

Zimbabwe:

***Impact of Family Planning on Women's
Participation in the Development Process***

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**This summary highlights findings from a larger scientific report
and includes recommendations from in-country researchers**

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Impact of Family Planning on Women's Participation in the Development Process

I Background and Introduction

The development process in Zimbabwe has proceeded unevenly since the country achieved independence in 1980. Although the new government took steps to create a climate of equal opportunity for men and women, men have tended to play the more prominent roles in development. This study examines the question of how family planning use may affect the ability of women to participate in the development process. It investigates the extent to which women who control their fertility also control other important aspects of their lives.

The roles of women in Zimbabwe's development tend to have been more circumscribed than the roles of men, attributable in part to the country's colonial history. The colonial administration imposed a "hut tax" on every male head of household, which had to be paid in cash. The tax forced men to migrate to sell their labor in the rapidly growing areas of mining and commercial agriculture. Thus, migration for work and the dual economy were established. The influence of this pattern persists today. When men were absent from rural areas, women became the *de facto* heads of households. Men acquired skills and technical knowledge through training and experience, but women who remained behind achieved little or no improvement in status.

Independence brought changes in Zimbabwe, many of which benefited women. More schools were established, and more opportunities for women were created in fields that traditionally were regarded as male preserves. Legislative changes gave women the right to own property and to enter into contracts. However, despite significant developments in the law, women remain subordinate to men in most areas of household life. The majority of women do not have full decision-making powers, even on matters that affect their health and that of their children. Moreover, in the 1990s, economic stagnation has slowed progress toward gender equity. Economic growth has been sluggish, and high unemployment and inflation have brought hardship to the country's entire population. Women have been especially disadvantaged in competing for scarce resources.

The assumption that a high rate of population growth undermines economic development was the basis for the initiation of family planning programs in developing countries. Only in the last two decades have policy-makers begun to recognize the importance of other socioeconomic factors, such as the status of women, education and reproductive health. The focus is shifting from a macro-level view of national rates of population and economic growth to the realization that individuals must have access to the means of improving their incomes and exercising some control over their futures. Family planning in this context is seen as a way of achieving desired family size. Lower fertility, so the logic goes, will promote women's participation in the development process and enhance the quality of their lives and the lives of their families. This study is based on the assumption that contraceptive use can give women greater control over

decisions concerning the number and spacing of children. This control may then translate into a greater sense of autonomy in other areas of their lives.

Surveys of contraceptive prevalence and fertility behavior in Zimbabwe, including the census and census-based surveys and the Demographic and Health Surveys (DHS), have shown that women in Zimbabwe are adopting contraceptives, especially modern contraceptives, in large numbers. The contraceptive prevalence rate in the 1994 DHS was 48 percent, in contrast to 38 percent in 1984. Fertility decline, from a total fertility rate of 6.5 in 1984 to 4.3 in 1994, has been most evident among women with at least a secondary school education and women in urban areas. However, the question of participation in the development process depends to a large extent on the ways in which men and women are able to translate the benefits of smaller families into social and economic opportunities. In recent years, the Economic Structural Adjustment Program has imposed hardships on the economy, including a high unemployment rate which limits opportunities in the development sector for both men and women.

In 1997, a large, nationally representative survey collected data on key social, economic and political activities in women's lives in relation to their reproductive histories. More than 2,000 women of reproductive age (15 to 49) were interviewed using field teams and interviewers from earlier demographic and health surveys in Zimbabwe. The survey included a combination of closed and open-ended questions and focused on the timing of events in the reproductive and productive spheres of women's lives. The study was carried out in conjunction with the Population Studies Centre at the University of Zimbabwe in Harare.

The study uses Young's (1988) distinction between the *conditions* and *positions* of women. The *condition* of women refers to women's practical or material needs and includes such things as education, health, food, water, fuel, improved technology, skills and wages. The *position* of women, however, is concerned with their status in society and is related to the underlying structures of subordination and inequality, especially as they determine the position of women with regard to that of men. Questionnaire items on education, literacy, education of partner, income of partner, place of residence and work status were used as proxies for the condition of women. Questions on decision-making in several domains of women's lives were proxies for the position of women.

II Study Goals and Objectives

The primary objectives of this study were

- To identify and describe common patterns in women's reproductive histories, including the use of contraceptive methods,
- To examine the association between reproductive events in women's lives and their conditions and positions with respect to *Women's economic condition* labor force participation, ownership of land and use of credit facilities, indicators of women's current status

Women's position in the household participation in decisions such as family size, use of household income, children's education, and labor force participation indicators of the potential for women's empowerment in household decision-making

Women's position in the community participation in community and local political activities indicators of gender equity in the public arena

III Study Design

The first phase of the study was a secondary analysis of data from earlier surveys, principally the 1988 and 1994 DHS and the 1984 Reproductive Health Survey (RHS), to determine trends and differentials in reproductive behavior and to identify and define key variables of interest. Variables included family planning practices, birth intervals, family size, women's participation in different types of activities, women's education, and urbanization. Both the DHS and the RHS had limited information on women's participation in development activities. Nevertheless, these analyses of earlier surveys were useful in developing and designing the household survey for the next phase of the study.

The second and major phase of the project was a cross-sectional household survey of a nationally representative sample of 2,465 women ages 15 to 49. This survey focused on women's participation in household, economic and sociopolitical activities as they related to reproductive behavior. To analyze the relationship between the two sets of variables, women were asked about current and previous participation in development activities, as well as the timing of key events in their reproductive history and contraceptive use.

The sampling frame for this study was the Zimbabwe Revised Master Sample, a self-weighting household area sample based on the 1992 census and designed to collect nationally representative data. The final sample consisted of 70 percent rural and 30 percent urban residents, consistent with countrywide levels reported in the 1992 census. Sample households were selected by systematic sampling in 61 enumeration areas and screened for the presence of eligible women; one woman per household was selected. The response rate was 100 percent; women expressed appreciation for being selected for the survey, which they regarded as a way of having a voice in issues that affect their lives.

Interviews were conducted in the respondent's first language, most often Shona or Ndebele. The interview schedule contained both closed and open-ended questions and covered sociodemographic background, reproductive health history, participation in the labor force, community activities and politics, and household decision-making. Using the birth dates of children as reference points, interviewers queried women on reproductive events that occurred in the course of their lives. Responses to open-ended questions on selected behavioral issues were recorded verbatim on the questionnaires and later coded for analysis. The instrument translated and back-translated for accuracy, was pretested and revised on the basis of a pilot analysis. (Findings from open-ended questions are not included in this report.)

Following a three-day training period, professional enumerators from the Zimbabwe National Family Planning Council worked in all ten provinces. The field team's experience in other surveys reduced the length of time necessary for training and enhanced the quality of the data. The research team introduced the study in each enumeration area by visiting male and female leaders in each community to explain the study and to obtain local authorization to visit the sampled households. Interviewers explained the survey to respondents, assuring them of their option to decline participation. With the respondent's informed consent the interview was conducted and lasted approximately 40 minutes.

Supervisors checked the data for completeness and consistency while interviewers were still in the field. Analysis was carried out at the University of Zimbabwe, using SPSS and SAS computer software for descriptive statistics and logistic regression models to examine relationships between use of family planning, work experience, community participation and decision-making. Units of analysis were intervals between births, called segments, events of interest for each segment were use of contraceptives and participation in economic and social activities.

A major limitation of most cross-sectional studies is their reliance on retrospective data. In studies like this one which require sometimes lengthy productive and reproductive histories, memory can affect the accuracy of recall, particularly of events that occurred long before the survey. Moreover in many societies, women - especially in rural areas - do not typically recall events in terms of dates. An attempt was made to circumvent this difficulty in Zimbabwe by using birth dates of children as reference points. However, the survey questionnaire did not elicit information on the exact length of time that elapsed between events. Therefore, since the criteria for event history analysis could not adequately be met, the researchers did not use this method of analysis.

IV Results

The following results represent analysis carried out to date. Additional analyses, including analyses of the data on women's land ownership, use of credit programs, and responses to open-ended questions, will be posted on the Family Health International web site as they become available.

A Characteristics of the Study Population

The mean age of survey respondents was 27, and approximately 30 percent of the sample lived in urban areas. Education levels were high. Nearly 93 percent of the women had attended school, and 96 percent could read and write. The average number of years of schooling was 8.6, with 58 percent of the women having at least some secondary education (grade 8 and higher). The educational gap between males and females and between urban and rural residents has narrowed considerably in recent years. The women's 8.6 years of schooling compare favorably with the 9.3 years of education of their partners. While 95 percent of urban residents had attended school, 92 percent of rural residents had also obtained at least some formal education. Among women under

age 30 – including those in rural areas – school attendance rates had reached 98 percent, compared with 82 percent for women 30 and over

B Fertility Behavior and Contraceptive Use

The mean number of children ever born to the survey respondents was 1.8, and the average number of desired children was 4.1. Of all respondents, 81 percent had become sexually active and 66 percent had at least one live birth. As expected, these proportions vary by age, with 52 percent of women under 30 having had a live birth compared with 94 percent among women 30 and over. Current contraceptive use for married women ages 15 to 49 was 56 percent, higher than the figure of 48 percent reported for the same subgroup of women in the 1994 DHS. Current contraceptive use for all women was 39 percent, a figure similar to the 1994 DHS figures for all women. Contraceptive use was higher among urban women than rural women, among younger than older women, and among women with more education. Contraceptive use prior to marriage or early in marriage was not common but increased dramatically after the birth of the first child, underscoring the expectation that couples demonstrate fertility soon after marriage. The highest fertility occurred among women in remote agricultural areas.

Data showed that most reproduction occurs within marriage. The typical respondent reported having her first sexual experience at the age of 18, being married at 19 and giving birth to her first child at 21. The proportion of married women in the population has been declining, caused both by increased divorce and by a delay in marriage, especially for women who remain in school.

C Contraceptive Use in Reproductive Intervals

As seen in Table 1, only 11 percent of respondents used contraception at first sex, despite the fact that first sex typically preceded marriage. The percentage was even lower at first marriage (8 percent), but rose to 58 percent after the first birth. Younger women were more likely than older women to use contraception at every point. The decrease in contraceptive use after the fourth birth may be partly explained by increasing age and infecundity of respondents, in the case of women under 30 those with four or more children are a small proportion of the population (2 percent). The latter live mainly in rural areas and probably represent the more traditional and less accessible regions of the country.

D Education in Reproductive Intervals

As seen in Table 2, women were unlikely to attend school after marriage and the births of children. School attendance was somewhat higher for younger women with children than for older women. About one-fourth of the women in the survey reported that they had first become sexually active while they were still in school. This tendency was more common among younger women. Only 16 percent of the older women said they had their first sexual encounter while they were in school, compared with 31 percent of women under 30 years of age.

Table 1 Percent using contraception at each reproductive point by age group

Reproductive Point	Total	< 30 yrs	30+ yrs
Current all women aged 15-49	39 2%	33 9%	49 8%
Current women who had sex	48 5%	47 3%	50 1%
Current all married women	56 1%	54 8%	57 9%
At first sex	10 7%	14 6%	5 1%
At first marriage	8 9%	10 9%	6 5%
After first birth	58 4%	71 3%	43 8%
After second birth	63 3%	78 4%	54 4%
After third birth	64 5%	72 5%	62 5%
After fourth and later births	53 9%	65 6%	53 2%

Table 2 Percent attending school at each reproductive point by age group

Reproductive Point	Total	< 30 yrs	30+ yrs
At first sex	25 0%	31 4%	16 0%
At first marriage	8 0%	10 3%	5 1%
After first birth	4 1%	5 0%	3 2%
After second birth	1 7%	2 3%	1 4%
After third birth	3 1%	4 6%	2 7%
After fourth and later births	1 0%	1 8%	0 9%

E Employment in Reproductive Intervals

Table 3 shows that about one-third of the women were currently employed and that the older women were more likely to be currently working for pay than were the younger women. Employment at first sex, at marriage, and during each individual birth interval was considerably lower than the level of current employment.

Table 3 Percent employed at each reproductive point by age group

Reproductive Point	Total	< 30 yrs	30+ yrs
Current	32 1%	25 9%	44 7%
At first sex	13 9%	15 0%	12 3%
At first marriage	12 8%	13 2%	12 3%
After first birth	8 6%	7 0%	10 2%
After second birth	11 5%	9 5%	12 6%
After third birth	12 3%	13 7%	11 9%
After fourth and later births	9 8%	0 6%	10 3%

Women who used contraception at first sex, at marriage and after the first birth were more likely to be employed than women not using contraception at those reproductive points, the difference in proportion working immediately after birth was statistically significant. This association did not hold for current contraceptive use and current employment, either among all women or for women who reported ever having had sex] (Table 4)

Table 4 Work Status at Reproductive Point by Contraceptive Use at Reproductive Point

Reproductive Point	Percent Working	
	Contraceptive Users	Non-Users
At first sex	19.9%	13.2%
At marriage	16.8%	12.4%
At first birth	10.5%	6.0%
Currently all women	35.9%	30.2%
Currently women who ever had sex	35.2%	36.6%

F Community Involvement in Reproductive Intervals

Participation in community activities was even lower than labor force participation for the sample surveyed, ranging from 5 percent after first birth to 10 percent after four or more births (Table 5). Despite this slight increase with number of children born, logistic regression analysis found no association between community participation and family planning in the respective birth intervals. Women who participated in community affairs at an early age tended to be participants throughout their reproductive lives. Community activities included, for example, women's clubs, cooperatives, church groups, and political organizations.

Table 5 Percent involved in community activities at each reproductive point by age group

Reproductive Point	Total	< 30 yrs	30+ yrs
At first sex	5.4%	5.0%	6.0%
At first marriage	6.0%	5.0%	7.3%
After first birth	5.3%	3.9%	6.9%
After second birth	8.0%	7.8%	8.1%
After third birth	9.7%	7.6%	10.2%
After fourth and later births	9.8%	0.0%	10.4%

G Decision-making about Family Planning

Table 6 suggests that autonomous decision-making about use of family planning increased with the number of children: about 21 percent of women using family planning after the birth of their first child made that decision on their own, compared to 29 percent after their fourth child. Nevertheless, those using family planning at any parity were twice as likely to have made that decision jointly with their husbands. Women who believed that others expected them to work

were more likely to make autonomous decisions about family planning than those who did not. The more education a woman had, the more likely she was to make autonomous family planning decisions.

Table 6 Percent making the decision to use family planning by birth interval family planning users only

Birth Interval	Woman Herself	Woman w/ Partner	Health Workers	Others
After first birth	21.2%	51.8%	23.7%	3.3%
After second birth	25.0%	58.2%	15.5%	1.3%
After third birth	28.3%	52.8%	16.0%	2.9%
After fourth birth	29.0%	54.6%	16.0%	0.4%

H Relationship of Contraception to Condition and Position of Women

The major finding of the survey was that, although contraceptive use is relatively high in Zimbabwe and fertility has declined substantially as a result, women remain marginalized in the productive and political sectors of the country. Additionally, in spite of greatly improved education and literacy rates for women, opportunities in the economic, social and political spheres are extremely limited. The deteriorating economic conditions in Zimbabwe have slowed progress for both men and women and have created further demand for family planning services, since many families cannot support additional children. Nearly all the women in the survey (92 percent) believed that family planning has a role in determining the success of women.

Only 32 percent of the women in the survey were currently working. Logistic regression analyses suggested that increased parity brought increased pressure to work in urban areas, but a lower likelihood of working in rural areas. Women who lived with their partners were less likely to work. Older women with more education were more likely to be working. Women who used family planning at younger ages were more likely to report that they were currently working, but this relationship is not statistically significant. Women's perception that others expected them to work was significantly related to current work. Similarly, having worked at marriage was significantly associated with current work. These findings suggest that the link between contraceptive use and labor force participation should be communicated to women at an early age.

V Conclusions and Recommendations

Family planning has helped women in Zimbabwe achieve their reproductive goals, but alone, contraception can not make women active participants and leaders in the development of their country. Although joint decision-making on reproductive issues is increasingly the norm, the status of women in other domains remains low. Education and other characteristics often

associated with modernization are somewhat related to higher positions, but women are still underrepresented in the formal economic and political sectors

All Zimbabweans will benefit from economic reform that removes the barriers to employment. Although family planning has helped women to achieve their reproductive goals, most will not be able to participate fully in development unless jobs are available and they have the training and skills to compete equitably with men in the labor force. Women need training and support for leadership, including skills in project planning and management.

Many women begin sexual activity while they are still in school, but about 90 percent do not use family planning at first sex. This finding points to a clear need to strengthen family life education in the schools. Young women and men need realistic education and counseling for healthy reproductive decision-making. Reproductive health education could be augmented by trained peer educators and accessible family planning services that are responsive to the needs of sexually active people of all ages, whether married or not.

In view of the association between contraceptive use at first sex and at marriage and women's sustained role in the formal economy, reproductive health education should emphasize the link between planning the family early and having the freedom to pursue a career.

Women's advocacy programs, both government and non-government, need to increase opportunities for women to exercise leadership in community action and political activity. To participate in organized social change, women need political education, information and fora where they can be heard. Programs which acquaint women with political issues and bring them into contact with their Members of Parliament should be expanded and made available to more women, so that more can learn to advocate for programs that will improve their own lives as well as the lives of their families and communities. Both men and women need to acknowledge and appreciate women's contributions in politics and community action.

Family planning is not an end in itself, it is the means to a better quality of life for women, which also requires equal access to all the resources women will need for full participation in their country's development.

VI Study Details

The principal investigator for this study was Dr. Marvellous Mhloyi, assisted by the late Mr. Tinodaishe Hove, Dr. Ravai Marindo Ranganai and Mr. Owen Mapfumo of the University of Zimbabwe. Ms. Caroline Marangwanda of the Zimbabwe National Family Planning Council, and Dr. Emily Wong and Ms. Cynthia Visness of Family Health International (FHI). Dr. Priscilla R. Ulin of FHI was the technical monitor.

References

Mutambirwa J *Consequences of Family Planning for the Quality of Women s Lives in Zimbabwe August 1996 - December 1997* Report written for the Women's Studies Project, Family Health International, 1998

Young, K *Women and Economic Development Local, Regional and National Planning Strategies* Oxford Berg Publishers Ltd and Paris UNESCO, 1988