

Expanded Community-based Distribution Program: 2003 Baseline Survey Report, Zimbabwe

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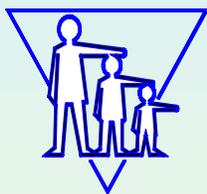
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Expanded Community Based Distribution (CBD) Programme

2003 Baseline Survey Report

Zimbabwe National Family
Planning Council



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Table of Contents	Page
List of Tables	2
List of Figures.....	3
Foreword.....	4
Acknowledgements.....	5
Abbreviations.....	6
Executive Summary.....	7
Chapter 1: Background and Objectives.....	11
Chapter 2: Methodology.....	17
Chapter 3: Background Characteristics of Respondents.....	20
Chapter 4: Reproductive Health Knowledge and Attitudes.....	25
Chapter 5: Reproductive Health Practices.....	37
Chapter 6: Conclusions and Recommendations.....	48

List of Tables	Page
Table 2.1. Distribution of sampled CBDs/wards by district.....	16
Table 2.2. Distribution of respondents by sex and district.....	18
Table 3.1. Percentage distribution of respondents by selected background characteristics.....	21
Table 4.1. Percentage of respondents by their knowledge of the health workers in their locality.....	23
Table 4.2. Percentage of respondents who were exposed to CBD activities.....	24
Table 4.3. Percentage of respondents who were visited by a CBD by topic discussed and IEC materials received/shown.....	25
Table 4.4. Percentage of respondents by type of person they would consult if they needed information or counselling about HIV/AIDS.....	27
Table 4.5. Percentage of respondents by type of HIV/AIDS/STI knowledge.....	28
Table 4.6. Percentage of respondents by main source of information on HIV/AIDS.....	30
Table 4.7.a. Percentage distribution of respondents by their self perception of HIV/AIDS risks.....	31
Table 4.7.b. Percentage distribution of respondents by reasons for their self- perceived HIV/AIDS risks.....	31
Table 4.8. Percentage of respondents who know of an HIV testing centre.....	32
Table 4.9. Percentage of respondents by source of information on HIV testing centre.....	33
Table 4.10. Percentage of respondents by reason for not willing to be tested.....	34
Table 4.11. Percent of respondents who know of contraceptive methods.....	35
Table 5.1. Percentage of respondents who have ever had sex by given age.....	37
Table 5.2. Percentage of respondents who have had sexual intercourse by exact ages at first experience.....	37
Table 5.3. Percent distribution of sexually-active respondents by relationship to sexual partner(s) in last 12 months.....	38
Table 5.4. Percentage of respondents currently using contraception by family planning method.....	39
Table 5.5. Percent of sexually-experienced current users of contraception by background characteristics.....	40
Table 5.6. Percent of current users of contraception by source of supply...	41
Table 5.7. Percent of sexually-experienced respondents who have ever used condoms by age group, marital status, education, and religion.....	42
Table 5.8. Percent distribution of condom users by reason for using condoms.....	43

Table 5.9. Percent distribution of respondents who had never used condoms by reasons for not using condoms.....	43
Table 5.10. Percent of respondents who have used a condom by usual source of supply.....	44
Table 5.11. Number of reported cases of referrals ever made by CBDs to health facilities by type of referral.....	45
Table 5.12. Percent of respondents who have ever been pregnant by age group, marital status, education, and religion.....	45
Table 5.13. Children born and average parity by age group.....	46

List of Figures	Page
Figure 4.1. Percentage of respondents who attended a meeting addressed by CBD by type of topic she/he discussed.....	26
Figure 4.2. Percent of males and females by their willingness to be tested for HIV.....	34
Figure 4.3. Percent distribution of women by whether they want to have a birth within the next 12 months.....	36
Figure 5.1. Percentage of respondents currently using contraception.....	38
Figure 5.2. Percent of respondents who ever used a condom and those who used a condom at last sex.....	42
Figure 5.3. Average number of children ever born to women by level of education.....	47

FOREWORD

The Zimbabwe National Family Planning Council (ZNFPC), with technical assistance from Advance Africa and funding from the United States Agency for International Development (USAID), initiated the expansion of the roles of community-based distributors (CBDs) beyond the provision of family planning information and services. The major objective of expanding CBD roles is to improve HIV/AIDS/STI knowledge among communities as a strategy for preventing the spread of HIV.

The Expanded CBD Programme was conceptualized in 2000 as a response to the recommendations of the *1999 CBD Review Study*. Implementation of the project started in August 2001 in eight selected districts throughout Zimbabwe. The Expanded CBD Programme is being implemented in phases. Lessons learnt from each phase will be used to improve implementation of subsequent phases.

The Expanded CBD Programme is increasingly seen as an innovative, cost-effective, and results-oriented intervention to transfer family planning, HIV/AIDS/STI and other reproductive health knowledge and experience among Zimbabweans. As a result of this success, the decision was made to expand the programme to eight other districts during the year 2003. A baseline survey, whose findings are documented in this report, was conducted in January 2003 before the implementation of the Expanded CBD Programme activities in the eight expansion sites.

ZNFPC is looking at prospects and opportunities for strengthening this programme and for implementing it nationwide.

Godfrey Tinarwo
Executive Director, ZNFPC

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Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
BCC	Behaviour Change Communication
CBDs	Community-Based Distributors
CAFS	Centre for African Family Studies
CPR	Contraceptive Prevalence Rate
CSO	Central Statistical Office
FHI	Family Health International
IUD	Intra-Uterine Device
FPA	Family Planning Association
BC	Home-Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
MIS	Management Information System
MOH&CW	Ministry of Health and Child Welfare
M&E	Monitoring and Evaluation
RDC	Rural District Council
SDC	Service Delivery Coordinator
SPSS	Statistical Package for the Social Sciences
STIs	Sexually Transmitted Infections
USAID	United States Agency for International Development
VCW	Village Community Worker
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
ZDHS	Zimbabwe Demographic and Health Survey
ZNFPC	Zimbabwe National Family Planning Council

EXECUTIVE SUMMARY

The 2003 Community-Based Distributor (CBD) Baseline Survey is a representative survey of 1,227 women aged 15-49 and 1,229 men aged 15-55. Among the respondents, 956 females and 960 males were randomly selected from eight project districts for the Expanded CBD Programme. The remainder of the sample – 271 females and 269 males – was randomly drawn from two comparison districts where there were no Expanded CBD Programme activities. Fieldworkers were trained at the ZNFPC Head Office during the period 6-12 January 2003. The fieldwork was carried out from 13 January – 5 February 2003. Data analysis and report writing were executed by ZNFPC with technical assistance from Advance Africa.

The 2003 CBD Baseline Survey was developed to provide baseline data for subsequent evaluation of the Expanded CBD Programme. The survey questionnaire was designed to collect information on respondents' characteristics, their interaction with CBDs, and their knowledge and practices regarding HIV/AIDS/STIs, family planning, sexuality, pregnancy, and fertility.

Background Characteristics of Respondents

Age distribution: Both the programme and comparison areas exhibit youthful populations. Fifty-four percent of male respondents and 46% of female respondents in the project areas were aged 15–24 years. In the comparison areas, 48% of male respondents and 45% of female respondents were aged 15-24 years.

Marital Status: Fifty nine percent of females in project areas and 58% of females in comparison areas were married. Fifteen percent of females and 4% of males in project areas were either widowed or divorced, compared with 19% of females and 3% of males in the comparison areas.

Religion: Religious affiliation patterns were similar between the project and comparison areas, with Zionism/Apostolic faith ranking top, followed by Protestantism. Thirty eight percent and 37% of females in the project and comparison areas, respectively, were of Zionism/Apostolic religion. As for males, 27% of those in project areas and 26% of those in comparison areas were of Zionism/Apostolic faith.

Education: The majority of respondents had received some schooling, but levels of education were higher among males than females. Seventy percent of males in project areas had attended secondary school, versus 58% of females. In comparison areas, 55% of males and 40% of females had attended secondary school.

Occupation: Economic activity patterns were similar between project and comparison areas, with agriculture being the mainstay of the respondents' household economy. Thirty-six percent of males and 27% of females in project areas had agricultural occupations, while 43% of males and 45% of females in comparison areas had agricultural occupations.

Language: The majority of respondents in both the project and comparison areas spoke Shona. Eighty percent of males and 78% of females in project areas and 90% of males and 88% of females in comparison areas reported that they spoke Shona.

Reproductive Health Knowledge and Attitudes

Knowledge of community health workers: In both the project and comparison areas, at least 90% of the respondents knew one type of health worker or another who was active within their community. The top three health workers known by respondents were the CBD, the village health worker, and the village community worker. Although no differences were observed between the project and comparison areas, female respondents were more knowledgeable of the CBDs by name than their male counterparts.

Interaction between CBDs and their clients: Thirty percent of males and 39% of females in the project areas said that they were visited by a CBD in the 12-month period preceding the survey. CBDs had also visited 38% of males and 41% of females in the comparison areas during the same period. Less than 10% of the respondents reported ever attending a community meeting addressed by a CBD.

Information received by respondents from CBDs: Most of the talks given by CBDs during their household visits revolve around family planning. Seventy seven percent of males and 93% of females in project areas, and 73% of males and 96% of females in comparison areas indicated that the CBD discussed family planning issues. Home-based care, VCT, and youth reproductive health were seldom mentioned. CBDs did not commonly use IEC materials and such materials seemed to be used more frequently with male respondents as compared to their female counterparts. Nineteen percent of males and 12% of females in the project areas had received a pamphlet/written material from the CBD, while 21% of males and 9% of females in comparison areas had received a pamphlet/written material from the CBD.

Attitudes towards CBDs: When asked which person they would turn to if they needed some information or counseling about HIV and AIDS, nurses ranked top, followed by the CBD. Nineteen percent of males and 39% of females in the project areas and 18% of males and 50% of females in the comparison areas mentioned the nurse as their most preferred person to consult on HIV and AIDS.

HIV/AIDS knowledge: Knowledge of HIV/AIDS, its mode of transmission, and the lack of a cure was almost universal in both the project and comparison areas. All respondents had heard of HIV/AIDS. Ninety two percent of males and 78% of females in the project areas and 92% of males and 76% of females in the comparison areas knew at least one correct mode of HIV/AIDS transmission. Although there were no significant differences between project and comparison areas, male respondents were more knowledgeable of HIV/AIDS and other STIs than their female counterparts. The main sources of information about HIV/AIDS were school/teachers (38% of males and 25% of females in the project areas and 31 percent of males and 18% of females in the comparison areas) followed by friends/neighbors/relatives, and radio. The CBDs

and other community-based health workers played a minor role in disseminating HIV/AIDS information.

Self-perceived HIV/AIDS risks: Sixty-nine percent of males and 56% of females in the project areas and 76% of males and 57% of females in the comparison areas considered their risks of being infected with the HIV/AIDS as low to non-existent. In the project areas, 26% of males and 19% of females considered themselves as having at medium or high risk of contracting HIV/AIDS. In the comparison areas, 19% of males and 20% of females considered themselves as being at medium or high risk of contracting HIV/AIDS. Respondents who perceived themselves as being at no or low risk of contracting HIV/AIDS further explained their perceptions by the fact that they were abstaining or had only one sexual partner. There were significant gender differentials between respondents who thought they were at medium or high risk of contracting HIV/AIDS. Seventy-four percent of females in project areas and 73% of females in comparison areas believed they were at medium or high risk of contracting HIV/AIDS because they did not trust their partners, compared to 6% and 8% of males in project and comparison areas, respectively.

Knowledge of HIV testing centers: When asked where one could be tested for HIV/AIDS; 24% of males and 26% of females in the project areas could not name a testing center. Seventeen percent of males and 44% of females in the comparison areas were also unable to name a testing centre. Government health facilities and VCT centers were the most well-known HIV testing centers. Females in the comparison areas seemed to be the least knowledgeable of HIV testing centers. The majority of respondents indicated that they received information about HIV testing centers from friends/neighbors/relatives (26% males and 29% females in project areas, 29% males and 41% females in the comparison areas) and from the radio (38% males and 21% females in project areas, 30% males and 10% females in comparison areas). Males relied more on the radio, and females more on friends/neighbors/relatives, as sources of information on HIV testing centers.

Attitudes towards HIV testing: Seventy-seven percent of males and 81% of females in the project areas reported that they were willing to be tested for HIV. Seventy-six percent of males and 73% of females in comparison areas were also willing to be tested for HIV. About half of female and male respondents who were not willing to be tested said they were afraid of positive results.

Knowledge of contraception: All respondents interviewed during the 2003 CBD Baseline Survey had heard of at least one modern method of contraception. Knowledge of the pill and male condoms was also nearly universal. The least known methods were implants and diaphragm/foam/jelly for females. Fourteen percent of males and 38% of females in project areas and 15% of males and 17% of females in comparison areas knew about implants.

Fertility desires: At least 80% of female respondents in both the project and comparison areas reported that they did not want to give birth within the 12-month period following the survey date.

Reproductive Health Practices

Sexual Experience: In the project areas, 21% of male respondents and 36% of female respondents, all aged 15-19, had had sexual intercourse. In the comparison areas, 34% of males and 39% of females in the same age category had had sexual intercourse. By the time they reached their 30th birthday, almost all respondents had had sexual intercourse. Among respondents aged 15 to 19 years, sexual activity was more common among males in the comparison areas as compared to their counterparts in the project areas. Risky sexual behavior seemed to be more common among men than women. Twenty-six percent of males and at most two percent of females reported having had sex within the past 12 months with a casual partner or a commercial sex worker.

Contraceptive use: Forty-six percent of males and 41% of females in the project areas and 45% of both males and females in the comparison areas were using contraception at the time of the survey. The pill, the male condom, and injectables largely dominate contraceptive method mix. Among those who were using contraception, 40% of males and 52% of females in the project areas and 48% of males and 41% of females in comparison areas mentioned the CBD as their major source of contraceptives.

Condom use: Seventy-nine percent of males in the project areas and 76% of males in the comparison areas reported ever use of a condom compared to 20% of females in the project areas and 16% of females in the comparison areas. The percentage of females who reported that they had used a condom during their last sexual encounter was higher than the percentage of females who had reportedly ever used a condom (28% and 20% in project areas and 19% and 16% in comparison areas). When asked why they used condoms, most males mentioned the prevention of STIs, while most females mentioned pregnancy prevention. Among males, reasons for non use of condoms revolved mainly around lack of trust of their partners, while female respondents mostly mentioned partner refusal.

Pregnancy and fertility: Ninety-three percent of sexually active females in the project and comparison areas reported that they had been pregnant. Women with secondary education or higher had half as many children as those with primary education or less. In both areas, women bear an average of at least four children by the time they reach their 30th birthdays.

Chapter 1: Background and Objectives

1.1. The Original CBD Programme¹

The family planning programme in Zimbabwe began in 1953 in urban and peri-urban areas. In 1965, the Family Planning Association (FPA) of Rhodesia was formed to consolidate all family planning activities in the country. The Community-Based Distributor (CBD) Programme was established in 1967 to provide safe, low-cost, and effective family planning services in both rural and urban areas using the door-to-door model. CBDs move from house to house in their catchment areas, informing, educating, and motivating men and women about family planning methods and services and providing pills and condoms to those who need them. The door-to-door approach was the ideal model, given the low contraceptive prevalence rate of about 10% in the 1970s.

After independence, the adoption of a primary health care approach by the government of Zimbabwe resulted in the strengthening of preventive health care systems. Access to family planning services was improved through the recruitment of over 600 CBDs to serve primarily rural areas. By the end of 1993, the number of CBDs had been increased to 800 in an effort to improve coverage. The CBD Programme has, among other achievements, contributed to the acceptance of family planning and the adoption of small family size norms, especially in rural areas.

The CBD Programme has made significant contributions to the overall contraceptive prevalence rate (CPR) in the country. The 1988 Zimbabwe Demographic and Health Survey (DHS) showed that 25% of users of modern family planning methods, mainly in rural areas, obtained their methods from CBDs. This proportion declined to 18% in 1994 and down to six percent in 1999. The decline in the CBDs' contribution to overall contraceptive supply is mainly due to the increase in the number of Ministry of Health and Child Welfare (MOH) and Rural and District Council (RDC) health facilities since 1980, the shift by clients from short- to long-term contraceptive methods, and the increase in the number of organisations providing family planning services.

The 1991 and 1996 Situation Analysis Studies of the family planning programme in Zimbabwe showed that CBDs spent most of their time re-supplying established clients and very little time recruiting new clients. The reduction of “medical barriers” in 1994-5 allowed CBDs to issue a maximum of six cycles of oral contraceptives on each visit to established clients. Consequently, CBDs spent less time with re-supply clients, and were thus able to take on other functions.

1.2. The Expanded CBD Programme

The 1999 CBD Review Study highlighted the need for CBDs to:

- Broaden their role beyond family planning services and include the provision of information on HIV/AIDS/STIs

¹ Chapters 1 & 2 are adapted from *Report on the 2001 Baseline Survey for the Expanded Community Based Distribution Programme*, Harare: ZNFPC. December 2002.

- Make referrals to clinics for the management of HIV/AIDS/STIs
- Motivate communities for VCT and refer individuals or couples to the nearest VCT centers
- Provide supportive counselling to clients on the home based care (HBC) programme
- Provide reproductive health information to young people
- Increase male involvement and participation in reproductive health issues

The 1999 CBD Review Study also highlighted the need to establish mechanisms to improve the supervision of CBDs at the community level, strengthen the referral system, and strengthen linkages between the CBD Programme and the MOH. The suggested expansion of CBD roles necessitated the review of the service statistics forms to facilitate the monitoring of the expanded roles of CBDs. The CBD Review Study also showed that CBDs' catchment areas were too vast and this resulted in CBDs spending a substantial portion of their working hours cycling between clients' homes.

In view of the devastating impact of the HIV/AIDS epidemic in Zimbabwe, where prevalence is estimated to be 24.6%, and following the 1999 CBD Review Study, ZNFPC initiated the expansion of the roles of CBDs beyond the provision of family planning information and services, with technical assistance and funding from USAID through Advance Africa. The major objectives of expanding CBD roles included increasing knowledge of transmission and prevention of HIV/AIDS/STIs among community members, ensuring outreach to young people and men whom CBDs previously excluded, motivating those at-risk for VCT, providing supportive counselling to both the infected and the affected, and promoting the adoption of safer sexual and reproductive health behaviour.

Zimbabwe has ten provinces, including the two urban metropolitan provinces of Harare and Bulawayo. The ZNFPC administrative structure works through the eight provinces of Manicaland, Mashonaland Central, Mashonaland East, Mashonaland West, Midlands, Matabeleland North, Matabeleland South, and Masvingo. ZNFPC and MOH staff in each of these provinces selected two districts for the Expanded CBD Programme. These selected districts were ones with a VCT referral centre and full ZNFPC administrative staffing in place, including trained and experienced CBDs and Group Leaders.² One district from each province was then selected for the first phase, first year, with the remaining eight districts to be included in the second phase, second year. The selection for the first phase, first year was based on administrative and logistic convenience, considering current budgetary constraints due to the difficult economic circumstances in Zimbabwe.

Prior to implementation of the first and second phases of the Expanded CBD Programme, CBDs underwent a two-week training course to strengthen their skills in the provision of expanded services through two community-based models. The first model, the depot holder model, requires the recruitment and training of depot holders who supply oral contraceptives and

² Prior experience in implementing new systems showed that new staff is not ideal for implementing new programmes, because they are still in the process of learning their basic jobs and gaining acceptance from the communities.

condoms and make referrals to the CBD. The second model, referred to as the satellite model, required the CBD to be stationed at a pre-arranged location in his/her catchment area on specified days so that clients come for services as opposed to the CBD providing door-to-door services. Sites selected for the depot holder model were densely populated as opposed to those selected for the satellite model. In both models, the CBD covers a ward, an area usually made up of six villages with an estimated population of six thousand people. Both the depot holder and satellite models enable the CBDs to spend more time providing services, such as presenting and discussing issues at group meetings with men, women, youth, and community leaders, visiting homes where there are sick people to support home-based care (HBC) activities, and making referrals to health centers and VCT centres.

The CBDs were trained for the Expanded CBD Programme by ZNFPC provincial service delivery and IEC staff. These trainers in turn received their training from Centre for African Family Studies (CAFS) through Advance Africa. Resource persons from other key stakeholders were invited to assist with the training. Programme implementation of the first phase began in January 2002, after training of CBDs, but the programme was fully implemented in March 2002 following the training of the new depot holders. Implementation of the second phase began in April 2003, following the process outlined below:

- CBDs, depot holders, and group leaders in the selected eight districts undergo a two-week re-orientation course with a focus on their new roles
- Trainees are provided with demonstration kits (penile model, DepoProvera and syringe, oral contraceptives, and condoms), checklists, manuals, oral contraceptives and condoms, client cards and register books, MIS forms, a cash box, a trunk and locks³
- Group leaders undergo a week long supervisors' course to strengthen their skills, especially the supervision of the CBDs in their augmented roles
- Using province-specific, Expanded CBD Programme advocacy packages, advocacy workshops are conducted in communities to mobilise support
- Depot holders are recruited with community participation
- Recruited depot holders are trained by ZNFPC provincial training teams
- IEC support materials are distributed to CBDs and group leaders
- Coordination meetings between the CBD programme and stakeholders are held to strengthen linkages between relevant sectors
- The depot holder and CBD service statistics forms are reviewed and standardised to monitor implementation and results of the Expanded CBD Programme

³ The cash boxes, trunks, and locks were supplied by the DELIVER project, which also assisted with the design of the logistics reporting forms.

1.3. Monitoring and Evaluation of the Expanded CBD Programme

A comprehensive Monitoring and Evaluation (M&E) plan was prepared to provide evidence of project implementation, outputs, effects, and outcomes.⁴ The M&E plan consists in the following components:

- Baseline surveys in the relevant districts to document the situation prior to the implementation of both the first and the second phases of the Expanded CBD Programme. The first phase baseline survey was carried out in August 2001,⁵ focusing only on men and women aged 15 to 29 years. Information was collected from 1,812 respondents on their knowledge of transmission and prevention of HIV/AIDS/STIs, utilization of VCT services, use of contraception, use of condoms for infection prevention and contraception, and sexual behaviour
- Pre- and post-training tests to assess knowledge acquired during training
- Regular supervisory visits to assess practice of new knowledge, skills, and responsibilities, using a checklist
- An initial assessment to provide early guidance and feedback on the initial implementation of the programme⁶
- A midterm review. Although this activity was planned, it was never implemented due to financial constraints
- An impact evaluation (endline) survey to measure changes over time and to compare the effects and outcomes of the project

Prior to implementation of the second phase, lessons learned from the first phase were used to improve the following areas:

- The Management Information System (MIS): data collection forms were reviewed and modifications made to reporting forms, including the addition of a column to the commodity logistics form to account for and correct stock-outs, and the simplification of the revenue reporting form. An upgraded database was created for the data collected using revised MIS forms
- Training: group leaders, CBDs, and depot holders were trained on the importance of the MIS and on how to complete the revised MIS forms comprehensively and accurately
- Programme indicators: These were reviewed and revised.

⁴ ZNFPC Expanded CBD Programme Monitoring and Evaluation Plan, Harare: October 2002

⁵ See 2001 Baseline Survey Report for the Expanded Community Based Distribution Programme, Harare: ZNFPC. December 2002.

⁶ Wazara M.C., Initial assessment of the expanded CBD programme. Harare: ZNFPC 2002.

1.4. Survey Objectives

The major objective of the Second Phase Expanded CBD Baseline Survey was to collect data that would be used as a benchmark in evaluating key outcomes of the Expanded CBD Programme.

The specific objectives of the baseline study were to:

- Collect baseline data on the services offered by the CBDs in the original CBD programme
- Gather information on the reproductive health knowledge, attitudes, and behaviour of the target population prior to the introduction of the Expanded CBD Programme

Chapter 2: Methodology

2.1. Study Design

This is a quasi-experimental study with intervention and comparison sites. A comparison of the baseline and planned endline survey data will be done to assess the impact of the intervention.

2.2. Sampling

Sample selection criteria

Zimbabwe is administratively divided into ten provinces, including the cities of Harare and Bulawayo. The CBD Programme operates primarily in eight provinces, although the cities of Harare and Bulawayo also have CBDs. The Expanded CBD Programme operates in rural areas within these provinces. Provinces are divided into districts, districts into wards, and wards into villages. Districts vary in population size from about 30,000 to 110,000. Wards contain on average 6,000 people, living in about six villages. The ultimate sampling unit for this survey was the programme's target population of men aged 15 to 55 and women aged 15 to 49.

The survey was designed to collect information from one district in each province where implementation of the second phase of the Expanded CBD Programme was planned. Due to lack of funds, not all wards are covered by the original CBD Programme, and the Expanded CBD Programme will only cover wards in which CBD coverage already exists. Therefore, in the selected districts, every ward covered by a CBD formed the sampling frame, resulting in a total of 62 wards.

Two comparison areas were selected for the survey, with a total of 18 wards and CBDs in the sampling frame. These two comparison areas were selected by collecting comparative demographic, family planning, and socioeconomic background data on all the districts. The two comparison districts were in neither the first nor the second phases of the Expanded CBD Programme, and were similar in characteristics to the districts selected for the second phase of the Expanded CBD Programme.

Sampling procedures

The first stage of the sampling process consisted of the random selection of wards by each of the three fieldwork teams. This was done by drawing names of CBDs written on folded pieces of paper from an envelope. Numbers of CBDs for each district were allocated proportionally to district population size and numbers of wards served by CBDs (Table 2.1).

Table 2.1: Distribution of sampled CBDs/wards by district

Province	District	Total CBDs	CBDs sampled
Mashonaland East	Goromonzi	9	5
Mashonaland Central	Mazowe	9	4

Province	District	Total CBDs	CBDs sampled
Masvingo	Chivi	12	6
Mashonaland West	Makonde	4	2
Manicaland	Mutare Rural	11	5
Matabeleland North	Tsholotsho	4	2
Matabeleland South	Gwanda Rural	9	6
Midlands	Kwekwe Rural	4	2
Mashonaland Central	Guruve*	10	5
Matabeleland South	Beitbridge*	8	4
TOTAL		80	41

* Comparison areas where the traditional door-to-door programme model will continue to be implemented

At the second stage of the sampling, villages were selected within each CBD catchment area (ward). Each catchment area has an average of six villages. From the list of villages in each ward, supervisors were to randomly selected four – two for conducting interviews of females aged 15-49 and two for conducting interviews of males aged 15-55. However, in some districts supervisors limited their selection of villages to the ones that the CBD told them he/she works in, thus introducing two possible biases – undersampling of people in more remote villages and oversampling of people who receive more services.

This second stage resulted in the selection of a total of 164 villages – 82 for females and 82 for males - with a target of 1230 male and 1230 female respondents, i.e. 15 respondents (male or female) per village.

The third stage of the sampling consisted of the selection of households. Beginning at a specific spot in the selected village (market area or, if no market area, headman’s home), the interview teams proceeded in different directions while ensuring that their paths did not overlap. A nearest-neighbour technique was used to systematically select households along a randomly selected “line” until the target number of interviews was completed. If enough interviews could not be completed along a line, interviewers moved to the next line of homes. Care was taken to avoid interviewing people along main roads (roadside bias). However, another bias may have resulted from the fact that residents in the same line may share some similar background characteristics.

In one district, respondents were only sampled from villages that the CBD visited regularly - even though s/he is supposed to cover all villages, s/he typically does not go to the more distant ones. This issue of including better served people in the sample might be a source of possible bias.

The final stage of the sampling consisted of the selection of respondents from within the selected households. A household listing form was completed to determine which *de facto* household members were eligible for interview. This same form was also used to randomly select one man or one woman from each household for interview.

The overall target sample was 2460 (1230 males and 1230 females). A total of 2456 male and female respondents residing in private households were interviewed for the study. Table 2.2 shows the distribution of survey respondents by sex and by district. Both men and women were

interested in participating in the survey and there were very few reported cases of refusals. Examples of the few refusals include an elderly man who felt that the interviewer was too young and two women who would only be interviewed together and not individually as per the survey instructions.

Table 2.2: Distribution of respondents by sex and by district

Province	District	Male	Female	Total
Mashonaland East	Goromonzi	150	150	300
Mashonaland Central	Mazowe	121	119	240
Masvingo	Chivi	180	180	360
Mashonaland West	Makonde	60	60	120
Manicaland	Mutare Rural	149	151	300
Matabeleland North	Tsholotsho	60	60	120
Matabeleland South	Gwanda Rural	181	179	360
Midlands	Kwekwe Rural	59	57	116
Mashonaland Central	Guruve	149	151	300
Matabeleland South	Beitbridge	120	120	240
TOTAL		1229	1227	2456

2.3. Data Collection Instruments

An English version of the questionnaire was designed with questions similar to those used in the first phase baseline. However, the English version was modified to reflect the enlarged target population (the first survey covered only young people aged 15 – 29 years) and the revised list of programme indicators. This questionnaire was translated into the two major local languages, Shona and Ndebele. The male and female questionnaires were identical, except for the questions on pregnancy and fertility which were asked only to female respondents.

2.4. Research team and Training of Interviewers

A total of 25 potential interviewers were identified from a pool of experienced interviewers used in other ZNFPC surveys. Six men and six women were selected for training, based on their qualifications, experience, availability, and fluency in the major languages and dialects spoken by the populations targeted by the survey. Two IEC officers and one service delivery coordinator were appointed from ZNFPC provincial management staff to work as team leaders for the survey. Two programme managers (research) and the acting Assistant Director of Service Delivery trained the research team and accompanied them during the first few days of the survey/data collection.

The training took place at ZNFPC head office in Harare over the period 6-12 January 2003 and culminated with a pre-test in three CBD catchment areas in Marondera Rural District, Mashonaland East Province. Each interviewer conducted at least one interview during the pretest.

2.5. Fieldwork

Interviewers were assigned to three teams, with each team comprising two male and two female interviewers, and one team leader / supervisor. Fieldwork was undertaken from 13 January - 5 February 2003. Male interviewers collected data from male respondents while female interviewers collected data from female respondents.

The fieldwork had its own challenges; interviewers had to wait for people to come home from queuing for relief food. Also, the research team could not proceed with fieldwork without CBDs getting approval from local leaders due to the political environment at the time of the survey.

2.6. Ethical Considerations

As mentioned above, the survey took place during a period of drought and hardship. The interview teams were scrupulous about not interfering with people's efforts to obtain food. In some cases this meant waiting until evening to conduct interviews. In order to be sure that people understood that the survey was not part of a food relief programme, local leaders were contacted and full explanations of the purpose of the research were given to them. The interview teams and CBDs secured approvals from local leaders before doing the interviews.

All respondents were informed about the objectives of the study and they were given an opportunity to ask questions about the research before being asked for their verbal consent to participate in the study. People who were ill and for whom being interviewed would have been an obvious hardship were excluded from the survey. Every interview was conducted in strict privacy.

Names of respondents were recorded during the household listing for the purpose of determining eligibility for the individual interviews. However, in order to ensure confidentiality, names and other identifiers were neither recorded on the questionnaire nor entered into the electronic databases.

2.7. Data Entry, Processing, and Analysis

Data were entered into electronic files 18 March -15 April 2003. Data cleaning started thereafter. Data was entered and cleaned at the ZNFPC Harare office using EPIINFO version 6. The data were analyzed using the Statistical Package for the Social Sciences (SPSS) and STATA.

Chapter 3: Background Characteristics of Respondents

3.1. Age Distribution

Youth aged 15-24 years constitute about half of the male respondents in both the project and comparison areas (Table 3.1). In the project areas, 54% of males and 46% of females were aged 15 – 24 years, while in the comparison areas, 48% of males and 45% of females were aged 15 – 24 years. It is likely that female respondents in the youngest age group (15-19) were under-sampled in the comparison areas (Table 3.1).

3.2. Marital Status

In the project areas, 41% of males compared to 57% of females were married, while in the comparison areas, 51% of males compared to 58% of females were married. Conversely, the percentage never married in both the project and comparison areas was much higher among males than females. There is a higher percentage of divorcees and widows among females compared to males, most likely due to higher marriage rates among females. These marriage patterns are very similar to the national picture depicted by the 1999 Zimbabwe DHS (CSO and Macro, 2000).

3.3. Religious Affiliation

Zionism and Apostolic faiths are the most practiced religions, followed by Protestantism. Catholicism was mentioned by a much lower percentage of respondents as compared to Protestantism and Zionism/Apostolic faiths. Men were much more likely to report that they did not follow any religion than women. Twenty-eight percent of males and 7% of females in the project areas did not follow any religion. In the comparison areas, 42% of males compared to 27% of females mentioned that they did not follow any religion.

3.4. Education

Ninety-eight percent of males and 96% of females in the project areas and 97% of males and 92% of females in the comparison areas have attended school. Educational attainment is usually concentrated at primary/secondary levels, with a small percentage of respondents reporting tertiary schooling. Levels of education are higher among males as compared to females, a finding that is consistent with results of the 1999 Zimbabwe DHS. Both females and males in the project areas had higher education levels than those in the comparison areas.

3.5. Occupation

Agriculture was the mainstay of the respondents' household economy. Roughly 25% of the respondents were unemployed, while about one in ten male respondents and one in twenty of female respondents were students. Homemakers, building/construction workers, and traders/vendors were minorities. Although the differences were not substantial, more males (36 percent) than females (27 percent) seemed to be involved in agriculture in the project areas.

3.6. Language

When asked about the languages they could speak, the majority of respondents mentioned Shona. Eighty percent of males and 78% of females in the project areas and 90% males and 88% females in the comparison areas spoke Shona. English was the second most spoken language for males in project and comparison areas, while Ndebele ranked second for females in the same areas. In the comparison areas, there was a substantial proportion of male and female respondents (over four in ten) who mentioned languages other than Shona, Ndebele, and English.

Table 3.1. Percentage distribution of respondents by selected background characteristics

Respondents' Background Characteristics	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Age group:				
15-19	30.7	24.1	27.1	18.1
20-24	23.2	21.8	21.1	27.3
25-29	14.7	16.0	16.7	22.1
30-34	10.6	12.6	13.4	10.7
35-39	6.7	10.0	7.8	9.2
40-44	4.7	8.4	3.4	6.3
45-49	5.2	7.1	4.5	6.3
50-55	4.2	0.0	6.0	0.0
Marital status				
Married	41.0	58.6	51.1	58.3
Widow/widower	1.4	8.0	0.4	5.5
Divorced/separated	2.6	7.1	2.6	13.3
Never married	55.0	26.3	45.9	22.9
Religion				
Protestant	22.4	31.7	11.2	10.7
Catholic	13.5	11.7	8.2	10.0
Zionism/Apostolic	27.4	38.1	26.0	36.9
None	27.8	6.6	42.3	26.9
Other	8.9	11.9	12.3	15.5
Education				
None	1.9	3.5	2.6	7.8
Primary	25.4	38.3	39.0	52.4
Secondary	69.8	57.9	55.4	39.9
Tertiary	2.9	0.3	3.0	0.0
Occupation				
Agriculture	35.6	27.3	43.1	45.0
Homemakers	0.3	2.2	0.0	3.0
Building/construction	4.5	0.1	6.3	0.0
Traders/vendors	2.8	9.5	0.7	5.5
Students	12.0	5.9	10.4	4.8

Unemployed	24.5	27.9	21.7	28.0
Other	20.3	27.1	17.8	13.7
Language*				
Shona	80.1	77.9	89.6	88.2
Ndebele	31.6	31.7	28.6	26.2
English	48.9	16.4	45.0	5.9
Other	9.9	7.9	46.1	43.5
Total	100.0	100.0	100.0	100.0
Number of respondents	960	956	269	271

* Totals do not add to 100% because of multiple responses.

Chapter 4: Reproductive Health Knowledge and Attitudes

4.1. Knowledge of Community-Based Health Workers

To gauge their knowledge of community-based health workers, survey respondents were asked to report on the types of health workers in their communities. Respondents who said they knew the CBD working in their area were further asked to give the name of said worker.

As shown in Table 4.1, only a minority of respondents (8% males and 11% females in project areas and 0.4% males and 11% females in comparison areas) did not know of any health worker within their community. Males in the project areas seemed to be generally less knowledgeable of health workers in their community.

Table 4.1. Percentage of respondents by their knowledge of the health workers in their locality

Type of Community-Based Health Worker Known	Project Areas		Comparison Areas	
	Male	Female	Male	Female
<i>Type of health worker known*</i>				
None	7.5	11.1	0.4	11.2
CBD	42.9	46.2	54.4	48.3
Other Depot Holder (<i>exc ZNFPC DHs</i>)	0.6	1.5	1.1	3.0
Village Health Worker	45.5	38.5	62.4	25.1
Village Community Worker	11.1	23.0	10.3	4.1
Environmental Health Technician	2.1	2.7	4.6	0.4
Peer Educator	1.2	1.0	0.0	0.4
Other	10.6	4.9	6.8	0.8
Does not know/Can't remember	11.2	15.1	12.6	20.2
<i>Knowledge of name of CBD**</i>				
Name known and correct	83.5	89.4	78.4	92.3
Name given but incorrect	4.1	3.8	5.7	5.5
Name not known	12.4	6.8	15.9	2.2
Total	100.0	100.0	100.0	100.0
Number of respondents	540	677	176	181

* Totals do not add to 100% because of multiple responses.

**Only for respondents who said they knew the CBD operating in their area.

Among female respondents, the top three health workers known were CBDs, village health workers, and village community workers. While these were also the three most known health workers among males, it is important to note that, unlike the statistics with females, the CBDs did not rank first but second. This may be due to the fact that the CBDs used to target women more than men during their household visits.

There is no significant difference between the comparison and project areas when it comes to knowledge of the health workers' names. It is noteworthy that female respondents are more knowledgeable of the CBDs' names than men, probably because of their more intimate relationship with such workers. In the project areas, 89% of females and 84% of males knew the CBD by name while 92% of females and 78% of males in the comparison areas knew the CBD by name.

4.2. Interactions Between CBDs and Their Clients

Two indicators of interaction between CBDs and community members are presented in Table 4.2. The first one measures the extent of CBD outreach through household visits, while the second gauges community members' attendance of meetings addressed by a CBD.

Table 4.2. Percentage of respondents who were exposed to CBD activities

Exposure to CBD Activities	Project Areas		Comparison Areas	
	Male	Female	Male	Female
<i>Visited by a CBD (past 12 months)</i>				
No	54.7	58.5	50.0	56.4
Yes	29.9	38.8	38.1	40.9
Can't remember	15.4	2.7	11.9	2.7
<i>Attended a meeting addressed by a CBD</i>				
No	95.0	90.3	96.0	99.4
Yes	5.0	9.7	4.0	0.6
Total	100.0	100.0	100.0	100.0
Number of Respondents	541	680	176	181

In both the project and comparison areas, the majority of the male and female respondents indicated that a CBD had not visited them in the 12-month period preceding the survey. The CBD did not visit 55% of males and 59% of females in project areas, while 50% of males and 56% of females in comparison areas were not visited by the CBD in the 12-month period before the survey. Assuming that respondents who could not remember whether or not they were visited by a CBD over the past 12 months were probably not visited by a CBD, it emerges from Table 4.2 that female respondents from the project and comparison areas were equally reached by the CBDs, while males from the project areas were less likely to be visited by the CBDs than their counterparts in the comparison areas. As a result, overall household visitation rates were higher in the comparison areas than in the project areas.

Only a minority of the survey respondents reported having attended community meetings addressed by a CBD (Table 4.2.). Five percent of males and 10% of females in the project areas

reported that they had attended a meeting addressed by the CBD. In the comparison areas, 4% of males and about 1% of females had attended such a meeting.

4.3. Information Received by Respondents from CBDs

All respondents who reported that a CBD had visited them during the previous 12 months were asked to indicate the topic discussed during the most recent visit. As expected, most discussion sessions touched on issues related to family planning, and this pattern did not vary between the project and comparison areas. Among those who had been visited by a CBD, 93% of females and 77% of males in the project areas had discussed family planning, while 96% of females and 73% of males in the comparison areas had discussed family planning with the CBD (Table 4.3).

The second most important discussion topic was HIV/AIDS/STIs, an issue that was more frequently raised with male respondents than female respondents. Discussion of HIV/AIDS/STIs was more common among males in the comparison areas than among those in the project areas, while the reverse was true for females. Sixty-three percent of males in the comparison areas compared to 43% of males in the project areas had discussed HIV/AIDS/STIs with the CBD. Six percent of females in comparison areas compared to 18% of females in project areas had discussed HIV/AIDS/STIs with CBDs.

The CBD baseline survey results show that HBC, VCT, and young adult reproductive health were seldom mentioned by the CBDs during their household visits.

Table 4.3. Percentage* of respondents who were visited by a CBD by topic discussed and IEC material received/shown

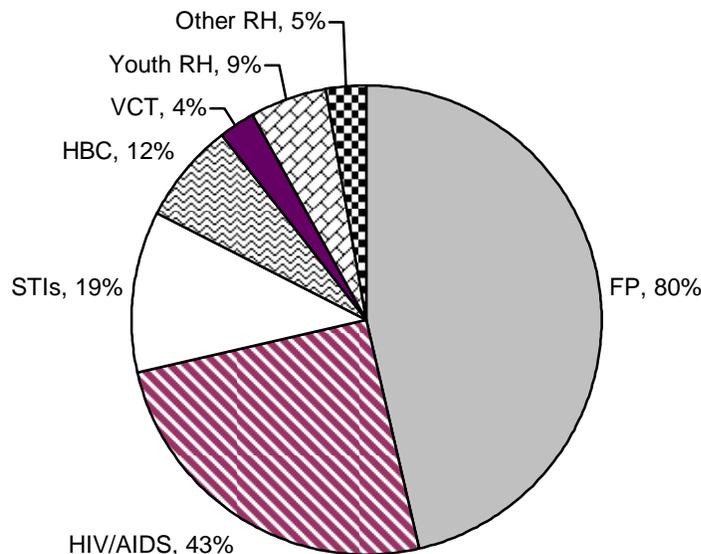
Topics/IEC material	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Topics discussed by CBD				
Family planning	76.5	92.8	73.1	96.0
HIV and AIDS	25.3	11.7	40.3	4.1
STIs	17.3	6.1	22.4	1.4
HBC	3.7	3.0	3.0	0.0
VCT	0.6	1.1	0.0	0.0
Youth reproductive health	3.1	1.5	1.5	2.7
Other reproductive health topics	42.9	50.0	0.0	50.0
Can't remember	7.4	7.2	3.0	2.7
Number of respondents	162	264	67	74
IEC material ever received from/shown by CBD				
Pamphlet/written material	19.2	12.4	21.0	9.4
Contraceptive kit	15.9	7.4	14.8	8.3
Flip book	10.7	7.7	11.4	11.1
Number of respondents	541	680	176	181

* Total does not add to 100% because of multiple responses.

The extent to which CBDs use IEC materials during their household talks is shown in Table 4.3. Pamphlets/written materials, contraceptive kits, and flipbooks are more frequently used when talking to men as compared to women. This was observed in both the project and comparison areas. For male and female respondents from the project areas, the most commonly used IEC material seems to be pamphlets/written materials. This was also observed among males, but not among females, of the comparison areas.

As indicated earlier, only a minority of respondents mentioned ever attending a meeting addressed by a CBD. Consequently, because of small numbers, it was possible to compare neither results of male and female respondents nor project and comparison areas on topics discussed during group meetings. The overall picture of issues discussed by CBDs during group meetings is shown in Figure 4.1. As for talks by CBDs during their household visits, family planning and HIV/AIDS/STIs were also the main issues discussed by these CBDs.

Figure 4.1. Percentage* of respondents who attended a meeting addressed by CBD by type of topic she/he discussed



* Percentages do not add to 100% due to multiple responses
 Number of respondents = 101

4.4. Respondents' Attitudes Towards CBDs

Attitudes towards CBDs are difficult to measure because of respondents' biases. Respondents may tend to exhibit positive attitudes to the interviewer if the questions are directly related to

value judgment of the CBD. To minimize such biases, respondents were asked to indicate which person they would turn to if they needed some information or counseling about HIV/AIDS. When inquiring about such an issue, the survey interviewers were instructed not to read out the list of persons shown in Table 4.4, but rather allow each respondent to come up with his/her own answer spontaneously.

Medical staff of fixed health facilities (nurses) ranked top as the persons to whom respondents would turn to if they were to seek information or counseling about HIV/AIDS. A higher proportion of females in the comparison areas (50%) responded thusly, as compared to females (39%) in the project areas, but no differences were observed between males in the project and comparison areas. Nineteen percent and 18% of males in the project and comparison areas respectively mentioned that they prefer to consult nurses on HIV/AIDS information or counselling. Females in both the project and comparison areas were more likely to report that they would rely on nurses than males.

The CBD was the second person that respondents would turn to if they needed information or counseling on HIV/AIDS. The differences between males and females in the project and comparison areas were not very large, with the exception of males in the comparison areas who were the least likely to mention CBDs.

Table 4.4. Percentage distribution of respondents by type of person they would consult if they needed information or counseling about HIV/AIDS

Type of person respondents would prefer to consult on HIV/AIDS	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Doctor	11.8	7.0	11.9	4.1
Nurse	19.1	38.5	17.5	50.1
Teacher	5.2	2.5	6.0	3.7
CBD	20.1	18.1	23.7	12.2
Village Health Worker	11.4	6.2	14.9	5.5
Village Community Worker	1.0	1.4	1.1	0.4
Other*	21.8	12.5	20.8	15.5
Don't know/not sure	9.6	13.8	4.1	8.5
Total	100.0	100.0	100.0	100.0
Number of respondents	960	956	269	271

* "Other" includes friends, Brothers/Sisters, Aunt/Uncle, AIDS Coordinators/Counsellors etc

A low percentage, 5% of males and 3% of females in project areas and 6% of males and 4% of females in comparison areas, mentioned that they would turn to teachers for HIV/AIDS information or counseling (Table 4.4). Village community workers were also rarely mentioned, probably because their area of specialization is more related to community development than to health issues. The proportion of males who said they would seek HIV/AIDS information or counseling from the village health worker was twice or thrice as high as for females.

4.5. HIV/AIDS Knowledge

All male respondents and 99% of female respondents in both the project and comparison areas had heard of STIs, while all respondents in the comparison and intervention areas had heard of HIV/AIDS. The vast majority of respondents, (92% of males in both the project and comparison areas, 78% of females in project areas and 76% of females in comparison areas) could identify modes of transmission of HIV. Ninety-seven percent of males in both the project and comparison areas, 96% of females in project areas and 90% of females in comparison areas are aware that there is no cure for HIV/AIDS (Table 4.5).

Table 4.5. Percentage of respondents by type of HIV/AIDS/STI knowledge

HIV/AIDS/STI knowledge	Project Areas		Comparison Areas	
	Male	Female	Male	Female
<i>Ever heard of:*</i>				
Any STI	99.5	98.7	99.6	98.5
AIDS	99.9	99.8	100.0	100.0
Gonorrhea	70.2	31.7	71.9	25.0
Syphilis	43.1	30.0	50.6	27.6
Chancroid	19.7	13.9	28.1	10.5
Chlamydia	1.9	2.1	2.7	4.0
Herpes	11.5	7.7	16.0	7.0
Other	13.9	9.3	13.7	7.5
<i>Known modes of transmission of HIV*</i>				
Know at least correct mode of transmission**	92.3	77.9	91.8	76.0
Kissing on mouth	5.6	1.6	6.3	1.9
Shaking hands	2.2	1.4	3.0	0.8
Unprotected sex with infected partner	89.7	68.6	90.7	69.3
Multiple sexual partners	24.0	33.2	33.6	28.1
Blood transfusion	7.1	3.7	8.6	4.1
Sharing sharp instruments with an infected person	50.9	37.5	37.7	22.9
Mosquito bites	1.3	0.9	0.0	0.8
Witchcraft	0.2	0.2	0.0	0.0
Mother to child transmission	3.2	3.0	2.6	1.5
Using condoms	0.8	0.1	0.0	0.4
Other (Includes blood contact, accidents, caring for infected etc)	11.5	10.8	11.6	17.6
<i>Know there is no cure for AIDS</i>				
No	1.5	1.6	1.9	2.6
Yes	97.3	95.6	97.0	89.5
Don't know	1.2	2.8	1.1	7.9
Total	100.0	100.0	100.0	100.0
Number of respondents	960	956	269	271

* Totals do not add to 100% because of multiple responses. Questions on knowledge of specific STIs (AIDS, Gonorrhea, Syphilis, Chancroid, Chlamydia, Herpes, and other STIs), and known modes of transmission of HIV/AIDS were addressed to only respondents who reported that they had ever heard of STIs.

** Unprotected sex with infected partner, blood transfusion, sharing needles/sharp instruments with an infected person, or mother-to-child transmission

Other STIs were much less well-known than HIV/AIDS. While the majority of male respondents in both the comparison (72%) and intervention areas (70%) knew about gonorrhea, a much lower proportion (25% in comparison areas and 32% in intervention areas) of female respondents mentioned this STI. The same pattern of gender differentials is observed with respect to responses on other known STIs. Although the differences in STI knowledge levels between the intervention and comparison areas are not substantial, males' knowledge of STIs was always higher than that of females.

Knowledge of the modes of transmission of HIV is relatively accurate. The majority of the respondents in both the intervention (92% of males and 78% of females) and comparison (92% of males and 76% of females) areas knew at least one correct mode of transmission of HIV. As shown in Table 4.5, the responses to the question on the known modes of transmission cluster around the following correct answers: unprotected sex with an infected partner, sharing needles/sharp instruments with an infected person, blood transfusion, and mother to child transmission. Although a relatively large percentage of respondents mentioned 'multiple sexual partners' as a mode of transmission, this category is rather a high risk factor for HIV transmission which was not mentioned as frequently as those previously noted here.

Again, the level of knowledge of the modes of transmission of HIV is much higher among males as compared to females. There are no discernable differences between the intervention and comparison areas, except that respondents from the intervention areas seem to be more aware of 'sharing needles/sharp instruments with an infected person' as a mode of transmission of HIV.

4.6. Sources of Information About HIV/AIDS

The main sources of information about HIV/AIDS for both male and female respondents were schools/teachers, friends/neighbors/relatives, and radio in this order. Apart from these three categories, nurses were also a major source of information for female respondents in both the intervention and comparison areas (Table 4.6.)

There were no significant gender differences in the reporting of radio as a main source of information about HIV/AIDS. Variations in this indicator were also minimal between the intervention and comparison areas. Fourteen percent of males and 10% of females in the intervention areas mentioned the radio as their main source of information on HIV/AIDS. In the comparison areas, the radio was also mentioned by 14% of males and 8% of females as a source of HIV/AIDS.

More males than females reported that their main source of information was schools/teachers, and levels of reliance on this source of information were higher in the intervention areas compared to the comparison areas. Conversely, more females than males relied on informal sources of information about HIV and AIDS (friends, neighbors and/or relatives). Friends, neighbors and/or relatives were mentioned by 24% of females compared to 17% of males in the intervention areas, and by 31% of females compared to 17% of males in the comparison areas as a main source of HIV/AIDS information.

It is noteworthy that the CBDs and other community-based health workers played a minor role in disseminating information about HIV/AIDS (Table 4.6), probably because, at the time of the baseline survey, HIV/AIDS was not a component of these workers' service delivery package. The CBD was mentioned as a source of HIV/AIDS information by 4% of both males and females in the intervention areas and by 4% of males and 3% of females in the comparison areas.

Table 4.6. Percentage of respondents by main source of information on HIV/AIDS

Main source of HIV/AIDS information	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Doctor	0.8	1.2	1.5	1.9
Nurse	6.2	22.2	9.0	21.0
CBD	3.9	3.8	3.7	2.6
Other community worker	2.3	3.1	4.5	1.5
Radio	14.4	10.4	13.8	8.2
TV	1.7	0.7	0.4	0.4
Public meeting	3.7	3.2	5.6	4.1
School/teachers	38.3	25.2	31.0	18.4
Newspaper, magazine	4.1	2.1	3.7	3.0
Poster, pamphlet	2.7	0.6	1.5	1.5
Friends, neighbors, relatives	16.6	23.7	17.1	31.0
Rumors, gossip	0.5	1.1	2.2	1.9
Other	4.8	2.7	6.0	4.5
Total	100.0	100.0	100.0	100.0
Number of respondents	953	942	268	267

4.7. Self-perceived HIV/AIDS risks

Male and female respondents were asked whether they thought their risk of getting HIV/AIDS was high, medium, low or nonexistent. In the intervention areas, 69% of males and 56% of females considered their risk of being infected by HIV as low or nil. Seventy six percent of males and 57% of females in the comparison areas, also considered their risk of getting HIV as low or nil (Table 4.7a). It is striking that a low proportion of respondents (8% of males and 4% of females in intervention areas and 6% of males and 3% of females in comparison areas) considered themselves as being at high risk of contracting HIV.

The differences in self-perceived risk of HIV/AIDS between the intervention and comparison areas were not substantial. However, in both areas, male respondents perceived themselves as being at higher risk of being infected with HIV than their female counterparts.

Table 4.7a. Percentage distribution of respondents by their self perception of HIV/AIDS risks

Self perception of HIV/AIDS risk	Project Areas		Comparison Areas	
	Male	Female	Male	Female
None	38.3	39.8	42.5	36.0
Low	31.1	16.0	33.6	21.0
Medium	18.2	14.8	13.8	16.9
High	7.6	4.1	5.6	2.6
Already have HIV/AIDS	0.0	0.2	0.0	0.0
Don't know	4.8	25.1	4.5	23.5
Total	100.0	100.0	100.0	100.0
Number of respondents	960	956	269	271

To obtain further insight into respondents' self-perceived HIV/AIDS risks, both males and females were asked why they thought they were at no/low or high/medium risks. Table 4.7b shows that respondents who perceived themselves as being at no/low risk did so mainly because they were abstaining or had only one sexual partner. This pattern was observed among male and female respondents and across the intervention and comparison areas. Unlike females, who rarely mentioned it, 10% and 13% of male respondents in the intervention and comparison areas respectively thought they were at no/low risk of contracting HIV because they always use condoms.

Table 4.7b. Percentage distribution of respondents by reasons for their self-perceived HIV/AIDS risks

Reasons for self perceived HIV/AIDS risk	Project Areas		Comparison Areas	
	Male	Female	Male	Female
<i>Respondents who perceive themselves as being at no/low risk</i>				
Not yet sexually active	25.4	18.4	18.1	17.1
Abstains from sex	15.3	22.6	9.8	16.5
Only has one partner	40.9	48.3	48.1	50.6
Always uses condoms	9.8	2.1	13.2	2.0
Only has trustworthy partners	2.6	4.4	6.9	3.3
Other	6.0	4.2	3.9	10.5
Total	100	100	100	100
Number of respondents	665	533	205	154
<i>Respondents who perceive themselves as being at high/medium risk</i>				
Has more than one partner	14.7	1.7	3.9	0.0
Has many boyfriends/girlfriends	12.2	2.8	28.8	1.9
Does not use condoms	4.5	1.1	7.7	0.0
Partner has multiple sexual partners	3.7	9.6	3.9	7.7
Does not trust partner	5.7	73.6	7.7	73.1
Other (Includes "inconsistent use of condoms" & that "everyone is at risk")	59.2	11.2	48.0	17.3
Total	100.0	100.0	100.0	100.0
Number of respondents	247	180	52	53

The pattern of responses among those who considered themselves as being at high/medium risk points to some noteworthy gender dynamics. Eighty-five percent of females in intervention areas and 81% of females in the comparison areas think that they are at high/medium risk of contracting HIV either because they do not trust their partners or because their partners have multiple sexual partners. This hint from female respondents, that their male partners put them at high/medium risk, is reflected to some extent by the large proportion of males in both the intervention areas (27%) and comparison areas (33%) who said they considered themselves as being at high/medium risk because they had more than one partner or many girlfriends (Table 4.7b).

4.8. Knowledge of HIV Testing Centers

The majority of respondents mentioned at least one testing center where one could be tested for HIV, although a sizeable proportion of the interviewees could not mention any (Table 4.8). Seventy-six percent of males and 74% of females in the intervention areas mentioned at least one testing center while in the comparison areas, 83% of males and 56% of females also mentioned at least one HIV testing center.

The top two types of HIV testing centers most known by the respondents were government health facilities and VCT centers. These were followed by rural district council health facilities and private medical outlets. Although there is no clear pattern on knowledge of HIV testing centers between the project and comparison areas, females from the comparison areas seem to be the least knowledgeable of HIV testing centers.

Table 4.8. Percentage* of respondents who know of an HIV testing center

Known HIV testing place	Project Areas		Comparison Areas	
	Male	Female	Male	Female
At least one testing center	76.2	73.6	82.6	55.8
Government health facility	34.8	30.5	61.2	38.6
Rural district council health facility	11.8	18.3	13.6	6.8
Mission health facility	5.7	9.9	0.8	0.8
Private doctor/surgery	10.3	13.8	10.1	10.8
ZNFPC clinics	0.9	1.3	0.4	0.4
Youth Centre	0.7	0.6	0.0	0.0
VCT Centre	32.8	20.5	22.5	6.8
Other	4.6	2.1	0.4	0.0
Can't remember/not sure	23.9	26.4	17.4	44.2
Number of respondents	906	867	259	253

* Totals do not add to 100% because of multiple responses.

4.9. Source of Information on HIV Testing Center

The radio and friends, neighbors, and relatives are the main sources of information on HIV testing centers. Females in the comparison areas seem to rely more on friends, neighbors, relatives, or the nurses in their localities than on any other source of information on HIV testing. The prominence of school/teachers probably has to do with the high educational level of the interviewees.

In both the project and comparison areas, males rely more on the radio (38% in project areas and 30% in comparison areas) as a source of information on HIV testing than females (21% in project areas and 10% in comparison areas). The reverse is true when it comes to friends/neighbors/relatives as a source of information. In the project areas, 29% of females compared to 26% of males rely on friends/neighbors/relatives, while 41% of females in the comparison areas compared to 29% of males rely on friends/neighbors/relatives. It is likely that this is due to the fact that female informal networks are generally wider than those for men.

Table 4.9. Percentage of respondents by source of information on HIV testing center

Source of information	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Doctor	1.5	2.1	0.5	5.2
Nurse	6.2	21.3	4.2	18.4
CBD	3.8	6.6	4.7	1.5
Other community worker	2.8	5.4	3.3	0.0
Radio	38.1	21.4	30.1	10.3
TV	10.6	5.0	6.1	5.2
Public meeting	2.5	1.4	3.8	2.2
School/teachers	16.7	11.0	11.3	11.8
Newspaper, magazine	4.8	1.8	3.8	0.0
Poster, pamphlet	1.5	0.6	4.7	0.7
Friends, neighbors, relatives	26.0	28.9	28.6	41.2
Rumors, gossip	0.4	1.8	1.9	2.2
Other	2.2	3.5	2.8	3.7
Number of respondents	684	635	214	137

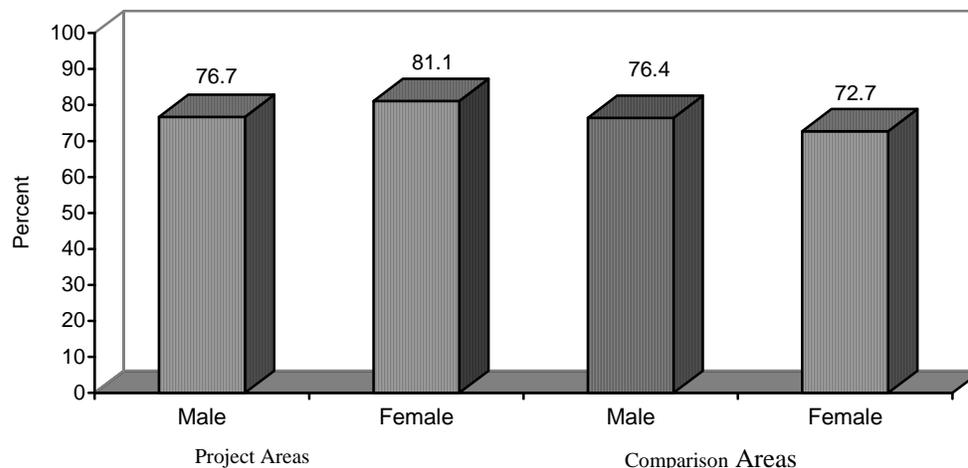
* Totals do not add to 100% because of multiple responses.

4.10. Attitudes towards HIV Testing

The vast majority of female and male respondents in both the project and comparison areas were willing to be tested for HIV. Seventy-seven percent and 81% of male and female respondents respectively in the project areas were willing to be tested for HIV. In the comparison areas, 76% of males and 73% of females were willing to be tested for HIV. The differences between results from the project and the comparison areas and between males and females regarding respondents' willingness to be tested for HIV were not substantial. However, females from the

comparison areas seemed to be less willing to be tested for HIV than their counterparts in the project areas (Figure 4.2).

Figure 4.2. Percent of males and females by their willingness to be tested for HIV



Respondents who reported that they were not willing to be tested for HIV were further asked about the reasons for such an attitude. Fear of positive results was the most common reason given by respondents who were unwilling to be tested for HIV. The second major reason given was the belief that they did not need HIV tests. These patterns did not vary much by gender or between the project and the comparison areas.

It is important to note that lack of knowledge about where to get an HIV test, access, and costs were not important factors for unwillingness to be tested for HIV.

Table 4.10. Percentage* of respondents by reasons for not willing to be tested

Reasons why respondents are not willing to be tested	Project Areas		Comparison Areas	
	Male	Female	Male	Female
No need	34.3	31.7	29.5	33.8
Afraid of positive results	47.6	47.2	49.2	52.9
Afraid others will get to know	2.4	0.6	3.3	0.0
Too far /expensive transport	0.5	1.2	1.6	0.0
Not sure how to get there, find it	0.5	0.6	0.0	2.9
Cost of test expensive	1.0	3.7	3.3	0.0
No reason	11.4	8.1	4.9	7.4
Other	1.9	7.5	8.2	2.9
Number of respondents	214	163	61	72

* Totals do not add to 100% because of multiple responses.

4.11. Knowledge of Contraceptives

Knowledge of contraceptives, as measured by having heard of a method, is nearly universal among the survey respondents in both the project and comparison areas. All males and 99% of females in both the project and comparison areas reported having heard of at least one contraceptive method, whether modern or traditional (Table 4.11). Knowledge of the pill and male condoms, two methods delivered through the CBD programme, was also nearly universal.

While the majority of respondents knew about injectables and the female condom, awareness of other methods needs substantial improvements. Among the least-known methods were implants (Norplant, Jadelle) and vaginal methods (Diaphragm, foam, jelly).

Table 4.11 indicates clearly that barrier contraceptives (diaphragm/foam/jelly, male and female condoms), male methods (vasectomy) and traditional contraception (natural methods and abstinence) are known by more men than women. Conversely, female methods (IUD, injectables, and implants) are known by more women than men. The only exception to this finding is tubal ligation, which does not seem to follow a clear pattern by gender.

Male knowledge of contraceptive methods does not seem to vary much between the project and comparison areas. However, females in the project areas are more knowledgeable of contraceptive methods than their counterparts from the comparison areas.

Table 4.11. Percent of respondents who know of contraceptive methods

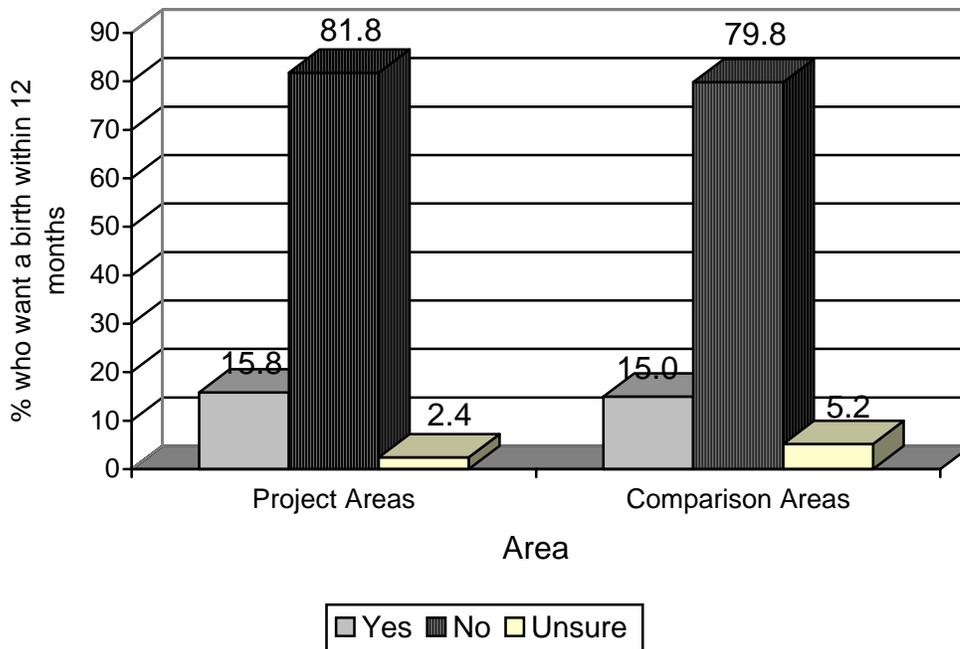
Family Planning Methods	Project Areas		Comparison Areas	
	Male	Female	Male	Female
<i>Any method</i>	99.9	98.7	99.6	98.5
<i>Any modern method</i>	99.8	98.7	99.6	98.2
Pill	94.7	97.2	96.3	96.7
IUD	43.0	69.2	45.7	45.8
Injection/Depo provera/Nuristerate	79.3	91.7	84.4	92.6
Norplant/Jadelle	14.1	38.0	14.9	17.7
Diaphragm/foam/jelly	25.6	19.2	21.9	12.6
Male condom	99.0	95.1	99.3	91.9
Female condom	74.2	68.5	79.2	60.2
Tubal ligation	55.7	59.8	57.3	49.1
Vasectomy	48.0	36.4	50.2	27.3
<i>Any traditional method</i>	99.9	98.7	99.6	98.5
Natural methods	60.9	24.9	54.7	22.5
Abstinence	39.7	26.6	33.5	32.8
Number of respondents	960	955	269	271

4.12. Fertility Desires

Information on fertility desires was collected from women only and was related to whether the respondent would have liked to give birth within the 12-month period following the interview. When analyzing such data, it is important to exclude respondents who were pregnant and those who gave birth within the last nine-month period since they are very likely to rationalize their current pregnancy or more recent births and thus bias the findings.

Levels of fertility desires were almost the same between the project and comparison areas (Figure 4.3). The majority of respondents, 82% in the project areas and 80% in the comparison areas, did not want to give birth within the 12-month period following the survey.

Figure 4.3. Percent distribution of women by whether they want to have a birth within the next 12 months



Chapter 5: Reproductive Health Practices

5.1. Sexual Experience

Most of the survey respondents had had sexual intercourse, with slightly more females than males having had sexual intercourse in both the comparison and project areas (Table 5.1). Twenty-one percent of male teenage respondents and 36% of female teenage respondents in the project areas have had sex while 34% of male teenagers and 39% of female teenagers in the comparison areas have had sex. At least 20% of female and male teenagers (15-19) have had sex. This figure rises steadily to over 60% of the respondents in the 20-24 age group, and by the time they reach their 30th birthday, all respondents reported having had sexual intercourse.

Table 5.1: Percentage of respondents who have had sex by given age

Current age	Project Areas		Comparison Areas	
	Male	Female	Male	Female
15 – 19	20.7	35.7	34.2	38.8
20 – 24	68.0	90.9	84.2	91.9
25 – 29	96.5	98.0	100.0	98.3
30 and above	99.0	99.7	100.0	100.0
All ages	67.4	82.1	78.8	86.3
Number of respondents	960	956	269	271

While sexual activity before age 15 is a rare event, over one-third of respondents had their first sexual encounter by their 18th birthday (Table 5.2). Sexual activity is more common among teenagers of the comparison areas than among their counterparts in the project areas.

Table 5.2: Percentage of respondents who have had sexual intercourse by exact ages at first experience

Exact age (Years)	Project Areas		Comparison Areas	
	Male	Female	Male	Female
15	7.0	3.1	9.0	5.1
18	34.8	34.4	41.5	40.9
20	57.5	64.5	68.1	70.5
22	76.9	87.9	85.1	89.8
25	88.6	97.0	94.7	96.6
Total	67.4	82.1	78.8	86.3
Number of respondents	960	956	269	271

To obtain a proxy for risky sexual behavior, respondents were asked the type of sexual partners they have had sex with during the 12 months prior to the survey. Table 5.3 clearly indicates higher-risk sexual behaviors among males as compared to females. Male respondents (26% in both the project and comparison areas) were much more likely to report having had sex within the past 12 months with a casual partner and/or a commercial sex worker than their female counterparts (2% in the project areas and none in the comparison areas).

Table 5.3. Percentage* of sexually-active respondents by relationship to sexual partner(s) in last 12 months

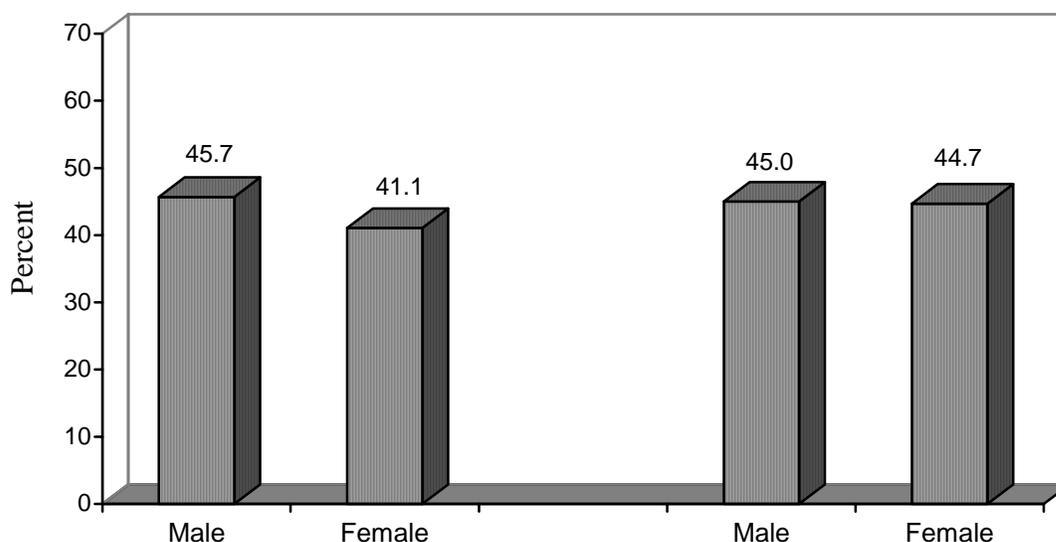
Relationship to sexual partner(s) in last 12 months	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Wife/Husband	60.1	72.8	65.1	69.2
Fiancée/steady friend	35.1	11.0	31.3	15.0
Occasional/casual	18.4	1.7	17.5	0.0
Commercial sex worker	7.1	0.4	8.5	0.0
Stranger	5.0	0.5	10.4	0.0
Number of respondents	647	785	212	234

* Totals do not add up to 100% because of multiple responses.

5.2. Contraceptive Use

Roughly four in ten respondents used contraception, with little variation between males and females and between project and comparison areas (Figure 5.1). Forty-six percent of males and 41% of females in project areas reported using contraception, while 45% of both males and females in comparison areas reported using contraception.

Figure 5.1. Percentage of respondents currently using contraception



Contraceptive method mix is largely dominated by the birth control pill, with little variations between the project and comparison areas (Table 5.4) The male condom and the injectables were the second most-used methods of family planning among males and females, respectively. Use of other methods was negligible.

Table 5.4 Percentage of respondents currently using contraception by family planning method

Family planning method currently used	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Any method	45.7	41.1	45.0	44.7
Any modern method	44.6	40.9	43.9	44.7
Pill	24.5	31.7	26.0	35.4
Injectable	4.2	7.3	3.0	8.1
Male condom	19.1	2.0	17.8	1.1
Female condom	0.1	0.0	0.0	0.4
IUD	0.1	0.1	0.0	0.0
Diaphragm	0.1	0.1	0.0	0.0
Norplant	0.1	0.1	0.0	0.0
Tubal Ligation	0.1	0.3	0.4	0.0
Vasectomy	0.0	0.0	0.0	0.0
Any traditional method	1.2	0.2	1.9	0.0
Withdrawal	0.3	0.1	0.0	0.0
Rhythm	0.3	0.0	0.4	0.0
Other	0.6	0.1	1.5	0.0
Not using	54.3	58.9	55.0	55.3
Number of respondents	960	956	269	271

5.2.1. Contraceptive use among sexually-experienced respondents

Levels of current use of contraception by respondent background characteristics for sexually-experienced respondents are shown in Table 5.5. The use of contraception is highest for the 25–29 age group for both males and females. In the project areas, 73% of males and 68% of females aged 25–29 were using contraception, while 64% of both males and females in the comparison areas were using contraception. More males than females start using contraception at an early age.

Use of contraception is higher among respondents with at least secondary education level than among those with primary education or less. These differentials are not substantial for females of the comparison areas.

Among the respondents who have never been married, more males (69% in project areas and 47% in comparison areas) than females (27% in project areas and 28% in comparison areas)

report that they use contraceptives. It is apparent from Table 5.5 that contraceptive use is at its highest among married women.

A significant proportion of Catholics and Apostolic/Zionists use contraception even though their religion forbids its use.

Table 5.5. Percent of sexually-experienced current users of contraception by background characteristics

Respondents' background Characteristics	Project Areas				Comparison Areas			
	Male		Female		Male		Female	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
<i>Age group</i>								
15-19	62.2	61	35.8	81	56.0	25	47.4	19
20-24	71.5	151	57.9	190	43.8	48	63.2	68
25-29	72.8	136	68.0	150	64.4	45	64.4	59
30+	66.6	299	43.0	363	60.6	94	36.4	88
<i>Education</i>								
Primary or less	55.3	199	42.7	365	47.0	100	52.7	146
Secondary+	74.3	444	57.7	414	66.1	112	51.1	88
<i>Marital status</i>								
Currently married	71.8	393	62.5	559	63.5	138	65.2	158
Ever married	34.2	38	18.1	144	---	8	23.5	51
Never married	69.0	216	27.2	81	47.0	66	28.0	25
<i>Religion</i>								
Protestant/Pentecostal	69.4	134	54.6	240	59.1	22	44.4	27
Catholic	71.0	93	45.7	92	68.8	16	57.1	21
Zionism/Apostolic	68.6	159	46.1	310	50.0	52	51.1	88
None	65.1	212	55.4	56	60.4	96	56.9	65
Other	77.6	49	58.1	86	50.0	26	48.5	33
All	68.6	647	50.6	785	57.1	212	52.1	234

5.3. Source of Supply of Family Planning Methods

The major sources of family planning methods used in the project and comparison areas were the CBDs, the rural district council (RDC) health facilities, and the MOH health facilities (Table 5.6). The shop/supermarket was fourth among most mentioned sources of family planning methods for male respondents.

Table 5.6 Percentage of current users of contraception by source of supply

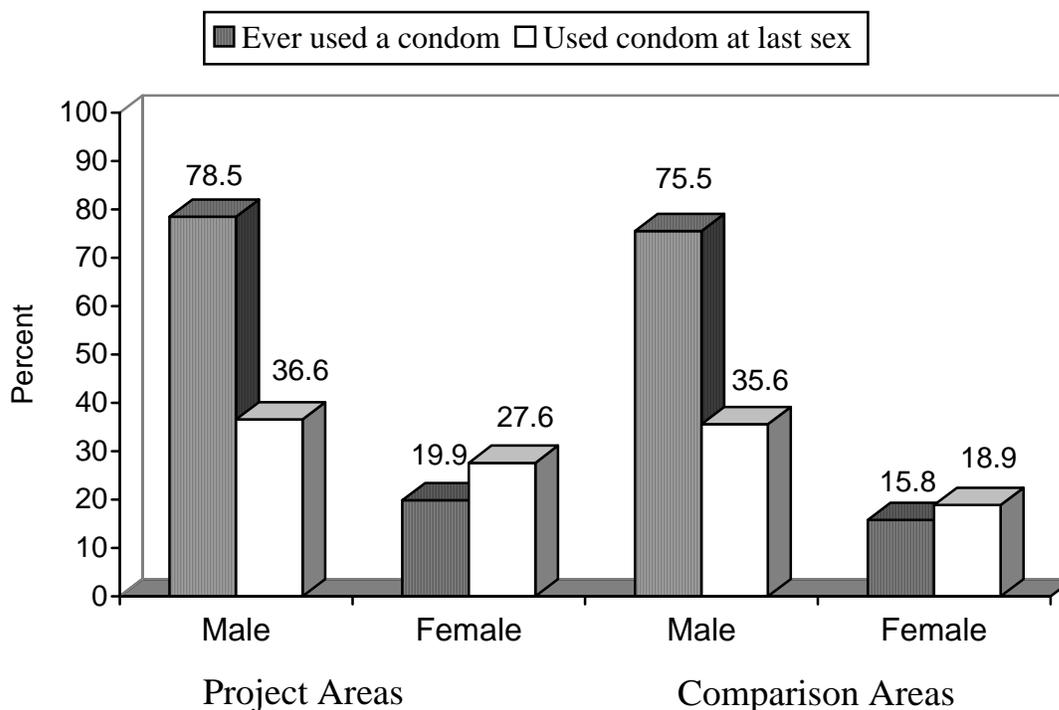
Source of supply	Project Areas		Comparison Areas	
	Male	Female	Male	Female
<i>Public</i>				
ZNFPC clinic	1.6	1.0	0.8	0.0
CBD	40.0	51.9	48.3	41.0
MOH health facility	11.9	20.4	23.3	16.4
RDC health facility	27.9	32.2	30.8	44.3
Community health worker	4.1	0.8	0.0	0.8
<i>Private</i>				
Mission health facility	2.1	3.3	0.0	0.8
Private health facility/doctor	1.1	2.5	0.8	0.0
Pharmacy	2.7	1.5	0.8	0.8
<i>Other Private</i>				
Shop/supermarket	20.1	1.8	15.8	0.8
Friends/relatives	1.8	0.5	1.7	0.7
Don't know	0.5	0.3	0.0	0.8
Other	2.7	0.5	3.3	0.0
Number of cases	444	397	121	122

5.4 Condom Use

Consistent and correct use of condoms prevents sexual transmission of HIV and other STIs. Condom use also encourages male participation in family planning. All these issues form some of the objectives for the Expanded CBD Programme.

Most condom users were males. Slightly over 75% of males have used a condom in both the project and comparison areas (Figure 5.2). The large gender differentials in condom use shown in Figure 5.2 certainly reflect the fact that women may not report condom use as they may consider these as being used by men. These patterns are also observed for condom use at last sex.

Figure 5.2. Percent of respondents who ever used condom and those who used condom at last sex



The number of respondents reporting they had ever used a condom is higher among respondents below 25 years of age, those who are not currently married, and those with the highest levels of education (Table 5.7). Religion does not seem to have much influence on level of respondents reporting having ever used a condom.

Table 5.7. Percent of sexually-experienced respondents who have ever used condoms by age group, marital status, education, and religion

Respondents' Background Characteristics	Project Areas				Comparison Areas			
	Male		Female		Male		Female	
	%	n	%	n	%	n	%	n
<i>Age group</i>								
15-19	83.6	161	25.9	81	80.0	25	26.3	19
20-24	90.1	151	27.4	190	77.1	48	23.5	68
25-29	84.6	136	18.0	150	82.2	45	13.6	59
30+	68.9	299	15.4	364	70.2	94	9.1	88
<i>Marital status</i>								
Currently married	72.8	393	16.8	559	73.2	138	13.9	158
Ever married	84.2	38	17.4	144	*	8	21.6	51
Never married	88.0	216	45.7	81	80.3	66	16.0	25
<i>Education</i>								
Primary or less	62.3	199	12.9	365	63.0	100	12.3	146
Secondary +	85.8	444	26.1	414	86.6	112	21.6	88

Respondents' Background Characteristics	Project Areas				Comparison Areas			
<i>Religion</i>								
Protestant/Pentecostal	82.8	134	21.3	240	81.8	22	18.5	27
Catholic	74.2	93	29.3	92	75.0	16	19.0	21
Zionism/Apostolic	78.0	159	13.9	310	69.2	52	17.0	88
None	78.3	212	26.8	56	77.1	96	9.2	65
Other	77.6	49	23.3	86	76.9	26	21.2	33
Total	78.5	647	19.9	785	75.4	212	15.8	234

All respondents who reported that they had ever used condoms were asked to state their reasoning for doing so. Most males indicated that they use condoms to prevent the transmission of STIs, while most females mentioned pregnancy prevention as their reason for using condoms (Table 5.8). A third of the male and female respondents who used condoms were using them for dual protection (to prevent both pregnancy and STIs).

Table 5.8. Percent distribution of condom users by reason for using condoms

Reason for condom use	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Prevent pregnancy	18.3	39.7	15.6	51.4
Prevent diseases	46.6	21.8	53.8	21.6
Prevent pregnancy and disease	34.3	34.6	30.6	27.0
Other	0.8	3.9	0.0	0.0
Total	100.0	100.0	100.0	100.0
Number of cases	508	156	160	37

Respondents who had never used a condom were also asked to give reasons for not using condoms. The most common response among men for never use of condom was that they trusted their partners, while females most often said they never used condoms because of partners' refusal.

Misconceptions about condoms are still prevalent among males, as suggested by the 17% of males in project areas and 14% of males in comparison areas who reported that they do not trust condoms (Table 5.9). Almost two out of ten respondents said they never used condoms because they did not want to.

Table 5.9. Percent distribution of respondents who had never used condoms by reasons for not using condoms

Reason for not using condoms	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Trust partner(s)	27.3	8.6	38.5	5.1
Partner refusal	3.6	22.9	3.8	39.6
No easy access to condoms	2.2	7.8	1.9	4.1
Want to get pregnant	1.4	17.2	0.0	3.5

Reason for not using condoms	Project Areas		Comparison Areas	
	Male	Female	Male	Female
Partner wants me to get pregnant	0.0	3.8	0.0	0.5
Not sure how to use	0.0	1.3	0.0	3.0
Don't want to	16.5	16.4	17.3	18.8
Don't trust condoms	17.3	1.6	13.5	2.0
Against religion	10.1	3.2	3.8	4.1
Other*	21.6	17.2	21.2	19.3
Total	100.0	100.0	100.0	100.0
Number of cases	140	628	52	197

*Others include: "did not know about condoms," "did not have condoms," "never thought about condoms," "feels will be insulting partner," "married," "sex just happened," etc.

The most frequently mentioned sources of condoms were the CBDs, MOH facilities, shops/supermarkets, and RDC health facilities (Table 5.10). Males in the comparison areas were more likely to use the CBDs and MOH and RDC facilities for their supplies of condoms than males in the project areas, while the reverse was observed with regards the private sector (shop/supermarket). The same pattern was also observed with females, except that those in the comparison areas reported less reliance on the CBDs than their counterparts in the project areas.

Table 5.10. Percentage of respondents who have used a condom by usual source of supply

Source of supply	Project Areas		Comparison Areas	
	Male	Female	Male	Female
<i>Public</i>				
ZNFPC clinic	2.2	5.8	4.4	0.0
CBD	28.4	22.4	38.1	18.9
MOH&CW health facility	13.4	18.0	22.5	35.1
RDC health facility	20.9	16.0	30.0	21.6
Community health worker	7.7	2.6	8.9	0.0
Peer Educators	2.0	1.3	0.6	2.7
<i>Private</i>				
Mission health facility	2.8	1.3	0.6	0.0
Private health facility / Doctor	3.5	5.1	1.3	0.0
Pharmacy	3.0	3.2	1.9	2.7
<i>Other Private</i>				
Shop / supermarket	33.7	23.7	24.4	8.1
Friends / relatives	3.7	1.3	5.6	0.0
Bar	4.1	0.6	8.8	0.0
Don't know	0.2	2.1	0.6	3.2
Other	2.2	10.9	0.0	16.2
Number of cases	508	156	160	37

5.5. Referrals

Very few referrals had been made by the CBDs in both the project and comparison areas, as shown in Table 5.11.

Table 5.11. Number of reported cases of referrals ever made by CBDs to health facilities by type of referral

Type of referral	Project Areas		Comparison Areas	
	Male	Female	Male	Female
STI services	3	1	3	0
Voluntary counselling and testing for HIV	0	0	1	0
Family planning services	4	2	2	0
Long term methods of family planning	0	1	0	0
Other	3	2	2	0
Number of cases	10	6	8	0

5.6 Pregnancy and Fertility

Information presented in this section is based on data collected from sexually-experienced female respondents aged 15–49. These women were asked questions on whether they had been or were currently pregnant and whether they had ever given birth. While less than one in ten respondents were pregnant at the time of the survey, the vast majority reported that they had been pregnant during their lifetimes. In both the project and comparison areas, 93% of respondents reported having ever been pregnant. The 15-19 age group and those never married were less likely to have ever been pregnant than women in older age groups and married women respectively (Table 5.12).

Table 5.12. Percent of respondents who have ever been pregnant by age group, marital status, education, and religion

Background characteristics	Project Areas		Comparison Areas	
	%	n	%	n
<i>Age group</i>				
15-19	68.4	79	63.2	19
20-24	90.5	190	91.0	67
25-29	95.3	150	98.3	59
30+	98.9	366	97.7	85
<i>Marital status</i>				
Currently married	97.1	559	98.7	157
Ever married	96.5	144	98.0	51
Never married	58.2	79	48.0	25
<i>Education</i>				

Background characteristics	Project Areas		Comparison Areas	
	%	n	%	n
Primary or less	96.4	365	93.8	145
Secondary +	90.0	412	92.0	88
<i>Religion</i>				
Protestant/Pentecostal	93.8	240	81.5	27
Catholic	90.1	91	90.5	21
Zionism/Apostolic	92.3	310	94.3	88
None	94.5	55	96.9	64
Other	96.5	86	93.9	33
Total	93.1	785	93.1	234

An analysis of average parity (the number of children previously born alive to a woman) shows that women in the project and comparison areas bear on average one live birth by the time they reach their 25th birthday. This points to the burden of childbearing in adolescence (Table 5.13).

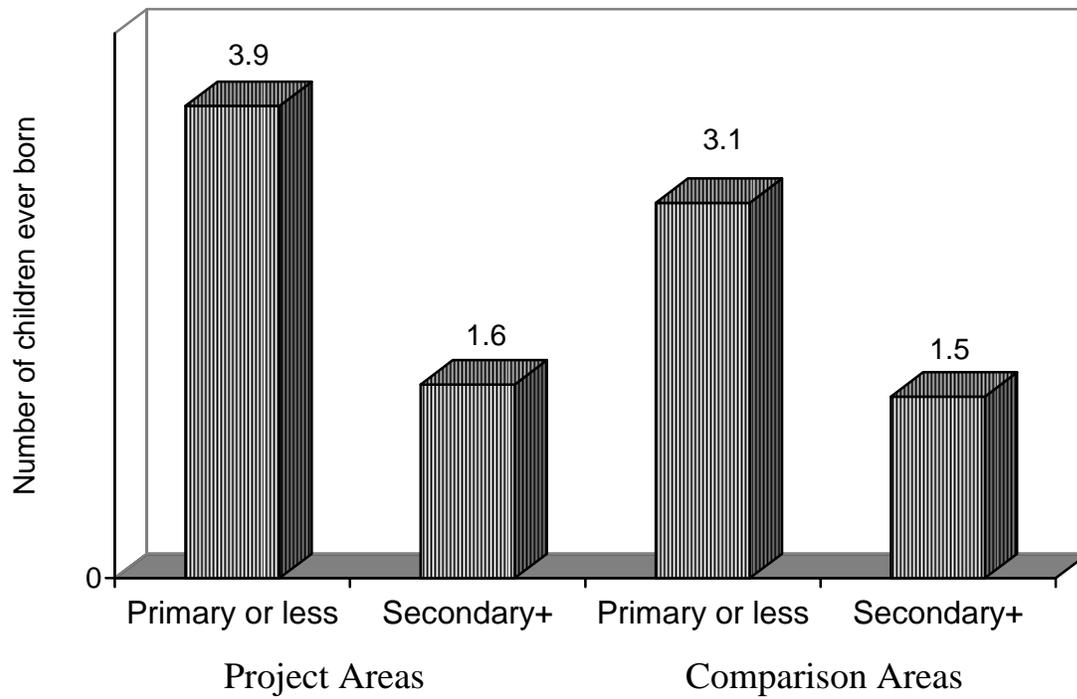
Average parity by the end of the reproductive age span (age 49) is about four children per woman. At all ages below 30, achieved fertility in the comparison areas is higher than in the project areas, but this is reversed for older women, a probable indication of better parity reporting in project areas compared to the comparison areas.

Table 5.13. Children born and average parity by age group

Age group	Number of women	Children ever born	Average parity
<i>Project Area</i>			
15 – 19	230	41	0.18
20 – 24	209	253	1.21
25 – 29	153	323	2.11
30+	364	1,649	4.53
Total	956	2,246	2.35
<i>Comparison Area</i>			
15 - 19	49	12	0.24
20 - 24	74	91	1.23
25 - 29	60	135	2.25
30+	88	381	4.33
Total	271	619	2.30

The largest differentials in average parity were observed by level of education, with women with at least a secondary education having half as many children as those with primary education or less (Figure 5.3).

Figure 5.3. Average number of children ever born to women by level of education



Chapter 6: Conclusions and Recommendations

The baseline survey findings have revealed that there is awareness of the CBDs and their services. There is evidence from the findings that CBDs are making family planning services, including condoms, more readily available to the communities. The awareness of the CBD Programme can be used as a springboard for the Expanded CBD Programme, whose objective is to provide integrated family planning and HIV/AIDS services and to reach more males and youth. According to the findings, it is evident that the CBD Programme has a positive reputation and is accepted by the communities. This acceptance is crucial to the success of the intervention.

Recommendations for improving the Expanded CBD Programme according to thematic areas of the baseline survey report are as follows:

Reproductive health knowledge and attitudes

- It is important to note that, unlike among females, the CBDs did not rank first but second among the health workers known to males. As indicated in this report, this may be due to the fact that the CBDs target women more than men during their household visits.

To address this disparity, the Expanded CBD Programme should work to meet the reproductive health needs of males.

- The majority of both male and female respondents indicated that they were not visited by a CBD in the 12-month period preceding the survey, and only a minority of the survey respondents reported that they have ever attended community meetings addressed by a CBD.

The issue of trying to cover a large number of people through the CBD Programme might be addressed by the use of depot holders under the Expanded CBD Programme. As depot holders are recruited, CBDs are expected to concentrate on reaching more clients with more information than before. This is because the CBDs' role in resupplying clients with contraceptives, which had previously taken up most of their time, would be transferred to the depot holders.

- The findings reveal that the CBDs seldom mention VCT and young adult reproductive health care during their household visits.

CBDs should utilize the skills they will receive from the training of the Expanded CBD Programme to provide information to clients and offer referrals to those in need of VCT and young adult reproductive health care so that the level of basic knowledge about these issues improves among local communities.

- Medical staff of fixed health facilities (nurses and doctors) ranked top as the persons to whom respondents would turn if they were to seek information or counseling on HIV/AIDS. The CBD was the second-ranked cadre that respondents would turn to if they needed information or counseling on HIV/AIDS.

CBDs need to network and collaborate intensively with staff at health facilities so that the Expanded CBD Programme is more effective in integrating HIV/AIDS/STIs information into family planning services.

- All respondents in the comparison and intervention areas had heard of STIs. All respondents had also heard of HIV/AIDS, and the vast majority of them knew its modes of transmission and the lack of a known cure. Knowledge of contraceptives, as measured by having heard of a method, was also nearly universal among the survey respondents.

The ZNFPC IEC Unit has made considerable investment in information awareness among the general population, and this has led to better knowledge of family planning and HIV/AIDS issues. The IEC component of the Expanded CBD Programme should, however, not only focus on disseminating information but also on inducing and sustaining effective behaviour change particularly for youth and men.

Reproductive health practices

- Young adults constitute a significant proportion of the population in the communities served by CBDs. The findings show that young adults have been and continue to be sexually active at an early age. At least one fifth of female and male young adults (15-19) reported having been sexually active. This figure rises steadily to over half of the respondents in the 20-24 years age group.

Young adult access to reproductive health information, education and communication and care is crucial to the success of the Expanded CBD Programme. Reproductive health information should be provided to both married and single young adults. Reaching this group early is important because information is most effective when provided before the onset of sexual activity.

- The findings clearly indicate higher risk sexual behavior among males than among females. Male respondents were much more likely to report having had sex within the past 12 months with a casual partner or a commercial sex worker than their female counterparts.

CBDs should focus more on addressing male involvement in the Expanded CBD Programme. The IEC component of the project should be shifted to behaviour change communication (BCC). This will help people, particularly men, to become aware of their own behaviours, vulnerability, attitudes, and beliefs. CBDs should also vigorously promote the value of dual protection against HIV/AIDS/STIs and unwanted pregnancy. Condoms should be made more popular to men who have many sexual partners. CBDs should talk openly about how culturally sensitive practices (e.g., males having more than one sexual partner) increase transmission of HIV/AIDS.

- Most males indicated that they use condoms to prevent sexually transmitted infections, while most females mentioned pregnancy prevention as their reason for using condoms. The most common response among men for never having used condoms was that they trusted their

partners, while females most often said they had never used condoms because of partner refusal.

These findings indicate that barriers for condom use still remain. Misconceptions about condoms are still prevalent among males, as suggested by the significant proportion of males who reported that they do not trust condoms. There is a need to improve IEC/BCC for both men and women through the Expanded CBD Programme to promote the use condoms not only for pregnancy prevention or STI prevention but for dual protection.

The major reported source of family planning methods used was the CBD, indicating that CBDs are effective agents for family planning promotion and can therefore also be effective in condom promotion.

- The pill largely dominates the contraceptive method mix. The male condom and the injectable were the second most-used methods of family planning among males and females, respectively. Use of other methods was negligible.

CBDs should ensure that their clients have a greater exposure to other available contraceptive methods, and should also refer clients for long-term methods. The greater the exposure to long-term methods, the more likely clients will use them.

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