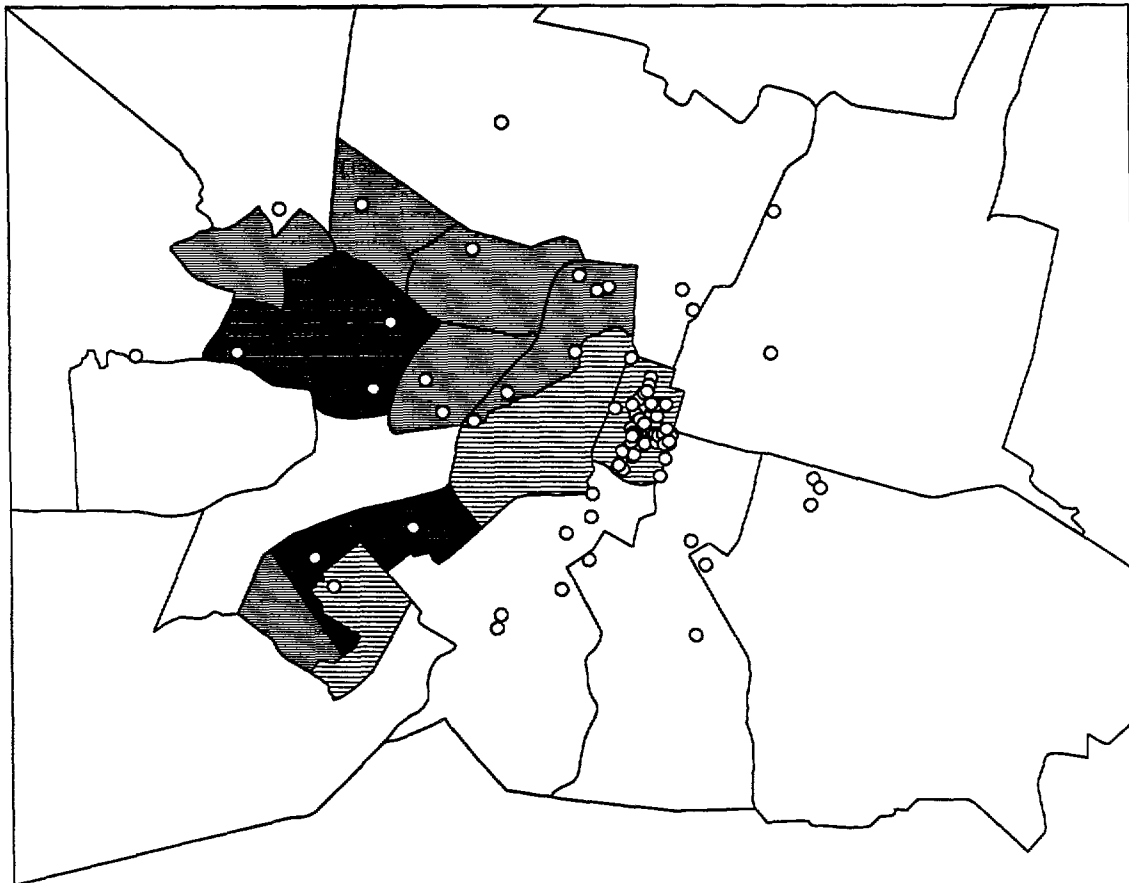
Map 2: Density of women of reproductive age in Bulawayo, Zimbabwe



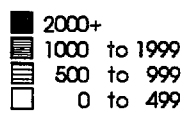
WRA per km²

- 2000 +
- ▨ 1000 to 1999
- ▤ 500 to 999
- 0 to 499

Map 3: SDP location and WRA density in Bulawayo, Zimbabwe

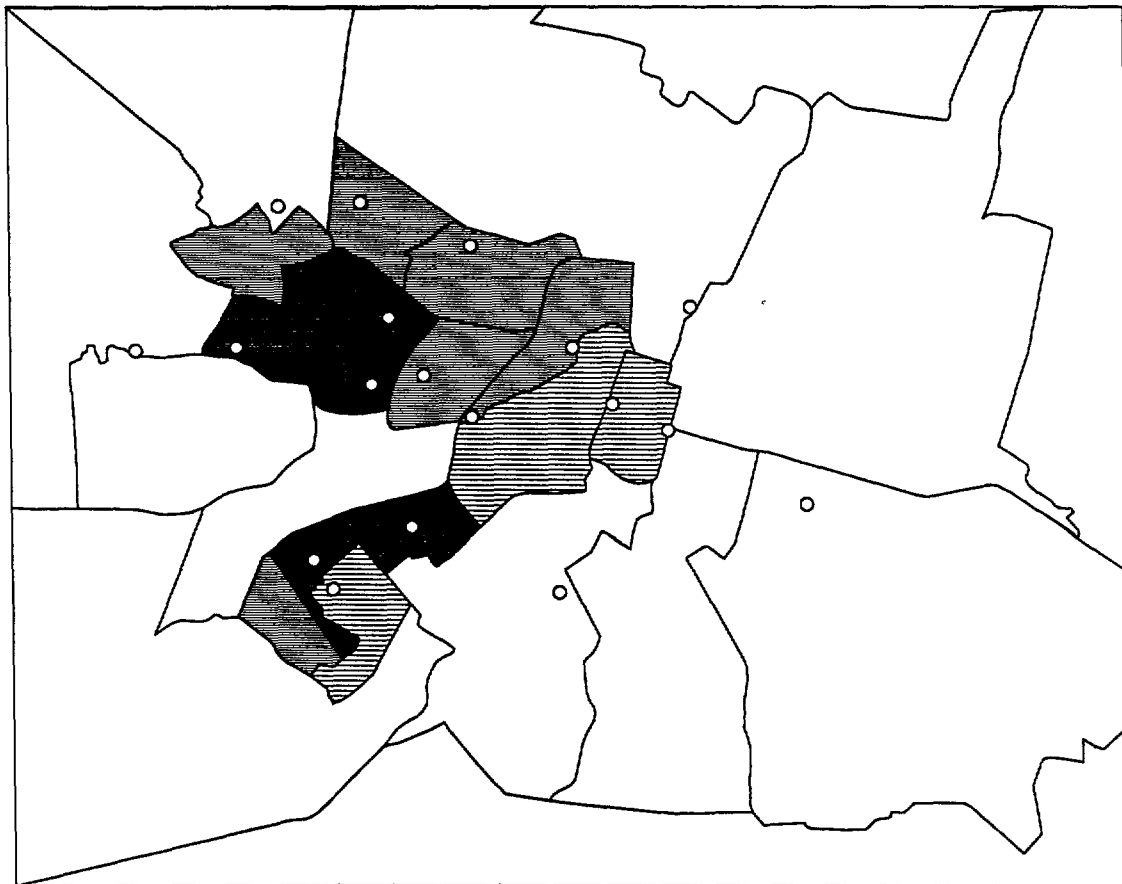


WRA per km²

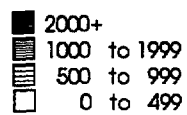


○ SDP

Map 4: Municipal clinic location and WRA density in Bulawayo, Zimbabwe



WRA per km2

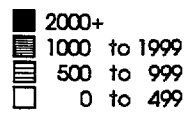


○ Municipal SDP

Map 5: Central government clinic location and WRA density in Bulawayo, Zimbabwe

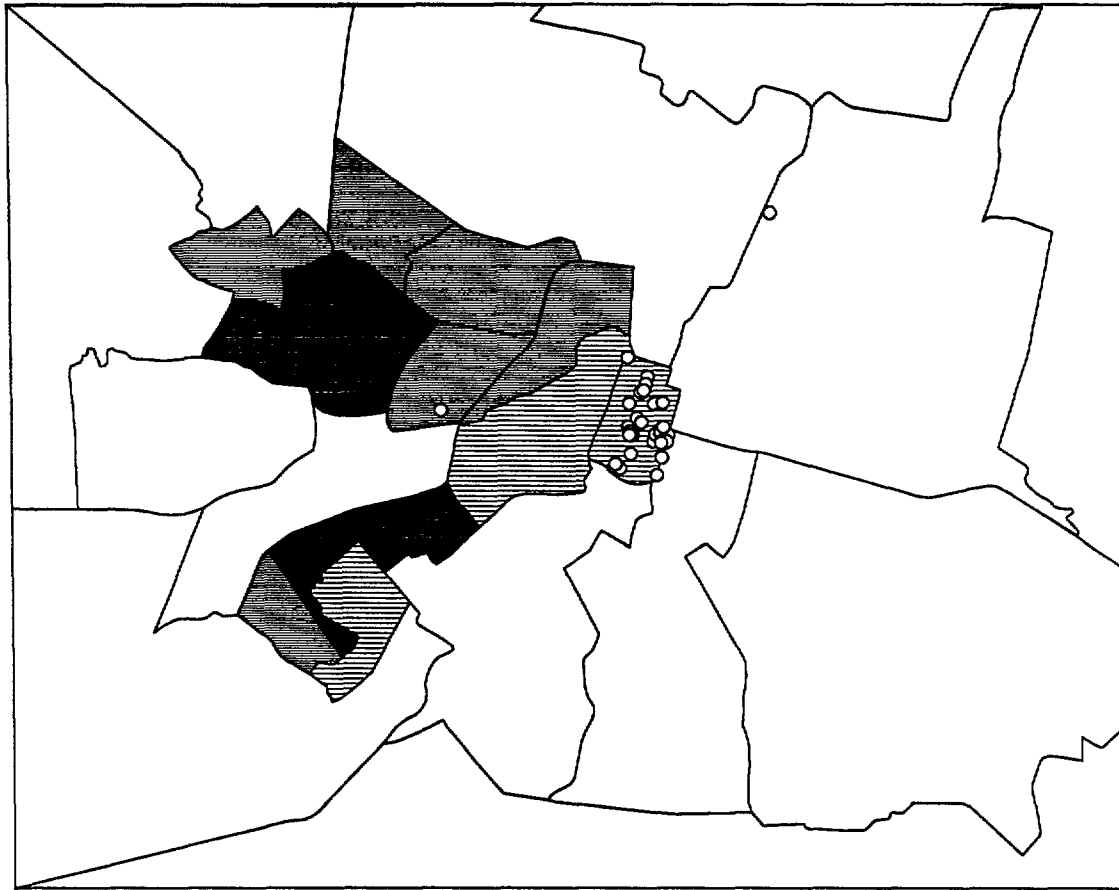


WRA per km²

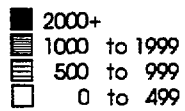


○ Central government SDP

Map 6: Private clinic location and WRA density in Bulawayo, Zimbabwe

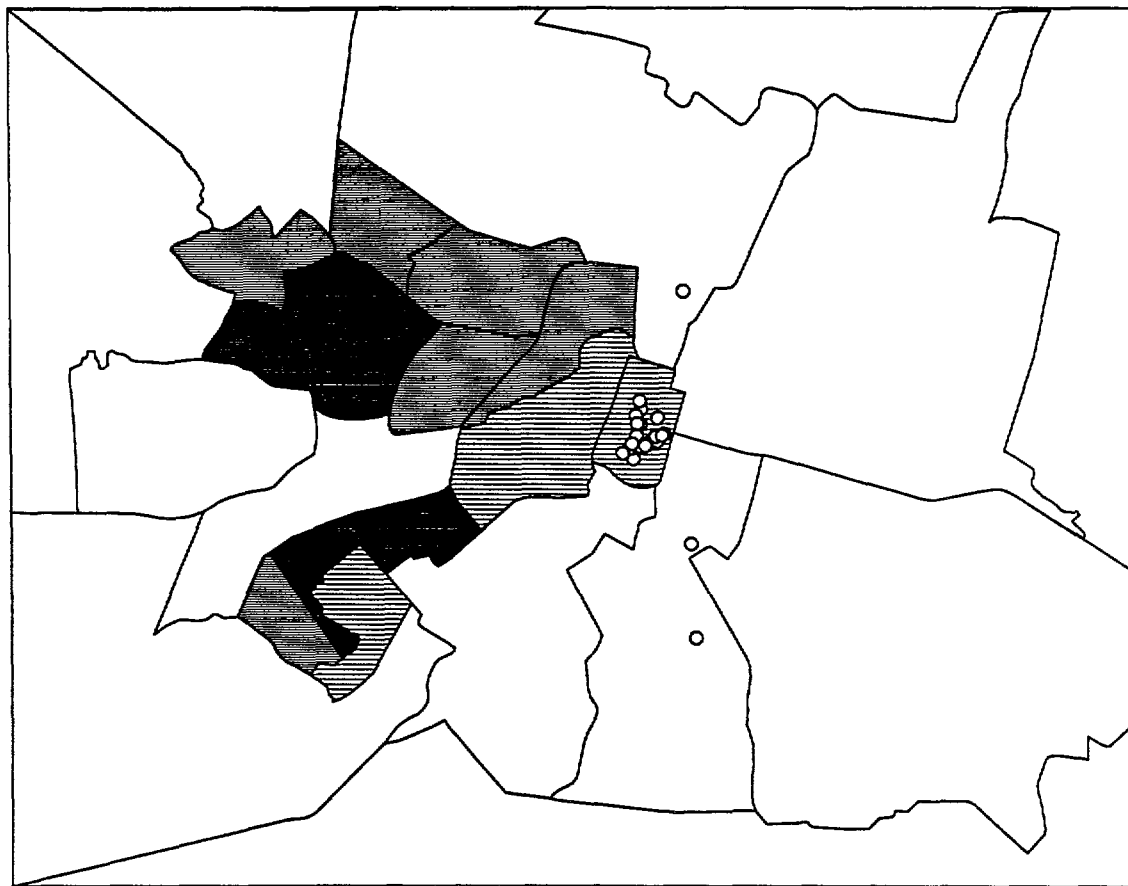


WRA per km2

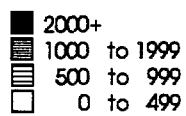


○ Private SDP

Map 7: Pharmacy location and WRA density in Bulawayo, Zimbabwe

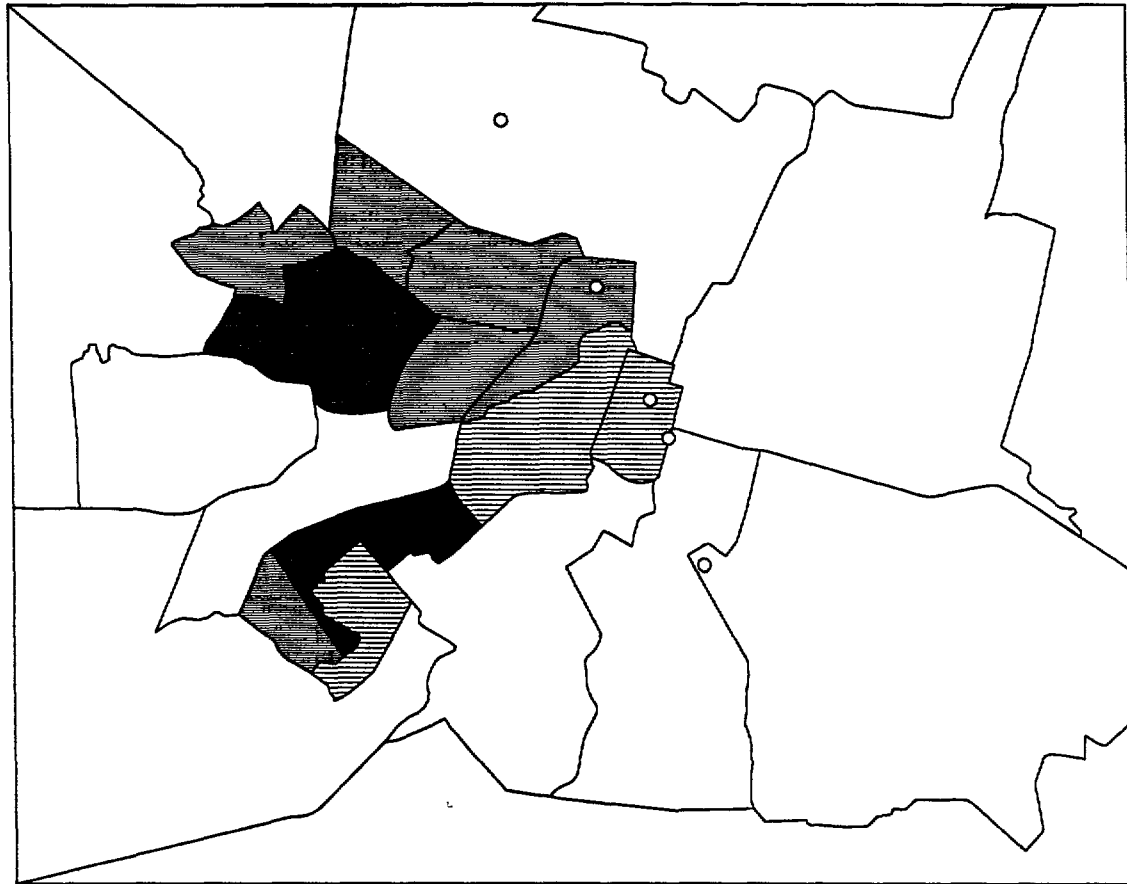


WRA per km2

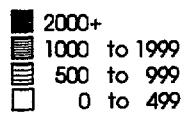


○ Pharmacy

Map 8: ZNFPC, NGO, and Mission clinic location and WRA density in Bulawayo, Zimbabwe

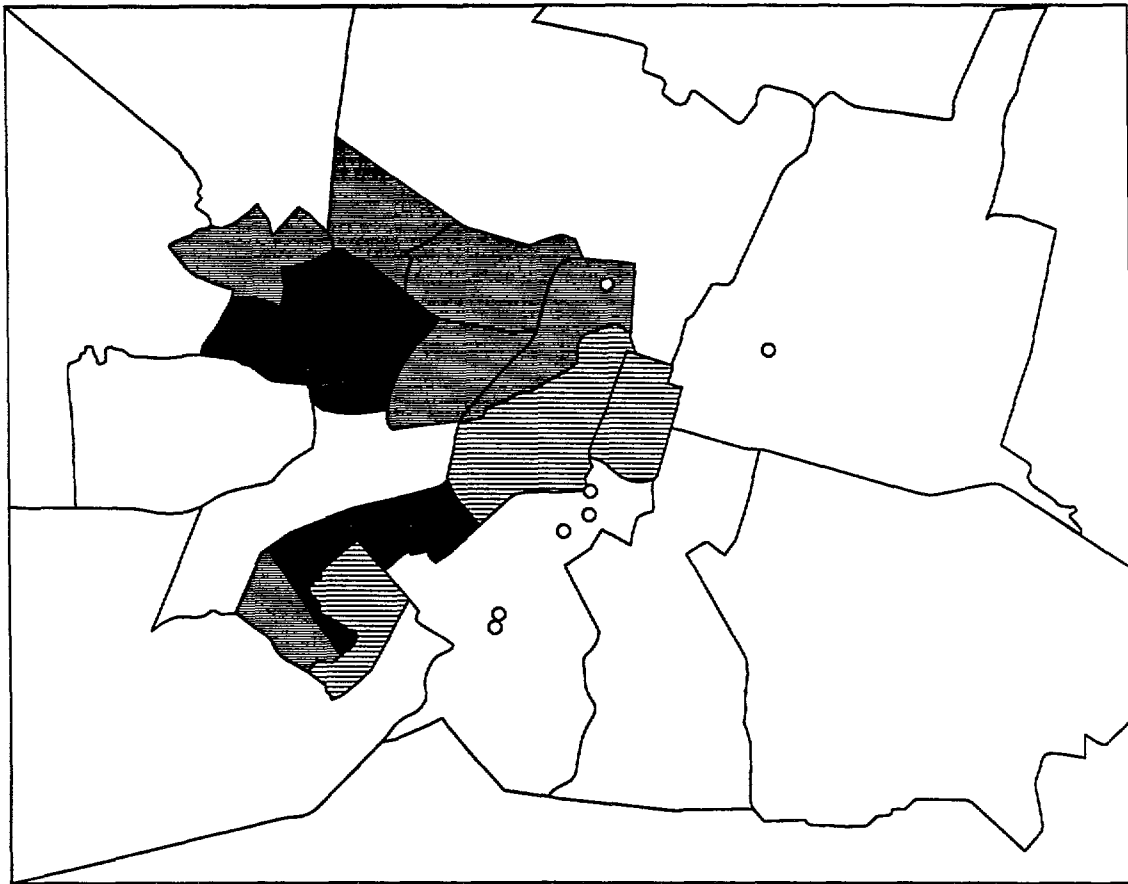


WRA per km²

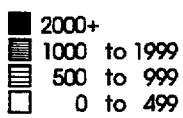


○ ZNFPC, NGO or Mission SDP

Map 9: Industry and army clinic location and WRA density in Bulawayo, Zimbabwe

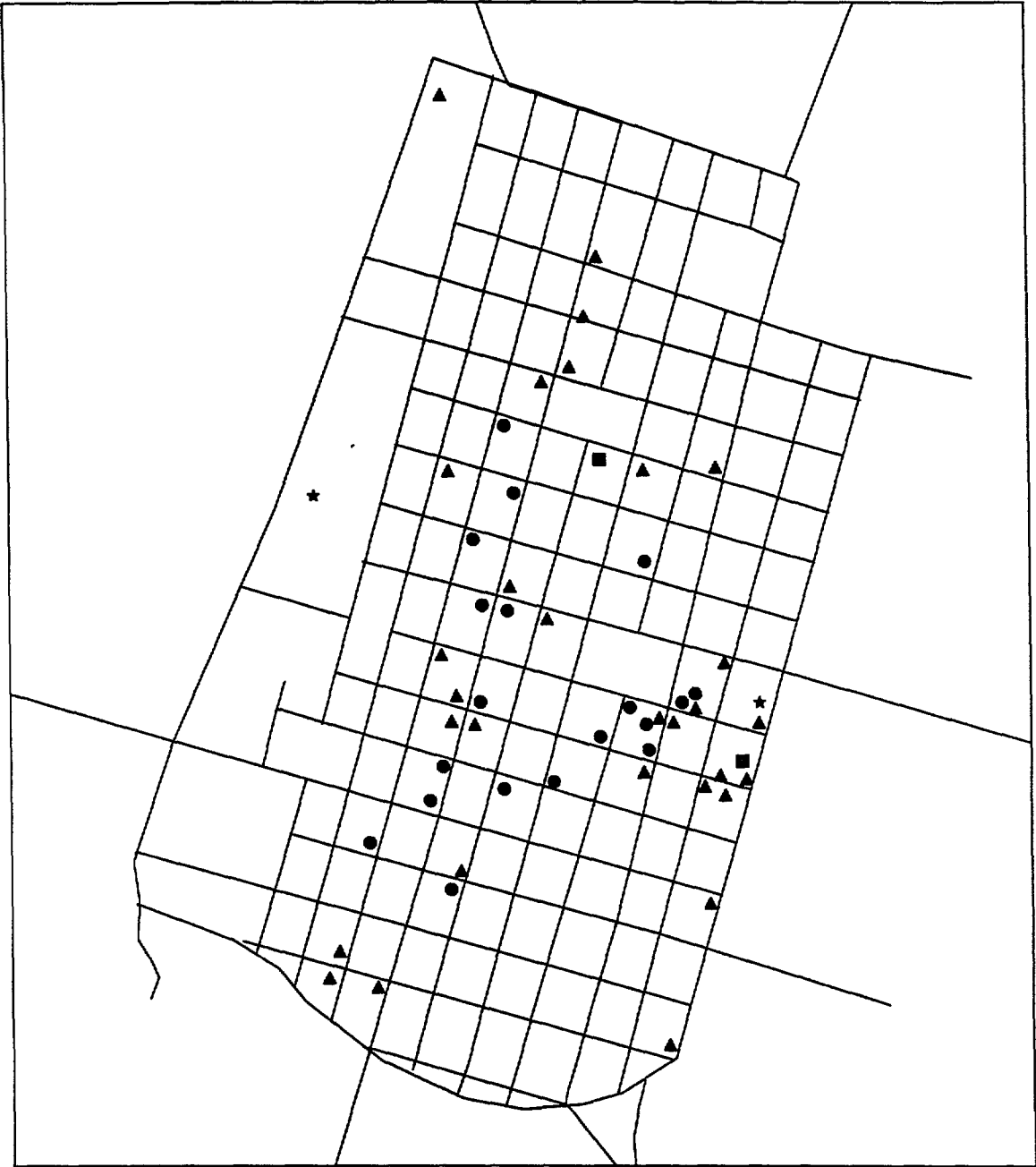


WRA by km2



○ Industry or army SDP

Map 10: SDPs of all types in the downtown area, Bulawayo, Zimbabwe



- ★ Municipal
- ▲ Private
- Pharmacy
- ZNFPC

Map 11: SDPs open after 17:00 and WRA density in Bulawayo, Zimbabwe

