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**Involving Men in Family Planning:  
The Zimbabwe Male Motivation and Family  
Planning Method Expansion Project, 1993-1994**

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## Preface and Acknowledgments

In family planning programs in developing countries, men have long been an underserved audience. Over the past decade, however, increasing recognition of men's influence on reproductive decisions and family planning practices has given rise to new communication projects promoting male involvement in family planning. The Zimbabwe National Family Planning Council (ZNFPC), a pioneer in this area, successfully implemented a male motivation campaign in 1988-1989. In September 1993, ZNFPC launched a second male motivation campaign with technical assistance from the Johns Hopkins Population Communication Services (JHU/PCS).

Using a mix of radio and television programming, print materials, and community events, the campaign sought to encourage couples to use long-term and permanent contraceptive methods, and promoted male participation in family planning decision-making. This paper describes ZNFPC's campaign strategies, materials, and activities. It also reports on campaign effects determined by several different analytic methods. Lessons learned from the Zimbabwe project—notably the value of different communication channels, the benefits of involving men, and the importance of multiple evaluation methods—should be useful for planning similar campaigns in other countries.

Young Mi Kim, of the Research and Evaluation Division of JHU/PCS, participated in all phases of the project evaluation, in designing the household survey questionnaire, in the data analysis, and in writing this paper. Caroline Marangwanda, head of the ZNFPC Research and Evaluation Unit, played a vital role in collecting household, service, and client data, as well as in preparing the paper. Adrienne Kols, a consultant to JHU/PCS, wrote significant portions of the text and served as primary editor of the paper. The authors owe thanks to the many people who contributed to the success of the Male Motivation Project and to this paper reporting the project activities and results.

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## Summary

By 1988, the national family planning program begun in Zimbabwe in the late 1960s had been so successful that contraceptive prevalence reached 36 percent, the highest rate in sub-Saharan Africa. Family size remained large, however, with the average woman bearing 5.5 children and with more than four-fifths of all contraceptive users relying on a single, short-term method, the pill. In addition, the program had been directed toward women only, overlooking men even though surveys showed that men exerted great influence on family size and family planning decisions. These issues prompted the Zimbabwe National Family Planning Council (ZNFPC), with technical assistance from Johns Hopkins University/Population Communication Services (JHU/PCS), to embark in 1988 on the first Male Motivation Campaign. A combination of radio dramas, pamphlets, and male motivation talks increased male participation in family planning and contraceptive use.

In September 1993, ZNFPC launched a second male motivation campaign (again with technical assistance from JHU/PCS) focusing on three of Zimbabwe's cities and two rural "growth points." The goal was twofold:

- To encourage male involvement in family planning, and
- To encourage use of long-term methods to limit family size.

Drawing on the lessons learned from the first campaign, planners broadened the second effort. The second round included radio dramas—in two vernacular languages as well as the *lingua franca*, English—radio and television spots, posters, newspaper and magazine advertisements, pamphlets, a football tournament with giant puppet shows at half-time, other puppet shows, motivational talks, family festivals, and live dramas. Planners also used messages and images designed to appeal to men, such as language borrowed from competitive sports and pictures of local football heroes. Local committees at each of the five sites managed the campaign activities, and service providers were trained in counseling before the campaign launch.

The evaluation was enriched by integrating data from three sources and by using multiple methods of analysis. Household surveys of both men and women were conducted before and after the campaign to reveal changes over time. A multiple regression analysis of the follow-up survey also examined differences in the attitudes and behavior of people who were and were not exposed to the campaign. Clients who started or switched methods during the campaign were interviewed about how they made their decisions and about referral sources. Service statistics were collected over an 18-month period from 23 facilities that offered long-term and permanent contraceptive methods to establish baseline trends and changes in contraceptive use.

The different perspectives offered by multiple sources of data broaden our understanding of the campaign's impact and increase confidence in the interpretation of events.

The campaign reached a large majority of adults in the five campaign areas; 88 percent were exposed to at least one campaign material or activity. Radio had the greatest reach (62 percent of men), followed by print materials (posters, newspapers and magazines, and pamphlets reached 57 percent, 48 percent, and 46 percent of men, respectively). Football matches drew far larger audiences (18 percent of men) than any other type of community event. The campaign reached equal proportions of men and women overall, but the intensity of men's exposure to the campaign was greater than that of women; 39 percent of men compared to 24 percent of women were exposed to four or more campaign components. Exposure to the campaign also was more intensive in the growth points than in the cities. Men read newspapers and magazines, and attended football matches as a source of information, while women listened to the radio drama or attended the motivational talks.

Exposure to the campaign was associated with a rise in the use of modern contraceptives. People exposed to three or more campaign components were 1.6 times as likely as others to use a modern contraceptive method, controlling for gender, age, marital status, residence, education, and socioeconomic status. While a comparison of the baseline and follow-up surveys shows a slight decline in contraceptive use, service statistics show a more complicated picture. Before the campaign contraceptive demand was declining, probably as a result of increases in contraceptive prices and primary health care fees. With the launch of the campaign, this trend reversed, and contraceptive demand, especially for long-term methods, began to rise.

According to the surveys, knowledge of long-term and permanent methods rose over the campaign period as did the number of people holding positive attitudes toward them. Knowledge of the injectable, intrauterine device (IUD), Norplant, and vasectomy increased; the largest gains were in women's knowledge of vasectomy and Norplant. After the campaign, men and women were more likely to approve of using long-term and permanent contraceptive methods, and they were more likely to believe that their spouses or partners approved.

The campaign also encouraged couples to communicate more about family planning and to decide jointly on a contraceptive method. The proportion of women who reported discussing family planning often with their spouses or partners increased from 37 percent before the campaign to 57 percent afterwards. As men became more interested in family planning, many wanted to play a more active role in the decision-making process. Rather than leave family planning decisions to their wives or partners, men were more likely after the campaign to believe that they alone should be responsible for making such decisions or that the decisions should be made jointly. The rise

in interest in solely male decision-making recorded by the surveys suggests that the campaign's reliance on traditional masculine images may have reinforced stereotypes about male decision-making and blurred campaign messages about the value of joint decision-making. Exit interviews, however, show that, regardless of opinions expressed in the surveys, 61 percent of couples in campaign areas actually decided jointly on a method.

The many components of the campaign reinforced one another, so that the greater their exposure to the campaign the more likely men and women were to take action, even controlling for other relevant variables. Thus 29 percent of men who were exposed to four or more campaign components reported that they had discussed family planning with their partners, consulted service providers, or adopted modern contraceptive methods. This compares with 16 percent of men exposed to two or three components and 2 percent of men exposed to just one or none of the campaign's components. At every level of exposure, men were more likely than women to report taking some action in response to the campaign.

The evaluation of the 1993-1994 male motivation campaign demonstrates the value of multiple data sources and analytical methods in assessing the impact of a communication campaign. The combined data show that well-designed family planning campaigns can reach men by using communication channels that appeal to them (such as radio dramas and sporting events) and by developing messages that evoke virile images. The results also show that involving men in family planning increases couples' communication which ultimately may lead to greater use of contraceptives.

## Chapter I

### The Male Motivation and Method Expansion Project

The national family planning program of Zimbabwe has made remarkable progress over the past two decades. By 1988, knowledge and approval of family planning had become almost universal, and 36 percent of married women reported using modern contraceptives, giving Zimbabwe the highest contraceptive prevalence rate (CPR) in sub-Saharan Africa (CSO and IRD, 1989). (See abbreviations list.) More than 80 percent of these women, however, relied on a single method: the pill. Only 11 percent used long-term or permanent methods such as the intrauterine device (IUD) or sterilization. Family size remained large, although the total fertility rate (average number of births per married woman of childbearing age) fell from 6.5 to 5.5 between 1984 and 1988.

#### The First Male Motivation Campaign

To continue the upward trend in contraceptive prevalence, the Zimbabwe National Family Planning Council (ZNFPC) expanded its focus to include men as well as women. Recognizing that the man has great influence on a couple's family planning decisions, the ZNFPC conducted its first male motivation campaign in 1988-1989 to promote male involvement in family planning and to increase contraceptive use.

##### Campaign activities

—a radio drama series, educational talks for men, and pamphlets on family planning—reached 52 percent of men ages 18 to 55 and produced a positive effect on the intended male audience. Analysis of survey results (which controlled for demographic variables and radio ownership) found that men who were exposed to the campaign were 1.4 times as likely to use a modern family planning method as were other men, 1.7 times as likely to use condoms, and 1.4 times as likely to believe that both husband and wife should participate in deciding how many children to have (Piotrow *et al.* 1992).

The campaign was not entirely successful in promoting the idea of joint decision-making, however. Men who were exposed to the campaign were 2.4 times more likely than others to state that the husband alone should decide whether to practice family planning (Piotrow *et al.* 1992). In addition, knowledge of long-term and permanent methods remained relatively low: only 43 percent of the men surveyed knew of the IUD and 38 percent, of vasectomy, compared with more than 97 percent who knew of the pill and condom (Kuseka and Silberman 1990).

The 1988-1989 campaign provided reassurance that Zimbabwean men want to learn more about family planning and that communication materials directed to men can change men's attitudes toward family planning, stimulate discussion between husbands and wives, and motivate men to support the practice of family planning.

## The Second Male Motivation Campaign

To continue promoting male involvement in family planning, in 1991 the ZNFPC planned a second male motivation project, the Male Motivation and Method Expansion Project, drawing heavily on the lessons learned during the original campaign. This second project was designed also to reinforce two broad strategies adopted by ZNFPC in the 1990s: the promotion of long-term and permanent methods; and the decentralization of information, education, and communication (IEC) activities.

By diversifying the method mix, ZNFPC hoped that more people would be attracted to family planning and that the contraceptive methods chosen would align more closely with clients' reproductive needs, resulting in increased continuation rates (ZNFPC and MOH 1991). Long-term and permanent methods were of special interest because they result in more couple-years of protection (CYP) than do short-term methods and because they are ideal for limiting family size. To diversify Zimbabwe's method mix, ZNFPC reintroduced injectables<sup>1</sup> (which earlier had been banned), began training physicians in urban areas to insert Norplant<sup>2</sup>, strengthened tubal ligation services, and broadened the selection criteria for tubal ligation so that the procedure is no longer limited to women who are over age 35 and have four or more children.

In planning the second male motivation campaign, one key change in ZNFPC's approach was to broaden the range of communication media used. The earlier campaign clearly demonstrated the power of radio: The radio drama reached by far the largest audience—41 percent of men as compared with the 11 percent who attended an educational talk and just 5 percent who received a pamphlet (Kuseka and Silberman 1990). Excluding those men who were exposed to more than one communication channel, the figures are 38 percent for the radio drama, 4 percent for the talks, and 3 percent for the pamphlets (Piotrow *et al.* 1992). Radio is also the leading choice of both urban and rural men in Zimbabwe as a source of family planning information (Adamchak and Mbivzo 1991; Kuseka and Silberman 1990). The success of the drama suggested further use of the radio as well as the exploration of other communication channels that offer entertainment—for instance, musical shows or sports events. Surveys also found that many Zimbabwean men look to news-papers, pamphlets, posters, television, and films, as well as to community-based distributors, spouses, and community meetings (Adamchak and Mbivzo 1991; Marangwanda *et al.* 1993). Therefore, the second campaign used a wide variety of media, in part, to reach more

<sup>1</sup> Robert E. Lande, *New era for injectables*, **Population Reports**, Series K, Number 5. Baltimore, Johns Hopkins School of Public Health, Population Information Program, August 1995.

<sup>2</sup> Norplant is a registered trademark of the Population Council for levonorgestrel subdermal implants.

men and, in part, to expose men to multiple, reinforcing sources of information. Thus the second campaign included radio, television, news-papers, magazines, community mobilization events, football matches, live dramas, and musical shows.

The second campaign also benefited from efforts to improve the counseling skills of service providers, who had shown a bias toward short-term contraceptive methods in the past (Lewis 1992). During the first phase of the Male Motivation and Method Expansion Project, new training curricula and a video on counseling and interpersonal communication were developed to improve the quality of services offered by clinic-based health workers and community-based distribution (CBD) agents. Before the launch of the multimedia campaign, service providers in the project areas attended training courses to improve their communication skills and to learn more about long-term family planning methods. This training enabled them to respond to the increased demand for family planning services stimulated by the campaign.

While the project anticipated the need for provider training, planners could not foresee the effect on the campaign of increased contraceptive prices and primary health care fees. These price increases, which took effect during the year before the campaign, dampened demand for family planning and presented an additional obstacle to the campaign.

Experience gained during the first male motivation campaign also suggested improvements in the evaluation strategy. Only men were surveyed during the original campaign, so there were no data on how communication directed toward men affected women; the second campaign, therefore, surveyed women as well as men. The evaluation of the first campaign was also limited by its reliance on data from only one source, namely surveys conducted before and after the campaign. The second campaign supplemented these surveys with information from two other sources, namely, service statistics to show the impact of the campaign on the demand for contraceptives and client exit interviews to explore how much influence husbands exerted on the decision to visit a clinic or on the choice of a method. The baseline survey posed another problem in the evaluation of the first campaign. Instead of conducting a survey to gather baseline data before the campaign, researchers relied on a preexisting survey of male fertility. Unfortunately, this substitute for a baseline survey had sampled only men who spoke Shona, one of Zimbabwe's predominant languages, while the follow-up survey was national in scope. The exclusion from the baseline survey of speakers of Ndebele, another widely used language, created a comparability problem that severely restricted the usefulness of the baseline data. To ensure the comparability of the data during the second campaign, researchers designed and conducted baseline and follow-up surveys that relied on the same sampling strategies.

## **Training in Counseling and Interpersonal Communication**

Strengthening service providers' skills was the first step in Zimbabwe's Male Motivation and Method Expansion Project. To develop counseling training modules for clinic- and community-based providers, ZNFPC staff members joined service providers at a three-week Training Materials Development workshop in April 1992. To identify providers' strengths and weaknesses, workshop participants reviewed existing research, interviewed providers and clients, and observed clinic-based providers and CBD agents at work (Lettenmaier *et al.* 1993). This assessment identified three areas in which weaknesses in providers' counseling skills could be corrected:

- Offering clients information about a full range of contraceptive methods, rather than just the pill and condom;
- Tailoring information to the needs of an individual client or to the needs of an audience gathered for a group talk; and
- Using visual aids during counseling sessions.

With these considerations in mind, workshop participants developed two training modules to teach community- and clinic-based providers the interpersonal communication skills so critical to family planning counseling. The five-day course for CBD agents covers interpersonal communication skills, the benefits of family planning, countering common fears and misconceptions about family planning methods, how to conduct a community analysis and develop a communication plan, the use of visual aids, and how to conduct home visits and group talks (ZNFPC and JHU/PCS 1992b). The four-day course for nurses and other clinical personnel covers similar topics but emphasizes the counseling and interpersonal communication skills needed in the clinic environment (ZNFPC and JHU/PCS 1992a).

Two training courses, one for nurses and the other for CBD supervisors, were held immediately after the workshop to pretest the modules. Ten of the trainees were videotaped conducting a mock counseling session both before and after the workshop. A team of three trainers reviewed the videotapes and rated each trainee's skills. The results, which showed more improvement in the nurses' scores than in the those of the CBD supervisors, were used to revise and improve the curricula. The final modules incorporated more training on how to assess a client's information and counseling needs, more exercises in maintaining a nonjudgmental attitude, and more practice in actually counseling clients and conducting group talks (Lettenmaier *et al.* 1993).

A video on the so-called “GATHER approach” to counseling training was also produced by the campaign and distributed to training centers. This mnemonic is named for the six critically important steps in good family planning counseling:

- G** Greet clients and make them comfortable;
- A** Ask clients about themselves;
- T** Tell clients about the family planning methods available;
- H** Help clients choose a method;
- E** Explain how to use or obtain the chosen method; and
- R** Recommend and schedule a return visit or refer to other services if needed.

Both the video and the modules were used to train clinic-based providers and CBD agents in the campaign areas so that they would be able to counsel clients about the long-term and permanent methods on which the campaign focused. The emphasis was on the recently reintroduced injectables. These five-day courses, which were held several months before the campaign launch, also improved providers’ ability to respond to the reproductive needs of individual clients. In addition to providing an update on contraceptive technology, the in-service training advised providers how to counsel male clients, discussed the timetable and content of the upcoming campaign, and previewed the campaign materials.

## **Multimedia Campaign**

The second phase of the project began in September 1993 when ZNFPC launched a six-month multimedia campaign to encourage male involvement in family planning. The objectives were twofold: to increase men's participation in family planning and to promote the use of long-term and permanent methods. To test the campaign before expanding it nationwide, the campaign was limited to five locations: three cities (the capital, Harare; Zimbabwe's second largest city, Bulawayo; and the small city of Gweru) and two officially designated rural "growth points" (Gutu Mupandawana and Murehwa). (In an effort to slow rural-to-urban migration, the government has designated certain rural town centers as “growth points,” increasing employment opportunities and services available. Rural growth points offer services such as banks, post offices, shops, and health clinics.)

Men ages 18 to 54 years were the primary intended audience. Secondary audiences included women ages 15 to 49 years, service providers, and influential community leaders. Campaign materials and activities were designed to accomplish three goals:



- Encourage couples to communicate about family planning and related matters;
- Improve the image of long-term and permanent contraceptive methods such as injectables, IUDs, Norplant, and sterilization; and
- Encourage couples to practice family planning, especially using long-term and permanent contraceptive methods.

As part of a broader ZNFPC effort to disperse its activities, campaign management and activities were decentralized. In each of the five campaign areas, a provincial IEC officer coordinated the campaign, and a local IEC intersectoral committee was established to help direct local activities. The committees included community leaders and representatives from organizations collaborating on the campaign. All committee members attended leadership workshops to learn appropriate management skills. The committees set local campaign goals, organized a launch ceremony for the area, scheduled campaign events, and ensured community support for and participation in campaign activities. Because the campaign was decentralized, somewhat different activities took place in the five areas.

One of the key campaign strategies was to gain the support of community leaders and influential government officials. One-day orientation sessions held two to three months before the campaign launch mobilized the support of business, political, and religious leaders. High-level officials showed their support for the project by participating in the press conferences and family festivals launching the campaign in each of the five sites. These carefully organized events drew large crowds and media attention. In Harare, for example, the campaign began with a press conference held by the Executive Director of ZNFPC and the U.S. Ambassador to Zimbabwe—who highlighted the occasion by announcing that he had had a vasectomy! That evening the Mayor of Harare hosted a reception attended by key policy-makers, including the Minister of Health and Child Welfare. The Minister of Local Government and Construction then officially launched the campaign at a ceremony held at the Rufaro Football Stadium, which attracted more than 5,000 people, mostly men and youths (Kumah 1993). In each of the five campaign sites, live music and drama performances were the major drawing cards for the launch ceremonies.

The ZNFPC also encouraged ample press coverage by sponsoring workshops to brief journalists and editors about population issues and campaign activities. The workshops and accompanying press kits helped to ensure editorial support for family planning, gave needed background information for feature articles and news stories, and stimulated journalists' interest in the campaign. As a result, radio and television newscasts and Zimbabwe's leading newspapers featured many stories about

population growth and the need for family planning as well as reports on various campaign events. Media endorsements of campaign objectives contributed to the campaign's success, as did all the free publicity that was generated. Some journalists became even more involved in the campaign by serving on a local campaign committee.

**Campaign themes and strategies.** The campaign's central theme was "Family Planning: It's Your Choice," which challenged each audience member to take responsibility for his or her family's future by adopting a contraceptive method. The six-month campaign was divided into three brief phases, each featuring its own slogan. The first asked men, "Do you have a dream?" and explained how family planning could help make that dream a reality by limiting the size of their families. The second phase advised men to "Play the game right" by consulting a service provider about the many contraceptive methods available. The third phase encouraged men to include their partners in family planning decisions with the slogan, "It takes two to plan a family."

To increase the second campaign's appeal to men, planners took advantage of the surge of interest in football in Zimbabwe before the World Cup and sponsored a four-game tournament called the "Family Planning Challenge Cup." Football provided a source of images and analogies for campaign materials of all kinds. Campaign rhetoric promised to show men how to *win the family planning game by reaching the goal of a small family with the help of their teammates* (spouses or partners) *and coaches* (service providers). In a reference to Zimbabwe's World Cup team, heralded as the "Dream Team," one television spot announced, "The Dream Team. Do you have a dream? Are you one of life's losers or winners? Do you know how to play the game right? A small family makes it easy to be a winner." The idea of winning was reiterated throughout the campaign, because it was thought to be a compelling, virile image that would prompt men to take action.

Not every component of the campaign was directed solely to men, however. Some messages addressed both members of a couple, and a few were written especially for the campaign's secondary audience, women. Most of the posters, for example, were designed to appeal to both men and women with pictures of prosperous, small families and messages stressing the convenience of long-term methods. Women also received special badges and stickers declaring, for example, "Family planning makes me an independent woman" or "I love my man. Family planning: It's our choice."

**Broadcast media.** To reach as large an audience as possible, the campaign used both radio and television to disseminate messages. Radio dramas in the widely used languages of Shona and Ndebele were broadcast weekly throughout the campaign at 7:15 p.m. on Thursday and Saturday evenings, respectively. The central characters in

both dramas were men, and the focus was on male responsibility. The Shona drama, *Ndakambokuyambira (Forewarned Is Foretold)*, contrasted the different destinies of three male friends and co-workers. Grey served as the serial's role model: intelligent and ambitious, he adopts family planning, studies to improve himself, and prospers. Grey's friend, Chikwama, in contrast, never plans ahead, has more children than he can support, begins drinking, and becomes a hopeless vagrant—all the while blaming his troubles on Grey. The third friend, Joshua, is an indecisive character who drifts though life on borrowed money and fantasies of wealth.

The Ndebele drama, *Uzazisola (You Will Regret)*, centers instead on a young man, December, who becomes enraged when he discovers that his wife is secretly taking the pill. The drama shows how December, a father of two, gradually changes his attitude toward family planning after local leaders talk to him and after he discovers just how costly his children's schooling and other expenses will be. The two dramas proved so popular that they continued on the air, with ZNFPC support, beyond the 26 weeks originally scheduled by the project.

Radio was also used to broadcast three 60-second family planning spots, one for each phase of the campaign. Each opened with the sounds of a football match to capture the attention of male listeners. Commentators then used sports analogies to promote the use of long-term methods, to encourage men to consult service providers, and to urge men to discuss family planning with their partners. Each spot was broadcast at peak hours in English, Shona, and Ndebele. During the campaign, one radio station also broadcast a series of talk shows on family planning methods. Thirteen episodes were aired in both Shona and Ndebele.

Two English-language television spots aired during peak hours, whenever possible before or after sports programs that attracted male audiences. The first of the 40-second spots showed a series of men on the street being interviewed about the need for couples to decide together about family planning. The second spot drew on the campaign's sports theme and featured a father watching a football game on television.

**Print materials.** Posters, newspaper and magazine advertisements, and pamphlets also carried the campaign's messages. Most of the 10 posters dealt with long-term and permanent contraceptive methods and featured messages such as: "Our child relies on us... We rely on the loop (IUD)" or "Using injectables helps my wife keep her good looks." The photographs accompanying the posters all featured prosperous, happy families, implying economic benefits from family planning. Some posters disseminated the same message explicitly, declaring, for example, "Of course we can afford it! We planned our family!"

The newspaper and magazine advertisements, unlike the posters, were designed strictly for a male audience. To attract men's attention, each advertisement featured a photograph taken on the football field, often of a well-known football player from Zimbabwe's national squad. Captions announced that these famous players supported family planning. Each of the three ads (one for each phase of the campaign) then used sports analogies to express family planning messages. For example, one asked:

*Are you playing the game right? When you're faced with a tricky situation, you've got to know what you're doing and make the most of your choices. Know the difference between fact and fiction. And don't be afraid to get a little coaching. Long-term and permanent methods of family planning are designed for couples who want smaller families. Clinics, doctors, and Community-based Distributors will help you choose the right method for you and your partner. Play the game right. Once you're in control, it's easy to be a winner.*

To reach a male audience and to reinforce the advertisements' sports theme, the ads appeared on or near the sports pages of six of Zimbabwe's leading journals. Depending on the publication, the ads appeared in English, Shona, or Ndebele.

A series of three pamphlets provided readers with more detailed information about contraception. One outlined the health and economic benefits of family planning; a second described various contraceptive methods, including the pill, IUD, barrier methods (condom and diaphragm), and sterilization; and the third focused on male and female sterilization. These pamphlets were widely distributed at clinics and at campaign events, including family festivals, football matches, and drama performances.

Campaign messages also appeared on banners at campaign events, on billboards at busy urban locations, and on campaign merchandise such as T-shirts, stickers, badges, key rings, and caps. Some of these promotional materials reinforced the theme of male responsibility, declaring "Be a man before you're a father" or "Think like a man: use family planning." Others relied on the sports metaphors at the heart of the campaign: "Home or away, play the game right!"

**Community and sports events.** Community events supplemented the campaign's broadcast-media programming and print materials. To launch the campaign, each of the five local organizing committees staged an all-day family festival. Processions through the streets attracted curious crowds to the celebrations, which featured a wide variety of entertainment including live music by top artists and local bands, puppet shows, traditional dances, songs on family planning themes sung by service providers and schoolchildren, drama performances and contests, poetry recitals by school children, and tug-of-war competitions between men and women. Each festival—all of

them free of charge and attended by thousands of men, women, and children—was unique. In rural areas, for example, performing groups competed for prizes such as seeds, maize, and fertilizer. Local dignitaries gave speeches. And service providers offered family planning counseling and contraceptives on the spot.

Of all the community events, a four-game football tournament held in Harare and Bulawayo attracted the largest audiences. Football was in high season at the time of the campaign, and the four regional teams that competed for the "Family Planning Challenge Cup" included all the stars of Zimbabwe's World Cup team. Each match featured an entertaining halftime performance by larger-than-life-size puppets vividly depicting a couple and the various contraceptive methods they adopted. (These giant puppets, called *Dori*, also performed at the family festivals and other public venues.) Family planning banners were displayed prominently on the field, and each football fan entering the stadium received a packet of family planning literature and condoms.

The ZNFPC engaged the *Amakhosi* Theater Workshop and the Zimbabwe Association of Community Theater (ZACT) to perform family planning plays at the press conferences, receptions, and family festivals launching the campaign. The *Amakhosi* troupe also staged plays in crowded public venues in Bulawayo, including shopping centers and beer halls. These dramas were designed to make audiences aware of social and economic changes taking place in Zimbabwe, to encourage discussion about family planning, and to increase knowledge of long-term and permanent contraceptive methods. The actors and actresses were briefed ahead of time about the campaign's objectives and about family planning methods, so that they could answer questions from the audience. ZACT's choreographed puppet show used football images to illustrate the various contraceptive methods. Other plays explored the consequences of having large families. In *The Pauper's Will*, for example, a poor man blames all his misfortunes on having too many wives and children; thievery, prostitution, toil, begging, and other ills are his only legacy.

Motivational talks already were an established part of ZNFPC's male motivation program before the campaign began. During the campaign, however, the number of talks increased, and the focus shifted to long-term and permanent methods. Male motivation teams conducted talks whenever and wherever men congregated—at workplaces, industrial sites, colleges, beer halls, marketplaces, and elsewhere; women, too, were free to attend. The talks gave listeners an opportunity to ask questions and express concerns about family planning. Each talk attracted from 100 to 200 people, depending on its location.

## Cost Recovery

Financial sustainability became a major goal set for the Zimbabwe National Family Planning Programme by the 1991-1996 five-year plan (ZNFPC and MOH 1991). To this end, ZNFPC tried to recover a substantial portion of the campaign's costs. During the campaign of 1988-1989, managers had had little success in finding commercial sponsors for the radio drama. To improve the prospects for cost recovery during the second round, ZNFPC decided to subcontract the fund-raising effort to specialists and to link their remuneration to the amount of money actually raised. The goal settled upon was to recover 40 percent of campaign costs of Z\$1,452,4888. Additional kinds of cost recovery included donations of mass-media time and space, raffle prizes, and cash; sponsorship of specific campaign activities, such as the radio drama; and sales of football tickets, raffle tickets, and campaign merchandise.

Unfortunately, a general economic recession in Zimbabwe at the time hampered the cost recovery effort. Although the fund-raising firm Roots Media approached dozens of companies, no sponsor for the radio drama emerged, and no substantial donations came in. Another problem was that Roots Media was so busy organizing campaign activities, such as the football tournament and drama troupes, that little time and energy were left for cost recovery efforts (Moyo *et al.* 1994). Two of the campaign's activities did generate income to offset the campaign's costs: the sale of tickets for the football games and the sale of campaign merchandise. In addition, there was one donation to cover the transportation of the football teams. Altogether Z\$193,072 was recovered or 13 percent of the total cost of the campaign.



## Chapter II

### Methods of Evaluating Campaign Effects

The main objective of the evaluation of the 1993-1994 ZNFPC family planning communication efforts was to study the campaign impact on family planning behavior, attitudes, and knowledge among men and women in the five campaign sites. In addition, the evaluation was to make recommendations for a third phase of the ZNFPC male motivation campaign. The key evaluation questions were:

- How many men and women were exposed to the campaign, and what key messages did they recall?
- Did the campaign lead to increased use of long-term and permanent methods?
- Did the campaign increase communication about family planning between partners and joint decision-making?
- What effect did the campaign have on knowledge and approval of long-term and permanent methods?
- What family planning actions did people take as a result of exposure to the campaign's materials and activities?

To interpret the results of the campaign more fully, the evaluation collected data from three different sources. *Household surveys* of randomly selected samples in the campaign areas were conducted both before and after the campaign. This pre-/post-test design enables researchers to measure changes over time and to compare the actions of people who were and were not exposed to the campaign. By collecting *service statistics* from clinics located in the campaign areas during the year before the campaign as well as during the campaign itself, researchers could look for changes in contraceptive use brought about by the campaign. *Exit interviews with clients* (mostly women, but including a few men) who adopted contraception or changed methods during the campaign period provide detailed data on decision-making, referral sources, and method switching.



## Household Surveys

A total of 2,052 men ages 18 to 54 and women ages 15 to 49 in all five campaign sites were randomly selected and interviewed. ZNFPC conducted the baseline survey with 1,019 respondents in July 1993, two months before the campaign was launched (see Table 1). The follow-up survey included 1,016 respondents and was conducted in May 1994, two months after the campaign concluded. Twenty trained interviewers and five supervisors carried out the field work, with the same interviewers handling the field work for both surveys whenever possible. Male interviewers spoke with male respondents; female interviewers, with women. Multistage random sampling was used. Thirty-nine enumeration areas (EAs) were randomly selected from the 1992 Central Statistical Office's (CSO) master sampling list. In each enumeration area, house-hold numbers were randomly drawn from the list of households, and within each household, a respondent was chosen at random.

There were quotas both for gender and for campaign site: respondents were equally divided by sex, and more respondents were drawn from Harare and Bulawayo than from the other sites. Appendix A presents the number of people interviewed grouped by age and location, as well as the population size after weighting the data. The data were adjusted on three variables—site, gender, and age—to 1992 Zimbabwe Census Data (CSO 1994).

Approximately 40 percent of the total sample were below the age of 25, while another 40 percent were between ages 25 and 39. More than 95 percent of the persons surveyed had at least a primary school education. About 60 percent were married. Approximately 40 percent of the respondents were Christian, 20 percent were Spiritual, and 20 percent identified with other religions. There are no significant differences in education, location, marital status, or religion between the baseline and follow-up samples when the numbers are weighted to population size and adjusted for age.

**Limitations.** Two analyses were performed on the survey data. First, baseline data were compared with follow-up data in a pre- /post- analysis to measure changes that took place over the campaign period. Second, persons who were exposed to many campaign elements were compared with those who were exposed to only a few or no campaign activities and materials; this analysis uses data only from the follow-up survey.

**Table 1.**  
**Percentage Distribution of Respondents to Baseline and Follow-up Surveys,**  
**by Various Sociodemographic Characteristics: Zimbabwe, 1993-1994**

Characteristic	Men		Women	
	Baseline (N=501)	Follow-up (N=508)	Baseline (N=518)	Follow-up (N=508)
<b>Age (years)<sup>a</sup></b> (adjusted)				
15-19	17.4	17.4	23.4	23.5
20-24	21.2	21.2	24.2	24.3
25-29	17.0	17.0	17.3	17.4
30-34	13.9	13.9	13.6	13.6
35-39	11.3	11.3	10.1	10.1
40-44	7.8	7.8	6.6	6.6
45-54	11.4	11.4	4.8	4.5
<b>Area<sup>b</sup></b> (adjusted)				
Bulawayo	26.6	26.6	28.4	28.5
Harare	58.1	58.1	53.1	53.3
Gweru	5.7	5.7	5.9	5.9
Gutu	5.2	5.2	7.1	7.2
Mupandawana				
Murehwa	4.5	4.5	5.5	5.1
<b>Educational level</b>				
No education	2.9	1.0	3.1	2.4
Primary	22.7	24.1	36.4	28.1
Secondary	70.2	71.4	57.3	65.6
Post secondary	3.6	2.2	2.7	3.4
Other	0.6	1.3	0.5	0.5
<b>Marital status<sup>c</sup></b>				
Married	53.0	53.4	60.3	65.1
Single	44.5	42.5	27.5	26.4
Other <sup>d</sup>	2.5	4.1	12.2	8.5
<b>Religion</b>				
None	27.3	35.8	8.4	7.1
Catholic	15.9	19.2	25.2	23.9
Protestant	19.6	17.3	17.8	26.1
Spiritual	20.0	13.4	25.3	23.2
Other	17.2	14.4	23.3	19.7

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: There was no significant difference between age, educational level, area, marital status, or religion variables in the Baseline and Follow-up Surveys.

Data were adjusted on site, gender, and age to 1992 Zimbabwe Census Data. Seventeen people were excluded because of lack of data for sex and age.

<sup>a</sup> Age range for women is 15-49; age range for men is 18-54.

<sup>b</sup> Bulawayo, Harare, and Gweru are cities; Gutu Mupandawana and Murehwa are growth points.

<sup>c</sup> Of all couples, 5.4 percent have polygamous relationships.

<sup>d</sup> Separated/divorced/widowed.

The chief limitation of the surveys is that data were collected only in campaign areas. Using a control site was not feasible because the campaign was directed for the most part to Zimbabwe's two largest cities, Harare and Bulawayo. Zimbabwe has no other, comparable urban centers to serve as control areas. The broad and general reach of the mass media also complicates designating a control area. Even newspapers and magazines—in addition to radio and television—circulate nationwide, thus reaching people well beyond the campaign areas. Only distribution of certain print materials and staging of community events could be confined to the five campaign sites.

Without a control site, it is difficult to determine conclusively the extent to which the campaign by itself caused changes in family planning knowledge and attitudes, in couple communication, and in the use of contraceptives. This is a common constraint in evaluating communication activities, especially mass-media broadcasts. Other factors may account for some of the changes observed between the baseline and follow-up surveys (Cook and Campbell 1979). For example, price increases in contraceptive supplies and family planning services might have dampened demand, while the introduction of Norplant in 1991 and injectables in 1992 might have attracted new users. Ongoing HIV/AIDS-prevention activities promoting the condom and the ongoing ZNFPC family planning program are some other factors complicating interpretation of the campaign data.

Analysis of the survey respondents' exposure to the campaign makes it possible, however, to test statistically to determine the independent effect of the campaign, controlling some of the factors that might influence family planning knowledge, approval, discussion, and use. A multivariate regression analysis of data from the follow-up survey controls for gender, marital status, residence, age, education, and socioeconomic status. Multivariate analysis of this kind can increase confidence in a causal interpretation of the campaign's impact, but it cannot provide certainty.

## **Service Statistics**

Family planning service statistics were collected from 23 health facilities located in the five campaign sites and administered by the Ministry of Health, Harare and Bulawayo City Health Departments, and ZNFPC. Clinics were selected at random from among those offering the long-term and permanent methods that the campaign sought to promote.

Researchers visited each site to ensure that the data collected were accurate. Data on the number of contraceptives issued were compiled from the facilities' daily registers and then used to calculate the couple-years of protection (CYP) based on the following equations: 13 cycles of pill, 100 condoms, 100 foams, or 4 injectables = 1 CYP; an IUD =

2.5 CYP; Norplant = 5 CYP; and sterilization = 12.5 CYP. Data collected from the third quarter of 1992 through the third quarter of 1993 were used to gauge the baseline trend, and data collected from the fourth quarter of 1993 through the second quarter of 1994 were used to monitor the campaign's impact.

**Limitations.** Service statistics were collected from relatively few health facilities because existing data collection systems were neither complete nor reliable at all relevant clinics. To overcome this problem, researchers set up a special system to collect service statistics, first training providers in each clinic to record the data and then periodically checking and compiling the figures. This labor-intensive effort made it impossible to collect statistics from a large number of clinics. To ensure that the small sample of clinics could capture changes in the use of long-term and permanent methods, which are used by relatively few women in Zimbabwe, only clinics that offered long-term and permanent methods were included. Facilities offering only short-term methods were excluded, which may have biased data on these methods.

The sheer effort involved in setting up the data collection system also explains, in part, why service statistics were collected only in campaign areas. A second reason is the lack noted above of comparable areas to serve as control sites. Thus the service statistics, like the survey data, have some limitations. The analysis can examine changes over time within areas served by the campaign but cannot compare them with prevailing trends outside the campaign areas. This makes it difficult to ascribe changes in contraceptive use to the campaign rather than to outside factors.

### **Client Exit Interviews**

A brief questionnaire was administered to all 2,919 ZNFPC family planning clients who accepted new methods or changed methods during the campaign from October 1993 to March 1994. It was feasible to conduct exit interviews only at ZNFPC facilities. Administrative difficulties precluded interviews in other facilities. ZNFPC clients, however, may not be representative of all family planning clients in Zimbabwe. ZNFPC serves less than one-fifth of the family planning clients in Zimbabwe, these clinics are available only in certain locations, and ZNFPC is the only public-sector service delivery system to offer clients appointments at "booking facilities," that is, services that see clients by appointment only.

Of the 2,919 clients interviewed, 1,064 resided in campaign areas. (No interviews were conducted in one of the campaign areas, Gutu Mupandawana, because it has no ZNFPC facilities.) About three-fourths of the exit interviews were conducted at walk-in facilities, while one-fifth took place at booking facilities (see Table 2). Nearly all

respondents were women, most of them married. The average age was 28 within an age range of 15 to 56.

As Table 2 shows, there are substantial differences between the clients interviewed in campaign and noncampaign areas. Respondents in the campaign areas are more likely to live in urban areas, to be single, and to attend booking facilities. Therefore, this analysis does not compare data from campaign and noncampaign areas. The results of exit interviews are used solely to provide insights into the perspectives of family planning clients during the campaign.

**Table 2.**  
**Percentage Distribution of Respondents to Client**  
**Exit Interviews, by Various Sociodemographic**  
**Characteristics and Area:**  
**Zimbabwe, 1993-1994**

<b>Characteristic</b>	<b>Campaign Areas (N=1,064)</b>	<b>Noncampaign Areas (N=1,855)</b>
<b>Sex*</b>		
Women	99.8	99.1
Men	0.2	0.9
<b>Age (years)***</b>		
15-24	33.6	43.7
25-34	47.9	35.6
35-56	18.5	20.7
<b>Residence***</b>		
Urban	88.1	55.5
Communal <sup>a</sup>	10.7	27.3
Commercial	0.9	14.7
Other	0.3	2.5
<b>Marital status***</b>		
Married	75.3	84.8
Single	21.1	13.3
Others <sup>b</sup>	3.6	2.0
<b>Number of births***</b>		
0-1	27.9	37.5
2-3	35.2	26.6
4 or more	36.9	36.0
<b>Type of clinic***</b>		
Walk-in	68.9	77.2
Booking <sup>c</sup>	29.6	15.5
Mobile	0.0	7.3
Other	1.5	0.1

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project  
Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: \*  $p \leq .05$  \*\*  $p \leq .01$  \*\*\*  $p \leq .001$

<sup>a</sup> Communal areas

<sup>b</sup> Separated/divorced/widowed

<sup>c</sup> Booking facilities offer appointments to clients

**Limitations.** The timing of the interviews, which were conducted neither before nor after the campaign, limits their value. It is not possible to analyze the interviews conducted during the campaign by month of interview. (This is important because clients interviewed in the earliest months of the campaign did not have as much opportunity as those interviewed later to attend campaign activities or see campaign materials.) Thus, researchers cannot examine changes in clients' responses over time.



## Chapter III

### Exposure to the Campaign

A primary objective of the follow-up survey was to measure the campaign's reach. Respondents were asked whether they had seen, heard, or attended each component of the campaign and whether they recalled the campaign's slogans. To determine whether the various campaign materials and activities reached their target audiences, campaign exposure is analyzed among difference sociodemographic groups.

#### Materials and Activities

Of the men and women surveyed in the three cities and two growth points after the campaign, 88 percent were exposed to at least one of the campaign's 10 major components (radio dramas, posters, newspaper and magazine advertisements, pamphlets, radio and television spots, football matches, family festivals, motivational talks, *Dori* puppet dramas, and *Amakhosi* dramas). This means the campaign reached more than one million adults. Many respondents were exposed to multiple campaign materials and activities: 41 percent were aware of two or three campaign components, while 36 percent had been exposed to four or more. Elements that continued throughout the campaign, such as the radio drama and the posters, reached more people than the community events, which were confined to particular times and places (see Figure 1).

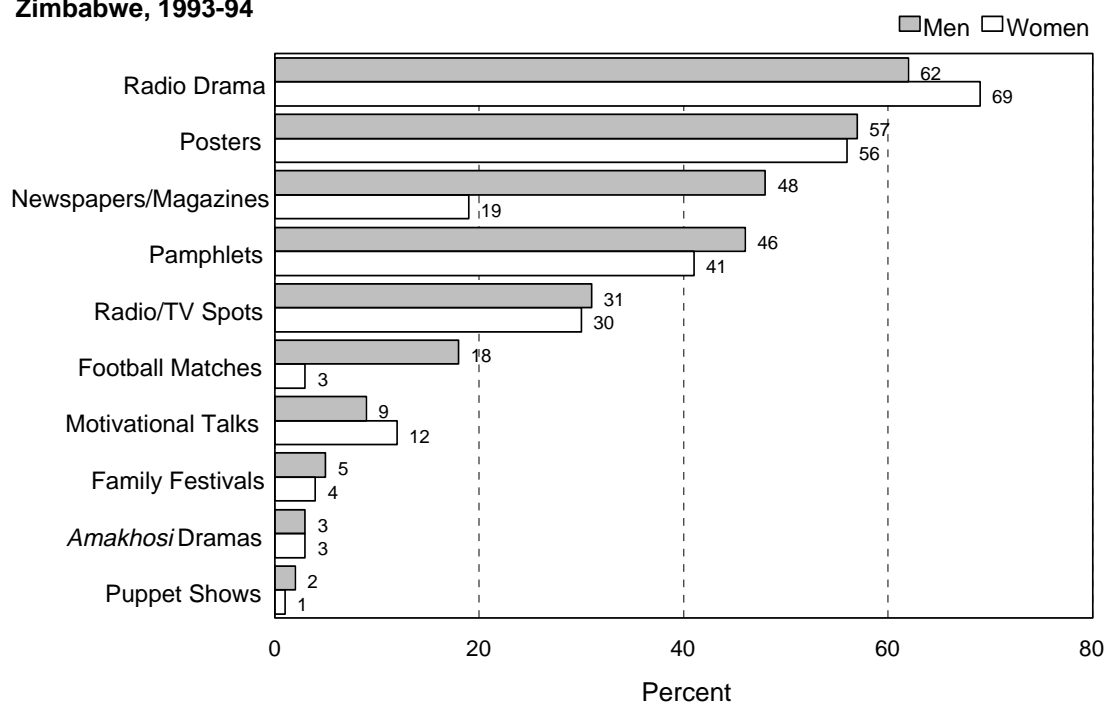
Of course, a simple count of the number of campaign elements is a rough measure of exposure that does not capture qualitative differences in the influence of these materials and events. Posters may not make as great an impact on a viewer as attending a drama, for example. Also, repeated exposure—for example, becoming a regular listener to the radio drama—far outweighs one-time exposure to material. Thus, while a more accurate measure of exposure is desirable, it is not possible with the data available.

There is no question that the 1993-1994 male motivation campaign reached far larger audiences than did the original 1988-1989 campaign, although differences in the sociodemographic characteristics of the samples surveyed make comparisons approximate. The first campaign reached 52 percent of men (there are no data available on women) compared to the 88 percent of men exposed to the second campaign. One reason for the increase is that two of the earlier campaign's three components reached a far larger audience the second time around. The audience for the radio dramas was 62 percent of men in the second campaign, compared to 41 percent during the first campaign; comparable figures for the proportion of men receiving pamphlets were 46 percent in the second campaign and 5 percent in the first



(Kuseka and Silberman, 1990). The much wider variety of communication channels used in the second campaign also contributed to the broader exposure. Posters, newspapers, magazines, television, and football matches all helped extend the reach of

**Figure 1.**  
**Campaign Media Seen/Hheard and Events Attended:**  
**Zimbabwe, 1993-94**



SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Follow-up Survey (5/94).

NOTES: N = 1,015.

Data are weighted by gender and site population and adjusted for age, using 1992 Zimbabwe Census Data.

the campaign.

**Gender.** While many campaign activities reached equal numbers of men and women, the newspaper and magazine materials and the football matches attracted much larger male than female audiences. More than twice as many men as women (49 percent *versus* 21 percent) saw the ads, which featured football celebrities in an effort to appeal to men (see Table 3). Also accounting for the difference was the fact that more men read newspapers and magazines than do women in Zimbabwe. Not surprisingly, the gender disparity was even greater for the football matches. More than twice as many men as women had heard of the matches (57 percent *versus* 26 percent), and nearly five times more men than women attended the football matches (19 percent *versus* 4

percent). Many men who did not attend the matches followed the games on television or radio. (Unfortunately, no data were collected on just how many men the broadcasts of the games reached.)

**Table 3.**  
**Exposure to Campaign Materials and Activities, by Gender, Marital Status, and Location:**  
**Zimbabwe, 1993-1994**

Material or Activity	Gender		Marital Status		Location	
	Men (N=508)	Women (N=508)	Married (N=315)	Unmarried (N=630)	Growth Points (N=283)	Cities (N=737)
<b>At least one component</b>	88.0	88.7	90.2	88.9	92.2	88.8
<b>Mass media</b>						
At least one	70.8	75.4	72.6	74.4	83.3	71.5 ***
Radio drama	62.1	70.3 **	66.8	65.1	78.9	64.4 **
Radio & TV spots	31.0	31.5	31.0	32.1	42.9	29.8 **
<b>Print media</b>						
At least one	77.2	71.8 *	74.2	76.8	73.5	74.7
Posters	57.7	58.5	58.1	59.6	54.0	58.6
Pamphlets received	46.1	41.8	47.6	38.4 **	43.2	44.1
Newspaper and magazine ads	48.5	20.5 ***	31.5	44.3 ***	31.8	35.6
<b>Community events</b>						
At least one	29.7	19.4 ***	25.1	24.1	42.8	22.6 ***
Football matches	18.7	3.7 ***	10.1	15.9 **	8.0	12.0 **
Family festivals	5.1	4.1	3.8	4.4	14.6	3.4 ***
<i>Dori</i> puppet dramas	2.3	1.4	1.4	2.6	10.1	0.9 ***
<i>Amakhosi</i> dramas	2.8	3.5	3.6	2.4	11.2	2.2 ***
Motivational talks	8.2	11.9 *	13.0	5.5 ***	20.0	8.8 ***

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: Data were adjusted on site, gender, and age to 1992 Zimbabwe Census Data.

\*  $p \leq .05$  \*\*  $p \leq .01$  \*\*\*  $p \leq .001$

The football matches illustrate an extremely effective and efficient approach to reaching an audience, that is, using established events that already have a loyal following among the intended audience. Because watching football matches is a regular pastime for Zimbabwean men, the campaign tournament was effectively guaranteed an audience. To develop and attract an audience to an ad hoc event such as a family festival takes far more effort. The campaign football matches also benefitted from the "football fever" sweeping Zimbabwe before the 1994 World Cup Championship.

Although the campaign was directed toward men, it also reached most women (89 percent), and two activities, the radio drama and family planning motivational talks, reached many more women than men. The drama was broadcast in the early evenings, when Zimbabwean women are generally home but when men may be out socializing at

beer halls and other locations. As for the motivational talks, past experience in Zimbabwe has shown that many men prefer to send their wives to family planning talks, even those designed for men. Assembling a male audience for a family planning talk requires extra effort and incentives. Despite large female audiences for many campaign components, the intensity of women's exposure to the campaign was significantly less than that of men: 39 percent of men were exposed to four or more campaign components as compared with just 24 percent of women ( $p \leq .001$ ). While their exposure may have been less intense, most women were aware of the campaign. The campaign's success in reaching this secondary audience undoubtedly enhanced the impact on contraceptive use.

**Marital status.** The campaign reached roughly equal proportions of married and unmarried people—90 percent of married respondents and 89 percent of unmarried respondents were exposed to at least one of the campaign's 10 major components (see Table 3). The intensity of exposure to the campaign did not vary significantly by marital status either. Certain activities, however, were more effective in reaching married than unmarried people. Pamphlets and motivational talks were more likely to draw married men and women, presumably because of their more immediate need for family planning. In contrast, unmarried respondents—who generally have more spare time—were more likely than their married peers to have heard the radio spots, to have seen the television, newspaper, and magazine ads, and to have attended a football match or family festival.

When the effects of gender and marital status are examined simultaneously, it becomes even more clear that some communication channels are better at reaching certain segments of the population than others. While the mass media penetrated all groups almost equally, there were striking disparities in the reach of the print materials. Less than a third (32 percent) of unmarried women received a pamphlet, compared with 42 to 48 percent of the other subgroups ( $p \leq .01$ ). Young, unmarried women may have felt uncomfortable standing in line for family planning materials in full public view, and campaign workers may have been reluctant to give them the materials. Disparities are even greater for newspaper and magazine ads, which reached about half the men (both married and unmarried) and a third of the unmarried women, but only 14 percent of married women ( $p \leq .001$ ). As for the community events, unmarried men (32 percent) were more likely to attend than married men (28 percent), married women (21 percent), or unmarried women (11 percent) ( $p \leq .001$ ). This pattern was most pronounced for the motivational talks. Less than 3 percent of unmarried women reported attending a talk, compared to 7 percent of unmarried men, 11 percent of married men, and 15 percent of married women ( $p \leq .001$ ).

**Location.** City dwellers were almost as likely as residents of the two growth points to have been exposed to at least one campaign component (89 percent and 92 percent), but

the intensity of exposure in urban areas was weaker. Only 31 percent of city dwellers had seen, heard, or attended at least four campaign components compared to 44 percent of respondents from the growth points ( $p \leq .05$ ). This difference is caused by greater exposure in the growth points to the mass media and, even more strikingly, to community events there. Twice as many growth point residents were found to be as likely as city dwellers to have attended a community event (42 percent *versus* 22 percent), even though the football matches—the community events drawing the largest audiences were held only in Harare and Bulawayo (see Table 3). Residents of growth points may have found campaign-sponsored activities more attractive than city dwellers, who can choose from a broader array of entertainments.

**Multivariate analysis.** A multivariate analysis of gender, marital status, location, age, education, and socioeconomic status provides a more accurate picture of which sociodemographic variables influenced exposure to the campaign. As Table 4 shows, three of the six variables were significantly associated with the intensity of campaign exposure. The campaign was more effective in reaching men than women, in reaching residents of growth points than city dwellers, and in reaching people with secondary education than less-educated people.

The multivariate analysis also explores the relationship between the sociodemographic variables and exposure to the three different types of communication channels. An examination of gender shows that both the print materials and community events worked as designed, attracting more male audiences than female. Women, however, were slightly more likely to hear or see the mass-media programming. As far as location is concerned, exposure both to the mass media and community events was greater in the growth points than in the city. Higher education is associated with greater exposure to every component of the campaign, but the relationship is by far the strongest for print materials.

**Table 4.**  
**Multivariate Analysis Coefficients for Intensity of Campaign Exposure, by Media Type and Message Recall on Sociodemographic Variables: Zimbabwe Male Motivation and Method Expansion Project, 1993-1994**

Independent Variable	Number of Campaign Exposure				Message Recall
	Total	Mass Media	Print Materials	Community Events	
Men	0.39 ***	-0.09 *	0.31 ***	0.16 ***	0.67 ***
Married	0.26 *	—	0.17 *	—	0.18 *
Growth point resident	0.59 ***	0.33 ***	—	0.36	—
Age 30 and above	—	—	—	—	—
Secondary and higher education	1.00 ***	0.23 ***	0.64 ***	0.12 *	0.58 ***
High socioeconomic status	—	-0.24 ***	—	0.12 **	—

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Follow-up Survey (5/94).

NOTES: Results of multiple regression analysis of data from Follow-up Survey.

N = 998; 10 responses are missing.

\*  $p \leq .05$  \*\*  $p \leq .01$  \*\*\*  $p \leq .001$  — = not significant

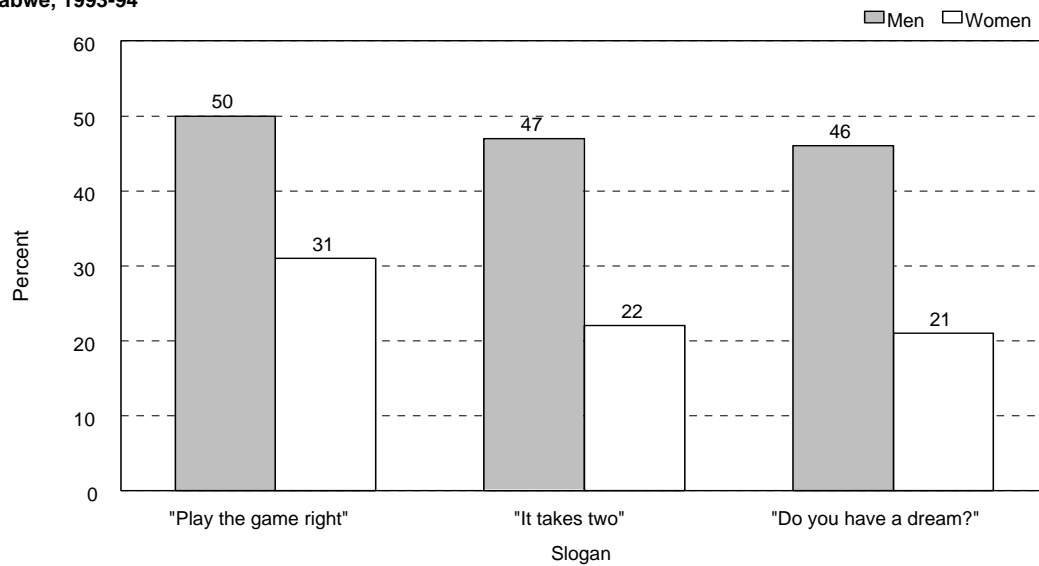
## Pre- and Post-Campaign Recall of Messages

Although exposure rates were high, did the audience remember the campaign messages?

The campaign developed several male-oriented slogans for use in print materials and radio and television spots. As Figure 2 shows, about half the men could recall the main campaign slogans, "Are you playing the game right?" (50 percent), "It takes two" (47 percent), and "Do you have a dream?" (46 percent). Recall was significantly lower among women; only 42 percent of the women could remember at least one slogan, compared to 57 percent of men ( $p \leq .001$ ). The male-oriented design of the messages and images may account for this disparity. Perhaps more important, more men read newspapers and magazines, the major channels for slogan dissemination.

A multivariate analysis of gender, marital status, location, age, education, and socioeconomic status confirms the significance of gender (see Table 4). Men were far more likely than women to recall one of the three main slogans, even controlling for other sociodemographic variables. Education is the only other variable significantly associated with message recall—not surprising considering the slogans mostly appeared in print materials.

**Figure 2.**  
**Men's and Women's Recall of Campaign, by Slogan:**  
**Zimbabwe, 1993-94**



SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Follow-up Survey (5/94).

NOTES: N = 1,015.

Data are weighted by gender and site population and adjusted for age, using 1992 Zimbabwe Census Data.

## **Chapter IV**

### **Analysis of the Pre- and Post-Campaign Surveys**

The household surveys offer the most complete information available on the impact of the second ZNFPC campaign on family planning knowledge and attitudes, couple communication and decision-making, and contraceptive use. This chapter compares data from the baseline and follow-up surveys to determine whether any changes occurred over the course of the campaign that might be attributable to its influence.

#### **Family Planning Knowledge**

A pre-/post- comparison of family planning knowledge shows that the campaign accomplished its goal of increasing knowledge of long-term and permanent contraceptive methods, though not uniformly among all respondents. The proportion of men who, with prompting, could identify vasectomy and the intrauterine device (IUD) increased significantly during the campaign (see Table 5 and Figure 3). While some men learned about additional long-term and permanent methods, however, the campaign apparently did not reach the least knowledgeable. Indeed, the proportions of men who knew of *any* long-term or permanent method actually fell slightly, although not significantly. The rise in men's knowledge of vasectomy and the IUD is notable when contrasted with the significant declines registered in knowledge of the condom and pill, which are known almost universally by Zimbabwean adults.

The campaign's impact was even greater among women. Their knowledge of all three long-term methods, as well as of vasectomy, rose significantly after the campaign. Women showed the most marked gains in knowledge of Norplant, which rose from 10 percent to 27 percent, and of vasectomy, which rose from 40 percent to 54 percent. In contrast, knowledge of pills and condoms declined slightly.

#### **Approval of Modern Methods**

At the start of the 1993-1994 campaign, approval of family planning was already high in Zimbabwe. According to the baseline survey, more than 90 percent of men and women approved of child spacing, limiting family size, and using modern contraceptive methods; an equally large majority also thought that their spouses or other sexual partners approved.

**Table 5.**  
**Prompted Knowledge of Long-term and Permanent Family Planning Methods,**  
**by Men and Women:**  
**Zimbabwe, 1993-1994**

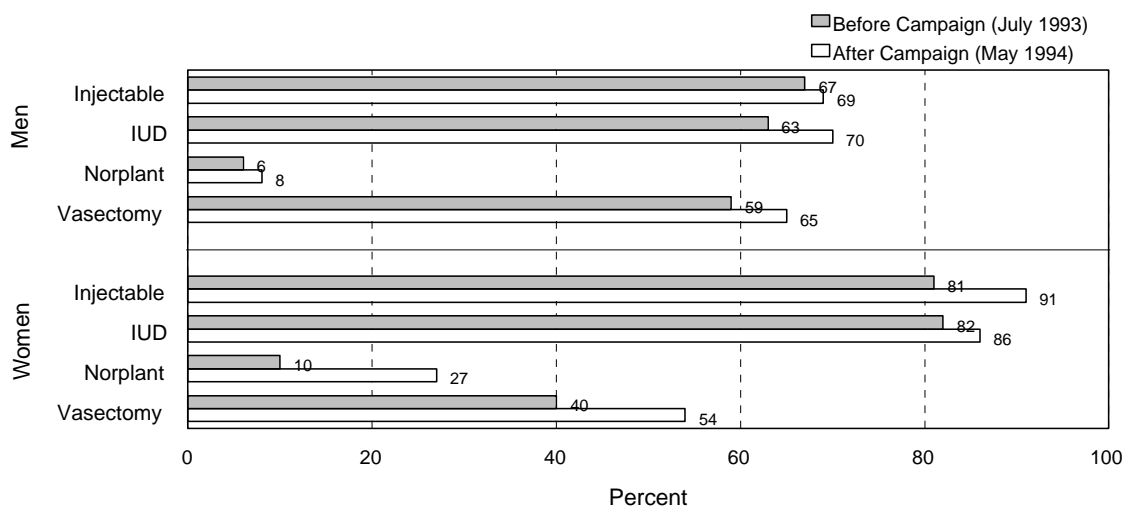
Contraceptive Method	Men		Women	
	Baseline (N=501)	Follow-up (N=508)	Baseline (N=518)	Follow-up (N=508)
<b>Any short-term method</b>	99.5	98.6	98.8	99.3
Pill	98.3	95.6*	98.7	98.3
Condom	98.9	97.0*	98.0	96.4
Diaphragm	46.6	42.3	23.2	33.8***
Foam	22.5	19.3	20.0	24.2
<b>Any long-term method</b>	86.6	84.2	90.8	94.4*
Injectable	67.1	68.8	80.8	90.8***
IUD	62.8	69.7*	81.6	86.1*
Norplant	5.9	8.0	9.9	26.9***
<b>Any permanent method</b>	80.2	78.1	81.8	80.7
Tubal ligation	79.7	79.4	78.2	77.0
Vasectomy	59.1	65.1*	40.4	54.2***

SOURCE: JHU/CCP & ZNFPC based on data from Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: Data were adjusted on site, gender, and age to 1992 Zimbabwe Census Data.

\* p ≤ .05 \*\* p ≤ .01 \*\*\* p ≤ .001

**Figure 3.**  
**Prompted Knowledge of Long-term and Permanent Family Planning Methods, by Gender and Method:**  
**Zimbabwe, 1993-94**

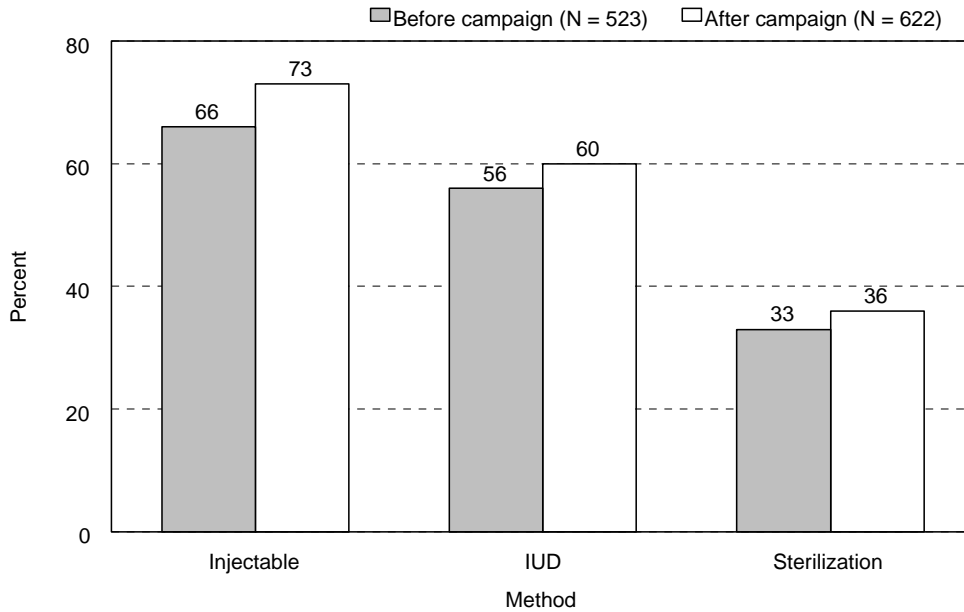


SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTE: Data are weighted by gender and site population and adjusted for age, using 1992 Zimbabwe Census Data.



**Figure 4.**  
**Overall Approval of Using Long-term and Permanent Family Planning, by Method:**  
**Zimbabwe, 1993-94**



SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).  
 NOTE: Data are weighted by gender and site population and adjusted for age, using 1992 Zimbabwe Census Data.

The campaign, however, focused on improving the image of long-term and permanent contraceptive methods. As Figure 4 shows, the campaign succeeded in increasing approval levels slightly for injectables, IUDs, and sterilization. There were significant gains among men in approval of injectables (from 62 percent to 71 percent,  $p \leq .05$ ) and among women in approval of the IUD (from 50 percent to 59 percent,  $p \leq .05$ ).

Equally important are the respondents' perceptions of how their spouses or other sexual partners feel about using these methods, since such perceptions influence decision-making. As Table 6 shows, married men and women were more likely after the campaign to believe that their spouses or partners approved of using injectables, the IUD, and sterilization. At the same time, the percentage of women reporting that they did not know whether their spouses approved of a method dropped substantially. For example, the proportion of married women who thought their spouses approved of using injectables rose from 46 percent to 60 percent, while the proportion of women who reportedly did not know about their spouses' attitudes dropped from 33 percent to 23 percent. The change in the proportion who thought their spouses disapproved was smaller, falling from 21 percent to 17 percent. Increased communication about family

planning between partners (discussed below) may account for why women had a better idea of their spouses' feelings about contraceptive methods after the campaign.

An examination of Table 6 also shows that, before the campaign, married men and women were more likely themselves to approve of using a contraceptive method than to believe that their spouses approved of using that same method. While this pattern continued after the campaign, the gap diminished. Thus the baseline survey found a difference of 21 percentage points between men's approval of the IUD (55 percent) and perceived approval of their wives (34 percent). That gap was halved after the campaign, with only 10 percentage points separating men's approval of the IUD (57 percent) and perceived approval of their wives (47 percent).

**Table 6.**  
**Percentage of Married Men and Women<sup>1</sup> Who Approve of Long-term and Permanent Family Planning Methods and Who Believe Their Partners Approve, by Method: Zimbabwe, 1993-94**

Approval Beliefs and Contraceptive Method	Men		Women	
	Baseline	Follow-up	Baseline	Follow-up
<b>Respondent approves of using method</b>				
Injectables	55.0	66.9**	64.8	73.4*
IUD	55.0	56.5	43.1	55.9**
Sterilization	13.8	19.8	39.3	44.8
Sample size (n)	(206)	(270)	(308)	(351)
<b>Respondent believes spouse or partner approves of using method</b>				
Injectables	43.4	58.2	45.8	60.1*
IUD	34.4	46.9*	29.0	44.7***
Sterilization	11.4	19.1	37.5	39.2*
Sample size (n)	(254)	(269)	(324)	(353)
<b>Respondent does not know if spouse or partner approves of using method</b>				
Injectables	22.2	20.0	33.3	22.8*
IUD	37.5	25.0*	39.9	22.8***
Sterilization	20.6	20.9	35.6	26.9*
Sample size (n)	(254)	(269)	(324)	(353)

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: "Married" excludes men and women in any unions outside of marriage.  
Data were adjusted on site, gender, and age to 1992 Zimbabwe Census Data.  
The number of cases varies because of nonresponses.  
\* p ≤ .05 \*\* p ≤ .01 \*\*\* p ≤ .001

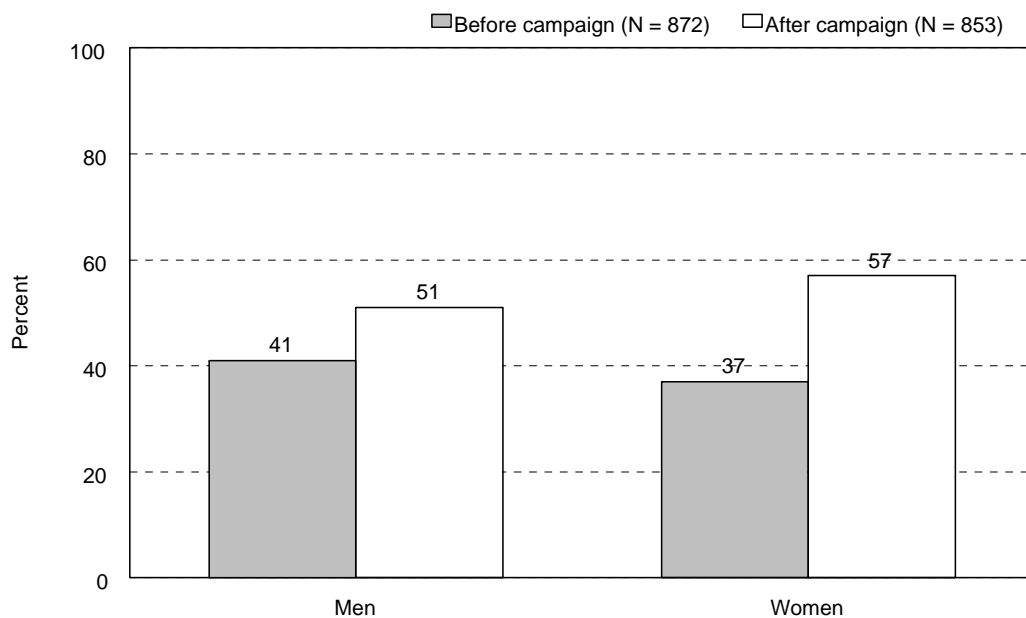
## Couple Communication and Decision-making

Both baseline and follow-up surveys asked respondents whether they talked with their sexual partners or spouses about a wide range of topics. The surveys found that

couples talked more often about financial matters (68 percent), future plans (66 percent), family matters (55 percent), and children's education (50 percent) than about family planning (47 percent), but they talked even less about matters related to sex (31 percent) or entertainment (29 percent).

Campaign materials and activities suggested that men discuss family planning with their partners and that a couple decides on a contraceptive method together. For many men and women, campaign materials and activities may have provided a starting point for such conversations. This potentially is an important contribution because focus group discussions indicate that Zimbabwean women are reluctant to broach the topic overtly, while men may feel that such discussions are unnecessary (Makomva *et al.* 1991). Forty-two percent of the men with partners who responded to the baseline, 43 percent of respondents reported talking often with their partners or spouses about family planning. This number increased to 51 percent in the follow-up survey ( $p \leq .001$ ). The proportion of women who reportedly discussed family planning often with their partners or husbands rose even more markedly, from 37 percent to 57 percent ( $p \leq .05$ ) (Figure 5).

**Figure 5.**  
**Couples Reporting Frequent Communication About Family Planning Before and After the Campaign, by Gender: Zimbabwe, 1993-94**



SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

The surveys also asked respondents whether, ideally, they thought that they, their spouses or other partners, or both members of the couple should be responsible for making family planning decisions. Table 7 presents the data for three of these questions: Who should decide what family planning method to use? Who should decide on going to the clinic for family planning services? Who should have the major say in seeking family planning information?

Male respondents show a consistent and significant pattern of change between the baseline and follow-up surveys (see Figure 6). After the campaign, men were far less likely to believe any of the decisions should be left to their female partners. Despite messages encouraging joint decision-making, however, men were far more likely to believe that *they alone should be responsible for the decisions*. Men were also more likely to believe that going to the clinic or getting family planning information should be a joint decision. But they were less likely to believe that choosing a family planning method should be a joint decision. While these results indicate that the campaign made men more conscious of their responsibility to participate in family planning decisions, the campaign apparently was not altogether successful in conveying the value of joint decision-making. For each question, the shift in opinion from "woman's decision" to "man's decision" was greater than the shift from "woman's decision" to "both partners' decision."

Women also underwent significant opinion changes over the campaign period. Both before and after the campaign, the largest percentage of women felt that they alone should be responsible for all three decisions. After the campaign, however, far fewer women felt these decisions should be left solely to their male partners. Instead, more women believed the decisions should be made jointly by both members of the couple. Thus, the campaign's message about joint decision-making apparently dissuaded women from leaving decisions to their husbands or partners, but it did not shake the convictions of many men that they alone should be responsible for family planning decisions. Given traditional expectations about husbands' and wives' roles, however, the increasing proportions of men and women who believe that family planning decisions should be made jointly marks an important change in thinking about marital responsibilities.

**Table 7.**  
**Percentage of Men and Women by Who They Say Is Responsible for Family Planning Decisions, Seeking Information, and Obtaining Services: Zimbabwe, 1993-1994**

Issue	Men		Women	
	Baseline (N=424)	Follow-up (N=507)	Baseline (N=449)	Follow-up (N=508)
<b>Deciding which FP method to use***</b>				
Self	27.1	35.7	51.0	44.7
Partner	14.6	7.8	22.5	11.4
Both	58.3	56.5	26.4	44.0
<b>Getting FP information***</b>				
Self	13.2	21.5	62.7	54.1
Partner	30.5	13.4	14.4	7.8
Both	56.4	65.1	22.9	38.1
<b>Going to the clinic for FP services***</b>				
Self	9.9	33.7	62.4	62.2
Partner	54.2	21.9	19.0	7.4
Both	35.8	44.4	18.6	30.5

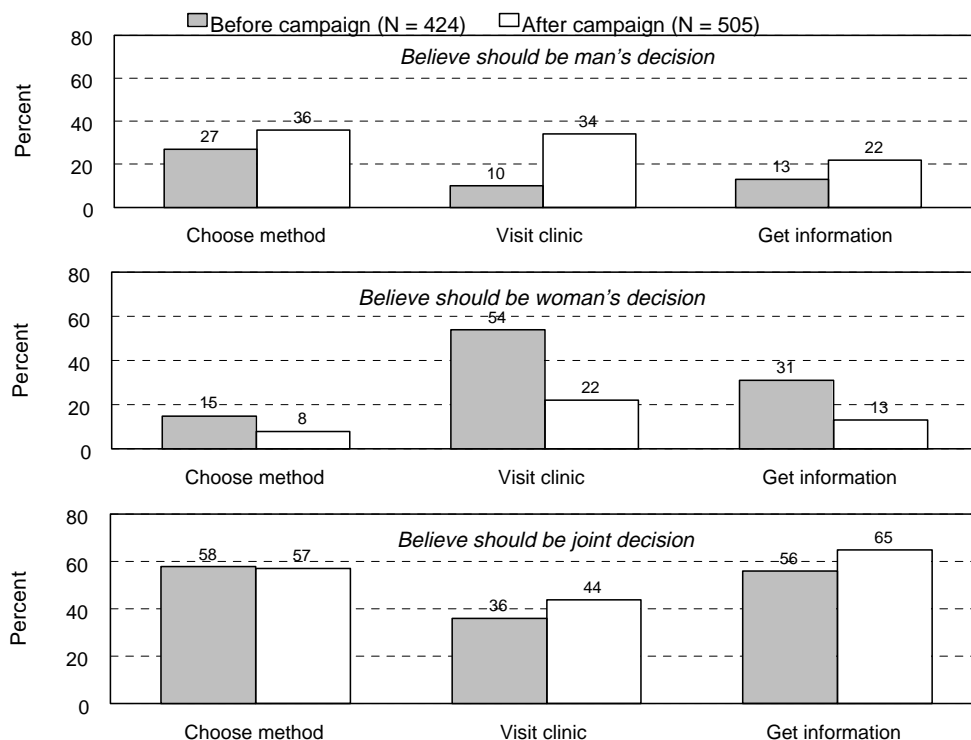
SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: Data were adjusted on site, gender, and age to 1992 Zimbabwe Census Data.

\* p ≤ .05 \*\* p ≤ .01 \*\*\* p ≤ .001.

Results are significant comparing baseline and follow-up surveys for men, and also comparing baseline and follow-up surveys for women.

**Figure 6.**  
**Men's Beliefs About Family Planning Decision-making:**  
**Zimbabwe, 1993-94**



SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Baseline Survey (7/93) and Follow-Up Survey (5/94).

## Contraceptive Use

When contraceptive prevalence rates before and after the campaign (as measured by the two household surveys) are compared, the changes are small and not statistically significant. The use of short-term methods declined overall, from 47 to 45 percent, as did the use of permanent methods, from 1.2 to 0.5 percent. At the same time, the use of long-term methods rose from 3 percent to 4 percent. When the data are analyzed by education, there is a significant drop in the use of any modern method among respondents with primary education or less: from 52 percent to 41 percent ( $p \leq .01$ ). In contrast, contraceptive use shifted little among the more educated, moving from 50 percent to 52 percent.

When analyzed by gender, all changes are small and statistically insignificant. When both gender and marital status are considered, however, unmarried women show a significant increase in contraceptive use, with the use of any modern method rising from 9 percent to 14 percent (see Table 8). Increased use of both short- and long-term methods contributed to this change. There was also an increase in married women's use of long-term methods (from 5 percent to 7 percent) but it is not statistically significant.

If the campaign did have any impact on contraceptive use, it should have been concentrated among men and women with substantial exposure to campaign activities and materials. Indeed the picture changes when only those respondents who were exposed to two or more components of the campaign are considered. Among these respondents, the follow-up survey found higher levels of contraceptive use than the baseline survey. Unmarried women showed the greatest rise, from 9 percent to 21 percent ( $p \leq .05$ ). Contraceptive use increased slightly, but not significantly, among men and among married women. Unmarried women registered substantial gains in the use of the pill and all three long-term methods. Before the campaign, none of the unmarried women were using long-term methods and fewer than 5 percent used the pill. After the campaign, more than 7 percent reported using a long-term method ( $p \leq .01$ ) (with the injectable more popular than the IUD or Norplant), and pill use more than doubled, rising to 12 percent ( $p \leq .05$ ).

**Table 8.**  
**Percentage Distribution of Men and Women Using Modern Family Planning, by Type of Method:**  
**Zimbabwe Male Motivation and Method Expansion Project, 1993-1994**

Method	Married Respondents				Unmarried Respondents			
	Men		Women		Men		Women	
	Baseline (N=258)	Follow-up (N=214)	Baseline (N=325)	Follow-up (N=268)	Baseline (N=229)	Follow-up (N=173)	Baseline (N=120)	Follow-up (N=77)
<b>Any modern method</b>	65.8	60.1	58.9	56.0	45.5	45.8	8.8	14.0*
<b>Short-term methods</b>	62.4	57.4	51.7	48.2	45.2	45.8	8.3	9.2
Pill	55.4	50.0	48.4	45.5	7.3	2.4*	4.5	8.1
Condom	7.0	6.7	3.3	2.7	37.9	42.8	3.8	1.1
Diaphragm	0.0	0.7	0.0	0.0	0.0	0.3	0.0	0.0
Foam	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0
<b>Long-term methods</b>	2.5	2.4	4.8	6.7	0.2	0.0	0.0	4.8
Injectables	0.5	1.7	4.0	5.2	0.0	0.0	0.0	2.2
IUD	2.0	0.8	0.8	1.5	0.2	0.0	0.0	1.9
Norplant	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.7
<b>Permanent methods</b>	0.5	0.0	2.4	1.1	0.9	0.0	0.5	0.0
Tubal ligation	0.9	0.2	2.4	0.7	0.0	0.0	0.5	0.0
Vasectomy	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: Data were adjusted on site, gender, and age to 1992 Zimbabwe Census Data.

\* p ≤.05 \*\* p ≤.01 \*\*\* p ≤.001

While the numbers of Zimbabweans relying on injectables, the IUD, and Norplant are small, they do indicate a pattern of increasing use of long-term methods, while the use of short-term methods declined slightly. This suggests that the campaign made progress in increasing use of long-term methods but not of permanent methods. Any impact on permanent methods, however, might take longer to become evident, because the decision to use a permanent method is more complex and is made over a longer time period. Also such methods are less easily obtained.

Of the three long-term methods, injectables showed the greatest increase in use, perhaps because their recent reintroduction in Zimbabwe had generated unusual interest in the method. Injectables were the focus of training courses to update service providers about contraceptive technology before the campaign launch, and they were readily available during the campaign. Mass-media news and feature stories also dealt with the reintroduction of injectables, which had been available but were banned shortly after Independence until 1992.





## Chapter V

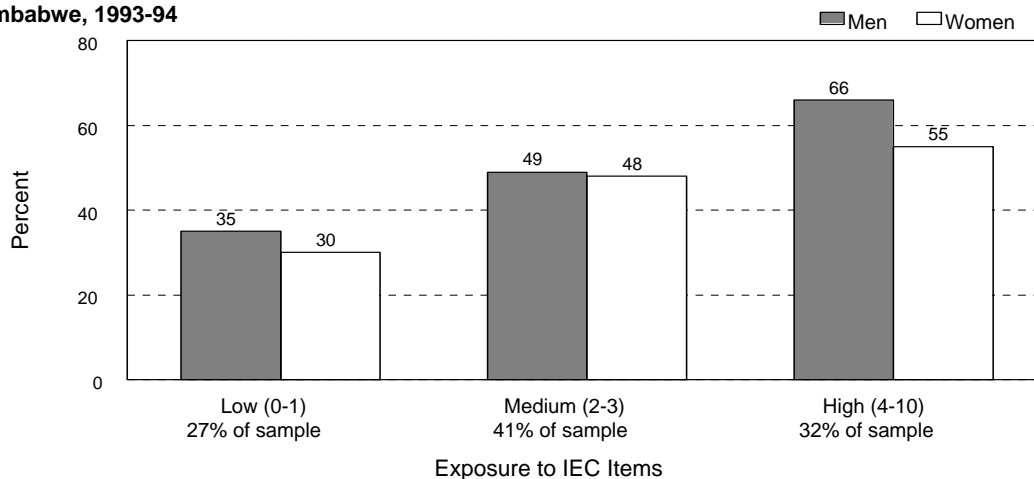
### Analyzing Post-Campaign Survey Data by Exposure Status

A second analysis of the follow-up survey looks for a link between the exposure of respondents to the campaign, their use of contraceptives, and any actions they reported taking in response to the campaign. The next step is to combine data on campaign exposure with sociodemographic information and data on family planning knowledge, attitudes, and practices in a multivariate logistic regression analysis. This analysis can indicate the extent to which campaign exposure has a separate effect on each step in the process of adopting family planning.

#### Campaign Exposure and Family Planning Behavior

Depending on the number of campaign components to which they were exposed, respondents to the follow-up survey were divided into low exposure (zero to one component), medium exposure (two or three components), and high exposure (four to 10 components) groups. As Figure 7 illustrates, campaign exposure is associated with contraceptive use. The percentage of men using a modern contraceptive method rose with increasing exposure to the campaign from 35 percent to 49 percent to 66 percent ( $p \leq .001$ ). Women exhibit a similar pattern, with use increasing with campaign exposure from 30 percent to 48 percent to 55 percent ( $p \leq .001$ ). This does not establish the direction of the causal relationship, however, since it is possible that family planning users were more likely than other men and women to listen, view, or read campaign materials and to attend campaign events.

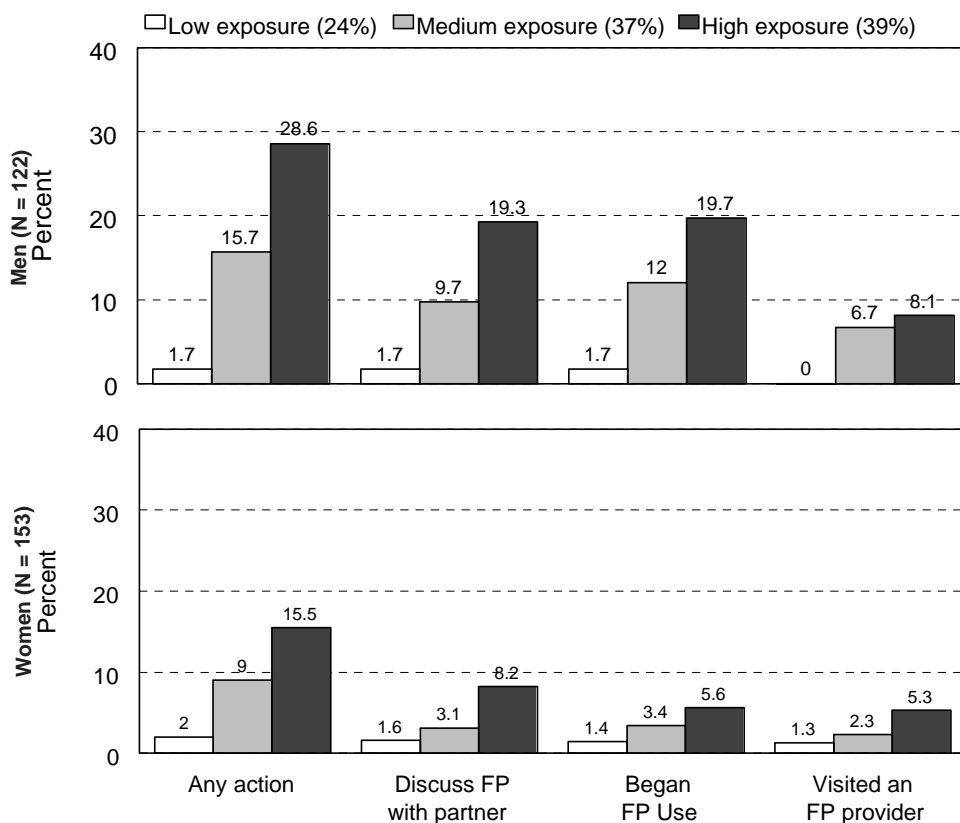
**Figure 7.**  
**Modern Method Use, by Level of Campaign Exposure:**  
**Zimbabwe, 1993-94**



SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Follow-up Survey (5/94).  
NOTES: N = 1,016.  
Data are weighted by gender and site population and adjusted for age, using 1992 Zimbabwe Census Data.

The follow-up survey asked respondents what actions, if any, they took as a result of exposure to campaign materials and activities. Figure 8 shows that, regardless of gender, the greater a respondent's exposure to the campaign, the more likely he or she was to report taking action. Thus 29 percent of men with high levels of exposure to the campaign (i.e., four or more components) reported taking some action compared to just 16 percent of those with medium exposure (two or three components) and 2 percent of those with low exposure (no or just one component) ( $p \leq .001$ ). The comparable figures for women are 16 percent, 9 percent, and 2 percent ( $p \leq .001$ ). These results support earlier findings that multiple communication channels reinforce one another and so are more likely than campaigns relying on a single channel to change family planning behavior.

**Figure 8. Actions Taken by Men and Women, by Level of Campaign Exposure: Zimbabwe, 1993-94**



SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Follow-up Survey (5/94).

NOTE: Data are weighted by gender and site population and adjusted for age, using 1992 Zimbabwe Census Data.

When men reported taking action, they were equally likely to discuss family planning with their partners or to adopt a method (13 percent, not shown). They were half as likely to consult service providers or community-based family planning workers (6 percent), presumably because most couples relied on female contraceptive methods that require the woman to visit a provider. Women, in contrast, were slightly more likely than men to discuss family planning with their partners or spouses (4 percent) than either to see a provider (3 percent) or adopt a method (3 percent).

Given the same degree of campaign exposure, men were more likely to report taking action than women. Among respondents with high campaign exposure, for example, men were one and a half times as likely as women to see family planning providers (8 percent *versus* 5 percent), twice as likely to discuss family planning with their partners (19 percent *versus* 8 percent), and three times as likely to adopt contraception (20 percent *versus* 6 percent). These results indicate that the male-oriented design of the campaign worked as planned. It was more effective in persuading men than women to take a positive step towards family planning. While the campaign did convince many women to take action, its impact on this secondary audience was smaller than its impact on the primary audience of men. Women were less than half as likely as men, overall, to report taking some action in response to the campaign (8 percent *versus* 18 percent,  $p \leq .001$ ).

## Multivariate Analysis

Exposure to the campaign is associated with some of the same sociodemographic variables that affect family planning knowledge and behavior. Education, for example, is associated both with exposure to the campaign and with the knowledge and use of family planning. To determine whether campaign exposure had an independent effect on family planning practices, a multivariate logistic regression analysis was conducted. This analysis looks at the effect of exposure to at least three campaign elements and includes six key sociodemographic factors: gender, marital status, residence, age, education, and socioeconomic status.

The multivariate analysis confirms the impact of the campaign on the knowledge and approval of modern family planning methods (see Table 9). People exposed to three or more campaign components are 2.5 times more likely than others to know at least three modern family planning methods and 1.6 times more likely to approve of using a modern method after controlling for the six sociodemographic variables. These increases in knowledge and approval are linked, in turn, with increased couple communication. Exposure to the campaign thus may affect couple communication indirectly even though there is no direct link.

Campaign exposure is directly associated with contraceptive use, with persons exposed to at least three campaign elements 1.6 times more likely to use a modern family planning method (see Table 9). Further analysis shows that exposure to the campaign is significantly associated with only one specific method: injectables.

**Table 9.**  
**Odds Ratios of Family Planning Use, Attitudes, Knowledge, Campaign Exposure, and Sociodemographic Variables Determined by Multivariate Logistic Regression Analysis: Zimbabwe, 1993-1994**

Variable	Percent	Odds Ratio				
		Exposed to $\geq$ Three Campaign Elements	Knows $\geq$ Three Modern Methods	Approves Use of Modern Method	Discussed FP with Partner	Uses Modern Method
Men	52	1.4 *	0.5***	—	—	—
Married	58	—	—	14.6***	4.4***	2.0***
Growth point resident	11	1.6 **	—	—	2.0***	—
Age $\geq$ 30	40	—	—	.5**	—	—
Secondary education or more	72	3.0 ***	2.4***	—	1.6**	1.6*
High socioeconomic status	55	—	—	—	1.5**	—
Exposed to $\geq$ 3 campaign elements	54	—	2.5***	1.6**	—	1.6**
Knows $\geq$ 3 modern methods	59	—	—	2.3***	1.8***	1.5**
Approves of using modern methods	80	—	—	—	9.6***	4.7***
Has discussed FP with partner in last 9 months	45	—	—	—	—	1.8***
Pseudo R <sup>2a</sup>		0.057	0.081	0.224	0.236	0.167

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Follow-up Survey (5/94).

NOTES: Results of multiple regression analysis of data from follow-up survey.

N = 1,008

\*  $p \leq .05$  \*\*  $p \leq .01$  \*\*\*  $p \leq .001$  — = not significant

<sup>a</sup> Proportional reduction in the log likelihood estimate after fitting the model indicated, and hence it approximates the proportion of variance explained in Ordinary Least Squares regression.

## **Chapter VI**

### **Client Exit Interviews and Service Statistics**

Exit interviews with family planning clients and clinic service statistics provide additional data on the impact of the campaign. While neither source provides information as complete as that supplied by the household surveys, the exit interviews provide useful insights into the decision-making process, while the service statistics reveal how the campaign fits into long-term trends in contraceptive use.

#### **Exit Interviews and the Decision-making Process**

To explore how the campaign affected the decision-making process, researchers interviewed family planning clients who adopted or switched methods during the campaign. Since the clients interviewed in campaign and noncampaign areas are not comparable, only data collected in campaign areas are discussed here. Nearly all clients in campaign areas said that their partners approved of their using family planning (96 percent) and that they had discussed family planning with their partners in the preceding three months (92 percent). Clients reported discussing family planning an average of four times over a 3-month period, indicating a high level of couple communication before family planning decisions are made in Zimbabwe.

Most clients (61 percent) reported that family planning was a joint decision. Only 16 percent said that their partners made the decision, while 20 percent reported that they themselves had made the decision. (Three percent reported that the provider or another person made the decision.) Male involvement was largely confined to discussion and decision-making, however. Only 12 percent of the mostly female clients were accompanied by their partners to the clinic.

Almost half the clients (49 percent) reported that they had learned of the family planning facility from a health or family planning worker. Friends and relatives were the second most important source of information, reported by 27 percent of respondents. Thirteen percent cited the media, either radio, television, or print materials.

One of the campaign's goals was to encourage active users of short-term contraceptives to switch to long-term and permanent contraceptive methods. Of the clients interviewed during the campaign, 1,024 (almost one-third) switched methods. More than two-thirds started as pill users, and most of these switched to injectables. The largest group of clients who switched methods (60 percent) discontinued the pill in order to start the injectable. Eight percent reported dropping the pill in favor of the IUD.

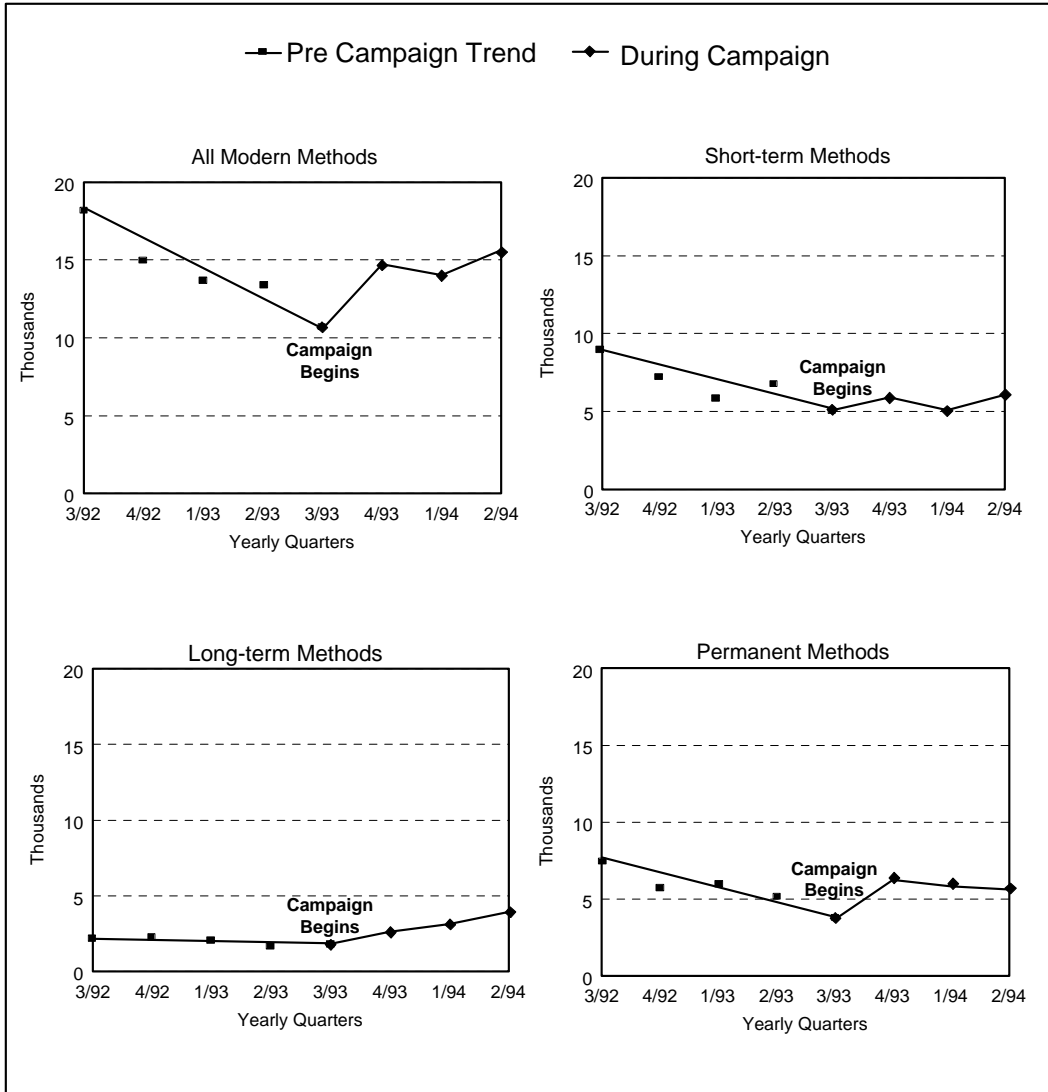
## Service Statistics and Contraceptive Use

Family planning service statistics were collected for a full year before the campaign launch to indicate the baseline trend in contraceptive use in the campaign areas. As Figure 9 shows, demand for contraceptives of all kinds was declining in the year preceding the campaign. The decline was probably caused by price increases for contraceptives in November 1992 and November 1993 and for primary health care in mid-1993. Data from the 1993 Family Planning Program Monitoring and Evaluation System (FPPMES) confirm this downward trend in Harare and Bulawayo (Ojemark *et al.* 1994). The price increases also dampened demand for other health services; the number of women visiting facilities for immunization and ante- and postnatal care reportedly declined after fees were raised.

Service statistics show that this trend reversed direction during the campaign period, with long-term and permanent methods making greater gains than short-term methods. The rise in the use of long-term methods is most dramatic, with couple-years of protection (CYP) at the end of the campaign well above the levels recorded during the baseline period (see Figure 9). By the end of the campaign, CYP for short-term and permanent methods had not recovered to 1992 levels. The survey results, because they record contraceptive use at two discrete points in time, cannot capture these kinds of trends.

Although the timing suggests that the campaign may have halted the recent decline in contraceptive use, other factors may have contributed to this change. Experience with price increases in other countries suggests that contraceptive use in Zimbabwe eventually would have recovered without any intervention (Ciszewski and Harvey 1994; Lande and Geller 1991; Lewis 1986). It is also possible that the introduction of Norplant and injectables in 1992 and their subsequent integration into clinic services attracted new users during the campaign period. Broader economic and social trends in Zimbabwe that are part of overall socioeconomic modernization may also contribute to increasing contraceptive use. Conversely, the economic recession which affected Zimbabwe during this period may also have provided economic pressure on couples to postpone or avoid additional births.

**Figure 9.**  
**Trends in CYP for Various Types of Contraceptive Methods**  
**Before and During the Campaign:**  
**Zimbabwe, 1993-94**



SOURCES: JHU/CCP & ZNFPC  
 Service statistics from 23 health facilities





## Chapter VII

### Discussion and Conclusions

This evaluation of the 1993-1994 male involvement campaign in Zimbabwe and the use of several approaches to evaluate impact offers answers to two qualitatively different sets of questions.

- Did the various campaign materials and activities reach their intended audiences, stimulate male involvement in family planning, and increase the use of long-term and permanent contraceptive methods as planned?
- Did the multiple evaluation methods complement each other and help form a more detailed picture of the campaign's impact?

The lessons learned here, whether they concern program planning or research design, can contribute to more effective future communication campaigns.

### Reaching Men

Findings from the 1993-1994 male involvement campaign in Zimbabwe clearly indicate that a well-designed communication campaign can reach everyone with family planning messages—including men, who are often considered unreachable. The 6-month male motivation campaign reached most adults in both the cities and growth points; 88 percent were exposed to at least one of the 10 major campaign activities and materials, and most were exposed to multiple communication channels. The radio dramas, radio and television spots, posters, and pamphlets each reached more than half the target audience in campaign areas. Compared to the original male motivation campaign in 1988-1989, this campaign reached many more men (88 percent *versus* 52 percent), reflecting improvements both in the design and implementation of the campaign's components.

Radio proved to have the greatest reach of all the media used, as had been the case in the first campaign. The success of the radio programming confirms earlier findings that Zimbabwean men regard radio as an excellent source of family planning information. While the drama was scripted for a male audience, it attracted an even larger female listenership: about 62 percent of men and 69 percent of women listened to the radio drama. The motivational talks also attracted more women than men, and, overall, the campaign reached equal numbers of men and women (88 percent and 89 percent). The campaign's ability to reach women in addition to its primary audience of men magnified its impact. Because women as well as men were surveyed during this

campaign, the evaluation could document the campaign's impact on women—data that were lacking during the earlier campaign.

As intended, the campaign was more effective in reaching men than women. Apart from radio dramas, most elements of the campaign reached a larger percentage of men than women, and men's exposure to the campaign was more intense than women's. Nearly 40 percent of men were exposed to four or more campaign components, compared to just 24 percent of women. One of the campaign's most innovative activities, the football tournament, was especially attractive to men: 18 percent attended a game, while 57 percent had heard of the matches. Football is always popular among men in Zimbabwe. That was especially true at the time of the campaign as the entire nation rooted for the Zimbabwean "Dream Team" to make it to the World Cup. Television and radio broadcasts of the World Cup football matches enlarged the audience far beyond those fans who attended the games. Thus the campaign cleverly capitalized on the popularity of a sport with an established and exceptionally large male audience and virtually guaranteed itself an audience; selling tickets to the matches also limited expenses. Publicizing and attracting large audiences to events designed solely to promote family planning, such as a family festival or puppet show, is far more difficult. Twice as many men attended a football match as the next most popular community event of the campaign, the motivational talks (18 percent *versus* 9 percent).

The football tournament also provided a virile theme for other aspects of the campaign. Campaign slogans used sports metaphors; newspaper and magazine ads featured famous local football players; and radio and television spots urged men to "win" the family planning "game" with the help of their "teammates" (sexual partners). Winning is a compelling, virile concept that campaign planners hoped would encourage men to take action. The sports images succeeded in attracting male audiences. Those campaign components that emphasized sports themes—the football matches and the newspaper and magazine advertisements—attracted a largely male audience, and men were twice as likely as women to recall the main campaign slogans featured in the print ads. The campaign also achieved its goal of persuading men to take some positive steps, discussing family planning with their partners, consulting service providers, or adopting modern contraception. Men were twice as likely as women to report taking one of these actions in response to the campaign. Thus the clear focus on men during the design of the campaign enabled it to reach and sway an audience long considered hard to reach.

The campaign's reach was extended and reinforced by widespread media coverage of activities. Journalists were included in the membership of the local committees that managed the campaigns at each of the five sites and were briefed on the campaign

beforehand at special workshops. The appearance at press conferences and launch ceremonies of high-level government officers, such as the Minister of Health and Child Welfare and city mayors, also attracted television, radio, and newspaper coverage. This free publicity disseminated campaign messages even more broadly, enhancing the credibility of the campaign.

## **Changing Knowledge, Attitudes, and Behavior**

The ultimate goal of the campaign was to increase contraceptive use, especially of long-term and permanent methods. Indeed, the greater their exposure to the campaign, the more likely men and women were to use a modern contraceptive method. People exposed to three or more campaign elements were 1.6 times more likely than others to use a modern method, even when controlling for sociodemographic factors that might influence contraceptive use, including gender, marital status, residence, age, education, and socioeconomic status.

The baseline and follow-up survey comparisons, however, show small decreases (although statistically insignificant) in the use of modern contraceptives. The price increases for contraceptive supplies of 1992 and 1993, coupled with increases in the price of primary health care mid-1993, apparently dampened contraceptive demand. At the time of these price increases, the numbers of women visiting facilities for ante- and post-natal care (also for immunization) reportedly declined. Thus, it is not surprising that service statistics collected from health facilities in the campaign areas showed a downward trend in CYP during the year preceding the campaign—a trend confirmed by the 1993 Family Planning Program Monitoring and Evaluation System (FPPMES). Although there is some suggestion that clients who previously used public-sector facilities sought services from private doctors instead, no data are available on this shift in source of services.

As noted in Chapter VI, the service statistics show that the downward trend in contraceptive use reversed during the campaign period. This suggests that the campaign may indeed have had a substantial effect on contraceptive use. If the baseline survey measured contraceptive use before it reached its low point and the follow-up survey measured use just after it had rebounded, the two surveys would have missed the shift in trends indicated by the service statistics. Alternatively, the service statistics may be flawed, either because of problems in collecting accurate clinic data or because the sample was limited to clinics offering long-term and permanent methods. If so, the survey data showing no change in contraceptive use may be a more reliable indicator than the service statistics.

Close examination of the survey results reveals that demand for at least one of the methods promoted, the injectable, did in fact rise over the campaign period. Married men reported a fourfold increase from 0.6 percent to 2.4 percent in their wives' use of the injectable; married women also showed a substantial rise in injectable use, from 3.7 percent to 5.6 percent. Use also increased among unmarried women. Of the family planning clients interviewed during the campaign who switched methods, more than half switched to the injectable. Results from the 1988 and 1994 Zimbabwe Demographic and Health Surveys (ZDHS) confirm the increasing use of the injectable; the portion of all Zimbabwean women using injectables rose from 0.7 percent to 2.4 percent between 1988 and 1994 (CSO and IRD 1989, CSO and DHS 1995). Reintroduction of injectables in Zimbabwe in 1992 may have fueled interest in the method. The focus on the injectable during service providers' in-service training before the campaign also may have affected clients' choice of methods. But usage did not actually increase in the sentinel clinics until the campaign began, nearly a year after the injectables were introduced.

While the pill still accounts for three-fourths of all modern contraceptives used in Zimbabwe according to the 1994 ZDHS, the male motivation campaign did improve the image of long-term and permanent methods. Men and women were more likely to approve of using such a method after the campaign and also were more likely to feel that their spouses or other partners would approve of using such a method. Knowledge of the injectable, the IUD, Norplant, and vasectomy also increased. The greatest gains were in women's knowledge of vasectomy, which rose from 39 percent to 55 percent, and of Norplant, which climbed from nearly 10 percent to 27 percent. These gains are important because knowledge of long-term and permanent methods in Zimbabwe has lagged far behind the almost universal knowledge of the pill and condom.

The campaign's success in reaching both men and women encouraged couples to discuss contraceptive use more often. Before the campaign, only 41 percent of men and 37 percent of women reported discussing family planning often with their spouses or partners. After the campaign, more than half (51 percent of men and 57 percent of women) did. Exit interviews also found that family planning clients in campaign areas were more likely to have discussed family planning with their partners than were those in noncampaign areas. Increased communication between partners may account for the fact that after the campaign women were less likely to report that they did not know their husbands' or partners' opinions about contraceptives.

**Male involvement.** The campaign also encouraged men to get more involved in family planning. After the campaign, men were far less likely to think they should leave family planning decisions to their wives or partners. They were more likely to believe decisions to obtain family planning information and to go to the clinic should be made

jointly. Many men, however, apparently misinterpreted the campaign's messages to mean that family planning decisions should be left solely to the man (a problem also encountered during Zimbabwe's earlier male motivation campaign). The surveys showed a marked increase in the percentage of men believing they alone should make the couple's family planning decisions (for example, the proportion of men believing they should be responsible for choosing a method rose from 27 percent to 37 percent).

The campaign may have affected actual behavior in a more positive way than these figures suggest, however. According to exit interviews, most family planning decisions in campaign areas (61 percent) were made jointly; clients (mostly women) reported that only 16 percent of decisions were made by their spouses. In noncampaign areas joint decision-making (41 percent) was far less prevalent and sole decision-making by the spouse far more prevalent (31 percent).

The campaign's use of overtly masculine sports images may have reinforced traditional male stereotypes, including the idea that men make the family planning decisions. Thus, the campaign may have been sending messages that could be misinterpreted. More likely, established cultural patterns may lie at the root of the problem. An evaluation of the first ZNFPC male motivation campaign also found changes toward males-only decision-making. That campaign, however, did *not* use specifically masculine images. The more plausible explanation for this misinterpretation of messages may lie in the duration of the campaign. A brief campaign of only a few months is simply not sufficient to overcome traditional attitudes toward gender roles, especially with respect to decision-making. Thus, involving men in family planning may be easier than getting them to accept the notion of joint decision-making. Future efforts in Zimbabwe must communicate the need for couple communication and joint decision-making even more clearly and unambiguously. Visual images and verbal analogies should be chosen to complement the meaning of the message.

**Heightening impact with multiple communication channels.** No matter what the impact of the campaign—on couple communication, on visits to service providers, or on contraceptive use—use of multiple communication channels heightened it. For both men and women, the greater their exposure to the campaign, the more likely they were to take some action in response. Thus, 29 percent of men exposed to four or more campaign components, 16 percent of men exposed to two or three, and 2 percent of men exposed to one or none reported taking some action.

It is worth the effort to organize a wide variety of activities and materials. They will reinforce one another, add strength and credibility to the message, and help persuade individuals to take action.

## Evaluation Issues

**The value of multiple measurements.** Multiple data sources and analytic methods can yield a fuller understanding and better explanation of a campaign's impact. To interpret the impact of the male motivation campaign more fully, this study examined data from three complementary sources (household surveys, client exit interviews, and service statistics), each of which had different strengths. Because the household surveys were conducted both before and after the campaign, they revealed changes that took place over the campaign period. By surveying a random cross-section of the population, the follow-up survey also provided data on how knowledge, attitudes, and behavior varied both by exposure to the campaign and by sociodemographic characteristics. This information permitted a multiple regression analysis of the campaign's impact.

While the household surveys involved the broadest possible pool of respondents, the client exit interviews were restricted to persons who decided to adopt or switch contraceptive methods during the campaign. This narrow focus provided information on family planning decision-making and referral sources that general household surveys cannot collect. The service statistics also were narrowly focused on contraceptive use, but data were gathered for a full year prior to the start of the campaign to establish the baseline trend in contraceptive use in the campaign areas. Without this trend data, the effect of the campaign on contraceptive use might have gone unrecognized.

Collecting and analyzing these three types of data entailed more work and greater technical proficiency than relying on a single source of data. Having these different perspectives on the campaign's outcome, however, helped researchers to interpret the results, increased understanding of the campaign's effects, and lent confidence to discussions of causality. For example, service statistics documenting longer-term trends in contraceptive use provided a broader context for the interpretation of survey results on contraceptive prevalence. In a similar fashion, the reality of joint decision-making, as documented by the client exit interviews, offset hypothetical preferences for male decision-making revealed in the surveys.

Sometimes the results of different research methods may appear to conflict, complicating interpretation. The key is to keep an open mind and consider all possible ways to explain or reconcile apparent conflicts. Further analysis or other sources of data may be necessary to explain fully the differing data. For example, the discrepancy in service statistics and household survey data on contraceptive use prompted a review of other information on contraceptive trends in Zimbabwe.

**Constraints in the field.** Practical difficulties complicated the design and implementation of this research. For instance, client exit interviews relied on a subsample of national family planning service facilities. Because of administrative obstacles, exit interviews were conducted only at ZNFPC clinics and not at the Ministry of Health facilities that serve the majority of family planning clients in Zimbabwe. In addition, abstracting service statistics from centralized computerized files was not feasible in Zimbabwe. Thus, service statistics were collected using a sentinel site approach from only a small number of sites. Researchers had to set up a special system to gather the data needed. Given the limited size of the sample and the need to document changes in the prevalence of rarely used long-term and permanent methods, researchers decided to gather service statistics only from clinics which offered long-term and permanent methods. Clinics offering only short-term methods that were excluded.

While these design decisions made it possible to collect the data, they raised concerns about possible bias. When such problems arise, researchers should try to devise alternative approaches to gather the information needed. In Zimbabwe, for example, researchers considered adding a single question on source of referral to all new-client record cards rather than conducting limited exit interviews with clients. Because not all clinics keep client record cards, however, this approach was not feasible.

Another design issue surfaced when planners decided to include Zimbabwe's only two large cities in the campaign areas in order to heighten the impact of the male motivation project. This effectively precluded the use of control sites, since Zimbabwe has no other comparable urban areas. Indeed, the exit interviews, which collected data in non-campaign areas as well as campaign areas, found that the two groups of respondents were quite different from one another. The campaign's use of national broadcast media also made it difficult to identify unexposed control areas. When it is not feasible to identify a control site (a frequent problem in this type of communication project), the evaluation is constrained in its ability to draw inferences about causality. If an IEC program manager wants to evaluate a campaign's impact with more confidence by using experimental and control groups, matching control and project sites must be chosen early, in the design phase; legitimate matching sites must exist; and the program must be able to prevent contamination of those control sites by IEC media interventions.

**Additional research.** Only 10 months separated the two household surveys—too short a time period in which to see a major shift in family planning behavior, especially if couples were to discuss and decide on a long-term or permanent method of contraception. While delaying the follow-up survey would have allowed more time for the impact to register, it would also have weakened the ability of respondents accurately to report their exposure to the campaign. It would also provide a greater



opportunity for contamination from other program interventions designed to increase contraceptive use. One solution might be to conduct an additional survey, perhaps a year or two later, to continue following changes in male involvement, couple communication, and contraceptive practice. Given a limited budget for research and evaluation, however, such a long-term follow-up survey may not be feasible; it is certainly not a common practice. In this project, long-term follow-up was not one of the stated objectives for the research component.

Also not included in this analysis is any type of qualitative data that might shed light on how the campaign changed individual attitudes and behavior. Future evaluations should consider conducting qualitative research with the men and women who report, for example, discussing family planning with their partners or adopting or changing a contraceptive method in response to a campaign. This kind of qualitative research is cost-effective and relatively quick, and it can explain how the process of behavior change takes place.

## **Conclusion**

The 1993-1994 male motivation campaign in Zimbabwe has demonstrated that men can be reached with family planning messages. The keys are to select appealing and appropriate communication channels, such as radio dramas and sports events, and to develop messages that use virile images, such as winning games. The campaign has shown that involving men in family planning encourages couples to communicate and ultimately to decide to use contraception. In addition, the campaign helped to shift the method mix away from short-term methods to greater reliance on long-term and permanent methods.

At the same time, the evaluation has demonstrated the value of using multiple complementary data sources and methods of analysis to gain a fuller understanding of the impact of a communication campaign.

## Abbreviations

CBD	community-based distribution
CSO	Central Statistical Office
CYP	couple years of protection
EA	enumeration area
ERU	Evaluation and Research Unit (of ZNFPC)
FP	family planning
FPPMES	Family Planning Program Monitoring and Evaluation System
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
IEC	information, education, and communication
IRD	Institute for Resource Development
IUD	intrauterine device
JHU/PCS/PIP	Johns Hopkins University/Population Communication Services/ Population Information Program
MCH	maternal and child health
MOH	Ministry of Health
SEATS	Service Expansion and Technical Support Project
USAID	United States Agency for International Development
ZACT	Zimbabwe Association of Community Theater
ZDHS	Zimbabwe Demographic and Health Survey
ZNFPC	Zimbabwe National Family Planning Council

## Appendix A.

### Population Size and Number of Respondents to Baseline and Follow-up Surveys, by Age Group, Location, and Gender: Zimbabwe Male Motivation and Expansion Project, 1993-1994

Province	Age Group <sup>a</sup>	Population Size		Number of Survey Respondents			
		Men	Women	Baseline		Follow-up	
				Men	Women	Men	Women
<b>Bulawayo</b>	15-19	29,003	38,922	19	33	23	23
	20-24	34,612	40,388	49	37	40	35
	25-29	29,251	31,562	42	55	23	32
	30-34	26,153	24,919	25	21	13	25
	35-39	22,000	18,182	20	21	25	17
	40-44	15,276	11,321	14	12	10	11
	45-54	21,908	8,545	13	4	13	4
<b>Harare</b>	15-19	57,393	73,837	19	24	6	22
	20-24	87,319	84,324	59	53	30	26
	25-29	71,197	58,165	32	31	33	22
	30-34	55,760	43,495	11	30	32	30
	35-39	44,338	31,458	18	24	18	23
	40-44	30,337	19,880	7	12	19	15
	45-54	42,533	13,689	21	3	12	7
<b>Gweru</b>	15-19	6,211	8,426	4	11	16	9
	20-24	7,762	8,842	19	8	24	16
	25-29	6,222	6,402	5	16	13	12
	30-34	5,568	4,989	5	10	6	15
	35-39	4,764	3,618	6	5	5	9
	40-44	3,113	2,149	6	2	4	10
	45-54	4,202	1,418	6	1	5	4
<b>Murehwa</b>	15-19	10,145	9,229	3	8	6	13
	20-24	5,842	6,693	16	9	13	21
	25-29	3,745	4,598	11	12	19	22
	30-34	2,797	4,283	7	12	14	11
	35-39	2,231	3,638	5	5	6	4
	40-44	1,787	2,891	5	1	3	2
	45-54	3,337	2,201	3	3	4	0
<b>Mupandawana</b>	15-19	13,648	12,726	4	5	7	6
	20-24	6,161	7,994	13	11	15	15
	25-29	3,594	5,118	13	14	16	22
	30-34	2,946	5,458	12	7	14	18
	35-39	2,633	4,765	4	9	9	5
	40-44	1,974	4,062	4	3	6	3
	45-54	4,173	3,492	1	1	6	3

SOURCE: JHU/CCP & ZNFPC Zimbabwe Method Expansion Project Baseline Survey (7/93) and Follow-up Survey (5/94).

NOTES: Data were adjusted on site, gender, and age to 1992 Zimbabwe Census Data.

<sup>a</sup>Age range for women is 15 to 49; age range for men is 18 to 54.

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