DETERMINANTS OF UNMET NEED FOR FAMILY PLANNING IN ZIMBABWE

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Prepared by:
J Chitereka (ZNFPC) and Busiku Nduna (LATH)

DFID LATH MOHCW ZNFPC UNFPA
ABSTRACT

The 2005-06 Zimbabwe Demographic and Health Survey (ZDHS) reported unmet need for family planning of 13%. This figure was unchanged from the 1999 survey. The surveys provide quantitative data which needs to be augmented by qualitative information to explore underlying reasons and aid understanding of the dynamics. The decline in the outcomes of the Community Based Distribution (CBD) program and its contribution to the Contraceptive Prevalence Rate (CPR) has also prompted an enquiry into the determinants of unmet need in Zimbabwe.

The goal of the study is to determine the underlying causes of unmet need for family planning in Zimbabwe among sexually active women and couples. The study also presents challenges being faced in family planning service delivery as well as offering recommendations.

Four provinces including Matabeleland North, Matabeleland South, Manicaland and Harare Metropolitan were studied because of the high unmet need in 2005-06 ZDHS. The sample includes youth between the age of 14-24 years, adult men and women from 25-49 years and other elders above the age of 49 years. Focus Group Discussions and in-depth interviews with key informants were used to collect data. Random sampling, stratified and convenient sampling were also utilized to assemble the discussions.

A total of 80 focus group discussions were held with the beneficiaries of family planning programs, Community Based Distributors (CBDs) and 62 in-depth interviews with key informants from different institutions and gatekeepers in the communities. The results indicate that knowledge of family planning methods is inadequate. Most clients only know the name of the method but not how it works, or possible side effects. Cultural beliefs, gender dynamics and power relations at household level, myths and misconceptions are some of the causes of unmet need. Service delivery sites including clinics and hospitals lack specialized training in family planning although their staff covered the topic during their pre-service training. Resettlement areas and other farming communities are underserved and unmet need is particularly high in these areas. There is a shortage of CBDs throughout the country hence service delivery at community level is limited. Some NGOs offer services through mobile clinics, but clients need continuity of care and management of side effects which is a challenge due to shortages of CBDs and health staff trained in family planning. The coordination of family planning services is generally weak. The cost of contraceptives is not a major reason for not using family planning methods but other factors such as family disapproval, side effects and physical access outweigh the monetary cost of family planning methods.
Although the CPR in Zimbabwe is very high (65%) when compared to other countries in the region, unmet need is also high. Knowledge of family planning is not translating into use because of cultural and religious beliefs, myths and misconceptions. Lack of specialized training among the majority of service providers and shortage of CBDs is contributing to the unmet need. Resettlement areas and other farming communities are underserved. The study recommends the strengthening of family planning coordination to improve quality of service, comprehensive training of service providers on family planning, recruitment of relatively young and energetic CBDs as well as increased funding for family planning programs in Zimbabwe.
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<td>ART</td>
<td>Anti-retroviral Therapy</td>
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<td>ARV</td>
<td>Anti-retroviral</td>
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<td>CBD</td>
<td>Community Based Distributor</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CSO</td>
<td>Central Statistical Office</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>HIV</td>
<td>Human Immuno-Deficiency Virus</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>LATH</td>
<td>Liverpool Associates in Tropical Health</td>
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<td>MIMS</td>
<td>Multiple Indicators Monitoring Survey</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>ZDHS</td>
<td>Zimbabwe Demographic Health Survey</td>
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<td>ZNFPC</td>
<td>Zimbabwe National Family Planning Council</td>
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CHAPTER 1

INTRODUCTION

1.0 Background to the study

The concept of unmet need for family planning has obtained a position of centrality in the formulation of population policies and family planning programming. The Demographic Health Surveys define unmet need for family planning as all fecund women who are married or living in union, and thus presumed to be sexually active, who either do not want any more children or who wish to postpone the birth of their next child for at least two more years but are not using any method of contraception. However, there is no universal definition of unmet need and the utility of the concept has been questioned. There are more than 200 million women with an unmet need for family planning globally and this impacts on population policy and service delivery. Countries in Sub-Saharan Africa (SSA) experience the highest levels with approximately 24 percent of married woman having an unmet need for family planning.

Zimbabwe has received regional and international acclaim with regards to its family planning program, which has achieved a contraceptive prevalence rate (CPR) of 65% and contributed to the adoption of small family sizes and the reduction in the total fertility rate (TFR) which is at 3.8. The unmet need however remains high at 13% (ZDHS, 2005-06) and has not changed over the past decade (Demographic Health Surveys of 1999 and 2005-06).

The family planning program has been a collaborative effort among all service providers. Since its establishment ZNFPC has used the Community Based Distribution (CBD) programme as the main service delivery model. Community Based Distributors (CBDs) are men and women recruited at community level to distribute contraceptives through a door to door approach informing, educating and motivating clients to use contraception. The CBD program is one of the most successful community based family planning service delivery initiatives in Sub-Saharan Africa and has enabled Zimbabwe to improve the CPR from a low rate of 35% in 1984 to the current rate of 65% in 2009 (MIMS 2009). It is of concern that the contribution of the CBD programme to the overall CPR has diminished from 18% in 1994 to 6% in 1999 and 4.8% (ZDHS 2005-06). It is against this background that ZNFPC in collaboration with LATH (Liverpool Associates in Tropical Health) and UNFPA has undertaken this study to establish the reasons behind the constant

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1 Karin Ringheim et al (2009) Supporting the integration of Family Planning and HIV Services, Population Reference Bureau

2 Keriann Schulkers, Issakha Diallo, Jennifer Litzow, Diana Silimperi, (2009), Contraceptive Use: Levels and Trends II: Strong Predictors of the Unmet Need for Limiting and Spacing Births in Sub-Saharan Africa

3 Multiple Indicator Monitoring Survey (2009), Central Statistical Office
unmet need for Family Planning in four provinces that include Matabeleland North, Matabeleland South, Manicaland and Harare Metropolitan.

1.1 Statement of the Problem

Knowledge of modern methods of contraception is almost universal and the CPR has increased in every DHS conducted in Zimbabwe but the unmet need for family planning is maintaining a constant rate. Ideally, the CPR and unmet need should present an inverse proportion where the CPR will be increasing and the unmet need decreasing. However, the situation in Zimbabwe presents a programming challenge where universal knowledge of contraception is not translating into use due to a number of reasons that need to be understood to improve service delivery. The recent decline in the contribution of the CBD program to the CPR is a cause for concern since it is a model of service delivery that is capable of reaching clients in difficult to reach areas. The current efforts by the health delivery system in Zimbabwe to integrate family planning and HIV services aim to prevent both new HIV infections and unintended pregnancies. Addressing unmet need for family planning is a critical step to this end.

1.2 Justification of the study

In a region marked with high fertility levels Zimbabwe stands out for its success in lowering fertility and in increasing the CPR which is currently at 65% (MIMS, 2009). Over the last two decades the total fertility rate (TFR) has decreased from 5.3 to 3.8 children per woman in 2005 (ZDHS, 2005-06). Despite these achievements 13% of women have an unmet need for family planning (ZDHS 2005-06). A number of studies have shown that reducing unmet need can improve maternal survival and health. Family planning also has additional health, social and economic benefits. It can reduce child and infant mortality through avoiding unintended pregnancies. In the context of integrated services the promotion of dual protection and dual method use reduces the transmission of HIV. Translating unmet need into contraceptive use realizes substantial benefits and it is important to understand the reasons and dynamics behind the residual unmet need. Several studies, especially the ZDHS, have concentrated on quantitative information on unmet need and need to be supplemented with qualitative information to help inform improvements in planning and service delivery. It is hoped that the information from this study will help inform the family planning program to address this critical gap.

1.3 Goal and Objectives of the Study

The goal of the study is to establish the underlying causes of unmet need for family planning among sexually active women and couples in Zimbabwe.

Specific objectives are:
- To determine the reasons for not using contraceptives among sexually active women and couples in Zimbabwe;

To identify the causes of unmet need by socio-economic, demographic, ethnic and religious factors;
- To identify key challenges and make recommendations that will guide policy making to address the unmet need

1.4 Definition of Terms

Unmet need for family planning refers to women in the reproductive age who prefer to avoid or postpone childbearing but are currently not using any method of contraception.

Contraceptive Prevalence Rate (CPR) refers to the population of women of reproductive age who are married or living in union and are using any effective method of family planning.

Total Fertility Rate (TFR) is the number of children a woman would have if she were to bear children at the prevailing age specific rates.

1.5 Delimitation of the study

The study concentrated on four provinces namely Manicaland, Matabeleland North, Matabeleland South and Harare Metropolitan.

1.6 Limitations

The research failed to include the desired number of women who are exclusively not using any contraceptives because it was difficult to organize those groups in communities. The absence of marginalized and special groups including physically handicapped (the blind, deaf, etc) was a challenge since they also have family planning needs which are not well addressed with the current programs.
2.1 Magnitude of Unmet Need

The concept of unmet need has been useful in formulating population policies, reproductive health and family planning programs. Studies have been commissioned in many parts of the world including Sub-Saharan Africa to understand the scale and underlying causes or determinants of unmet need. Unmet need remains high in developing countries. According to the Guttmacher Institute (2007) between the periods of 1990 to 1995 and 2000 to 2005, unmet need declined only 2 percent in Sub-Saharan Africa. In other regions of the developing world—including Latin America and the Caribbean, North Africa and West Asia, and South and Southeast Asia—more progress has been made and unmet need has fallen between 4 percent and 7 percent. Figure 1 below shows the distribution of unmet need by region from 1990 to 2005.

Figure 1: Percent of Married Women with an Unmet Need for Contraception, by Region, 1990-1995 and 2000-2005

In developing countries an estimated 51 million pregnancies are unintended and attributed to non-use of contraception. Another 25 million pregnancies occur because of incorrect use of a contraceptive method or method failure (Westoff, 1988; 1978). According to Sedgh et al (2007) complications of abortions due to unplanned pregnancies make a large contribution to maternal morbidity and mortality in Zimbabwe. Unmet need declined from 14.6% in 1994 to 13% in 1999 (ZDHS 2005-06) and has maintained at this level since.
2.2 Determinants of Unmet Need for Family Planning

Unmet need exists even where knowledge of contraception is high and the reasons need to be understood. A study conducted by Oyedokun (2007) in the Osun State of Nigeria confirms that knowledge level does not necessarily translate to use. Women interviewed in the Osun State had high knowledge levels of modern contraceptives but the majority of them preferred to have more babies and contraceptive use was deemed unnecessary.

Bongaarts and Bruce (1995) analysed data from 13 DHS surveys and noted that lack of knowledge was a principal reason for non-use of contraceptives among women who were otherwise keen and willing to use family planning methods. Westoff and Bankole (1995) indicated that lack of information about family planning, opposition to family planning and ambivalence about future childbearing were the principal factors responsible for unmet need for family planning.

In some regions women have a low risk perception on becoming pregnant. According to Sara Maki (2007) the reasons women cite for not using contraceptives vary across regions. In North Africa and West Asia more than 60% of women with unmet need do not use contraception because they believe they are not at risk of getting pregnant. In Latin America about half of women and in both South East Asia and Sub-Saharan Africa approximately 35% of women cited this low risk perception as a reason for not using contraception.

Omwango and Khazakhala (2007) in Kenya highlighted that many studies on unmet need have been women focused with some passing inferences for men or couples yet reproductive decisions are not made by women alone. They argued that unmet need for family planning is multi-faceted and cannot be explained clearly if individuals are treated separately. This is due to the fact that the desire for and timing of additional children and contraceptive practice are influenced by extra-individual factors, such as ability to communicate, lack of knowledge, societal disapproval and husband’s approval (Ngom, 1997).

This leads to another conclusion that unmet need is as much a reflection of primary social relations as it is of individual attitudes and experiences. This “social component” takes different forms depending on the setting. In Pakistan, most women are convinced that their husbands oppose most methods of family planning, and contraceptive practice without the husband’s approval is unthinkable. Their husbands, in turn, are concerned about the social acceptability of contraception in their social circle of extended kin and community members (Population Council/Islamabad 1997) cited by Casterline and Sinding (2000). Spousal communication on matters relating to fertility and contraceptive use also influences unmet need, where there is no communication it is difficult for one partner to unilaterally decide on contraception (Robey et al, 1996).

Health concerns or side effects have been cited in a number of studies and by family planning field workers as contributing to the unmet need. Interviews in Egypt, Nepal, Pakistan, and Zambia reveal that fear of the health side effects of
contraceptives inhibit women from using a method, not only because of aversion to the expected physical discomfort but also because of the expected time and financial costs of managing the side effects, the potential loss of labour productivity, the possibility of interference with spousal sexual relations, and a sense that the side effects signify divine disapproval (Casterline and Sinding, 2000). Decisions to use contraception also take into consideration method attributes such as effectiveness, safety and absence of side effects (Guzman et al, 1997). In a study by Barnett and Stein (1998) in Mashonaland East Province of Zimbabwe, women revealed that oral contraceptives altered their menstrual cycle, gave them headaches, cause them to gain weight and reduced their libido. These side effects have led them to prefer traditional methods such as withdrawal and vaginal douching which are less effective but have no side effects.

An individual is a member of a community and the community defines social and cultural norms, gender roles, social networks, religion and local beliefs that affect contraceptive use (Bosveld, W, 1998). Asha (1991) conducted a study in India and found out that religion or caste had an influence on acceptance of contraception and method choice. Some religions do not accept the use of contraceptives as they believe that contraceptives are against the law of multiplicity which is a biblical command from God. Traditionally, mothers-in-law also have an influence on the use of family planning methods. In a study carried out in some provinces in Zimbabwe mothers-in-law viewed contraceptive use as a means of limiting pregnancies yet a large family was seen as important as it extends lineage (Barnett and Stein, 1998).

Educational attainment and occupation directly affect unmet need in a positive way. Education only increases awareness of social mobility and creates a new outlook and rationalism among couples, and also reduces desired family size by raising desired living standards, bringing about a better understanding of the reproductive process, better knowledge about health care and access to modern means of birth control. All of these eventually affect unmet need for family planning. Men and women involved in the job market will see additional children as costs to time and money, and also generate additional responsibility of maintaining and rearing more children. Female education has been seen as a key determinant of contraceptive use (NPC and ORC Macro 2004). Better-educated women are more willing to engage in innovative behaviour than are less educated women, and in many developing country contexts, the use of contraception remains innovative (Caldwell 1979; Dyson and Moore 1983).

People are also concerned with the availability and quality of family planning services. It is assumed that service quality influences the unmet need for family planning. Improving the family planning services and making contraceptives easier to obtain and use will help meet the needs of many men and women. It is difficult to

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realize reproductive health goals if people are not satisfied with the range of family planning services available to them (John Hopkins University, 1996). The place of residence influences the use of contraceptives and can limit the methods available. Urban areas for instance offer a wide range of contraceptives by virtue of many facilities that offer services and are more easily accessible than rural areas.

The monetary cost of contraception can be a factor for some women (Bhushan, 1997). Furthermore, people decide to regulate fertility on the basis of the perceived cost of contraceptive use, rather than its actual cost (ibid). Contraceptive use entails both monetary and non-monetary costs and the latter may be a greater deterrent to use than monetary costs. Therefore, unmet need can be better explained if contraceptive cost is broadly defined to include the non-monetary costs, as suggested by Easterlin (1975).

The current study seeks to identify the major predictors of unmet need in Zimbabwe and is guided by previous studies and the available literature.

2.3 Conceptual Framework

It is often argued that unmet need is related to the perceived cost of contraception. Clients do a cost benefit analysis before they make a decision to either use or forgo contraception. If the cost outweighs the benefits the decision is likely to not use contraceptives. According to Bhushan (1997), as cited by Ahmadi (2005), there are three categories of costs that can be incurred in the use of contraceptives:

- Costs related to availability (geographical and physical, qualitative and cognitive aspects of availability)
- Cost related to health concerns and fear of side effects (discontinuation, fear of side effects among never users)
- Cost related to social, cultural and familial disapproval of family planning (disapproval of family, religion and customs)

Besides the costs highlighted above a person’s behaviour is influenced by two sets of factors that are personal and social in nature. Personal factors are comprised of an individual’s positive or negative evaluation of a certain behaviour while social influences is the effect of other individuals’ attitudes on one’s behaviour. In this conceptual framework it is assumed that background factors like demographic, socio-economic and cultural variables interact with proximate determinants such as knowledge about contraceptives, desire to control fertility and perceptions on contraceptive use to produce unmet need as shown in Figure 2.
FIGURE 2 – CONCEPTUAL FRAMEWORK

Source: Adopted from Bhushan (1997) and modified

BACKGROUND FACTORS

Demographic variables
- Age of women
- Number of living sons
- Marital status

Socio-economic variables
- Work status
- Standard of living
- Education
- Exposure to mass-media

Cultural variables
- Religion
- Women attitude about equity of spouses

PROXIMATE DETERMINANTS

Family perception about contraceptive use

Spousal communication regarding fertility

Cost of contraceptives

Desire to control fertility

Availability of contraceptives

Knowledge about contraception and side effects

Myths and misconceptions

UNMET NEED

Independent variables

Dependent variable
CHAPTER THREE

**Methodology**

3.1 Introduction

The study has undertaken a qualitative methodological design to understand the dynamics of unmet need in Zimbabwe. Qualitative data was collected through focus group discussions (FGDs), open-ended questions for key informants and gatekeepers in the communities.

3.2 Study Sites and Justification

The study considered four provinces including Matabeleland North, Matabeleland South, Manicaland and Harare Metropolitan. In Matabeleland North, three districts including Bulawayo, Nkayi and Ntabaezinduna were included; in Matabeleland South Province Gwanda and Matobo districts; in Manicaland Province Makoni and Mutare and in Harare Metropolitan, Harare district was part of the study site. The two Matabeleland Provinces were selected because the level of unmet need in these provinces was high in the ZDHS of 2005-06. The unmet need for Matabeleland North was 20% and for Matabeleland South was 19.7%. Manicaland province was also selected because the unmet need was considerably high at 16.8% (ZDHS, 2005-06). Harare Metropolitan Province was selected even though it had the lowest level of unmet need (6%). It was chosen as a control because in Harare there is a wide array of contraceptives and family planning service outlets.

3.3 Sample and Sampling Procedures

The sample comprised youth (males and females) aged 14-24 years, men and women aged 25-49 years, and mothers-in-law and other elders in villages above the age of 49 years because in most cases they are the decision makers and custodians of traditions in their different cultures. Program Managers, Officers and Heads of institutions offering family planning services were also part of the sample. Cluster sampling was used to select the provinces and random sampling for the selection of districts. Stratified and convenient sampling methods were used for the formation of the focus group discussions and selection of key informants.

3.4 Data Collection Instruments

3.4.1 Focus Group Discussions (FGDs)

Focus Group Discussions were based on a facilitated discussion with a group of individuals selected because they were believed to represent a particular demographic. FGDs were used to bring out insights and understanding on the causes of unmet need which simple questionnaires may not have tapped. An FGD guide was developed in English and translated to vernacular languages (Shona and Ndebele) to ensure uniformity in the way questions were asked by all facilitators.
The FGDs were done with beneficiaries (all family planning clients) and the CBDs. Trained note-takers or rapporteurs were used to record information during the FGDs. As a way of ensuring quality two rapporteurs were assigned in every FGD and MP3 recorders were also used to ensure quality data as well as for comparison purposes.

3.4.2 In-depth Interviews

In-depth interviews were conducted with key informants and gatekeepers. Key informants were people assumed to have a great deal of knowledge on sexual and reproductive health, especially family planning. Gatekeepers are influential people in the community who hold strategic leadership positions for example traditional and local leaders, church leaders and other village elders. In this study the key informants were drawn from the Ministry of Health and Child Welfare, ZNFPC Clinics, NGOs offering family planning and multi-lateral agencies like UNFPA. Key informants were chosen to obtain a picture of the unmet need at implementation level and also to get information pertaining to policy issues and service delivery systems of contraception.

3.4.3 Training of Research Assistants

Research Assistants were drawn from all the four provinces under study. The criteria used for selection was based on prior experience of conducting qualitative research biased towards reproductive health and family planning. A two-day training was carried out covering the following aspects:

- Rationale and objectives of the study
- Interviewing techniques
- Ethical considerations
- Communication skills
- Translation of data collection instruments into Shona and Ndebele
- Research Protocol
- Role Plays
- Pilot Study
- Revision of Data Collection Tools

3.4.4 Pilot Study

A pilot study was conducted in Chinhoyi Urban and Mhangura in Mashonaland West Province. During the pilot the research team had an opportunity to meet all the target groups considered in this study. The pilot study helped to clarify and revise questions. Key informants also helped to add questions that were left out in the initial draft data collection tools. Results from the pilot study were then used to improve the final survey instruments.
3.4.5 Data Analysis

Data from all the FGDs was analyzed qualitatively using typology which is a classification system of data with mutually exclusive and exhaustive categories of information. The recorded information was transcribed by professional transcribers.
CHAPTER FOUR

RESEARCH FINDINGS

4.1 Introduction

A total of 80 Focus Group Discussions (FGDs) were conducted across the four studied provinces. Interviews were carried out with 25 key informants from various organizations with 37 gatekeepers in different communities. Appendix 1 shows the schedule of FGDs and interviews.

4.2 Knowledge of contraceptive methods

In all the FGDs conducted knowledge of contraceptive methods was almost universal and each participant was able to mention at least two methods of family planning. However, a knowledge gap was noted especially on how the family planning methods work. This gap was noticed even among tertiary level students. Clients may be aware of a method of contraception but lack information on how to use the method. One of the participants in a focus group discussion with tertiary students mentioned that, “There is an injection called Depo which can be administered to a woman and protect her from pregnancy for two years or five years depending on her choice”.

Other respondents were unaware of the dual protection provided by condoms and argued that male and female condoms are not contraceptives but only protect against STIs, HIV and AIDS. This shows a knowledge gap that needs to be addressed by service providers when they issue these contraceptives.

Another segment of the respondents was not even aware of methods of family planning at all. In Manicaland Province women from the John Marange Apostolic Sect revealed that they were not aware of any modern method of contraception but had knowledge of traditional methods like the withdrawal method and because of their religion they believed in ‘holy water.’ Such knowledge gaps though linked to their religious beliefs contribute highly to the level of unmet need among these groups.

4.3 Conceptual understanding of family planning

The whole concept of contraception is understood differently by different people. Respondents argued that family planning is something which was imposed by the West and is not compatible with African culture. A traditional leader in Mtshabezi area Matabeleland South Province mentioned that the concept of family planning was brought by white colonial settlers as a way of limiting population growth among the black majority but as that era is over there is now no need to limit the populations. Some respondents also believe that family planning is only meant for those who are married and have had children before. Participants in Headlands
argued that a person who does not have a family cannot begin to plan a family instead the need for contraception should be driven by the existence of a family first. This conceptual meaning of contraception also influences the decision to use contraception or not.

4.4 Attitude towards contraceptive use

Attitude in this study refers to a positive or negative feeling towards something, family planning in this case. Most respondents had a positive attitude towards the use of contraception and, as cited, the benefits that can be derived from using family planning. However, it was also noted that some women and couples do not use contraceptives because of a negative attitude. A respondent in Mbare said, “Contraceptives do not work and are a waste of time and money.”

Upon probing his attitude the respondent cited that he had close relatives who have used contraceptives, but they had not worked well. In another discussion with university students, participants mentioned that ignorance, carelessness, and wrong information cumulatively results in a negative attitude towards family planning. Other participants also mentioned that they don’t want to put unknown chemicals and substances in their bodies.

Some have a negative attitude towards the use of contraceptives because society relates family planning to promiscuity. According to a respondent in Ntabazinduna Area in Matabeleland North extensive knowledge of contraceptive methods implies previous or current promiscuous behaviour. On the same note, respondents in Matabeleland South categorized some contraceptives as respectable and some as unrespectable. Respectable contraceptives included oral contraceptives and injectables while unrespectable methods include the female condom which was referred to as an instrument used by sex workers. This kind of thinking leads to a negative attitude towards contraception.

4.5 Religion and use of contraceptives

Religious beliefs and affiliation also contribute significantly to the unmet need in Zimbabwe. Some religions like the Apostolic Sect and Catholics do not believe in contraception. The Apostolic Sect women whom the research team interviewed in Mutare stated that it was forbidden to use family planning methods and members are always under surveillance from their Church Elders. In Harare Metropolitan Province a follow up interview with another Apostolic Sect leader revealed that they regard contraceptive use as a sin against God. He further mentioned that even the natural methods like withdrawal and rhythm is a sin because “Men were created by God to be fruitful and not to waste their seed to the ground”. He also argued that using contraception is like killing undeveloped eggs and sperms which is in parallel with God’s plan hence couples should follow the book of Genesis in the bible which says, “Be fruitful and multiply.” However, there is an interesting finding among these Apostolic members. They use withdrawal as a method but once men fail to withdraw they secretly allow women to use contraceptives and those who live far
away from other church elders can access family planning methods because of lack of surveillance. This means family planning programs may capitalize on that relaxation of belief.

Also some mission hospitals discourage the use of contraception. The mission Mubma hospital in Nkayi District argued that children are a gift from God and there is no need to plan in terms of spacing and limiting. In areas surrounding the mission contraceptives are issued to married people only. For clients who are not married it is difficult to access contraceptives. In an in-depth interview a key informant at the hospital noted that accordingly unmet need only applies to psychiatric patients and those raped, because it was not their intention to get pregnant.

4.6 Culture and contraception

Cultural practices and tradition usually oppose the use of contraceptives. According to respondents in Mutare a typical African family should have five children or more. The number of children was regarded as a sign of virility. This belief still prevails, albeit to a lesser extent. Another respondent noted that long ago families used to be bigger and that desire and mentality continues especially in terms of labour provision in farming and as source of financial security when one gets old. Participants in other FGDs disputed this notion because the current pattern is of young people who are dying at a faster rate than before therefore investment in children in anticipation of later support becomes void.

Traditionally, a newly married couple is expected to have a baby in the first year of marriage. Newly married women in Mtshabezi area of Gwanda echoed that the first child in the first year of marriage is an expectation and not an option. Moreover, in-laws expect the number of cattle given during lobola to be directly proportional to the number of children that a woman is going to bear.

Traditional leaders, especially Chiefs and Headmen, are the custodians of the culture in their domain. Mostly their command is followed. In one of the interviews with traditional leaders in Chiendambuya area, on introducing the topic of family planning the Chief explained that contraceptive use was obnoxious as the cows that he gave to the wife’s family were not injected with depo, instead they are reproducing. The traditional leaders emphasized the point that family planning limits the potential of families to reach their full reproductive capacity and limits production. In this discussion the point was raised that family planning service providers are free to teach about contraception but should also target youths upholding abstinence. This means that local leadership can be a target group for propagating contraceptive use.

The importance of a boy child

Unmet need is exacerbated by a couples’ desire to have one or more sons. Respondents highlighted that the importance of male children remains culturally relevant even if within couples there are fertility preferences. Respondents in Glen Norah High Density suburb of Harare explained that in a deteriorating economic
setting a female child is perceived to be more advantageous to her future husband’s family. Another respondent said that he is not using any contraception with his ‘small house’ because she had given birth to a baby boy and is trying for a second son since his original wife has given birth to three daughters.

**Polygamy**

In a polygamous family it is difficult to use contraception. A respondent mentioned that in a marriage security and status is earned by having children, particularly male children. A woman in such a marriage who uses family planning methods will run a risk of losing favour with her husband whose goal is to increase lineage. Women married to polygamists may be willing to limit or space their children but because of competition for attention and resources they are forced not to do so.

**Preservation of indigenous knowledge**

The desire to maintain and preserve indigenous knowledge also leads to shunning of the modern way of life and adoption of some practices like contraceptive use. Traditional Birth Attendants who were interviewed as gatekeepers in Matabeleland North, South and Manicaland emphasized the importance of preserving indigenous knowledge systems and natural methods of family planning. They argued that oral contraceptives are a foreign technology which may erode the use of herbs which are seen as more efficacious and cause no harm to the reproductive system and the general health of a woman.

**4.7 Gender Dynamics and Contraception**

Gender roles and expectations are culturally and socially prescribed. In a patriarchal society like Zimbabwe men were socialized to be the heads of their families with the highest authority in decision making and women were to be subordinates of their husbands. This has created gender imbalances between men and women. It is difficult for women to unilaterally use contraceptives without the approval of men. In an FGD with high school students in Matabeleland South one of the girls mentioned that, “I can’t do my own thing because he married me and if he says no to contraception then I have to concur”. This shows that socially prescribed roles are powerful in determining one’s behaviour given that the girl is still at school but she already knows that when married she has to be under the leadership of her husband because he married her. Another woman in Sakubva, Mutare mentioned that her husband denied her to use contraceptives without any explanation.

However, some men interviewed in Glen Norah, Mbare and Sakubva argued that the power to use contraceptives is in the hands of women as they are the ones who know when and how to use them. A significant number of male respondents in FGDs are of the view that the whole business of contraception is biased towards women and most of the methods available are for them with the exception of male condoms and vasectomy which is again unpopular among men. One male respondent in Marlborough argued that women are provided with family planning information at
antenatal and post natal clinics where men do not frequent and as a result they lack information.

Men feel that family planning programs have left them out and weakened their positions as heads of households. The respondents indicated that men no longer control families anymore but women are now at the helm of power. A participant in one of the FGDs in Marlborough, Harare raised a concern that “A man might want a baby but the woman holds the key, she will only accept to conceive when she wants, therefore family planning is her responsibility”.

Another view coming from women is that men have a desire to ‘fix’ women. Fixing here is defined as making women unattractive to other men. “So one way of going about it is to make us pregnant on an annual basis,” said one woman in Mutare. As a result women may be willing to control their fertility but because their partners believe in fixing them it becomes extremely difficult to initiate contraceptive use.

Couple communication is also an influential factor leading to unmet need among married couples. Poor communication and the assumption by a husband that the wife is taking contraception contribute to non use of family planning. A respondent in Gwanda complained that his wife stopped using contraceptives behind his back because she wanted to have a baby. Another respondent in Glen Norah added that some women labelled by the society as having ‘loose morals’ such as bar ladies deliberately decide not to use contraceptives so that they can trick a man into fathering a child when they realize that they are getting old.

4.8 Myths and Misconceptions

Unmet need is also determined by myths and misconceptions associated with the use of contraceptives. Quite a number of men who participated in all the FGDs in the four provinces believed that they cannot enjoy sex when their wives are using contraceptives. A village elder in Mtshabezi added that contraceptives make the husband weak and reduces his performance during sexual intercourse.

In all the 32 FGDs conducted in Matabeleland North and South respondents indicated that they fear to give birth to babies with deformities if they use contraceptives. In Matabeleland South women indicated there are examples of their friends who were using pills and gave birth to children with big heads. Their thinking is that disability or any other deformities may be attributed to the use of contraceptives which contain chemicals with unknown properties.

The majority of respondents also believed that prolonged use of contraceptives causes infertility. There is a misconception that after using long-acting methods like Jadelle or IUCD which protect a woman for many years from becoming pregnant, the ovaries will have been blocked and will have run out of eggs when she wants to conceive. One woman in Nkayi District was wondering if she was going to be able to become pregnant after spending six years with an implant. All these misconceptions emanate from a lack of appreciation of how the reproductive system functions.
In some areas like Matabeleland South and Manicaland respondents still believe that if women tie strings around their waist for a certain period of time, say two years, they won’t get pregnant. If they now want to conceive it is a matter of just cutting the string. The respondents were very confident that the “folk method” works very well and they don’t need any pills or any other modern method of contraception.

Again, due to lack of information on the reproductive health system, some respondents, especially among the youth, interviewed in Mutare think that if one has sexual intercourse using a certain position there is no room for getting pregnant. One of the participants in a FGD where youth were represented mentioned that her boyfriend had told her that, “If we have sexual intercourse using the ‘dog style’ you won’t get pregnant”.

Young people in particular lack information on their sexuality and end up being vulnerable to unwanted pregnancies, STIs, HIV and AIDS. There is a critical need to establish youth friendly services throughout the country.

4.8.1 Youth and Contraception

There were mixed feelings on whether youth should access and use contraceptives in Zimbabwe. The majority of the parents interviewed were against the idea of youth accessing contraceptives instead they were championing abstinence as the only option available to them. The parents, however, mentioned that youth should receive education on sexual and reproductive health and contraception as much as possible but that access to contraceptives should be left to those who are married. In an FGD, university students in Harare raised a concern that their parents think that all the energy should be geared towards reading books and not sexual indulgence, yet in practice they are already sexually active. Another female student said: “Our parents want us to live up to the expectation of a perfect child which is utopian” meaning that it is an ideal situation which is far from reality on the ground.

Parents in Manicaland and Harare Metropolitan province had a different view. They mentioned that youth are now exposed to a lot of information through radio, TV and the internet which gives them information and zeal to experiment with their sexuality. The parents also mentioned that the young generation of today is different in that they mature at a faster rate than they used to. Because of all these factors they felt that youth should access contraceptives and education on reproductive health. “Otherwise our children will perish because of HIV and AIDS”, said one of the concerned parents.

Youth also raised a concern that even if they want to access contraceptives the services are not all that friendly. In one of the FGDs with youth, a girl mentioned that “Even if I want to use condoms and pills the nurse who is at the clinic is an old lady who is also a close friend of my mother, so there is a probability that she will tell my parents if I go there looking for contraceptives”. In as much as the youth are willing to gather knowledge and use contraceptives they are faced with a challenge
from the attitude of the service providers. This is an area that needs programmatic intervention by family planning programs.

4.8.2 Cost of contraceptives and perceived quality

There were also mixed feelings among respondents pertaining to the cost of contraceptives. In Nkayi District and Chindambuya Area of Manicaland, women felt that the cost of contraceptives can inhibit access given economic hardships which are currently being experienced in the country. Respondents in Headlands indicated that the needs of the family come first and food is prioritized over contraceptives.

Contrary to this view the majority of the respondents were sceptical about the low costs of contraceptives. A larger proportion of the participants in all FGDs concluded that cheap and free of charge equals poor quality. Some respondents asked why pills, injections, implants and IUCD have different costs if offered by different service providers. As a result they thought that the higher the cost the more effective the method. Lack of uniformity on the cost of contraceptives among service providers therefore also contributes to unmet need.

Another group of respondents comprising university students in Harare preferred to buy condoms than to be given them for free. The students believe that free condoms have higher probability of bursting and they hesitate to use them especially those placed in the toilets. In this case unmet need is contributed to by ambivalence on cost versus the quality of the product.

4.8.3 Health Concerns

Data collected from FGDs support the conclusion made by a number of research studies on unmet need which attests that fear of side effects result in discontinuation of contraceptive use. Weight gain, month-long bleeding, spotting and headaches are some of the common medical concerns mentioned by hormonal contraceptive users. Some respondents in Marlborough, Harare also highlighted that when they use pills sexual drive is weakened. Another group of women also said that their unmet need is caused by fear of secondary infertility especially at a time when one wants to have baby. In all the groups of women who attended the FGDs the concerns raised had to do with the counselling offered by service providers which they said is not comprehensive. The counselling lacks advance warning on the possible side effects associated with each method, how a method interacts with hormones and clear instructions on how to use a method. In terms of management of side effects, the respondents expressed that it is difficult especially in rural areas. For example in Nkayi where they have to travel for long distances to the clinic and where most of the clinic nurses are not well trained in family planning. As a result women resort to non-use of contraceptives. Due to limited information given on contraceptive methods some women highlighted that they end up using these methods wrongly and even share wrong information on peer to peer platforms. Wrong use can also result in side effects which causes discomfort. Consequently those who experience side effects influence others not to use contraception.
4.8.4 HIV positive and contraception

The research team also had an opportunity to discuss with people living with HIV and Program Officers working with these groups. The members raised a concern that family planning programs have left them out. They said that the unmet need for family planning is also common among their families. Service providers were ‘accused’ of limiting their reproductive health rights by emphasizing that if one is HIV positive it is better not to conceive yet being positive does not mean that one can no longer have a baby. Instead they urged family planning service providers to extend their programs reaching them with correct information and messages on contraceptives and their interaction with ART since a number of the people living with HIV are taking ARVs.

4.8.5 Migration and Unmet Need

Unmet need can also be caused by migration. The economic downturn in Zimbabwe has resulted in the outflow of a significant proportion of the population who leave the country in pursuit of livelihood opportunities and what is perceived to be a better life. Internally, the government embarked on a land reform program which also resulted in people being resettled. Some resettlements had no clinics, CBDs or any other source of contraceptives. In Nyazura, an area in Manicaland Province CBDs indicated that there are areas which are inaccessible especially newly resettled farms because of transport problems. This implies that clients in need of contraceptives will not receive any service which contributes to unmet need.

A large number of Zimbabweans have migrated to neighbouring countries such as South Africa, Botswana and Mozambique in search of jobs. Often it is the man who goes leaving behind his wife. According to a respondent in Mtshabezi, Matabeleland South her unmet need was caused by the fact that since her husband left for Botswana she no longer has the need for family planning. She explained that using contraceptives in the absence of her husband would tempt her into infidelity and become the subject of community gossip. So, each time her husband returns during his annual visit she would conceive. The respondent also noted that if the in laws saw her collecting contraceptives, the action will be misinterpreted as betrayal to the husband and his family and his efforts abroad.

4.8.6 Education and Contraceptive use

Education has an influence to unmet need as it raises awareness on contraceptive issues and their benefits. The more a woman or a couple becomes educated the more they appreciate family planning. However, FGDs with some educated women and university students revealed that the majority of them lack information on the range of family planning methods, the reproductive health system and stages in life like menopause. Such gaps in information also contribute to unmet need.
4.9 Service Delivery

Coordination of family planning services

The study noted that there is a gap in coordination of family planning service providers. In depth interviews with key informants in Matabeleland North and Harare Metropolitan provinces highlighted that the lack of coordination structures contributes to the unmet need because service providers at times concentrate in well covered areas instead of reaching out to hard to reach clients in resettlement areas where there are no clinics. One key informant in Harare mentioned that even if mobile services are introduced in these underserved areas there is still a need for a continuum of care and access to management of side effects which is lacking in most cases.

Another reproductive health expert suggested that the emphasis of family planning service providers should now be on the quality of service as opposed to increasing the number of clients receiving the services. He argued that clients taking contraception currently are being put off by the poor quality of services, for example lack of comprehensive counselling, lack of information on how to use the methods and management of side effects. It was also noted that the Zimbabwe National Family Planning Council which has the mandate to coordinate family planning services in the country has a weak coordinating and monitoring framework which needs strengthening both technically and financially.

Service Providers

Service providers interviewed at district and rural health centre's mentioned that they last received training on family planning long ago. Some senior nurses at district hospitals in Matabeleland North Province admitted that they were trained on family planning during their pre-service training but have never received any further training, for example on Jadelle insertion and removal. As a result, clients who require management of side effects and need alternative methods are referred to Bulawayo which is an extra cost. Capacity building of staff in local health facilities was noted as a gap in all the provinces visited during the study.

Most of the rural clinics are now being manned by Primary Care Nurses who only received introductory training on family planning. The Primary Care Nurses confirmed that no specialized training on family planning has been offered after graduation. “Therefore it becomes difficult for us to offer comprehensive service on family planning,” said one the Primary Care Nurses in Manicaland Province.

In another focus group discussion, one of the CBDs in Gwanda raised an important issue on referral systems. She highlighted that they refer clients for management of side effects to the nearest health facility where the nurses also have no capacity. As a result the nurses refer the clients back to the CBDs who also cannot help the situation. The clients in the end regret using contraceptives because the service providers lack competence and skills especially on counselling and giving information
on how to use contraceptives and on possible side effects associated with a particular method. This lack of capacity by service providers is an important determinant of unmet need.

**Community Based Distributors**

The majority of the Community Based Distributors are now approaching retirement age and some have even surpassed this. Because of advancing age they are no longer able to cover their catchment areas comprehensively. Recruitment of young clients is also now a challenge. Young people prefer to interact with younger service providers. In spite of their age the CBDs have earned respect in the community as a first port of call on health matters at community level, especially on reproductive health. During an FGD at Chiendambuya Growth Point in Manicaland women recalled that during the “heydays” the CBDs used to move around in villages door to door mobilizing women to use contraceptives and supplying them with pills as well as offering counselling services. The group of women asked for the revival of these cadres and called for the recruitment of new CBDs to replace those who have died as well as those who have retired.

An encounter with the CBDs themselves also revealed some challenges that are being experienced in the implementation of the program at various stages in the communities. The CBDs in Matabeleland North and Manicaland provinces mentioned that their areas of coverage are too big with a CBD covering a catchment area which is above the average of five villages per ward and a radius of more than 20km. With such a big catchment the major challenge is transport. “The bicycles that we received are not compatible with the terrain and are broken down so we end up using our own monies for bus fare which is not always available,” said one of the CBDs. They also highlighted that some of their clients have been resettled and transport is a problem in these resettlement areas, which mostly have no clinic. Consequently, people in these communities suffer from the lack of contraceptive supplies, information and counselling, all compounding the unmet need for family planning.

The CBDs also pointed out that in other districts Depot Holders were recruited to ease their work. Depot Holders are cadres recruited at community level. Their role is to resupply clients with contraceptives but they don’t train clients on contraception. The Depot Holders are in sixteen districts which were piloted on the Expanded CBD program in 2002. The CBDs in Manicaland and the two provinces in Matabeleland expressed the idea that Depot Holders in large catchment areas also require support in terms of allowances as part of motivation since they are volunteers.

**Access to family planning**

The majority of the respondents especially in Matabeleland North raised a concern on accessibility of family planning services. Besides financial, socio-cultural and other factors mentioned above, physical access to family planning services is also a
major factor influencing unmet need. Respondents in Nkayi District near Mbuma Mission for example noted that the distances to health facilities are too far from their communities, the nearest hospital does not offer family planning services and transport is a problem. According to a respondent in Nkayi, “One has to travel an average of 30km from my community to the nearest clinic called Sesengwe and as a result couples end up not using any contraceptive.” The respondent also added that the situation is exacerbated by the fact that there is only one male CBD who is also succumbing to age.

In Mbare High Density suburb respondents complained that the clinics offering family planning services are too few compared to the population in the suburb. One of the respondents in an FGD echoed that, “for you to access family planning services it means an allocation of half a day at a health centre, the heat and time spent is enough to put you off and resort not to use the contraceptives”. Another respondent also mentioned that the inconveniences that people encounter in trying to access contraceptives is leading to the proliferation of ‘black market’ pills which in many cases will have expired.

**Availability of contraceptives**

According to respondents in almost all the FGDs unmet need is also fuelled by the availability of service delivery points with a wider range of choices. Respondents in rural areas of the provinces visited during the study expressed their concern on the range of family planning methods which they argued was limited. A respondent in Matabeleland South said, “the CBDs only offer Pills and condoms but if I want other methods like Jadelle, IUDs and Female sterilization they refer me to the clinic where the clinic also further refers me to either a district hospital or the provincial hospital”. Limited range of methods in rural areas is also contributing to the unmet need.

In urban areas where the range of family planning methods is wide, respondents of high density suburbs like Glen Norah and Mbare mentioned that the nearest service providers like Council poly-clinics are overwhelmed and private doctors and pharmacies are expensive. Even though the facilities and range of methods are better than those in rural areas people still have to incur a cost in terms of time spent at the clinics or the bus fare to access a cheaper service.
CHAPTER FIVE

DISCUSSION OF FINDINGS

The survey unmasked a host of factors that are potentially attributable to the level of unmet need for family planning in Zimbabwe. Knowledge levels of modern methods of family planning are high among the population. However, knowledge of a method is incomplete if clients have no knowledge of how the methods are used, interaction of contraceptives with hormones and possible side effects associated with each method. On the other hand service providers assume that clients who come to collect their cycles of oral contraceptives already have knowledge on the method and alternatives available. While everybody who is educated is considered to be knowledgeable about contraceptives the findings reveal that education is not synonymous with knowledge of contraceptives. This highlights a programmatic gap in family planning programs in terms of their Information, Education and Communication (IEC) component.

Socio-cultural factors like traditional beliefs, gender dynamics, husband’s disapproval and religion are also major determinants of unmet need in Zimbabwe. Traditional and cultural beliefs are still binding in some parts of the country especially in Manicaland. Large families are still perceived as a sign of strength and wealth. The importance of a boy child as empire successors was valued among the elders who participated in the FGDs. This study showed that men prefer not to use contraceptives if their wives give birth to daughters only and even can look for a “second wife” (small house) who can give birth to a boy child. All this behaviour is deeply rooted and entrenched by the cultural beliefs of Zimbabwe. Though culture is dynamic, its dynamism is not accepted and distributed evenly among different people.

In a patriarchal society men are regarded as the highest authority at household level hence women seek authority and approval in whatever decision they want to take. In this study women also confirmed that husband’s disapproval and power dynamics result in them not using contraceptives even if they wish to do so. Yet men felt that the decision to use contraceptives is in the hands of the women because the majority of contraceptive methods are for women while men have a limited choice. At times men assume that their wives are responsible enough to be using contraceptives. The general feeling of men is that family planning programs have been biased towards women in Zimbabwe and all the allegations by women that they don’t approve the use of contraceptives are null and void since men are not involved. Again, such a bias by family planning programs causes a chain of reactions where men think family planning is for women and women also assume that their husbands disapprove of the use of contraceptives and communication on these fertility decisions in such a situation becomes difficult.
Religion is a major contributor to unmet need in Zimbabwe. From the study some religions do not approve the use of contraceptives on biblical grounds. The Apostolic Sect for example believes that using contraceptives is tantamount to defiance of the famous Genesis command of ‘multiplicity.’ In spite of the surveillance done by church elders on the members of the sect not to take contraceptives some members are beginning to show signs of rebellion. Focus Group Discussions with some women revealed that they are using contraceptives secretly with the approval of their husbands. This suggests there is an opportunity that continued social mobilization and advocacy to church leaders will lead to one day family planning being accepted universally among these groups. Some religions also believe that children are a gift from God which individuals cannot deny or have control over since gifts from God are beyond the limits of time and human preference. Beliefs are difficult to change especially those indoctrinated by religion but family planning programs can step up their market segmentation and target individuals accordingly. Those whom they successfully convert will also spread the family planning ‘word’ to their social networks.

Monetary costs of contraceptives are also determinants of unmet need for family planning but in this study social and physical costs tend to override monetary costs. One can financially afford to buy the contraceptives of choice but social and physical costs are predominant. Social costs may include ridicule from family members, mothers in law and husband disapproval. Physical costs may be the side effects experienced after using the contraceptives. In this study respondents clearly expressed the cost benefit analysis that they do before taking on any decision. In most cases presented during the FGDs social and physical costs are proving to be major determinants of unmet need while only a small proportion insisted that cost of contraceptives is a major deterrent factor to use. Making contraceptives free of charge raised the notion that free equates to poor quality. This again poses a challenge to policy makers on family planning to decide carefully on a position that ensures access, availability of contraceptives and confidence in the service provision and ultimately use.

Myths and misconceptions at face value appear to make a minor contribution to unmet need but in this study responses have indicated otherwise. Those ‘little’ misconceptions that family planning service providers take for granted cumulatively lead to non use of contraception. The bulk of these myths and misconceptions emanate from lack of knowledge and appreciation of the whole concept of contraception which family planning programmes can dispel through effective IEC programs to raise awareness and education.

The study has also noted the need for continuing capacity building of service providers to upgrade training, increase their numbers and increase the range of contraceptives provided. Service providers in clinics and hospitals at district and provincial hospitals who accept most of the referrals from CBDs acknowledged that they last received training on family planning a long time ago such that they have forgotten some of the basics. At times only the few doctors at district hospitals are trained on the administration of methods such as Jadelle, and male and female
sterilization. Doctors are being overwhelmed and where clients need to wait for months many give up. Service providers have also been blamed by respondents for not providing comprehensive services in terms of information on methods, counselling and possible side effects as well as management of those side effects. All these gaps contribute to poor quality of services which can also be linked to lack of a clear coordination, monitoring and evaluation framework of family planning service provision.

Access to family planning methods is a problem especially in resettlement areas which are difficult to reach due to lack of transport and absence of CBDs in these areas. Some service providers like Population Services Zimbabwe (PSZ) have adopted outreach services with mobile clinics. While mobile clinics are useful in such situations there is need for a continuum of care for clients who will have been served during the outreach days. This continuum can only be achieved if the rural health centres and CBDs have the capacity to handle most of the side effects presented to them by clients. The study has discovered that the majority of the CBDs are approaching the age of retirement and those who have resigned and passed on have not been replaced. There is need to recruit a cadre of new energetic and relatively young CBDs rather than to invest in the aging CBDs currently in post. Depot Holders also need to be recruited but a strategy will need to be developed to address volunteerism with expectations of payment of allowances.

The current efforts in integrating family planning and HIV/AIDS services are welcomed by those living with HIV but respondents who are living positively with HIV noted that there is a gap in terms of integrated service provision. At policy level integration of family planning and HIV has been applauded but implementation is lagging behind. The unmet need is also common among people living with HIV and they were concerned that it appears that service providers advise clients not to conceive without giving all the range of family planning methods available, possible drug interaction for those taking ARVs as well as emphasizing dual protection methods. The need to fully integrate service provision of family planning, HIV and AIDS is critical right from Community Based Distributors and other community health workers up to the referral centres. A holistic approach to unmet need for family planning is a prerequisite towards realization of family planning programs outcomes.

Youth and contraception is a controversial topic in Zimbabwe and caused much debate in the Focus Group Discussions conducted. Parents and other service providers grudgingly feel that family planning and sexuality information can be provided to youth but not the contraceptive products. Some parents believe that there is no need for family planning for someone not yet in marriage. While other parents have acknowledged that with the advent of HIV, the increase in teenage pregnancy, STIs and abortions it is better to let the youth have the full package of family planning service provision. In that sense the government has also supported the creation of youth friendly services in clinics and hospitals. The youth revealed that their lack information, knowledge and access to family planning services exposes them to a higher risk of contracting HIV, STI and unwanted pregnancies.
CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This study was long overdue. Two consecutive Demographic Health Surveys in Zimbabwe (1999 and 2005-06) produced the same figure of 13% unmet need and this has posed a challenge to family planning service providers and administrators. The study has revealed a number of the major reasons underlying this situation. Based on these findings a number of conclusions and recommendations can be made.

Knowledge levels of family planning methods do not translate to use. This confirms findings by many researchers. Knowledge of a method is not enough to lead to use without more detailed information on use, interaction of hormones, duration of protection and possible side effects.

The attitude of people towards contraception is generally positive. The majority of the respondents met during the FGDs indicated that they are aware of the benefits of contraceptives.

Cultural and religious beliefs are major determinants of unmet need. Deep cultural and religious resistance to contraception is slowly changing to acceptance, at times in secret. However, this change in behaviour lacks reinforcement since most of the family planning service providers have given up persuading such groups to use contraceptives.

Men strongly feel that the whole family planning business is for women since all the methods and programs are biased towards women. Husband disapproval has been labelled by women as the most influential factor on contraceptive use at the household level. But such perceived disapproval reflects poor couple communication, an often wrong assumption by women that men do not want contraception and a bias of family planning service providers.

The monetary cost of contraceptives is not as much of a major hindrance to use of family planning as the social and physical costs associated with contraceptives. This finding is also an affirmation of earlier findings by John Hopkins University (1997). Free distribution of contraceptives may be perceived by clients as a way of off loading poor quality products. Low priced contraceptives may be perceived to be less effective than those that are more highly priced.

Coordination of family planning services in Zimbabwe is weak. Family planning service providers are not being regularly supervised and monitored to ensure that a quality service is provided to clients. Respondents in this study highlighted that service providers are not giving comprehensive information on family planning methods, possible side effects and management of side effects. Some areas are
underserved with high unmet need while others have more services at their disposal.

The majority of the CBDs are now aged and/or approaching retirement age implying that the capacity to deliver is now limited given their catchment areas which are not proportional to their numbers. Transport for the CBDs is also a challenge. The bicycles which are their mode of transport are now broken down meaning they incur transport costs. There is no programme to replace CBDs who have retired and those who have died. There is need for a refresher course for CBDs to update them on new methods to enable them to carry out their duties.

The integration of family planning and HIV and AIDS services at the policy level is not matched by effective integration at the implementation level. People living with HIV are getting inadequate information on the family planning options available for them because service providers are not adequately trained.

Youth contribute to this high level of unmet need. Parents and service providers still consider that youth should only access information about contraceptives but not the products themselves. Youth argue that a parent view of the world is far from reality and that their stage of life is sexually vulnerable and youth friendly services should be universal.

**Recommendations**

- IEC programs should revive their awareness campaigns to increase awareness and the knowledge base of clients on contraception using a wide range of modern effective approaches.

- Men’s involvement including training in interpersonal communication in family planning programs is a requirement if unmet need is to be reduced.

- Community mobilization should target traditional leaders and other influential leaders at community level.

- There is need to adopt the ‘three ones’ principle in coordination which insists that there should be one family planning coordinating framework, one family planning coordinating authority and one family planning monitoring and evaluation system to ensure quality of service provision in Zimbabwe.

- The curriculum of all pre-service health worker training schools (CBD, nursing and medical) should be updated to ensure that all health cadres receive comprehensive training on family planning and are fully equipped in terms of contraceptive knowledge, guidelines and clinical procedures.

- There is an urgent need to recruit a new cadre of relatively young and energetic CBDs giving priority to underserved areas.
• Recruit and support new Depot-holders with standardized allowances especially in catchment areas that are too large for the CBDs to ensure a constant supply of contraceptives.

• Family planning service providers to revive outreach services and ensure that local clinics, hospitals and CBDs have the capacity to offer a continuum of care including the management of side effects and counselling.

• Access to youth friendly services should be universal in Zimbabwe to enable youth to access family planning services without restrictions.

• Develop and disseminate through a range of communication means clear messages and information on family planning options for people living with HIV.

• Peg the costs of contraceptives at an affordable price and provide free to those who cannot afford.

• Address the urgent funding gap needed to revive the range of family planning services including the CBD programme and mobile clinics which have made significant contributions to high levels of contraceptive use and falls in fertility.
REFERENCES


Dyson and Moore (1983)

Easterline (1975)

Gilda Sedgh et al. (2003), ‘Women with an unmet need for contraception in Developing countries and their reasons for not using a method’.

Guttmacher Institute (2007) accessed online at www.guttmacher.org

Karin Ringheim et al. (2009). ‘Supporting the integration of Family Planning and HIV Services’, Population Reference Bureau


Multiple Indicator Monitoring Survey (2009), Central Statistical Office


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Comment [B3]: Not a full citation

Comment [B4]: Not a full citation


APPENDIX 1: FGD GUIDE FOR BENEFICIARIES

Determinants of Unmet Need for Family Planning in Zimbabwe

Focus Group Discussion Guide for Beneficiaries

Introduction of self and the Team

The Zimbabwe National Family Planning Council in collaboration with LATH, UNFPA and DFID is conducting a research study on the determinants of Unmet Need for Family Planning in Zimbabwe. The Unmet Need for family planning refers to women of reproductive age who prefer to avoid or postpone childbearing but are not using any method of contraception. I would very much appreciate your participation in this study.

We are going to have a discussion about the use of contraceptives and your experiences with them. The information you are going to provide may help the country especially policy makers and family planning service providers to strategize and provide services in accordance with the needs of the people. Whatever answers you provide will be confidential and will not be disclosed to anyone. The results will be shared and used to improve provision of services

I hope you will openly give your views since they are important. Shall we proceed with the discussion?

1. Which methods of contraception are you familiar with?

2. What do you think about the use of contraceptives?

3. In your opinion why do women and couples who prefer to use contraception are not using any method?

4. What is the range of family planning methods and services offered in your area?

5. What are the types of family planning services and methods available to youth?

6. In your opinion what can be done to ensure that everyone who wants contraceptives has access? (geographical, financial and cultural access)

Community based Distributors (CBD) Focus Group Discussion interview Guide
Self introduction & Team

The Zimbabwe National Family Planning Council in collaboration with LATH, UNFPA and DFID is conducting a research study on the determinants of Unmet Need for Family Planning in Zimbabwe. The Unmet Need for family planning refers to women of reproductive age who prefer to avoid or postpone childbearing but are not using any method of contraception. I would very much appreciate your participation in this study.

We are going to have a discussion about the use of contraceptives and your experiences with them. The information you are going to provide may help the country especially policy makers and family planning service providers to strategize and provide services in accordance with the needs of the people. Whatever answers you provide will be confidential and will not be disclosed to anyone but the final results will be shared amongst us to improve provision of services.

I hope you will openly give your views since they are important. Shall we proceed with the discussion?

1. What services do you offer in this area as a CBD?
2. What is your catchment area in terms of wards and villages?
3. How do you manage to cover the remote areas?
4. Who are your clients (Probe into age groups and marital status of the clients?)
5. What are the most popular methods of contraceptives?
6. Which methods of contraception are not popular- Please explain why?
7. Can you please tell us about women or couples who would like to prevent pregnancy but are not using contraceptives. (Probe into factors that influence non use of contraceptives)
8. What recommendation can you make to address this situation?
APPENDIX 2: KEY INFORMANT INTERVIEW GUIDE

DETERMINANTS OF UNMET NEED FOR FAMILY PLANNING IN ZIMBABWE

Introduction of Self

The Zimbabwe National Family Planning Council in collaboration with LATH, UNFPA and DFID is conducting a research study on the determinants of Unmet Need for Family Planning in Zimbabwe. The Unmet Need for family planning refers to women of reproductive age who prefer to avoid or postpone childbearing but are not using any method of contraception. I would very much appreciate your participation in this study.

We are going to have a discussion about the use of contraceptives and your experiences with them. The information you are going to provide may help the country especially policy makers and family planning service providers to strategize and provide services in accordance with the needs of the people. Whatever answers you provide will be confidential and will not be disclosed to anyone.

I hope you will openly give your views since they are important. Shall we proceed with the discussion?

Date: ................ Province: ......................
Organization or institution: .........................
Position: .............................................
Period in position: .................................
Age: ........ Sex: ......................

1. What family planning services do you offer?

2. Please elaborate on family planning service provision and providers in your area?
3. In your opinion, to what extent are you meeting the needs of your clients? Explain
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4. In your opinion what factors influence people wishing to prevent pregnancy but are not using family planning?
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5. What has been your experience as an individual or as a team member of an institution providing family planning service? (Probe on time, and challenges)
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6. In your institution what factors influence family planning service delivery?
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7. What changes do you suggest for strengthening family planning service providers' abilities to reduce unmet need?
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8. What specific aspects of family planning guidelines/rules and regulations that could be revised to reduce unmet need?
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9. In your opinion, what other institutions/positions are key to influencing reduction of unmet need in Zimbabwe?
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10. What other suggestions can you make to reduce unmet need?
APPENDIX 3: GATEKEEPERS INTERVIEW GUIDE

DETERMINANTS OF UNMET NEED FOR FAMILY PLANNING IN ZIMBABWE

Introduction of Self

The Zimbabwe National Family Planning Council in collaboration with LATH, UNFPA and DFID is conducting a research study on the determinants of Unmet Need for Family Planning in Zimbabwe. The Unmet Need for family planning refers to women of reproductive age who prefer to avoid or postpone childbearing but are not using any method of contraception. I would very much appreciate your participation in this study.

We are going to have a discussion about the use of contraceptives and your experiences with them. The information you are going to provide may help the country especially policy makers and family planning service providers to strategize and provide services in accordance with the needs of the people. Whatever answers you provide will be confidential and will not be disclosed to anyone.

I hope you will openly give your views since they are important. Shall we proceed with the discussion?

Date……………………………………. Province……………………………………
Ward………………………………….. Position…………………………………..
Age…………………………  Sex…………………………

1. Which family planning services are offered in this area?
   …………………………………………………………………………………………………………………………
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   …………………………………………………………………………………………………………………………

2. To what extent are the family planning programmes accepted in this area?
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   …………………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………………

3. In this area what are the factors that influence family planning service delivery? Explain (Probe on culture, availability of services, presence of CBDs etc)
   …………………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………………
4. In your opinion which factors influence people wishing to postpone or prevent pregnancy not to use family planning methods?

5. What do you suggest should be done to address the problem?
APPENDIX 4: SHONA AND NDEBELE TRANSLATIONS OF THE GUIDES

Determinants of Unmet Need for Family Planning in Zimbabwe

BENEFICIARY FGD GUIDE: SHONA TRANSLATION

1. Ndedzipi nzira dzokuronga mhuri dzamunoziva?
2. Munofunegi nezvenzira dzokuronga mhuri?
3. Sekufunga kwenyu, sei vakadzi kana kuti vakaroorana, vanoda kudzivirira pamuviri vasiri kushandisa nzira dzourongamhuri?
4. Ndezvipi zvirongwa nenzi dzokuronga mhuri zvinowanikwa mudunhu rino?
5. Ndedzipi nzira dzokuronga mhuri dzinokwanisa kushandiswa nevechidiki?
6. Munofungu kuti zvingaitwa sei kuti munhu wese anoda nzira dzokuronga mhuri adziwane?

Determinants of Unmet Need for Family Planning in Zimbabwe

CBD FGD GUIDE: SHONA TRANSLATION

1. Mubasa renyu sa CBD, ndedzipi nzira dzokuronga mhuri dzamunopa vanhu munzvimbo ino?
2. Ko imimi munoshanda munzvimbo yakakura zvakadii?
3. Munukwanisa sei kusvika kunenzvimbo dzinonetsa mafambiro kana kuti dziri kure ?
5. Ndedzipi nzira dzokuronga mhuri dzinonyanyoshandiswa navanhu ?
6. Ndezipi mhando dze nzira dzokuronga mhuri dzisinganyonyoshandiswa? Sei zvakadaro?
7. Chii chinokonzera kuti nevakadzi navakaroorana vanoda kudzivirira pamuviri vatazve kushandisa nzira dzokuronga mhuri ?
8. Ndaapi mazano amungapa kuti dambudziko iri rigadziriswe?
Determinants of Unmet Need for Family Planning in Zimbabwe

BENEFICIARIES FGD GUIDE: NDEBELE TRANSLATION

1. Yiziphi indlela zokwelamisela katshana ezijayelekileyo?
2. Ucabangani ngendlela zokwelamisela khatshana?
3. Ngombono wakho kungani omama labathetheneyo abelesifiso sokwelamisa imuli bengazisebensisi indlela zokwelamisela khatshana?
4. Yiziphi indlela lenhlelo zokwelamisela khatshana ezitholakala esigabeni sakho?
5. Yiziphi indlela zokwelamisela khatshana ezinganikezwa ontanga?
6. Ngombono wakho kuyini ukungayeniwi ukuze labo abafuna indlela zokwelamisela khatshana bazithole kalula? (dingisisa, ngomganga, imali, loba ezamaseko)

Determinants of Unmet Need for Family Planning in Zimbabwe

CBD FGD GUIDE: NDEBELE TRANSLATION

1. Yiziphi inhlelo oziphayo esigabeni sakho – ngengoma CBD?
2. Isigaba osebenza kuso singanani mayelana lama(Ward/Villages)?
3. Indawo ezikhatshana lawe uzifinyelela njani?
4. Ngobani abanikeza inhlelo zahko mayelana lamaqembu? (leminyaka yavo lesimo sokuthathana)
5. Yiziphi indlela lenhlelo zokwelamisela khatshana ezijayelekileyo?
6. Yiziphi indlela zokwelamisela khatshana ezingajayelekana? (Chasisa)
7. Akusitshele ngabomama labathetheneyo abafuna ukuzivikela ukuzithwala, kodwa bengasebenzisi indlela zokuzivikela?
8. Ngombono wakho kungenziwani ukulungisisa isimo lesi?
DETERMINANTS OF UNMET NEED FOR FAMILY PLANNING IN ZIMBABWE:

GATE KEEPERS INTERVIEW GUIDE: NDEBELE TRANSLATION

The Zimbabwe National Family Planning Council in collaboration with LATH, UNFPA and DFID is conducting a research study on the determinants of Unmet Need for Family Planning in Zimbabwe. The Unmet Need for family planning refers to women of reproductive age who prefer to avoid or postpone childbearing but are not using any method of contraception. I would very much appreciate your participation in this study. The results will be shared and used to improve provision of services.

I hope you will openly give your views since they are important. Shall we proceed with the discussion?


1. Yiziphi indlela lenhlelo ezinikezwayo kuyonale indawo?
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   ............................................................................................................................
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2. Inhlelo zokwelamisela khatshana zemukelwa njani kuyonale indawo?
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   ............................................................................................................................
   ............................................................................................................................

3. Endaweni yonale, yiziphi izinto ezibangela ukhyqhatshwa komsebenzi zokwelamisela khatshana (Dingisiza ngokwezamasiko lombangazwe, lokhutolakala kwenhlelo lama CBD?)
   ............................................................................................................................
   ............................................................................................................................
   ............................................................................................................................

4. Ngombono wakho yiziphi izinto ezibangela ukuthi omama labateteneyo abangakafuni ukubalomntwana, kunganibengasebenzi indlela zokulamisela katshana?
   ............................................................................................................................
   ............................................................................................................................
   ............................................................................................................................

5. Uthi kungenziwani ukuti siqhede udubo lolu
   ............................................................................................................................
   ............................................................................................................................
   ............................................................................................................................
DETERMINANTS OF UNMET NEED FOR FAMILY PLANNING IN ZIMBABWE

GATE KEEPERS INTERVIEW GUIDE: SHONA TRANSLATION

The Zimbabwe National Family Planning Council in collaboration with LATH, UNFPA and DFID is conducting a research study on the determinants of Unmet Need for Family Planning in Zimbabwe. The Unmet Need for family planning refers to women of reproductive age who prefer to avoid or postpone childbearing but are not using any method of contraception. I would very much appreciate your participation in this study. The results will be shared and used to improve provision of services.

I hope you will openly give your views since they are important. Shall we proceed with the discussion?

Date: ................ Province: ......................... Ward: .........................
Position: ......................... Age: ....... Sex: ....................

1. Ndedzizi nzira dzokuronga mhuri dzinowanikwa mudunhu renyu/rino
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............................................................................................................................
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2. Icho chirongwa chokuronga mhuri chinogamuchirwa zvakadini mudunhu renyu/rino?
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............................................................................................................................
............................................................................................................................

3. Ndezvipi zvinhu zvinogona kukanganisa kana kuvandudza chirongwa chokuronga mhuri nudunhu renyu/rino? (Probe nezve magariro evanhu nokuvapo kwama CBDs)
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............................................................................................................................
............................................................................................................................

4. Sokufunga kwenyu chii chinotadziza vanhukadzi nevakaroorana vasati vavakuda kuita mwana kuti vashandise nzira dzokuronga mhuri?
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............................................................................................................................
............................................................................................................................

5. Sokuona kwenyu, chii chingaitwe kuti vanhu vakadaro vabatsirwe?
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### APPENDIX 5: DISTRIBUTION OF RESPONDENTS BY PROVINCE, AGE AND SEX

Focus Group Discussions held with Beneficiaries

<table>
<thead>
<tr>
<th>FGD No.</th>
<th>Date</th>
<th>Province</th>
<th>City/District</th>
<th>Location</th>
<th>Age Group Category Present(Years)</th>
<th>Sex</th>
<th>No. of Participants</th>
<th>Length of FGD (Minutes)</th>
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<tbody>
<tr>
<td>1</td>
<td>5/7/2010</td>
<td>Matabeleland North</td>
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<td>Magwegwe</td>
<td>18-25</td>
<td>Males</td>
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<td>Bulawayo</td>
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<td>18-25</td>
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<td>Females</td>
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<td>Mpopoma</td>
<td>18-25</td>
<td>Males</td>
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<td>5/7/2010</td>
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<td>Bulawayo</td>
<td>Mpopoma</td>
<td>18-40</td>
<td>Females</td>
<td>13</td>
<td>27</td>
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<tr>
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<td>6/07/2010</td>
<td>Matabeleland North</td>
<td>Nkayi</td>
<td>Nkayi District Hospital</td>
<td>25-40</td>
<td>Females</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>10</td>
<td>6/07/2010</td>
<td>Matabeleland North</td>
<td>Nkayi</td>
<td>Nkayi District Hospital</td>
<td>18-43</td>
<td>Males</td>
<td>9</td>
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<tr>
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<td>Matabeleland North</td>
<td>Nkayi</td>
<td>Nkayi District Hospital</td>
<td>18-20</td>
<td>Males</td>
<td>3</td>
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<tr>
<td>12</td>
<td>6/07/2010</td>
<td>Matabeleland North</td>
<td>Nkayi</td>
<td>Nkayi District Hospital</td>
<td>18-25</td>
<td>Females</td>
<td>10</td>
<td>30</td>
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<tr>
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<td>6/07/2010</td>
<td>Matabeleland North</td>
<td>Nkayi</td>
<td>Nkayi District Hospital</td>
<td>Above 40 Males &amp; Females</td>
<td>11</td>
<td>40</td>
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<td>Mafanisa</td>
<td>18- Above 40</td>
<td>Males</td>
<td>15</td>
<td>28</td>
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<td>6/07/2010</td>
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<td>Ntabazinduna</td>
<td>Mafanisa</td>
<td>18-40</td>
<td>Females</td>
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<td>6/07/2010</td>
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<td>Ntabazinduna</td>
<td>Bhekeni</td>
<td>18-25</td>
<td>Females</td>
<td>5</td>
<td>34</td>
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<td>Ntabazinduna</td>
<td>Bhekeni</td>
<td>18-25</td>
<td>Males</td>
<td>13</td>
<td>21</td>
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Focus Group Discussions held with the GLs, CBDs and other services providers.

<table>
<thead>
<tr>
<th>FGD No.</th>
<th>Date</th>
<th>Province</th>
<th>City/ District</th>
<th>Location</th>
<th>Age Group Category Present (Years)</th>
<th>Sex</th>
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<td>Ntabazind una</td>
<td>Bhekeni</td>
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<td>Females</td>
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<td>27</td>
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<td>Gwanda North</td>
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<td>Makoni</td>
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### APPENDIX 6: DISTRIBUTION OF RESPONDENTS BY PROVINCE, AGE AND SEX

Focus Group Discussions held with Beneficiaries

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<th>No. of Participants</th>
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