Zimbabwe

Demographic and Health Survey 1988

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PREFACE

The Zimbabwe Demographic and Health Survey (ZDHS) was conducted as part of the worldwide Demographic and Health Survey (DHS) program which has been implemented in Africa, Asia, Latin America and the Middle East. Zimbabwe is one of fourteen countries from Africa, participating in the DHS program. The results from the national sample survey presented in this main report focus on basic demographic and health parameters, which are of interest to policy makers, administrators of health and family planning programmes, researchers and other users.

The ZDHS was implemented by the Zimbabwe Government through the Central Statistical Office (CSO) in the Ministry of Finance, Economic Planning and Development (MFEPD). Technical assistance was received from the Ministry of Health (MOH); the Zimbabwe Family Planning Council (ZNFPC) and the Institute for Resource Development (IRD); financial support came from the United States Agency for International Development (U.S.A.I.D.) through the DHS program.

The ZDHS was conducted immediately after the second round of the Intercensal Demographic Survey (ICDS). The principal objectives of the ICDS were to obtain data on population parameters including fertility and mortality, to update and revise the Zimbabwe Master Sample (ZMS) and to serve as a pilot study for the 1992 census. The objectives of the ZDHS were to collect more detailed information on: (1) fertility levels, trends and preferences, (2) family planning awareness, approval and use, (3) basic indicators of maternal and child health including infant mortality, and (4) various other topics related to family health.

Planning for the survey commenced in 1987 when a working group composed of the CSO, MOH and ZNFPC was established to develop the survey content, sample design and fieldwork implementation procedures. The strong support of the MOH and ZNFPC, as well as various other government and donor organisations, facilitated the successful implementation of the project; warmest gratitude is extended to them.

A special thanks is owed to the respondents interviewed in the survey for their patience and generosity with their time. Without their cooperation, the survey would not have been possible.

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SUMMARY

The Zimbabwe Demographic and Health Survey (ZDHS) is one of a series of surveys carried out by the Central Statistical Office (CSO) as part of the Zimbabwe National Household Survey Capability Programme. Conducted immediately following the second round of the Intercensal Demographic survey in 1988, the objective of the ZDHS was to make available to policy-makers and planners current information on fertility and child mortality levels and trends, contraceptive knowledge, approval and use and basic indicators of maternal and child health. To obtain these data, a nationally representative sample of 4 201 women 15-49 was interviewed in the survey between September 1988 and January 1989.

FERTILITY AND FAMILY PLANNING

Fertility Levels and Differentials. The survey results suggest that Zimbabwe has been experiencing high and comparatively stable fertility levels, which have recently shown a decline.

- At current rates, a woman beginning her reproductive period at this time, will have an average of 5,5 births before her 45th birthday.

- Urban fertility is substantially lower than rural fertility; at current levels, a woman residing in an urban area will have an average of 4,1 births during her lifetime, while a woman living in a rural area will have 6,2 births.

- Fertility differentials by the woman's educational status are even more striking; at current rates, women with no formal education will have an average of 7 births and women with some primary education will have 6 births, while women with a secondary or higher education will have an average of less than 4 births.

Marriage. Early marriage has been a factor supporting high fertility. The ZDHS results suggest that there is a trend toward delayed marriage, particularly among women with a secondary or higher education.

- More than half of the survey respondents married for the first time before their 20th birthday, with 9 percent saying that they first married before they were 15.

- The median age at first marriage among women 20-24 is nearly one year later than the median age for women 25-29, suggesting that the age at marriage has been increasing recently.

- Increasing educational attainment is related to the increase in the age at marriage. The median age at first marriage is more than 3

SELECTED FERTILITY AND FAMILY PLANNING INDICATORS

Fertility

Total Fertility Rate[1]	5,5
Mean Number of Children Ever Born to Women 40-49	6,6

Marriage and Other Fertility Determinants

Percent of Women 15-49 Married before Age 20	52,3
Median Age at First Marriage for:	
Women 20-24	19,7
Women 25-29	18,8
Median Duration of Breastfeeding (in Months)	19,3
Median Duration of Postpartum Amenorrhoea (in Months)	12,6
Median Duration of Postpartum Sexual Abstinence (in Months)	4,3
Median duration of Postpartum Insusceptibility (in Months)	13,6

Knowledge and Use of Family Planning

Percent of All Women Knowing Any Method	96,0
Percent of All Women Knowing Source for Information or Services	93,0
Percent of Currently Married Women Ever Using Any Method	79,0
Percent of Currently Married Women Currently Using Any Method:	
1988 ZDHS	43,1
1984 ZRHS	38,4
Percent of Currently Married Women Currently Using:	
Pill	31,0
Other Modern Methods	5,1
Traditional Methods	7,0

Desire for Children and Need for Family Planning

Mean Preferred Number of Children among All Women	4,9
Percent of Currently Married Women:	
Wanting to Delay Next Birth for Two or More Years	35,3
Wanting No More Children	32,7
Percent of Currently Married Women Not Using Contraception and in Need of Family Planning to:	
Space the Next Birth	16,6
Stop Childbearing	17,6

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[1] Based on births to women 15-44 during the period 0-4 years before the survey

years later among women 25-49 who attended secondary school compared with women with no formal education (20,8 vs. 17,5).

- Improving educational opportunities for women will continue to be an important mechanism for encouraging later marriage. Currently, only two in five teenagers and one in twenty women 20-24 is attending school full-time.

Breastfeeding and Other Proximate Determinants. By influencing the length of time following birth when a woman is naturally infecund and, thus, protected from a subsequent pregnancy, breastfeeding plays an important role in determining fertility levels. For some women, traditional practices of postpartum sexual abstinence may also contribute to lower fertility.

- The average (median) duration of breastfeeding is 19 months. As a result, a woman is protected from the risk of pregnancy for an average of almost 14 months following delivery.

- The long period of protection from pregnancy is largely due to the extended period of amenorrhoea following birth. The median duration of postpartum amenorrhoea (12,6 months) is almost three times that of postpartum sexual abstinence (4,3 months).

- Higher educational attainment and, especially, urban residence are associated with shorter average durations of breastfeeding and protection from pregnancy.

Contraceptive Knowledge. The most important determinant of fertility decline is contraceptive use. Knowledge of contraceptive methods and service providers is a necessary precursor to use.

- Contraceptive knowledge is practically universal, with 96 percent of all women reporting that they have heard about at least one method. The most widely known modern method is the pill, followed by the condom, injection, IUD and female sterilisation.

- In addition to the widespread knowledge of modern methods, three in four women are familiar with at least one traditional method. Withdrawal is the most frequently recognised traditional method.

- Comparing knowledge levels in the ZDHS with those reported in the 1984 Zimbabwe Reproductive Health Survey (ZRHS), there has been increased recognition of all methods except vaginal methods and injection.

- Familiarity with a family planning service provider has increased since 1984, when only seven in ten women knew a place where they

could obtain contraceptive services. Currently, more than 90 percent are able to name a source for family planning services.

Contraceptive Use. Experience with using family planning methods is widespread in Zimbabwe. The level of current contraceptive use is the highest reported among countries in sub-Saharan Africa.

- Among currently married women, 43 percent are currently using contraception, and an additional 36 percent have used a method in the past.

- Considering the method mix among current users, the pill (31 percent) is the most commonly used method. Current use of other methods is limited; 2 percent or less are using female sterilisation, the IUD, injection or the condom. The most prevalent traditional method, withdrawal, is used by 5 percent of currently married women.

- The current use rate represents an increase over that found in the 1984 ZRHS (38 percent). More importantly, today's users are much more likely to be relying on modern methods than they were four years ago.

- The urban-rural differential is fairly large; 52 percent are using in urban areas compared with 40 percent of rural women. Increasing educational attainment is directly associated with use; only one in three currently married women with no formal education is using, compared with half of all women with at least some secondary education.

- Almost all users rely on government-sponsored providers for contraceptive methods. Around two in five users obtained their method from a clinic operated by the Zimbabwe National Family Planning Council (ZNFPC) (13 percent) or one of the ZNFPC's community-based distribution workers (24 percent). Most other users rely on Ministry of Health (MOH) or local government clinics; only 4 percent obtained their method from a private doctor or pharmacy.

Obstacles to Family Planning Use. To increase the level of contraceptive use in the future, it is important to understand why nonusers are not currently using family planning. The ZDHS results provide information on a number of potential obstacles to contraceptive use.

- Many women express concern about the potential adverse effect on their health of contraceptive use. For example, nearly 40 percent of women who know about the pill think that the main problem with the method is its effects on a woman's health.

- For some women, disapproval of, or lack of interest in family planning, on the part of their husband, may be a barrier to contraceptive use. Overall, 15 percent of currently married women report that their husband disapproves of the use of family planning. For an even greater proportion of women there is little communication with their spouse about family planning; 31 percent never talked about family planning with their husband in the year before the survey.

- Additional insights into barriers to use come from the one in three nonusers for whom a pregnancy in the near future would pose major problems. Among these women, the principal reasons cited for nonuse are: infrequent sex, lack of access to methods, inconvenience of methods and opposition to family planning on the part of the woman or her husband.

Fertility Preferences. Information on childbearing preferences of women provide insights into their future fertility behavior. The ZDHS results indicate that most women in Zimbabwe want large families and, as a result, the majority currently want more children.

- Women want on average 5 children. Three in four women want at least four children, and one in three wants six or more children.

- Six in ten currently married women want more children. Among women wanting more children, a strong interest in spacing the next birth is expressed; one-third of all currently married women want to wait at least two years before having another child.

- There is a growing desire to limit family size. One in three currently married women wants to have no more children. This represents a one-third increase in the proportion wanting to limit births since the 1984 ZRHS, when only one in four currently married women reported that she wanted no more children.

Need for Family Planning. Women can be considered to be in need of family planning if they are not currently using a contraceptive method and either want no more births or want to postpone the next birth for two or more years. The ZDHS results indicate that, in spite of the high level of contraceptive use, there remain many women in need of family planning to avoid unplanned pregnancies.

- One-third of currently married women can be considered to be in need of contraception if they are to achieve their present childbearing preferences. These women are almost evenly divided between those in need for stopping purposes (18 percent) and those in need for spacing purposes (17 percent).

MATERNAL AND CHILD HEALTH INDICATORS

Mortality

Infant Mortality Rate[1]	52,7
Childhood Mortality Rate[1]	23,7
Under Five Mortality Rate[1]	75,1

Maternal Care Indicators

Percent of Mothers of Recent Births:[2]

Received Antenatal Care from Medical Personnel during Pregnancy	91,3
Immunised against Tetanus Toxoid During Pregnancy	78,7
Attended at Delivery by Medical Personnel	69,6

Child Health Indicators

<u>Immunisation Coverage</u>

Percent of Children 12-23 Months Immunised as Reported on a Health Card or by the Mother	96,2
Percent of Children With Health Cards Considered Fully Immunised	85,9

<u>Prevalence and Treatment of Childhood Illnesses</u>

Percent of Children Under Age Five with Diarrhoea in the Two-week Period Before the Survey	19,7
Percent of Children with Diarrhoea:	
Consulted Health Facility	33,4
Received Any Treatment	77,1
Treated with Sugar/Salt/Water Solution	70,0
Percent of Children with Cough in the Four-Week Period Before the Survey	46,4
Percent of Children with Cough:	
Consulted Health Facility	55,1
Received Any Treatment	89,9

<u>Nutrition Status</u>

Percent of Children 3-60 Months Considered:	
Wasted Based on Weight-for-height	1,3
Stunted Based on Height-for-age	29,0
Underweight Based on Weight-for-age	11,5

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[1] Rates are for the calendar period 1983-1988
[2] Based on births in the five-year period before the survey

- More than one-half of those currently in need of family planning say that they intend to use contraception in the future.

MATERNAL AND CHILD HEALTH

Infant and Child Mortality. The ZDHS results indicate that infant and child mortality levels have been declining. Significant differentials in mortality levels remain, however, among subgroups.

- The infant and child mortality rates for the period 1983-1988 are 53 and 24 deaths per thousand, respectively.

- Prospects for survival are much better for urban children than for rural children. For example, under-five mortality in urban areas is half that found in rural areas (55 vs. 99 deaths per thousand).

- Maternal education has a profound effect on child survival. Overall, under-five mortality varies from only 48 deaths per thousand for children of mothers with at least some secondary education to 125 for children whose mothers had no formal education.

- Higher mortality is observed for children of mothers under age 20 and of mothers nearing the end of their reproductive lives.

- There are significant differentials in mortality by the length of the preceding birth interval. Children born less than two years after an older sibling are almost twice as likely to die during infancy or early childhood as children born after an interval of two or more years.

Maternal Care Indicators. The health care that a mother receives during pregnancy and at the time of delivery is important to the survival and well-being of both the mother and the child. The ZDHS results suggest that most Zimbabwean mothers have contact with medical personnel during pregnancy and at the time of delivery.

- For 91 percent of the births during the five-year period before the survey, the mothers received some form of antenatal care, provided by trained medical personnel (doctors and nurses).

- Almost 80 percent of births were to mothers who reported receiving a tetanus toxoid injection during pregnancy.

- Medical personnel attended 70 percent of births in the five years before the survey.

Child Health. The ZDHS also provides information on several major child health indicators, particularly the extent of immunisation coverage and the prevalence and treatment of diarrhoea and cough (a symptom of acute respiratory illness), which are major causes of child deaths in developing countries like Zimbabwe.

- Immunisation coverage is quite good; 96 percent of children 12-23 months have received at least one immunisation--77 percent according to information on a Child Health Card and 19 percent according to the mother. Among children with health cards, 86 percent have been fully immunised.

- Twenty percent of children under five had diarrhoea during the two-week period before the survey. In one-third of the episodes, mothers consulted a health facility and, in 70 percent of the cases, they used a homemade sugar, salt and water solution to prevent dehydration (oral rehydration therapy).

- Knowledge of the solution as a treatment for diarrhoea is almost universal; 97 percent of mothers of children under five know about the solution.

- Mothers also seem to be aware of the importance of treating respiratory illnesses. Forty-six percent of children under five were reported to have had a cough during the four-week period before the survey. Almost half of the children experiencing cough were taken to a health facility. Two-thirds of the children were given cough syrup, and nearly one-quarter received oral antibiotics.
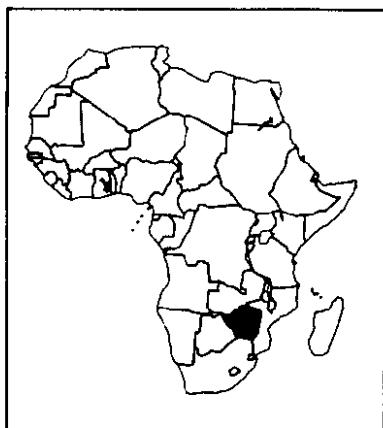
Nutritional Status of Children. The ZDHS collected anthropometric measures for children 3-60 months, permitting an assessment of their nutritional status.

- Among the children measured, more than one in four was found to be stunted (very short in relation to age), an indication of chronic malnutrition. Fewer than one in fifty were wasted (very thin in relation to height). Around one in eight were underweight in relation to age.

- The nutritional status of the child is related to residence and the mother's education level. Rural children were twice as likely to be stunted as urban children, and children of mothers with no formal education are twice as likely to be stunted as those of mothers with secondary or higher education.

- The adverse effect of closely spaced births is apparent. Children born within two years of an older sibling are significantly more likely than other children to be stunted.

AIDS. Acquired immune deficiency syndrome (AIDS), a result of infection with the human immunodeficiency virus (HIV), emerged in the 1980s as a major public health concern worldwide. Zimbabwe has an active program to disseminate information about AIDS. The ZDHS included questions to look at the effects of the campaign.

- In general, awareness of AIDS is widespread among women in Zimbabwe; 86 percent report having heard of AIDS. The chief sources of information about AIDS are pamphlets or posters (64 percent), radio (63 percent), health worker (51 percent) and newspapers (50 percent).

- The majority of women knowing about AIDS are aware that the disease is sexually transmitted and mention that those who have sex with many partners are at high risk.

- Most sexually active women have not taken steps to avoid getting AIDS. About one-third believe that they are not at risk. Among other frequently given reasons for taking no action are: (1) a belief that AIDS cannot be avoided and (2) lack of information about how to avoid the disease.

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Zimbabwe

ZAMBIA

MOZAMBIQUE

NAMIBIA

MASHONALAND
CENTRAL

MASHONALAND
WEST

MASHONALAND
EAST

HARARE

MATABELELAND
NORTH

MIDLANDS

MANICALAND

BULAWAYO

BOTSWANA

MASVINGO

MATABELELAND
SOUTH

SOUTH AFRICA

Chapter 1

BACKGROUND

1.1   GEOGRAPHY

Zimbabwe lies north of the Tropic of Cancer and includes 391 thousand square kilometres between the Limpopo and the Zambezi Rivers. The country is landlocked, bordered by the People's Republic of Mozambique in the east, South Africa in the south, Botswana in the west and the Republic of Zambia in the north and northwest. It is part of a great plateau, which constitutes the major feature of the geography of southern Africa. Although only about five percent of Zimbabwe's land area is more than 1500 metres above sea level, almost all of the country is more than 300 metres--and nearly 80 percent lies more than 900 metres--above sea level.

About 70 percent of the country's surface area is made up of granite, schists and igneous rocks, which serve as the basis for Zimbabwe's mineral wealth. Soil types range from sandy/loamy in the high veld to sandy in the west. The sunny, temperate to hot climate attracts tourists and provides the basis for agricultural production, especially along the central ridge. Generally, temperature decreases and rainfall increases with altitude, ranging from the cool wet eastern highlands to the hot dry river valleys of the Zambezi, Limpopo and Save rivers.

1.2   HISTORY

The African population, mainly of Bantu origin, entered what is now Zimbabwe during the 15th and 16th centuries. Beginning about the mid-19th century, a series of foreign invaders entered the region. From the west came the Portuguese for slaves; from the east, Arabs and Islamic Africans for ivory and slaves; and from the south, the English and the Dutch, mainly attracted by ivory. The invasions destabilised the established African communities.

Spurred by the idea of establishing a trade route from the Cape of Good Hope to Cairo, and, thus, gaining control of the whole of Africa, white settlers fully established themselves in the region--then known as Southern Rhodesia--by 1890. Dissatisfaction with the white takeover on the part of the African population resulted in the uprisings of 1893 (Matabele) and 1896 (Matabele and Mashona). In spite of African resentment, white settlers continued to arrive, establishing rail communications, mining, especially gold and coal, and farming, principally along the high veld where communication lines were centered. In the 1920s, the country was annexed to the British Crown. Despite black opposition, the Land Apportionment Act, which reserved half of the land area (including the industrial and mining regions and the areas served by rail and road) for whites, was enacted in 1930.

The Federation of the Rhodesias and Nyasaland was established during the period 1953-1963. At this point, demands for self-determination on the part of blacks increased, further fueled by the granting of independence to both Zambia and Malawi. The refusal by the British to grant independence to the Rhodesian government without majority rule led to the Unilateral Declaration

of Independence (UDI) in November 1965. The struggle for majority rule continued and resulted in a protracted war, leading finally to the Lancaster House Talks and independence for Zimbabwe in 1980.

1.3 ECONOMY

Zimbabwe has abundant natural resources, including 8,6 million hectares of potentially arable land and over 5 million hectares of forests, national parks and wild life estates. There are adequate supplies of surface and ground water for electric power, irrigation, and domestic and industrial use. Mineral resources are varied and extensive, including gold, asbestos, coal, nickel, iron, copper, lithium and precious stones such as emeralds.

The economy is fairly diversified, with relatively developed commercial, industrial, mining and agricultural sectors. Manufacturing and agriculture are the leading producers for both domestic and export markets, with mining contributing more to export earnings than to the domestic economy. In addition to mining, major industries include food production, construction, chemicals, textiles, wood and furniture, transport-equipment and paper printing.

Main agricultural exports include tobacco, maize, cotton, sugar and groundnuts. The agriculture sector has a well developed commercial component, co-existing with subsistence farming. The noncommercial (subsistence) agricultural sector is largely undeveloped, lacking essential physical and social infrastructure. Government development efforts lay increased emphasis on strengthening this sector, as reflected in the Government's Economic Policy Statement of Growth With Equity.

1.4 EDUCATION

Education is considered a basic need and fundamental right. The formal education system begins with a seven-year primary cycle, which is basically free under the Universal Primary Education (UPE) policy. It is followed by a secondary system with three levels: junior; middle/ordinary and upper/advanced. At the tertiary level, the University of Zimbabwe offers three- and four-year degree courses, plus postgraduate diplomas and masters and doctorate degrees in a number of subjects. Various postsecondary courses also are offered at teacher training, technical and agricultural colleges. The nonformal system includes afternoon/evening classes, study groups, private independent colleges, correspondence education, literacy campaigns and postliteracy programmes.

Before independence, there were gross disparities at various levels in the education system, including an overall shortage of schools and inequities in educational opportunities between racial groups, males and females, rural and urban communities, and other subgroups. Efforts to overcome these inequities have resulted in a rapid expansion in the education system. As illustrated in Table 1.1, since 1979, there has been a substantial increase at all levels in the number of schools and teachers and the total enrolment. In addition, it is estimated that about 75 thousand people are participating in adult literacy classes and about 150 thousand in other nonformal education. Thus, about three million Zimbabweans are covered in either formal or nonformal educational programmes.

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Table 1.1   Total Number of Schools and Teachers and School Enrolment
            (In Thousands) by Level of Education and Year, Zimbabwe,
            1979-1988


Level of
Education              1979       1983       1985       1988


Primary
Number of schools       2,4        4,0        4,2        4,5
Number of teachers     18,0       51,0       57,0       58,0
Enrolment             819,0     2044,0     2217,0     2221,0

Secondary
Number of schools       0,2        0,8        1,2        1,5
Number of teachers      3,5       11,2       17,3       23,9
Enrolment              66,0      316,0      482,0      653,0

Higher
Enrolment               8,5       18,4         --       49,7

Source: Central Statistical Office, 1987b
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The increased attention placed on broadening educational opportunities has resulted in greater literacy. Immediately following independence, the 1982 census found that literacy[1] was 58 percent among the population 10 years and older (64 percent for males and 53 percent for females). The corresponding figure for the population 15 years and over was 62 percent (70 percent for males and 56 percent for females) (Central Statistical Office, 1985, p. 93).

1.5   POPULATION

In Zimbabwe, censuses counting the full population were carried out only in 1961/1962, 1969 and 1982, but estimates of the size of the total population are available from the beginning of this century when the first census of non-Africans was undertaken. Table 1.2, which shows these estimates as well as the census figures, indicates that the average annual increase in the population has been 3 percent or more since the 1930s. According to the 1982 census, the total population in Zimbabwe had reached 7,6 million. There had been a decline in the European population. Ninety-eight percent of the 1982 population was of African origin compared to 95 percent in 1969 (Table 1.3).

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Table 1.2  Population Size and Annual Rate
           of Increase in the Population,
           Zimbabwe, 1900-1982


                                    Annual
                    Population      Increase
Year                (in Thousands)  (Percent)


1901                    713            --
1911                    907           2,4
1921                  1 147           2,4
1931                  1 464           2,5
1941                  2 006           3,2
1951                  2 829           3,5
1961                  3 969           3,5
1962                  4 098           3,3
1969                  5 134           3,3
1982                  7 608           3,0

Source: Central Statistical Office, 1987b
        and 1989
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[1] A person was considered to be functionally literate if he/she had completed Grade Three.

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Table 1.3 Selected Demographic Indicators, Zimbabwe, 1982 and 1969

Indicator	1982 Census	1969 Census
Total Population (in Thousands)	7 608	5 130
Distribution by Ethnic Group (Percent):		
African	97,7	95,0
European	1,9	4,5
Asian	0,1	0,2
Coloured	0,3	0,3
Distribution by Age Group (Percent):		
0-14	47,9	--
15-64	49,1	--
65 and over	3,0	--
Crude Birth Rate (CBR): Births per 1 000 Population	39,5	47
Crude Death Rate (CDR): Deaths per 1 000 Population		
Total	10,8	15
Male	11,6	--
Female	10,1	--
Number of Males per 100 Females in the Total Population	96	--
Number of Males per 100 Females among Children Ever Born	101	--
General Fertility Rate (GFR): Total Births per 1 000 Women 15-44	175,8	--
Total Fertility Rate (TFR): Total Births per Woman 15-44	5,6	6,6
Gross Reproduction Rate (GRR): Female Births per Woman 15-44	2,8	--
Infant Mortality Rate (IMR): Infant Deaths per 1 000 Births		
Total	83	101 (African)
Male	93	--
Female	73	--
Life expectancy at birth (e^0)		
Total	57,4	50,8
Male	55,7	49,2
Female	59,1	52,5

Source: Central Statistical Office, 1969, 1987b and 1989

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Table 1.4   Total Population, Area (in Square Kilometres), Population
            Density and Percent of Population Living in Urban Areas,
            by Province, Zimbabwe, 1982
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Province	Total Population (in Thousands)	Area	Population Density(1)	Percent Urban
Manicaland	1 103 837	34 870	31,7	8,8
Mashonaland Central	560 847	27 284	20,6	9,1
Mashonaland East	1 496 500	24 934	60,0	58,8
Mashonaland West	854 098	60 467	14,1	20,4
Matabeleland North	962 064	73 537	12,1	57,4
Matabeleland South	515 298	66 390	7,8	2,6
Midlands	1 086 284	58 967	18,4	18,6
Masvingo	1 029 504	44 310	23,2	6,2
Total	7 608 432	390 759	19,5	26,7

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Source: Central Statistical Office, 1989

(1) Population per square kilometre
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At the time of the 1982 census, the crude birth rate (CBR) and the crude death rate (CDR) were estimated at 40 births per thousand population and 11 deaths per thousand population, yielding a natural growth rate of 29 per thousand. The corresponding figures from the 1969 census were higher, suggesting that both fertility and mortality levels declined over the period between the two censuses (Table 1.3). The comparatively high fertility prevailing in Zimbabwe has produced a young age structure; 48 percent of the 1982 census population was below age 15 while only 3 percent were elderly, i.e., 65 years and over.

The population density increased from 13 per square kilometre in 1969 to 19.5 in 1982. Although much lower than the world average of 34 in 1982, it was higher than the average density for the African continent (16 persons per square kilometre) (Central Statistical Office, 1987b, p.16). The Zimbabwean population is largely rural. According to the 1982 census, only 27 percent of the population were living in urban areas, i.e., in localities with more than 2 500 inhabitants. More than half the urban population is found in the two largest cities, Harare and Bulawayo. There is substantial provincial variation in the degree of urbanisation, with the proportion of the population living in urban areas ranging from a high of 59 percent in Mashonaland East to 6 percent in Masvingo and less than 3 percent in Matabeleland South (Table 1.4).

1.6   FAMILY PLANNING PROGRAMME

Family planning services have been available in Zimbabwe since 1953. With the establishment of the Family Planning Association (FPA) in 1965, responsibility for the previously uncoordinated family planning activities were consolidated in a single organisation. In the beginning, the FPA's work was confined to the white community, and contraceptives were not generally available to the African population. In 1966, however, the Minister of Health approved

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the provision of family planning services through government hospitals, thus, making them available to the African as well as European population. Government support for family planning was further evidenced in the decision in 1968 to provide an annual subsidy to the FPA.

In Zimbabwe, the approach to family planning service delivery was initially largely clinic-based. Government family planning services were integrated into the maternal and child health care (MCH) delivery system at hospitals and clinics, and the prescription of hormonal contraceptives was limited to medical and paramedical personnel. The FPA offered services primarily through urban clinics, although it operated some mobile units, which worked in neigh- boring rural areas.

In 1967, to improve family planning services, the FPA began recruiting field educators. By 1970, 55 field educators were employed by the association, with 20 working in rural areas. At first, the field educator's role was to inform and motivate the population about family planning; clients wishing to use a method were referred to clinics. In 1976, however, the association obtained permission from the Ministry of Health for the field educators to distribute pills and condoms, forming the base for the current community-based distribution system.

During the struggle for independence, unfortunately, the FPA came to be perceived as trying to limit births among the African population while encouraging births among the Europeans. In order to restore its effectiveness and to more fully integrate family planning into the national health service delivery system, the newly independent Government of Zimbabwe placed the Family Planning Association under the control of the Ministry of Health in September 1981, renaming it the Zimbabwe Child Spacing and Fertility Association (ZCSFA). In January 1984, the association officially became the Zimbabwe National Family Planning Council (ZNFPC), a parastatal organisation under the Ministry of Health.

Through its network of clinics and the community-based distribution system, the ZNFPC continues to be the major provider of family planning services in Zimbabwe. ZNFPC clinics provide a full range of contraceptive methods, including the pill, IUD, injection, barrier methods and, at the main clinics in Harare and Bulawayo, voluntary female sterilisation. The ZNFPC also supplies contraceptives to 200 non-ZNFPC hospitals and clinics. These outlets, which are generally operated by the Ministry of Health or local government, provide pills and condoms, although some hospitals and clinics have facilities for performing sterilisations or inserting IUDs.

The community-based distribution (CBD) system serves as the principal outreach mechanism for family planning service delivery in Zimbabwe and is the backbone of the ZNFPC programme. After they are selected by their communities, the distributors are trained to educate and motivate the population to use family planning, to supply clients with pills and condoms in their homes, and to refer women wanting to use other methods to clinics. The current work force of 600 distributors covers approximately 29 percent of the rural population in Zimbabwe (Zimbabwe National Family Planning Council, 1987).

In addition to service delivery activities, the ZNFPC works with the Ministry of Education and Culture (formerly the Ministry of Primary and Secondary Education) through its Youth Advisory Services Unit to provide Family Life Education (FLE) to young people and their parents. The Training Unit operates two centres which offer training in family planning for both medical and lay personnel. The Information, Education and Communication (IE&C) Unit has responsibility

for the development of a national programme of family planning education as well as for the production of information materials used by the ZNFPC units to educate and motivate the population to use family planning.

1.7   HEALTH PRIORITIES AND PROGRAMMES

Government priority in the health sector is to provide health services for all, hence the adoption of the slogan "health for all by year 2000". The emphasis is on the eradication of communicable diseases--the result of unsanitary living conditions, lack of a protected water supply and malnutrition. The latter health problem is rife in rural areas, where the diet is often not balanced.

Activities currently being undertaken in the health sector to ensure that the priority of health for all is achieved include:

- establishment of rural health centres and the village health workers' programme;
- construction of hospitals, especially rural hospitals, and of rural medical stores;
- maintenance and upgrading of existing hospitals;
- construction of rehabilitation villages for those discharged from hospitals but in need of physiotherapy;
- improvement of facilities in mental hospitals;
- improving and expanding family planning facilities;
- construction of accommodation for medical students and staff.

The National Health Service is established at four levels (primary, secondary, tertiary and quartenary (central)), with Primary Health Care (PHC) being regarded as the main vehicle through which health care programmes will be implemented. The main components of PHC include maternal and child health services; health education; nutrition education and food production; expanded programme on immunisation; communicable disease control; water and sanitation; essential drugs programme; and provision of basic and essential preventive and curative care.

The majority of health services in Zimbabwe are provided by the public sector (Ministry of Health and local government, both in urban and rural areas). The health delivery system is graded into hierarchies of care, with each lower level referring difficult cases to the next higher level. At the bottom of the formal health care system are clinics and Rural Health Centres (RHC). These facilities which collectively are the primary care facilities, are staffed by nurses, nurse-midwives and environmental health technicians. The primary care facilities refer difficult cases to District Hospitals, which have both doctors and nurses. The district hospitals in turn refer patients to the Provincial Hospitals which ultimately refer to the Central Hospitals.

Health service delivery is integrated so that every health facility offers the full range of available services at any time, i.e., both preventive and curative services are offered at the same time. Thus, a client will benefit from preventive services even if he/she originally visited the facility for curative services. For example, if a mother visits a clinic with a child to be treated for a cough, the staff will check on the immunisation status of the child and update it if necessary. They will also discuss family planning with the mother and start her on family planning if she is interested in using or update her supplies if she needs them. This is the so-called "supermarket

approach", where the whole range of health services is available under one roof at the same time. All health facilities are supposed to operate on this principle, which minimises unnecessary trips by clients who might otherwise have to come on special day for family planning, then on another day to immunise their child, etc. Under this approach, every health facility offers the full range of maternal and child health services (MCH), including family planning.

Recognising that there are segments of the population with special needs and who are at greater risk, there is an MCH department in the Ministry of Health. Its special role is to devise programmes that will lead to improved health for mothers and children, again in an integrated manner. Part of the department's responsibility is to identify the priority health problems of mothers and children and identify strategies to alleviate those problems. There are efforts to improve the nutritional status of young children (under-fives) through regular growth monitoring and taking appropriate action for those with faltering growth. In conjunction with other organisations and Ministries, efforts are being made to ensure that working mothers spend more time with their children. Pregnant working mothers are entitled to 90 days maternity leave and to one hour breastfeeding time per day after their child is born. The proper weaning of children is also emphasised, with bottle feeding discouraged (and banned altogether in maternity wards).

There is heavy emphasis on preventive services. Safe delivery is stressed, with the aim that every pregnancy end with a healthy mother and child. To achieve this objective, great emphasis is placed on ensuring that most deliveries occur in health facilities. In order to ensure that even those deliveries which occur at home take place under conditions of safety, however, there is also a programme to upgrade the skills of traditional birth attendants.

Efforts directed toward the prevention of diseases through immunisation were greatly strengthened after independence, when the Zimbabwe Expanded Programme of Immunisation (ZEPI) was started. The programme aims to immunise all children against measles, diphtheria, whooping cough, neonatal tetanus, poliomyelitis and tuberculosis. ZEPI is a national programme operative in all areas of the country, both urban and rural.

Diarrhoea and respiratory infections contribute significantly to ill-health in children. Special programmes have, therefore, been started to reduce suffering and deaths from these two diseases (the Control of Diarrhoeal Diseases (CDD) and Control of Acute Respiratory Infections (ARI) programmes). The concern in the CDD programme is prevent dehydration or to treat it early before it becomes severe. There is, therefore, great emphasis on teaching mothers about a salt and sugar solution, which they can prepare at home using their own ingredients and utensils and give their child at the start of a diarrhoea episode. The ARI programme aims at treating cases of respiratory infection early before complications develop. There is, therefore, emphasis placed on recognition of signs of impending severity, both by mothers and primary health care workers so that help can be sought early.

1.8   OBJECTIVE OF THE SURVEY

The ZDHS is one of a series of surveys undertaken by the Central Statistical Office (CSO) as part of the Zimbabwe National Household Survey Capability Programme (ZNHSCP). The ZDHS was conducted immediately after the second round of the Intercensal Demographic Survey (ICDS) in 1988. The main objective of the ZDHS was to provide information on:

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- fertility levels, trends and preferences;
- family planning awareness, approval and use;
- maternal and child health, including infant and child mortality; and
- other topics relating to family health.

The survey was designed to obtain information on family planning use similar to that provided by the 1984 Zimbabwe Reproductive Health Survey (ZRHS) and data on fertility and mortality which would complement information collected in the two rounds of the Intercensal Demographic Survey (ICDS). In addition, participation in the worldwide Demographic and Health Survey project offered an opportunity to strengthen survey capability in Zimbabwe, as well as further comparative research by contributing to the international demographic and health database.

1.9 ORGANISATION OF THE SURVEY

The ZDHS utilised a two-stage sample, which was self-weighting at the household level and nationally representative. It was drawn from the Revised Zimbabwe Master Sample (RZMS) on which the 1987 and 1988 ICDS samples were based. The RZMS is a subsample of the original Zimbabwe Master Sample constructed at the initiation of the ZNHSCP. Census enumeration areas (EAs) served as the first stage or primary sampling units and were selected with probability proportional to size, namely, the number of households in the 1982 census. The ZDHS sample included 167 of the 273 EAs from the RZMS, of which 114 were rural and 53 urban. The second stage units, households, were drawn systematically from the households residing in the selected EAs. A detailed description of the sample design is given in Appendix A, and sampling errors for selected variables are presented in Appendix B.

Two questionnaires were used for the ZDHS, a household and an individual woman's questionnaire. The questionnaires were adapted from the DHS Model "B" Questionnaire, intended for use in countries with low contraceptive prevalence. A pretest was conducted, and the questionnaires were modified, taking into account the pretest results. The household and individual questionnaires were administered in Shona, Ndebele, or English, with these major languages appearing on the same questionnaire.

Information on the age and sex of all usual members and visitors in the selected households was recorded on the household questionnaire and used to identify women eligible for the individual questionnaire. Eligibility for the individual interview was determined on a de facto basis, i.e., a woman was eligible if she was 15 to 49 years of age and had spent the night prior to the household interview in the household, irrespective of whether she was a usual member of the household or not. The individual questionnaire was used to collect information on the following topics:

> Respondent's background;
> Reproduction;
> Contraception;
> Health and breastfeeding;
> Marriage;
> Fertility preferences;
> Husband's background and women's work;
> Height and weight of children 3-60 months.

Copies of the questionnaires are reproduced in Appendix C.

Training for the ZDHS was conducted in three phases, starting with a one-week session for the CSO staff serving as trainers and a core group of field personnel who were to be deployed as supervisors or field editors in the main survey. The main training session, involving 56 female trainees, took place for one month during August 1988 and covered such topics as the objectives and purpose of the ZDHS, general interviewing techniques, detailed instructions for completing the questionnaires and training in weighing and measuring children. Immediately following the main training, an additional anthropometric training course was held for the 14 field staff who were to act as measurers. CSO staff were primarily responsible for the training, with staff from ZNFPC conducting sessions on reproduction and contraceptive methods. Sessions on anthropometric measurement were held by staff from the Ministry of Health's Midlands Provincial Medical Office.

Fieldwork was started on the 15th of September 1988 and was completed by the end of January 1989. The field staff included seven teams, composed of a supervisor, a field editor, four interviewers and a measurer. Each team was provided with a vehicle and a driver.

Data entry and editing began in October 1988 and was completed in February 1989, two weeks after fieldwork ended. The initiation of data processing during the fieldwork allowed the errors that were detected to be communicated immediately to the field teams for corrective measures, thus improving the quality of the data. All data processing activities were carried out in Harare, by a team of five data capture operators under a data processing coordinator. The operators were responsible for office editing and coding, as well as for the entry of the questionnaires. The computer hardware consisted of three IBM-compatible micro-computers. The Integrated System for Survey Analysis (ISSA) software package, developed by IRD for the DHS programme, was used for all phases of the data entry, editing and tabulation. Range, skip and most consistency checks were performed during the data capture itself; only the more sophisticated consistency checks were done during secondary editing.

1.10   BACKGROUND CHARACTERISTICS OF THE WOMEN SURVEYED

Of the 4 789 households selected for the ZDHS, 4 337 were located in the field; of these, 4 107 households were successfully interviewed. Within the households successfully interviewed, 4 467 women were identified as eligible, and, among these eligible women, 4 201 women were interviewed. The overall response rate, which is the product of the household (95 percent) and individual (94 percent) response rates was 89 percent (see Appendix A).

Table 1.5 presents the distribution of respondents by selected background characteristics. The data on age were obtained by first asking for the woman's date of birth and then her age at the last birthday, with the interviewer instructed to reconcile any differences. For most respondents the age data were complete; 90 percent were able to give both the month and year of birth, and 8 percent knew at least the year of birth. Reflecting the youthful age structure of the Zimbabwean population, a result of the past high fertility level, one in four of the respondents is in the 15-19 age group, and more than four in ten are under 25. Forty percent are between 25 and 39 years, and 14 percent are in the 40-49 group.

Table 1.5   Percent Distribution of Women 15-49 by Age, Urban-
            Rural Residence, Place of Residence, Level of
            Education and Religion, Zimbabwe DHS, 1988

Background Characteristic	Percent	Number of Women
Age		
15-19	24,3	1 021
20-24	20,0	840
25-29	16,2	679
30-34	14,0	589
35-39	11,0	464
40-44	7,6	318
45-49	6,9	290
Urban-Rural Residence		
Urban	33,5	1 407
Rural	66,5	2 794
Place of Residence		
Manicaland	12,5	527
Mashonaland Central	6,9	288
Mashonaland East(1)	12,9	543
Mashonaland West	11,8	495
Matabeleland North(2)	4,5	189
Matabeleland South	6,7	282
Midlands	15,6	656
Masvingo	11,8	497
Harare/Chitungwiza	8,2	345
Bulawayo	9,0	379
Level of Education		
No Education	13,5	566
Primary	55,9	2 349
Secondary or Higher	30,6	1 286
Religion		
Christian	67,1	2 818
Spiritual	20,2	848
Traditional	8,6	361
Other	2,7	113
No religion	1,3	56
Missing	0,1	5
Total	100,0	4 201

(1) Excludes Harare/Chitungwiza
(2) Excludes Bulawayo

One-third of the women are from areas defined as urban or semi-urban, with the remainder (66 percent) from areas designated as rural, including communal lands, large-scale commercial farms, small-scale commercial farms and resettlement areas. Respondents living in the two largest cities (Harare/Chitungwiza and Bulawayo) account for 17 percent of the total sample and more than half of the urban sample. The proportion of respondents varies by province from a high of 16 percent in Midlands to 4 percent in Matabeleland North.

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Most of the respondents have had some schooling; only 14 percent never received formal education, 56 percent have had some primary schooling, and 31 percent have achieved at least the secondary level. Two out of three women are members of major Christian denominations (e.g., Anglican, Methodist, Presbyterian, Dutch Reformed and Roman Catholic), while one in five belongs to a Spiritual church. A small minority (9 percent) adhere to tribal, animistic or other traditional beliefs.

Table 1.6 looks at the association between educational attainment and other background characteristics. The younger generation is attaining higher education levels than the older. For

Table 1.6   Percent Distribution of Women 15-49 by Level of Education, According to Age, Urban-Rural Residence, Place of Residence and Religion, Zimbabwe DHS, 1988

Background Characteristic	No Education	Primary	Secondary/ Higher	Total Percent	Number of Women
Age					
15-19	2,5	47,7	49,8	100,0	1 021
20-24	7,0	42,4	50,6	100,0	840
25-29	18,0	61,9	20,2	100,0	679
30-34	17,3	65,4	17,3	100,0	589
35-39	17,5	68,8	13,8	100,0	464
40-44	29,6	61,0	9,4	100,0	318
45-49	28,3	64,8	6,9	100,0	290
Residence					
Urban	6,4	42,6	51,0	100,0	1 407
Rural	17,0	62,6	20,4	100,0	2 794
Place of Residence					
Manicaland	14,2	64,3	21,4	100,0	527
Mashonaland Central	26,0	52,8	21,2	100,0	288
Mashonaland East(1)	15,1	57,5	27,4	100,0	543
Mashonaland West	19,8	58,8	21,4	100,0	495
Matabeleland North(2)	25,4	56,1	18,5	100,0	189
Matabeleland South	6,0	69,1	24,8	100,0	282
Midlands	11,9	52,0	36,1	100,0	656
Masvingo	12,5	62,4	25,2	100,0	497
Harare/Chitungwiza	3,8	43,2	53,0	100,0	345
Bulawayo	4,7	40,6	54,6	100,0	379
Religion					
Christian	8,4	54,7	36,9	100,0	2 818
Spiritual	13,3	64,3	22,4	100,0	848
Traditional	42,9	50,4	6,6	100,0	361
Other	33,6	50,4	15,9	100,0	113
No Religion	35,7	37,5	26,8	100,0	56
Missing	40,0	60,0	0,0	100,0	5
Total	13,5	55,9	30,6	100,0	4 201

(1) Excludes Harare/Chitungwiza
(2) Excludes Bulawayo

example, only 2 percent of the 15-19 age group never received a formal education, compared with 28 percent in the 45-49 age group. Among those who attended school, educational achievement is generally greater for younger women than older; 50 percent of the youngest cohort attended secondary school, compared with only 7 percent of the women in the oldest age group. There appears to have been an especially sharp increase in the percent of women achieving the secondary level in the recent past; one in two women under age 25 has had some secondary education, compared with only one in five women 25-29.

Educational differences by residence are striking; the proportion of rural women without formal education is 17 percent, almost three times the urban rate. Moreover, among women who have attended school, those in urban areas are more likely than those in rural areas to have attained the secondary level. One in two women living in urban areas has attended secondary school, compared with only one in five rural women. There is also considerable variation in educational attainment by place of residence. The proportion having no formal education ranges from less than 5 percent in Harare/Chitungwiza and Bulawayo to 25 percent or more in Mashonaland Central and Matabeleland North. Those achieving at least the secondary level are most likely to be found in the two major cities--where half of the women have at least some secondary schooling--and Midlands--where 36 percent have attained the secondary level.

Religious affiliation is associated with education. Women belonging to Christian or Spiritual churches are more likely to have attended school than women adhering to traditional beliefs.

Chapter 2

MARRIAGE, BREASTFEEDING AND POSTPARTUM INSUSCEPTIBILITY

A number of factors influence the duration of exposure to the risk of pregnancy among women and, thus, determine fertility levels in a society. This chapter considers several of these variables, including marriage, breastfeeding, postpartum amenorrhoea and postpartum abstinence. Information on another major fertility determinant--contraceptive use--is presented in Chapter 4.

2.1 CURRENT MARITAL STATUS

There are basically two forms of marriage in Zimbabwe--civil/church marriage and customary marriage. For the first type, the point of entry into the marital union is marked by a civil or religious ceremony. In customary marriages, however, it is difficult to say exactly when a couple is married since such marriages are preceded by the payment of a brideprice (lobola) which the husband can take a long time to complete paying.

In the ZDHS, the concern was to identify couples who were cohabiting regardless of whether their unions had been formalised through either a civil/religious ceremony or through the payment of the brideprice. Therefore, the category "married" was defined to include cases where a couple was living together intending to have a lasting relationship, regardless of the formal status of the union. Any woman who reported herself as being in such a union was considered to be married. The remaining marital status categories include divorced/separated, widowed or never married. The joint divorced/separated category was used since it is difficult to distinguish between a divorce and separation in customary marriages. Thus, in any case where a woman had been married or lived with a man, but the couple was no longer cohabiting, she was assigned to the category divorced/separated.

Table 2.1 shows the percent distribution of women in the sample by current marital status. Overall, 27 percent have never married, 63 percent are married, and 10 percent are divorced/separated or widowed. The proportion never married decreases rapidly with age, from 80 percent of women 15-19 to 30 percent in the 20-24 age group. Less than 2 percent of women 25-49 have never married.

Among ever-married (married, divorced/separated and widowed) women, the large majority, in all age groups, are currently married. As expected, widowhood is more common among older than younger women. The percent widowed increases from less than 1 percent among women under 25 to 10 percent among women 45-49. The proportion divorced/separated is fairly uniform across age groups, except for the youngest cohort; among women under 20, only 2 percent are divorced/separated, while in the 20-49 age groups, 8 to 11 percent are divorced/separated.

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Table 2.1 Percent Distribution of Women by Current Marital Status, According to Age, Zimbabwe DHS, 1988

| | Current Marital Status | | | | | Number |
Age	Never-married	Married	Widowed	Divorced/ Separated	Total Percent	of Women
15-19	80,2	17,6	0,0	2,2	100,0	1 021
20-24	28,5	61,1	0,5	10,0	100,0	840
25-29	6,8	82,3	1,8	9,1	100,0	679
30-34	2,5	85,4	2,5	9,5	100,0	589
35-39	1,5	86,9	3,7	8,0	100,0	464
40-44	0,9	79,6	8,8	10,7	100,0	318
45-49	1,4	80,0	10,0	8,6	100,0	290
Total	27,0	62,9	2,5	7,6	100,0	4 201

2.2   SEXUAL ACTIVITY AMONG YOUNG ADULTS

One area of concern to health workers is the problem of unplanned pregnancy among young unmarried women. The ZDHS obtained data on sexual activity from all women, regardless of their marital status. This information can be used to identify the proportion of young adults who have ever had sexual relations and those who are currently sexually active (i.e., have had sexual intercourse at least once in the month before the interview). Although respondents were interviewed alone and were assured that their answers were confidential, it is likely that there was some underreporting of sexual activity among these young women, especially never-married teenagers, either because of embarrassment or reluctance to disclose that they were sexually active.

Although subject to reporting error, the questions on sexual activity are useful in defining the population of young adults potentially exposed to the risk of pregnancy. Reproductive risk is likely to be greater for married women in this group than for young women who are currently sexually active but not involved in a stable relationship since the former group is more likely to have regular sexual relations. However, the economic and social burdens of childbearing are presumably greater for women who conceive and give birth to a child outside a marital union. Moreover, pregnancy and childbearing among women under age 18 have been shown to be associated with increased risk of morbidity and mortality for both mother and child.
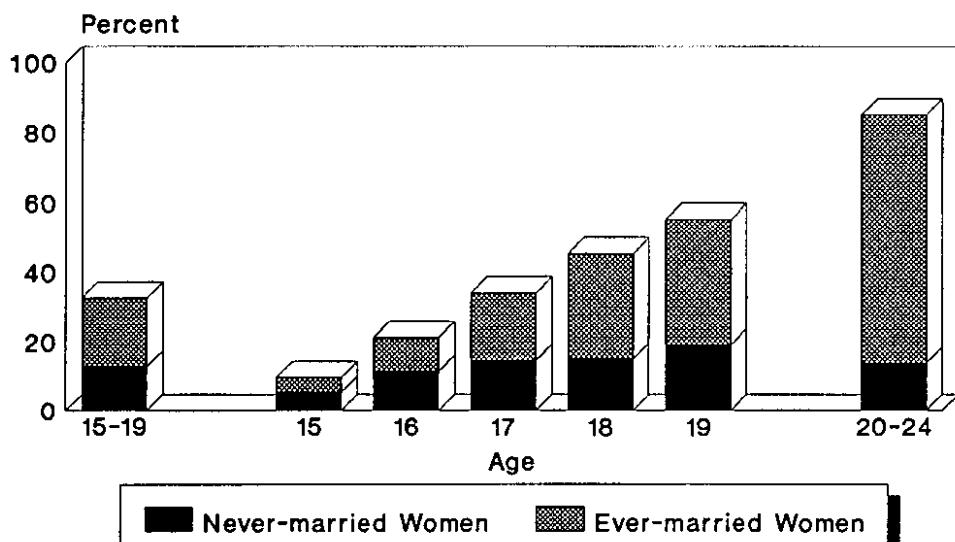
The first two columns of Table 2.2 show the proportion of all young adults who have ever had sexual intercourse and the proportion who are currently sexually active. Ever-married women are included among the ever sexually active, along with never-married women who report that they have ever had intercourse. The currently sexually active group includes all women who report having had intercourse at least once in the month before the survey.

Overall, one in two young adult women have had sexual intercourse at some time, and around one in three is currently sexually active. Although the majority of young adults who have had sexual intercourse are ever-married, nearly one in four is never-married (Figure 2.1). Among teenagers, two in five women who have ever had sexual relations have never been married.

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Table 2.2 Percent of Women 15-24 Ever and Currently Sexually Active and Percent of Never-married Women 15-24 Ever and Currently Sexually Active by Age, Zimbabwe DHS, 1988

Age	Among Women 15-24:		Number of Women 15-24	Among Never-married Women 15-24:		Number of Never-married Women 15-24
	Ever Sexually Active	Currently Sexually Active		Ever Sexually Active	Currently Sexually Active	
15-19	32,5	17,8	1 021	15.9	4.9	819
15	9,6	3,9	229	5.5	1.4	219
16	21,0	11,8	195	12.5	4.5	176
17	33,9	19,4	180	17.9	7.6	145
18	45,1	25,1	215	21.3	6.7	150
19	55,0	30,2	202	29.5	6.2	129
20-24	85,1	56,0	840	47.7	15.1	239
20	72,8	42,1	195	39.8	10.2	88
21	78,9	52,1	142	41.2	9.8	51
22	90,7	55,7	194	62.5	18.8	48
23	88,1	65,9	135	44.8	27.6	29
24	95,4	67,2	174	65.2	21.7	23
Total	56,2	35,0	1 861	23,1	7,2	1 058

Figure 2.1
Percent of Young Adults Ever Sexually Active by Marital Status and Age

Never-married Women   Ever-married Women

Zimbabwe DHS 1988

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Considering only never-married young adults, one in six teenagers has had sexual relations at some time, while, among women 20-24, one in two have had sexual intercourse (Table 2.2). The likelihood that a never-married young adult will have had sexual relations increases directly with age. Only 6 percent of never-married women age 15 report having ever had intercourse, while more than one-quarter of those age 19 and almost two-thirds of those age 24 have had sexual relations. Because premarital sexual unions are likely to be less stable than marital unions, it is not surprising that only about one-third of never-married young adults with sexual experience report that they are currently sexually active. It is also possible, however, that never-married women were willing to admit to having some sexual experience but reluctant to discuss recent sexual behavior.

The results in Table 2.2 indicate that a significant proportion of young adult women in Zimbabwe become sexually active before marriage. Since for many of these young women a consequence of the premarital sexual activity will be unplanned pregnancy and/or early marriage, the findings highlight the need to continue support for special education and counseling services for youth. More information on the prevalence of teenage pregnancy is presented in Chapter 3.

2.3   AGE AT FIRST MARRIAGE

For most women, the age at which they marry marks the beginning of regular exposure to the risk of childbearing. Increases in the average age at first marriage in a population are associated with the transition to lower fertility as the length of time the average woman spends at reproductive risk is reduced and, consequently, the number of children that she will bear over her lifetime declines.

Information on age at first marriage was collected by asking each ever-married woman for the date (month and year) when she began living together with her first husband. If a woman could not remember the date of marriage, then she was asked how old she was when she first married. Among ever-married women, 77 percent were able to give both the month and year when they first married, 18 percent knew only the year and five percent were only able to report how old they were when they first married. In addition to recall problems, the data on age at first marriage may be affected by a tendency on the part of some women to report the date (age) when the marriage was officially registered rather than the date (age) when the couple first began living together. To the extent that such errors occurred, the information on age at marriage will be upwardly biased.

Any analysis of the patterns in age at marriage must take into account the fact that the data on age at marriage are censored, i.e., they are available only for women who have ever married. Since never-married women in any age group will marry at later ages than those who are already married, the data on age at marriage from the ever-married group will give a downwardly biased picture of the pattern of age at entry into marriage for the age group. The effect of censoring is greatest in the youngest age groups where a significant proportion of women have never married. In describing trends and differentials in the age at marriage, the median is preferred to the mean, because it is not affected by censoring; the median is fixed once 50 percent of a group have married and, in contrast to the mean, will not increase as never-married women in the group continue to marry.

Table 2.3 Percent Distribution of Women by Age at First Marriage (Including Category "Never Married") and Median Age at First Marriage, by Current Age, Zimbabwe DHS, 1988

		Age at First Marriage							Number	
Age	Never Married	Under 15	15-17	18-19	20-21	22-24	25 and Over	Total Percent	of Women	Median Age
15-19	80,2	3,7	12,1	3,9	0,0	0,0	0,0	100,0	1 021	--
20-24	28,5	6,7	26,4	20,0	13,7	4,8	0,0	100,0	840	19,7
25-29	6,8	9,7	29,9	26,1	12,8	12,4	2,4	100,0	679	18,8
30-34	2,5	12,7	29,2	27,8	12,7	9,7	5,3	100,0	589	18,5
35-39	1,5	9,5	28,2	24,4	16,2	11,2	9,1	100,0	464	19,0
40-44	0,9	20,1	29,2	19,2	13,5	9,7	7,2	100,0	318	18,1
45-49	1,4	13,1	31,4	18,6	14,5	11,7	9,3	100,0	290	18,6
Total	27,0	9,1	24,7	18,5	10,4	7,1	3,3	100,0	4 201	--

Note: Median age is defined as the age by which 50 percent of the women have married.

-- Omitted due to censoring

The ZDHS results indicate that women marry at a relatively early age in Zimbabwe. More than half of the respondents reported that they married for the first time before their 20th birthday, with 9 percent saying that they married before they were 15 (Table 2.3). Among women marrying after age 20, most married before their 25th birthday. Only 3 percent were 25 years or older when they married for the first time. There is some indication that the age at marriage has recently been increasing. The median age at first marriage among women 20-24 years, 19,7 years, is nearly one year higher than the median age for women in the 25-29 age group (18,8 years). The somewhat erratic variation in the median age among older cohorts is probably due to greater reporting error in these groups.

Table 2.4 shows the variation in the median age at first marriage across age cohorts for women in various subgroups. No medians are presented for women 15-19 because more than 50 percent of this cohort have never married. For some subgroups, more than 50 percent of women 20-24 also have never married so that the median age at marriage for women 20-24 in these subgroups are not shown. In order to avoid the slight bias that the inclusion of women 20-24 from these subgroups would have on the median age for the subgroup as a whole, the medians presented in the total column in Table 2.4 are limited to women 25-49.

The median age at first marriage for women 25-49 is slightly higher in urban areas (19,2 years) than in rural areas (18,4 years). Although the pattern is again somewhat erratic among older women, there is an upward trend in the age at first marriage among women under age 35 in both urban and rural areas. As expected, a woman's educational level also is strongly associated with her age at first marriage. The median age at first marriage for those with a secondary education is 20,8 years compared to 18,5 years for those with primary education and only 17,5 years for women who never attended school. The inverse relationship between age at first marriage and a woman's educational attainment is observed in all age cohorts. Within each educational status group, however, there is no clearcut trend in the age at first marriage across age cohorts.

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| Table 2.4 | Median Age at First Marriage by Current Age, According to Selected Background Characteristics, Zimbabwe DHS, 1988 |

Background Characteristic	Current Age						Total 25-49
	20-24	25-29	30-34	35-39	40-44	45-49	
Urban-Rural Residence							
Urban	--	19,4	19,1	19,3	18,6	20.3	19,2
Rural	19,3	18,5	18,2	18,9	17,8	18,2	18,4
Level of Education							
No Education	16,7	17,2	17,3	18,9	16,7	17,8	17,5
Primary	17,9	18,5	18,5	18,8	18,1	18,3	18,5
Secondary or Higher	--	21,3	20,3	20,3	20,3	22,5*	20,8
Total	19,7	18,8	18,5	19,0	18,1	18,6	18,6

Note: Median age is defined as the age by which 50 percent of the women have married.

* Median based on fewer than 25 cases
-- Omitted due to censoring

In summary, although the age at first marriage appears to be increasing, the ZDHS results show that many Zimbabwean women are marrying at an early age. In the absence of deliberate control of fertility, the longterm consequence of early marriage is higher lifetime fertility. The immediate consequence may be to limit educational and employment opportunities for many of the women who marry early. Table 2.5 shows the proportion currently attending school full-time among young adult women. Virtually none of the ever-married women under 25 were attending school full-time at the time of the survey. While early marriage may be the outcome of leaving school, many young adult women may drop out of school to marry. The results in Table 2.5 suggest that improving educational opportunities for young adult women may be an important step in encouraging later marriage. Overall, only two in five teenagers, and one in twenty women 20-24 is currently attending school full-time.

| Table 2.5 | Percent of Women Who Are Currently Attending School Full-time by Marital Status, According to Age, Zimbabwe DHS, 1988 |

Age	Never-married Women	Ever-married Women	All Women
15-19	49,7	0,5	40,0
15	71,7	0,0*	68,6
16	51,1	0,0*	46,2
17	44,1	0,0	35,6
18	44,0	1,5	31,2
19	23,3	0,0	14,9
20-24	13,0	2,5	5,5
20	17,0	6,5	11,3
21	21,6	2,2	9,2
22	4,2	0,0	1,0
23	10,3	1,9	3,7
24	0,0*	2,6	2,3
25-29	8,7	2,2	2,7
30-49	0,0	1,4	1,4
Total	39,0	1,7	11,8

* Percent based on fewer than 25 cases

2.4 POLYGYNY

In many sub-Saharan African countries, the custom of polygyny, in which a husband takes more than one wife, is common. The effect that polygyny has on fertility levels is the subject of some debate, although it is generally assumed that the aggregate fertility of women in polygynous unions will be lower than that of women in monogamous unions because of reduced exposure to the risk of pregnancy.

In Zimbabwe, polygyny is most prevalent in rural areas where the population remains more traditional in its approach to marriage and among members of some religions that believe a man may have more than one wife. Factors which contribute to a trend away from polygyny include the increasing cost of supporting more than one wife, especially in an urban setting and, as the population becomes more educated, the belief that the practice is old-fashioned.

In order to gain some insight into the extent to which polygyny is currently practiced in Zimbabwe, married respondents in the ZDHS were asked if their husband had other wives. Overall, one in six married women is in polygynous union (Table 2.6). Polygyny is more common among older than younger women; around 25 percent of women age 40 and over say that their husbands have more than one wife compared to less than 15 percent of women under age 30. The greater prevalence of polygyny among older than younger women may simply be a life cycle effect--as their wives grow older, husbands are more likely to take additional younger wives. However, the pattern may also be evidence that polygyny is becoming less common.

Table 2.6 Percent of Currently Married Women in a Polygynous Union by Age, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Age							Total
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Urban-Rural Residence								
Urban	17,6	7,5	5,7	9,4	8,9	15,0	17,0	9,4
Rural	13,7	14,1	17,7	19,8	18,6	31,1	27,4	19,6
Level of Education								
No Education	23,5*	24,4	25,0	32,7	30,3	36,5	36,1	30,7
Primary	16,3	12,1	13,3	14,0	13,6	26,2	21,5	15,5
Secondary or Higher	9,2	8,3	5,6	6,9	7,4	0,0*	6,3*	7,2
Religion								
Christian	8,0	8,6	11,2	13,4	13,7	22,9	18,4	13,3
Spiritual	26,7	17,8	15,3	27,8	13,9	34,2	43,9	22,4
Traditional	17,6	11,1	21,3	11,4	38,5	43,3	25,0	22,8
Total	14,4	11,7	14,0	16,5	15,9	27,3	25,0	16,6

* Percent based on fewer than 25 cases

Polygyny is clearly less prevalent among urban than rural women. Only around 10 percent of married women in urban areas are in a polygynous union compared with around 20 percent of rural women. A woman's educational level is strongly associated with the likelihood that her husband will have other wives. Among women who have never attended school, 31 percent are in a polygynous union, more than four times the rate for women with some secondary education. Religious affiliation also is related to the likelihood that the union will be polygynous; only 13 percent of women who are Christian are in such unions compared with 22 percent among women in the Spiritual or traditional categories.

2.5   BREASTFEEDING AND POSTPARTUM INSUSCEPTIBILITY

Three other variables for which information is collected in the ZDHS--breastfeeding, postpartum amenorrhoea and postpartum sexual abstinence--play an important role in determining fertility levels by influencing the duration of the period following birth when a woman is not susceptible to the risk of another pregnancy.   Table 2.7 presents cross-sectional data on the proportion of births whose mothers were found to be still breastfeeding, postpartum amenorrhoeic, abstaining and insusceptible.   It should be noted that the information in Table 2.7 is birth-based rather than woman-based, i.e., a woman who had more than one live birth during the 36 months preceding the survey is included as many times as the number of births she had, with multiple births being treated as a single birth.   Because the data are drawn from births at a single point in time rather than representing the experience of an actual cohort over time, the number of cases in the duration categories tend to be small.   As a result, the proportions do not always decline in a steady fashion at increasing durations since birth as would be expected.   To help minimise such fluctuations, the births are grouped in two-month intervals.

In Zimbabwe, breastfeeding is almost universal, and most babies are breastfed for more than a year following birth.   Table 2.7 shows that almost 90 percent of babies born about one year before the survey are still being breastfed and the proportion continuing to be breastfed is around 50 percent among babies age 18-19 months.   Most children are fully weaned by their second birthday; only 11 percent of babies age 24-25 months are still being breastfed.

The period of postpartum amenorrhoea following birth, in which most women do not ovulate and hence are not at risk of pregnancy, is related to the duration and nature of breastfeeding.   Generally, the longer a mother breastfeeds her child and the longer she waits before introducing supplements, the longer will be the period of amenorrhoea.   The long duration of breastfeeding among Zimbabwean mothers is associated with an extended period of amenorrhoea. Table 2.7 shows that menstruation has not returned for more than 70 percent of mothers who are 6-7 months postpartum and around half the mothers 12-13 months postpartum are still amenorrhoeic.   However, there is a rapid decline in the proportion amenorrhoeic after that point; only 20 percent of mothers 18-19 months postpartum are still amenorrhoeic, and almost all mothers whose babies are two years old or more have resumed menstruating.

In many sub-Saharan countries, postpartum sexual abstinence is customary and may be enforced by cultural sanctions.   A primary purpose of the custom is to delay the next pregnancy in order to ensure the full recovery of the mother after birth and the normal growth of the new baby.   The results in Table 2.7 suggests that the practice of postpartum sexual abstinence is observed in Zimbabwe, but for a comparatively short time following birth.   Around two-fifths of

Table 2.7 Percent of Births in the 36 Months Before the Survey Whose
Mothers Are Still Breastfeeding, Postpartum Amenorrhoeic,
Postpartum Abstaining and Insusceptible to Pregnancy, by the
Number of Months Since Birth, Zimbabwe DHS, 1988

Months Since Birth	Still Breast- feeding	Still Amenor- rhoeic	Still Abstaining	Still Insuscep- tible(1)	Number of Births
Less than 2	95,0	88,7	82,5	91,2	80
2-3	94,9	78,8	56,8	87,3	118
4-5	91,8	70,9	31,8	75,5	110
6-7	92,2	73,5	27,5	77,5	102
8-9	89,4	61,5	10,6	62,5	104
10-11	89,8	50,9	13,9	55,6	108
12-13	87,6	49,6	7,1	51,3	113
14-15	81,7	43,5	9,2	48,9	131
16-17	73,4	30,3	7,3	34,9	109
18-19	52,1	18,8	6,3	22,9	96
20-21	33,3	13,1	1,0	14,1	99
22-23	16,1	2,7	7,1	9,8	112
24-25	11,4	0,8	3,8	4,5	132
26-27	6,5	0,0	5,8	5,8	138
28-29	3,9	0,8	0,8	1,6	128
30-31	2,8	0,0	2,8	2,8	106
32-33	1,7	0,0	3,4	3,4	119
34-35	0,0	0,0	0,0	0,0	97
Total	49,7	30,9	14,3	34,6	2 002

(1) Amenorrhoeic, abstaining or both

the mothers whose babies are 2-3 months have resumed intercourse, and nearly three-quarters of women 6-7 months postpartum are no longer abstaining (Table 2.7). Among mothers whose babies are age one year, less than 10 percent are continuing to abstain from sexual intercourse.

Table 2.7 also provides information about the proportion insusceptible to pregnancy because of either postpartum amenorrhoea or postpartum sexual abstinence (or both). Around 90 percent of mothers whose babies are under three months are not at risk of pregnancy, and half of the mothers whose babies are 12-13 months remain protected against pregnancy, either because they are amenorrhoeic and/or abstaining. The proportion who are insusceptible drops off rapidly after this point, with only one-fifth of mothers whose babies are 18-19 months not at risk and less than five percent of mothers still insusceptible 24-25 months after delivery.

2.6 DIFFERENTIALS IN BREASTFEEDING AND POSTPARTUM INSUSCEPTIBILITY

Estimates of the median duration of breastfeeding, postpartum amenorrhoea and postpartum abstinence for various population subgroups are presented in Table 2.8. For each subgroup, the estimates are based on current status information (i.e., cross-sectional data on the proportion of births whose mothers were found to be still breastfeeding, amenorrhoeic, etc.) similar to that presented in Table 2.7.

Table 2.8   Median Number of Months of Breastfeeding, Postpartum Amenorrhoea,
           Postpartum Abstinence, and Postpartum Insusceptibility, by
           Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Breast-feeding	Amenor-rhoea	Abstinence	Insuscep-tibility(1)	Number of Births
Age					
15-29	19,0	12,6	4,3	14,0	1 226
30-49	20,0	12,6	4,5	13,0	776
Urban-Rural Residence					
Urban	17,3	9,6	3,7	10,3	517
Rural	20,1	13,4	4,7	14,2	1 485
Level of Education					
No Education	21,6	13,9	5,4	14,4	355
Primary	19,6	12,6	4,3	13,5	1 216
Secondary or Higher	16,9	11,8	4,0	13,2	431
Total	19,3	12,6	4,3	13,6	2 002

Note: The median number of months is based on the current status distribution
      for each subgroup like that presented in Table 2.7 for the
      population as a whole.
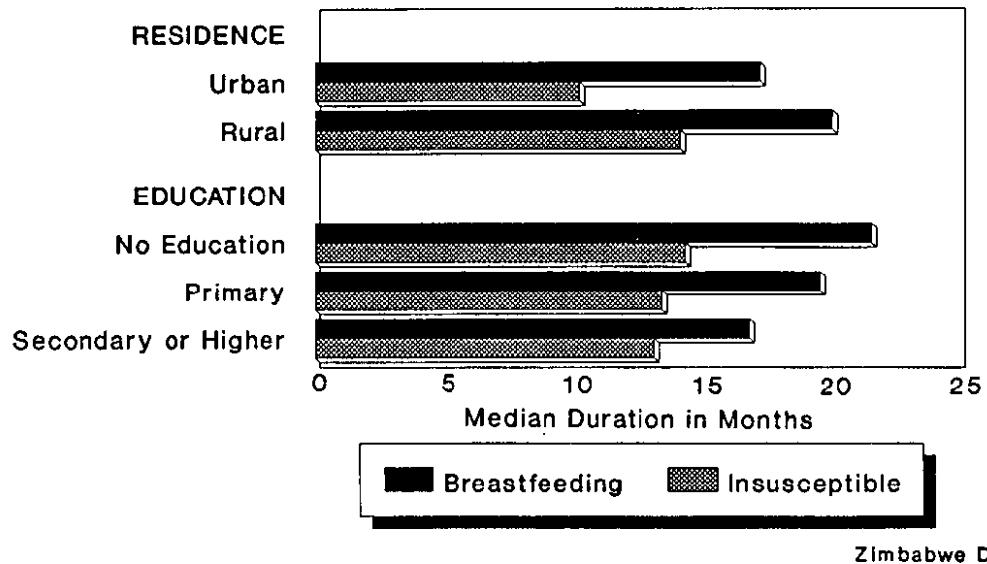
(1) Amenorrhoeic, abstaining or both

The results in Table 2.8 again highlight the long average duration of breastfeeding in Zimbabwe. The median duration of breastfeeding is more than 19 months, and, as a result, the average mother is insusceptible to the risk of pregnancy for more than 13 months following delivery. The long period of insusceptibility is largely due to the extended period of amenorrhoea following birth. The median duration of postpartum amenorrhoea (12,6 months) is almost three times the median duration of postpartum abstinence (4,3 months).

The median duration of breastfeeding is only one month shorter among births to younger mothers than among births to mothers age 30 and over (Figure 2.2). This is encouraging since a substantial decrease in the duration of breastfeeding among women under 30--which is commonly found as developing countries modernize--would increase the risk of unplanned pregnancies and shorter birth intervals among women in the key childbearing ages. Of more concern is the evidence that urban residence is associated with shorter median durations of breastfeeding and the other postpartum-related variables. The median duration of breastfeeding is nearly three months longer for rural births than urban births (20,1 vs. 17,3 months). The longer rural breastfeeding duration is associated with longer periods of both postpartum amenorrhoea and abstinence. As a result, the median duration of insusceptibility to pregnancy is nearly four months longer for rural than urban births (14,2 vs. 10,3 months).

Breastfeeding duration is negatively associated with educational attainment of the mother, with the median duration for women with secondary education being five months shorter than that for women with no formal education. Differences in the median durations of postpartum amenorrhoea and postpartum abstinence across education categories are much smaller. As a result,

Figure 2.2
Duration of Breastfeeding and Postpartum
Insusceptibility by Urban-Rural
Residence and Level of Education

Zimbabwe DHS 1988

the average mother with a secondary education becomes susceptible to the risk of pregnancy only about one month earlier than the average mother with no formal education.

The patterns in Table 2.8 suggest that, currently in Zimbabwe, it is urban residence more than increasing educational attainment which is leading to behavior changes that significantly reduce the length of time a woman is insusceptible to the risk of pregnancy following a birth. The average duration of breastfeeding for urban births is, in fact, slightly longer than the median breastfeeding duration for births to mothers with a secondary education (17,3 months vs. 16,9 months). The median duration of postpartum amenorrhoea for mothers with secondary education is considerably longer than for urban mothers (11,8 months vs. 9,6 months). A tendency on the part of urban mothers, regardless of their educational level, to supplement earlier (and more oftener) than other mothers would help to explain this pattern. In order to maintain the comparatively long duration of postpartum insusceptibility among Zimbabwean women, it will be important to encourage all mothers--but particularly those in urban areas--to continue the traditional practice of extended breastfeeding.

Chapter 3

FERTILITY

In this chapter, childbearing information collected in the ZDHS is used to examine a number of topics, including past and present fertility levels and trends and the age at which women initiate childbearing. Attempts to arrive at reasonable fertility estimates within the scope of the ZDHS are important in view of the limited availability of reliable data on this topic for Zimbabwe.

3.1 FERTILITY LEVELS, DIFFERENTIALS AND TRENDS

The fertility data from the ZDHS are based on responses to a series of questions designed to obtain information on the number and timing of births. All respondents were first asked about the total number of live births and surviving children. In addition, a full birth history was collected from each woman, including the name, sex, and date (month and year) of each live birth; the age at death for children who died; and whether or not living children were residing with their mother. Finally, as an indicator of future fertility, all women were asked if they were currently pregnant.

Estimation of fertility levels from birth history can be affected by underreporting of the number of children ever born, while errors in the reporting of dates of birth can distort trends in fertility over time. In the ZDHS data, there exists the possibility of some underreporting of children, especially those who die immediately after birth. According to cultural practice, the death of such children should be ignored by the community at large and, in rural areas, children who die in early infancy are often buried without a funeral ceremony in unmarked graves. With regard to the reporting of birth dates, although the accuracy of the dates reported by the mother cannot be fully assessed in this report, one indicator of the quality of the information is the completeness of the dates; in the ZDHS, both the month and year of birth were obtained for 99 percent of the children. In considering the ZDHS fertility data, it is also important to note that errors due to omission of births or the misreporting of birth dates are likely to be less serious for time periods close to the survey date, which are the main focus in the analysis of the levels, trends and differentials in fertility presented in this chapter.

Current and Cumulative Fertility

Table 3.1 presents data on current and cumulative fertility patterns in Zimbabwe. The total fertility rate (TFR), which is a measure of current fertility, represents the average number of births a woman would have at the end of her reproductive life if she gave birth according to the age-specific fertility rates prevailing during a given period. The first two columns of Table 3.1 show total fertility rates for women 15-44 for two calendar periods, 1985-1988 and 1982-1984, while the third column shows the total fertility rates for the five-year period before the survey. The final column in Table 3.1 presents the mean number of children ever born (CEB) among women 40-49. The latter indicator, which is a measure of cumulative fertility, is the product of the past childbearing behavior of these women who are nearing the end of their reproductive lives. The current trend in fertility in Zimbabwe can be assessed by comparing the TFRs for the two calendar

Table 3.1 Total Fertility Rate for the Calendar-Year Periods
1985-1988 and 1982-1984 and for the Period 0-4 Years
Before the Survey and Mean Number of Children Ever
Born to Women 40-49 Years of Age, by Selected
Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Total Fertility Rates (a)			Mean Number of Children Ever Born to Women Age 40-49
	1985-1988(b)	1982-1984	0-4 Years Before Survey	
Urban-Rural Residence				
Urban	3,86	5,33	4,13	5,20
Rural	6,06	7,28	6,23	7,15
Level of Education				
No Education	6,74	8,02	6,97	6,73
Primary	5,70	7,09	5,96	6,86
Secondary or Higher	3,68	4,63	3,84	4,50
Total	5,31	6,66	5,53	6,62

(a) Based on births to women 15-44 years
(b) Includes period up to the survey date
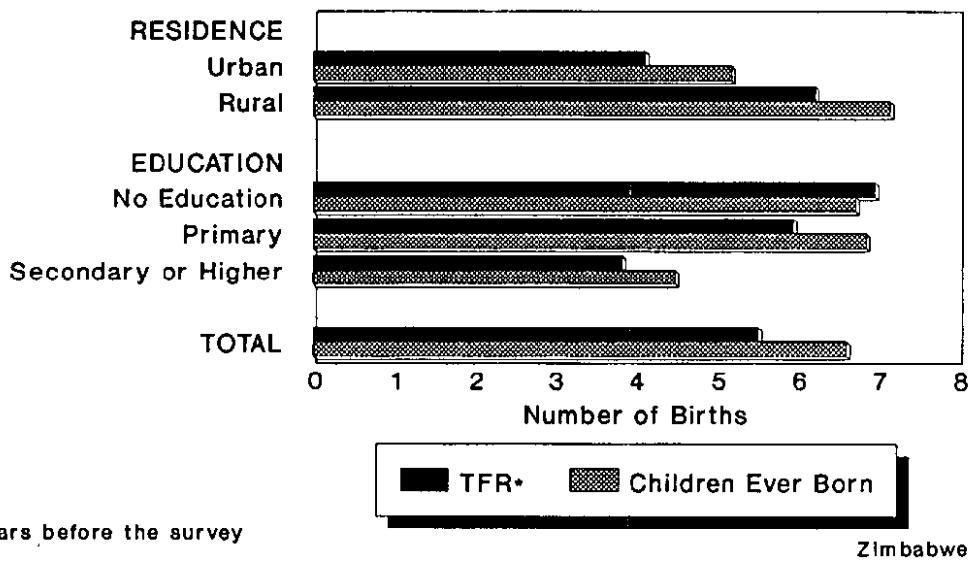
periods, while a comparison of the total fertility rate with the measure of completed family size provides a rough indication of the longterm trend in fertility levels.

The total fertility rate for the five-year period preceding the ZDHS is 5,5 births per woman. A comparison of that rate with the mean number of children ever born per woman (6,6) suggests that fertility is declining. Much of that decline appears to be recent; the total fertility rate estimated for the period 1985-1988 (5,3 births per woman) is 21 percent lower than the rate of 6,7 births for the period 1982-1984.

All of the fertility indicators in Table 3.1 point to higher rural than urban fertility. The TFR for the five-year period before the survey is 6,2 for rural women, two children higher than the urban rate. A similar differential is observed in the children ever born figures, although the level is one child higher in both groups, suggesting that fertility levels have been declining in both urban and rural areas (Figure 3.1). The apparent decline in fertility in both urban and rural areas suggested by a comparison of the mean children ever born with the five-year TFR is also observed in the rates for the two recent calendar periods. Fertility levels have declined sharply in both urban and rural areas, with the pace of the decline being somewhat faster in the urban areas.

Differentials in the fertility indicators across educational status groups are even more striking than the urban-rural differentials. Looking at the TFRs for the five-year period before the survey, the rate among women who never attended school (7,0) is one birth higher than the rate for women with primary education (6,0) and three births higher than that for women with a secondary education (3,8). In contrast, there is almost no difference in the mean number of children ever born between the two lowest education groups, and the difference in the mean number between women who never attended school and women with some secondary education

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**Figure 3.1
Cumulative Fertility (CEB) and Current
Fertility (TFR) by Urban-Rural Residence
and Level of Education**

RESIDENCE
Urban
Rural

EDUCATION
No Education
Primary
Secondary or Higher

TOTAL

Number of Births

■ TFR•   ▨ Children Ever Born

• 0-4 years before the survey

Zimbabwe DHS 1988

is only slightly more than two children. This suggests that the fertility decline in Zimbabwe began with women who had at least some secondary education and only recently spread to women with less education. The current downward trend in fertility appears to be shared fairly equally by all educational groups, with the relative decrease in the TFR between the 1982-1984 and 1985-1988 periods being only slightly smaller for women with no education (16 percent) as compared to the other groups (20 percent).

For many societies, the decline in fertility levels that accompanies mass schooling is not a direct consequence of a deliberate policy. Although it is difficult to predict with any certainty, further declines in fertility may be expected in the future in Zimbabwe as a consequence of the policy of improving educational opportunities for women. The governmental policy of universal primary education is likely to mean increasing participation of women in the educational system, which by lengthening the time spent in school, will lead to delayed marriage. Improved educational opportunities will also lead to increased employment opportunities for women in the productive sectors of the economy, again delaying marriage.

Fertility Trends

The fertility data presented in Table 3.1, which focus on current fertility levels, indicate that there has been a sharp decline in fertility recently in Zimbabwe. The birth history information in the ZDHS allows for a more extensive examination of the trend in fertility over a longer time period. Using the birth history data, Table 3.2 shows age-specific fertility rates for successive five-year periods preceding the survey. To compute the numerator for these rates, births were classified by the segment of time preceding the survey (e.g., 0-4 years, 5-9 years, etc.) and by the age of the mother at the time of the birth. The denominator is the number of women-years lived in the spec-

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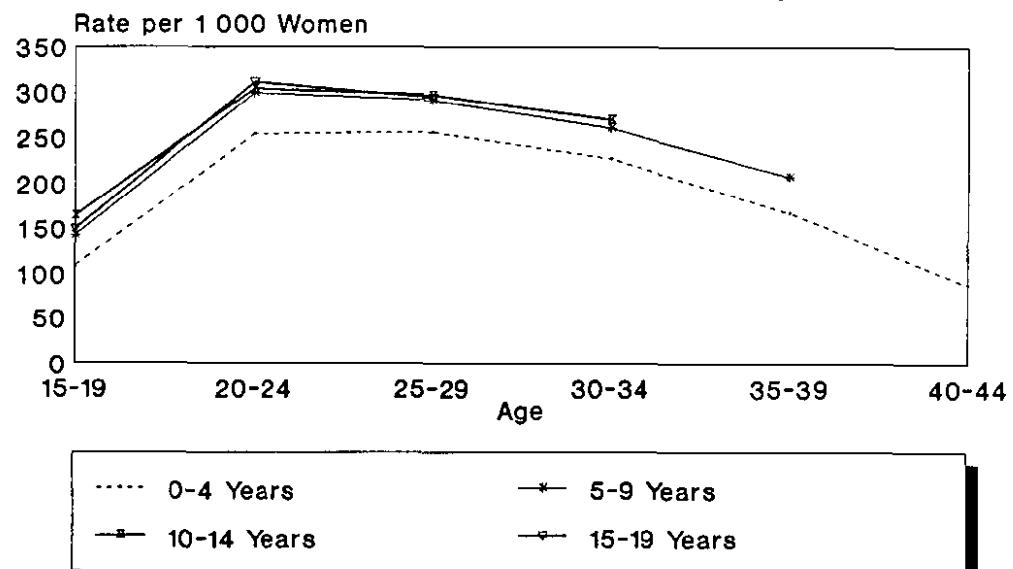
Table 3.2 Age-Period Fertility Rates (per 1 000 Women) for Five-Year
Periods Preceding the Survey by Age of Woman at Birth, and
Cumulative Fertility (per Woman 15-34), Zimbabwe DHS, 1988

Maternal Age	Number of Years Preceding Survey						
	0-4	5-9	10-14	15-19	20-24	25-29	30-34
15-19	109	143	165	150	153	178	(132)
20-24	255	300	305	312	305	(279)	--
25-29	257	293	298	295	(291)	--	--
30-34	228	261	270	(236)	--	--	--
35-39	168	208	(195)	--	--	--	--
40-44	88	(125)	--	--	--	--	--
45-49	(34)	--	--	--	--	--	--
Cumulative Fertility Ages 15-34	4,2	5,0	5,2	5,0	--	--	--

Note: Figures in parentheses are based on partially truncated
      information.

-- Not calculated due to age truncation

Figure 3.2
Age-Period Fertility Rates for Five-Year
Periods Preceding the Survey

Rate per 1 000 Women

Legend:
···· 0-4 Years
—*— 5-9 Years
—■— 10-14 Years
—▽— 15-19 Years

Zimbabwe DHS 1988

ified five-year age interval for each time segment. There is one obvious drawback in using these data for examining fertility trends; because women age 50 years and older who were bearing children during the time periods in question were not included in the survey, the rates for the older age groups in Table 3.2 become progressively more truncated further back in time. For example, rates cannot be calculated for the 45-49 age group for the period 5-9 years before the survey, because women who would have been 45-49 at that time were 50-54 at the time of the ZDHS and, consequently, not interviewed in the survey. Partially truncated rates are shown in parentheses.

Looking at the age-period fertility rates in Table 3.2, it appears that fertility has been fairly stable over a 25-year period before the survey, decreasing only recently. The age-specific rates, which are depicted graphically in Figure 3.1, are remarkably similar, with a decline evident only in the most recent period. The highest rates are consistently observed for the 20-24 and 25-29 age groups.

Another indicator of the essential stability in past fertility is the fact that the cumulative fertility rate for women 15-34 years varies only slightly, increasing from an average of 5,0 births per woman 15-34 in the period 15-19 years before the survey to 5,2 births in the period 10-14 years, before decreasing to 5,0 births in the period 5-9 years before the survey (Table 3.2). A significant decline in the fertility for this group is observed only in the most recent period, when the rate dropped to 4,2 births per woman. All age-groups appear to be contributing to the recent decline, although the decreases are proportionately greater for the youngest and oldest age groups (Figure 3.2).

Table 3.2 relies on information collected in the ZDHS itself to examine trends in fertility over time. Another approach to looking at trends is to compare the ZDHS rates with those from other sources, including the 1969 Census, the 1982 Census ten-percent sample, the 1984 Zimbabwe Reproductive Health Survey and the 1987 Intercensal Demographic Survey. Table 3.3 presents the

Table 3.3 Age-Specific Fertility Rates (per 1 000 Women) and Total Fertility Rates, Zimbabwe, 1969-1988

Age	Census 1969	Census 1982	ZRHS 1984	ZDHS 1982-1984	ICDS 1987	ZDHS 1985-1988
15-19	79	91	131	129	69	103
20-24	272	258	289	299	213	247
25-29	304	253	299	307	240	247
30-34	257	225	263	273	214	219
35-39	218	165	220	214	168	160
40-44	145	93	92	111	84	86
45-49	73	38	11	-	41	36
TFR, 15-44	6,4	5,4	6,5	6,7	4,9	5,3
TFR, 15-49	6,7	5,6	6,5	6,7	5,1	5,5

Source: Central Statistical Office, 1985; Johansson, 1989;
and Zimbabwe National Family Planning Council, 1985

age-specific and total fertility rates for all of these data sources. It is important to bear in mind, that except for the ZDHS, in which a birth history was collected, the rates from the various sources are based on questions concerning the timing of the last live birth. The census results also are generally more subject to omission of births or misreporting of birth dates than are surveys in which women of childbearing age are interviewed directly.

The fertility estimates from the various data sources indicate that Zimbabwe has been experiencing high and comparatively stable fertility levels, which have only fairly recently shown a decline. However, in view of the different methodologies used to collect data in the censuses and the surveys, it would be unwise to draw any definite conclusion regarding fertility trends, until the estimates from the various data sources are further evaluated. What is certain is that, unless the apparent recent fertility decline continues, a Zimbabwean woman beginning her childbearing years in 1990 will have an average of five children by the time she reaches her fiftieth birthday in 2025.

3.2 CURRENT PREGNANCY

Another indicator of current fertility is the proportion of women who are currently pregnant. One in eleven women interviewed in the ZDHS reported that she was pregnant at the time of the survey. This figure likely underestimates somewhat the actual proportion pregnant since some women in the early stages of pregnancy may be unaware or uncertain about their status. As shown in Table 3.4, the variation in the proportion pregnant by age follows a pattern similar to that of current fertility. The age group with the highest proportion currently pregnant is the 25-29 cohort (13 percent) while the 20-24 cohort has the second highest rate (12 percent); half of all currently pregnant women are found in these two groups.

Table 3.4 Percent of Women Who Were Pregnant the Time of the Survey by Age, Zimbabwe DHS, 1988

Age	Percent Pregnant	Number of Women
15-19	5,7	1 021
20-24	12,1	840
25-29	12,8	679
30-34	10,7	589
35-39	10,8	464
40-44	4,4	318
45-49	0,3	290
Total	8,9	4 201

3.3 CHILDREN EVER BORN

Data on the number of children ever born to the women interviewed in the ZDHS are presented in Table 3.5 for all women and currently married women. These data reflect the cumulative outcome of the childbearing experience of women over their entire reproductive lives up to the point of interview. The results indicate that women 15-49 have had an average of 3,0 live births. The mean number of children ever born is somewhat lower than the means reported in the 1969 and 1982 censuses (3,5 and 3,1 births, respectively), again suggesting that fertility has been declining.

As expected, since fertility levels have been high in the past, the number of children ever born increases rapidly with age. Women in their early twenties have had, on average, more than one birth. This increases to almost three children among women in their late twenties and to more than five children among women in their late thirties. Women 45-49 who are at the end of their childbearing years have had an average of almost seven births. The proportion who have never

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Table 3.5 Percent Distribution of All Women and Currently Married Women By Number of Children Ever Born and Mean Number of Children Ever Born, According to Age, Zimbabwe DHS, 1988

Age	None	1	2	3	4	5	6	7	8	9	10 or More	Total Percent	Number of Women	Mean
						Number of Children Ever Born								

All Women

Age	None	1	2	3	4	5	6	7	8	9	10 or More	Total Percent	Number of Women	Mean
15-19	83,7	13,8	2,4	0,1	0,0	0,0	0,0	0,0	0,0	0,0	0,0	100,0	1 021	0,2
20-24	28,8	33,8	21,7	11,2	3,7	0,7	0,0	0,1	0,0	0,0	0,0	100,0	840	1,3
25-29	7,2	12,2	21,2	23,7	20,8	9,9	4,1	0,7	0,0	0,1	0,0	100,0	679	2,9
30-34	3,7	4,9	10,4	13,6	20,9	18,3	13,8	8,0	4,1	1,7	0,7	100,0	589	4,3
35-39	2,2	3,0	6,5	9,5	10,6	15,3	18,1	15,3	8,4	6,7	4,5	100,0	464	5,5
40-44	2,5	5,0	5,0	6,3	10,4	8,5	9,4	10,4	15,1	11,6	15,7	100,0	318	6,4
45-49	3,4	3,4	5,5	4,8	7,6	8,6	11,4	9,7	10,7	11,0	23,8	100,0	290	6,9
Total	28,5	13,7	11,3	9,9	9,5	7,2	6,1	4,4	3,4	2,6	3,4	100,0	4 201	3,0

Currently Married Women

Age	None	1	2	3	4	5	6	7	8	9	10 or More	Total Percent	Number of Women	Mean
15-19	40,0	49,4	10,0	0,6	0,0	0,0	0,0	0,0	0,0	0,0	0,0	100,0	180	0,7
20-24	9,7	38,0	29,4	16,6	5,3	0,8	0,0	0,2	0,0	0,0	0,0	100,0	513	1,7
25-29	3,2	9,1	21,3	27,0	22,5	11,1	4,8	0,7	0,0	0,2	0,0	100,0	559	3,1
30-34	2,4	2,0	9,7	13,3	21,1	20,3	14,5	9,1	4,8	2,0	0,8	100,0	503	4,6
35-39	1,2	3,0	5,2	7,9	10,4	15,9	18,9	16,1	8,9	7,4	5,0	100,0	403	5,7
40-44	1,6	4,7	2,8	4,7	9,9	7,5	9,5	11,1	16,2	14,2	17,8	100,0	253	6,8
45-49	2,2	2,6	4,7	3,4	6,9	6,5	12,9	10,3	12,5	12,1	25,9	100,0	232	7,3
Total	6,3	14,2	14,2	13,5	12,9	10,1	8,7	6,4	4,9	4,0	4,9	100,0	2 643	4,1

had a child declines rapidly with age to 3 percent among women 45-49. This is within the expected 3-5 percent range and suggests that primary sterility is not a major problem for Zimbabwean women.

One important goal of family planning programmes is to prevent infant and maternal deaths by assisting women to avoid high risk pregnancies. Evidence suggests that pregnancies among women who have already had five or more births are associated with increased mortality and morbidity for both the mother and the child. The results in Table 3.5 show that many Zimbabwean women, particularly those in the older age groups, are in this high parity risk category. Overall, more than one in four Zimbabwean women has had five or more births. By age, the proportion with five or more births increases from less than 10 percent among women under 30 to almost 50 percent in the 30-34 group. Among women age 35 and over, who already are at greater pregnancy risk because of their age, the proportion in the high parity risk group increases from nearly 70 percent in the 35-39 cohort to almost 75 percent among women 45-49.

Many of these high parity women will go on to have additional births. According to current fertility patterns, women in the 30-34 cohort will have an average of two additional births before they complete childbearing, and women currently 35-39 may be expected to have, on average, one additional birth before reaching age 50. As discussed earlier, the recent fertility declines in age-

specific fertility rates have been greatest among women in the older age cohorts. Continuing fertility decline, which will limit births to older high parity women, will be an important factor in reducing health risks for both high parity women and their children.

3.4   CHILDREN EVER BORN AND AGE AT FIRST MARRIAGE

Table 3.6 shows the mean number of children ever born to ever-married women, controlling for age at first marriage and marital duration. The table permits an assessment of the relationship between age at marriage and the level of marital childbearing. The expectation is that women who marry early will bear more children since they will have more years of exposure to the risk of pregnancy than women who marry later. The population as a whole exhibits the expected pattern; the mean number of children ever born decreases from 5,2 among women who married for the first time before age 15 to 3,6 among women married at age 25 and above. To some extent this pattern is due to the fact that women marrying at young ages tend to be older, and, thus, have had more time to have children; the mean number of children ever born is directly associated with the duration of marriage, ranging from one child among women married less than five years to 7,5 children among women married 30 or more years.

The results in Table 3.6 suggest that, once the effect of marriage duration is taken into account, age at marriage has no clear effect on the level of marital fertility. At shorter marriage durations, the mean number of children ever born generally increases with increasing age at first marriage. This pattern may reflect a higher level of premarital births among late-marrying women or shorter birth intervals among these women. At longer marriage durations, the pattern becomes more erratic, although there is some suggestion that women marrying later have fewer births.

Table 3.6   Mean Number of Children Ever Born to Ever-married Women, by Age at First Marriage and Years Since First Marriage, Zimbabwe DHS, 1988

Years Since First Marriage	Age at First Marriage						
	Under 15	15-17	18-19	20-21	22-24	25 or More	Total
0-4	0,9	1,0	1,1	1,1	1,3	1,9	1,1
5-9	2,5	2,7	2,7	2,7	2,6	3,5	2,7
10-14	4,0	3,9	4,1	4,1	4,0	4,9	4,1
15-19	5,7	5,6	5,4	5,4	5,6	4,0	5,4
20-24	6,4	6,6	6,3	6,5	5,5	5,9	6,3
25-29	6,7	7,6	7,2	5,9	5,7	-	7,0
30 or More	7,7	7,3	7,4	-	-	-	7,5
Total	5,2	4,2	3,8	3,5	3,2	3,6	4,0

3.5 AGE AT FIRST BIRTH

Table 3.7 shows the percent distribution of women according to the age at first birth. As with the data on age at first marriage, the data on age at first birth are affected by censoring, i.e., they are available only for women who have already given birth. Since childless women in any age group will give birth at later ages, on average, than those who already have had a child, the information on age at first birth for those who have already given birth yields a downwardly biased picture of the average age at first birth for the group. The effect of censoring is greatest in the youngest age groups where a significant proportion of women have never had a birth. In describing trends and differentials in the age at first birth, the median is preferred to the mean because it is not affected by censoring.

In addition to the problems of censoring, the data on age at first birth depend on accurate reporting of both the woman's birth date and the date of birth of the first child. Any misreporting of dates or underreporting of first births who later die will affect the results. Such errors are likely to be greatest in the case of births to older women. Finally, it is important to remember that the age at first birth is not necessarily the age at first pregnancy.

Overall, somewhat more than one-quarter of women 15-49 have never given birth, with almost all of these women in the 15-24 age group. Nearly one-half had their first child before age 20, and one in four was under age 18 when she gave birth for the first time. Looking at the variation in the median age at first birth with the woman's current age, no clear trend is discernible. This may be the result of more frequent errors in the reporting of dates of birth among older women.

Table 3.7 Percent Distribution of Women by Age at First Birth and Median Age at First Birth, According to Current Age, Zimbabwe DHS, 1988

| Current Age | No Births | Age at First Birth | | | | | | Total Percent | Number of Women | Median Age at First Birth |
		Under 15	15-17	18-19	20-21	22-24	25 or More			
15-19	83,7	2,3	9,2	4,8	0,0	0,0	0,0	100,0	1 021	--
20-24	28,8	4,5	20,4	24,0	15,6	6,7	0,0	100,0	840	--
25-29	7,2	4,9	24,7	28,7	20,2	12,4	1,9	100,0	679	19,5
30-34	3,7	6,3	26,5	26,5	19,2	12,1	5,8	100,0	589	19,4
35-39	2,2	8,2	17,5	27,2	20,0	16,2	8,8	100,0	464	19,8
40-44	2,5	11,6	27,7	17,6	17,3	13,5	9,7	100,0	318	19,2
45-49	3,4	11,4	22,4	20,0	15,2	14,8	12,8	100,0	290	19,7
Total	28,5	5,7	19,6	20,0	13,6	8,9	3,7	100,0	4 201	--

Note: Median age is defined as the age at which 50 percent of the women have had a birth.

-- Omitted due to censoring

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Table 3.8   Median Age at First Birth Among Women 25-49 by Current Age,
            According to Selected Background Characteristics,
            Zimbabwe DHS, 1988
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Background Characteristic	Current Age					
	25-29	30-34	35-39	40-44	45-49	Total
Urban-Rural Residence						
Urban	19,8	19,6	19,7	19,4	21,2	19,8
Rural	19,3	19,2	19,9	19,2	19,3	19,4
Level of Education						
No Education	18,4	18,4	19,7	18,0	19,7	18,9
Primary	19,3	19,3	19,7	19,1	19,4	19,4
Secondary or Higher	21,2	20,5	21,2	21,4	23,0*	21,2
Total	19,5	19,4	19,8	19,2	19,7	19,5

```
Note:  Median age is defined as the age at which 50 percent of the
       women have had a birth.

*  Median based on fewer than 25 cases
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Table 3.8 presents the median age at first birth for various subgroups. Because of the problem of censoring, the medians are shown only for women 25-49. Among all women 25-49, the median age at first birth is 19,5 years. The differential in median age at first birth between rural and urban areas is small (19,4 vs. 19,8). Greater differences in the median age at first birth are observed when educational level is controlled. The median age at first birth is 21,2 years for women with secondary or higher education compared with 19,4 years for women with primary education and 18,9 years for women with no education. As in the population as a whole, there is no discernible trend by age in the median age at first birth for any of the subgroups.

3.6   TEENAGE PREGNANCY

The problems associated with teenage pregnancy are well-documented. Children born to very young mothers are less likely to survive following birth, and the mothers themselves are subject to much greater risks of illness and death associated with pregnancy than older mothers. As the last chapter showed, early marriage (and childbearing) are also associated with limited educational attainment for the mother.

The ZDHS findings indicate that, largely due to the patterns of early marriage, teenage pregnancy has been the norm in the past, and it continues to be the pattern among young women. For example, the results in Table 3.7 for women 20-24 provide a picture of the extent of childbearing among teenagers in the early 1980s. Around one-half of these women gave birth before age 20, and one in four was under 18 years of age.

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Table 3.9 Percent of Women 15-19 Who Are Mothers
           or Pregnant with Their First Child
           by Selected Background Characteristics,
           Zimbabwe DHS, 1988

| | Percent Who Are: | | Number |
Background Characteristic	Mothers	Pregnant with First Child	of Women 15-19
Age			
15	3,1	1,3	229
16	6,7	3,1	195
17	14,4	4,4	180
18	19,5	10,2	215
19	38,6	3,0	202
Marital Status			
Never-married	4,6	1,3	819
Ever-married	63,7	16,8	202
Urban-Rural Residence			
Urban	10,2	4,3	323
Rural	19,1	4,4	698
Level of Education			
No Education	38,5	3,8	26
Primary	18,3	4,5	487
Secondary or Higher	13,2	4,3	508
Total	16,3	4,4	1 021

Figure 3.3
Percent of Women 15-19 Who are Mothers
or Pregnant with First Child

Zimbabwe DHS 1988

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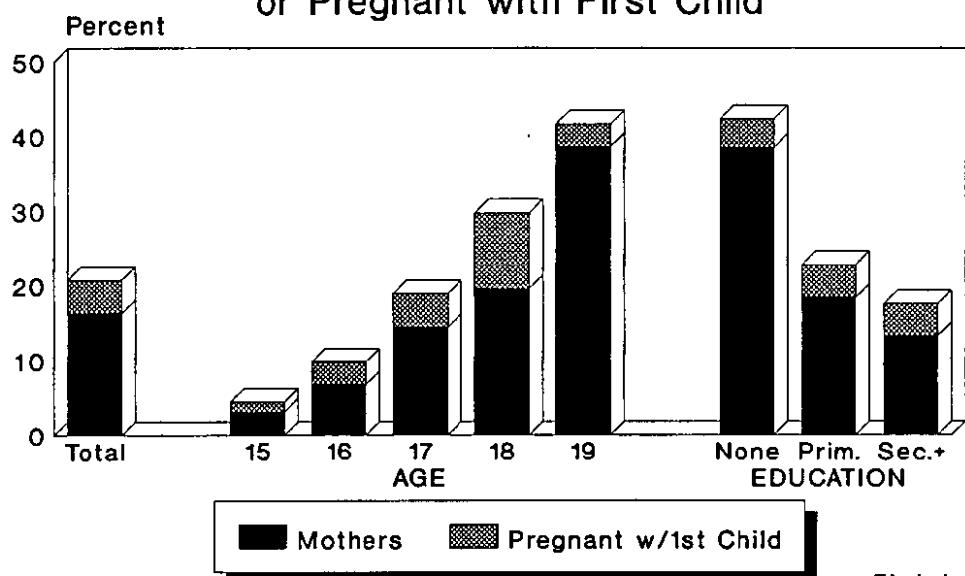
Table 3.9 looks at patterns of pregnancy and childbearing among women currently in the teenage years. Since some teenagers who have not yet given birth will go on to have a child before their 20th birthday, these data do not represent the complete childbearing experience of today's teenagers. As a result, they cannot be compared with information from women 20-24, all of whom have completed the teenage period. The information is important, however, because it highlights the substantial numbers of teenagers who have already had a birth or are pregnant with their first child.

Table 3.9 shows that 16 percent of teens are already mothers and 4 percent are pregnant with their first child. Among those under 18, for whom early childbearing presents the greatest risk, 10 percent are currently pregnant with or have had their first child. Most teenage mothers have married, but around one in 20 unmarried teens has had a child or is currently pregnant with her first birth. One in four rural teenagers is pregnant or already a mother compared with one in seven urban teens. The small number of teenagers who have never attended formal school are twice as likely as to be mothers as teenagers with some schooling (Figure 3.3). Among teens with some formal schooling, the proportion who have a child is somewhat higher for those with only primary education (18 percent) compared with those with secondary education (13 percent). The proportion currently pregnant with the first child varies little with educational level.

Chapter 4

FERTILITY REGULATION

This chapter focuses on issues relating to the use of contraception. Knowledge of contraceptive methods and service providers, a necessary precursor to use, is reviewed first. Obstacles to use, including perceived problems in using methods and husband's disapproval, are discussed. Information on other factors which may facilitate use, including discussion of family planning by the couple and exposure to information about family planning through the media is provided. Attention then turns to the levels, trends, and differentials in contraceptive use in Zimbabwe. Finally, consideration is given to reasons for nonuse and intention to use in the future.

4.1 KNOWLEDGE OF CONTRACEPTIVE METHODS AND PROVIDERS

Levels, Trends and Differentials

Knowledge of family planning methods and service providers are preconditions to use. In the ZDHS, data on knowledge of family planning methods were obtained by first asking respondents to name the ways a couple can use to delay or avoid a pregnancy or birth. If a respondent did not spontaneously mention a particular method, the method was described by the interviewer and the respondent was asked if she recognised it. Descriptions were included in the questionnaire for eight modern methods (pill, IUD, injection, diaphragm, condom, female sterilisation, male sterilisation and foam/jelly/foaming tablets) and two traditional methods (periodic abstinence (safe period) and withdrawal). In addition, other folk or traditional methods mentioned by the respondents were recorded. Finally, for all modern methods that the woman recognised, she was also asked where she would go to obtain the method if she wanted to use it. If the respondent recognised periodic abstinence, she was asked where she would go to obtain advice about the method.

As Table 4.1 indicates, knowledge of at least one modern method of family planning is practically universal, with 96 percent of all women and 99 percent of currently married women reporting that they have heard about at least one method. Among all women, the most widely known modern method is the pill (94 percent), followed by the condom (77 percent), injection (62 percent), the IUD (52 percent), and female sterilisation (50 percent). Other modern methods (diaphragm, foam/jelly/foaming tablets and male sterilisation) were recognised by less than one-fifth of the women. In addition to the widespread knowledge of modern methods, three in four Zimbabwean women are familiar with at least one traditional method. The most widely known traditional method is withdrawal (63 percent).

Comparing knowledge levels in the ZDHS with those reported in the 1984 Zimbabwe Reproductive Health Survey, there is increased recognition of all methods except vaginal methods and injection. The small decrease in the proportion of all women knowing about injection probably reflects the fact that injection has not been widely available since restrictions were placed on its use in the early 1980s. Some of the gains in method recognition may be attributed to differences

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Table 4.1 Percent of All Women and Currently Married Women Who Know a Contraceptive Method and Who Know a Source For Contraceptive Information or Services Zimbabwe DHS, 1988 and Percent of All Women Who Know a Contraceptive Method, Zimbabwe RHS, 1984, by Specific Method

Contraceptive Method	1988 ZDHS				1984 ZRHS
	Know Method		Know Source		Know Method
	All Women	Currently Married Women	All Women	Currently Married Women	All Women
Any Method	96,3	98,7	93,0	96,5	82,8
Any Modern Method	95,4	97,8	92,1	96,0	NA
Pill	93,6	97,0	89,4	94,6	80,5
IUD	51,6	59,1	45,0	52,6	40,2
Injection	62,2	72,4	56,5	66,2	67,6
Diaphragm	14,0	14,5	11,5	12,4	NA
Foam/Jelly/Foaming Tablets	13,5	14,9	12,3	13,6	17.4(a)
Condom	76,7	80,3	66,0	72,5	48,3
Female Sterilisation	49,7	54,6	46,3	51,3	40,0
Male Sterilisation	16,4	17,6	14,5	15,5	10,8
Any Traditional Method	75,3	86,8	47,6	51,8	NA
Periodic Abstinence	28,1	27,2	25,2	24,5	20,4
Withdrawal	63,4	79,2	-	-	56,1
Other(1)	34,2	40,6	31,9	37,8	NA
Number of Women	4 201	2 643	4 201	2 643	2 574

Source: Zimbabwe Reproductive Health Survey, unpublished data.
NA = Not available

(1) Includes herbs and other folk methods
(a) Includes diaphragm as well as foam/jelly/foaming tablets

in the way in which the data were collected in the two surveys.[1] However, the substantial increase in the proportion of women knowing about the condom is likely owed to the publicity given to the condom as one of the principal ways of preventing the transmission of the AIDS virus (See Chapter 7 for a discussion of AIDS awareness among ZDHS respondents).

Awareness of a source where modern contraception can be obtained also appears to have improved since 1984 when only seven in ten women knew a place where they could obtain contraceptive services (Zimbabwe National Family Planning Council and Westinghouse Public Applied Systems, 1985, Table 6.6). Currently, more than 90 percent of all women are able to name a source where family planning services or information are available. Considering specific methods,

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[1] In both surveys, women were first asked to name all of the family planning methods that they knew. Interviewers then probed to find out whether women recognized methods which they had not spontaneously mentioned. In the ZRHS, interviewers used only the name of the method when probing while, in the ZDHS, both the name of the method and a brief description were used.

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Table 4.2    Percent of Currently Married Women Who
             Know at Least One Modern Contraceptive
             Method and Who Know a Source for a
             Modern Contraceptive Method by Selected
             Background Characteristics, Zimbabwe
             DHS, 1988
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Background Characteristic	Know Modern Method	Know Source	Number of Women
Age			
15-19	96,7	89,4	180
20-24	98,4	97,3	513
25-29	98,4	97,1	559
30-34	99,0	97,8	503
35-39	97,8	97,0	403
40-44	94,5	92,1	253
45-49	97,0	93,5	232
Urban-Rural Residence			
Urban	98,8	97,9	779
Rural	97,4	95,1	1 864
Place of Residence			
Manicaland	97,7	94,3	352
Mashonaland Central	95,4	94,5	217
Mashonaland East(1)	98,2	96,8	341
Mashonaland West	98,8	95,8	336
Matabeleland North(2)	96,9	96,1	128
Matabeleland South	98,7	96,8	156
Midlands	97,2	95,5	398
Masvingo	96,8	94,9	312
Harare/Chitungwiza	99,0	97,5	204
Bulawayo	99,5	99,5	199
Level of Education			
No Education	94,1	90,2	489
Primary	98,4	96,9	1 601
Secondary or Higher	99,5	98,2	553
Total	97,8	96,0	2 643

```
(1) Excludes Harare/Chitungwiza
(2) Excludes Bulawayo
```

the gap between the proportion knowing the method and knowing a provider for the method exceeds five percentage points only in the case of the condom, IUD and injection (Table 4.1).

In view of the virtual universality of contraceptive knowledge among Zimbabwean women, it is not surprising that there is little variation across subgroups. In all subgroups shown in Table 4.2, over 90 percent of currently married women know a modern method, and almost as high a proportion can name a source for the method.

Perceived Providers

Table 4.3 shows the providers to which women knowing a specific contraceptive method say that they would go to obtain the method if they wanted to use it. It is important to note that these data are collected from both users and nonusers; information on the service providers from which users actually obtain their method is presented later in the chapter. The majority of women name government-sponsored clinical facilities run by the Zimbabwe National Family Planning Council (ZNFPC), the Ministry of Health (MOH) and local governments as providers they would use for both supply and clinic methods. The importance of the ZNFPC outreach programme is evident in the fact that its community-based distribution (CBD) workers are mentioned by more than one in four women as a source for pills and by nearly one in five women as a source for condoms. There is little perception of the private sector as a provider for most methods; only 2 percent of women knowing about the pill say they would obtain it from a private doctor or pharmacy, and fewer than one in seven mention private doctors or pharmacies as a source for any method except foam/jelly/foaming tablets.

Table 4.3   Percent Distribution of Women Who Know a Contraceptive Method by Source Where
            They Would Obtain Method if They Wanted to Use It, According to Specific Method,
            Zimbabwe DHS, 1988

Perceived Source	Pill	IUD	Injec-tion	Dia-phragm	Foam/ Jelly/ Foaming Tablets	Condom	Female Steril-isation	Male Steril-isation	Periodic Absti-nence
CBD(1)	26,7	2,2	1,2	4,6	4,2	19,5	0,1	0,1	6,6
ZNFPC Clinic	12,0	13,7	14,4	14,5	15,5	12,3	5,6	6,5	17,4
MOH Hospital/Clinic	19,2	40,7	39,3	31,5	24,2	19,0	65,8	59,4	9,6
Municipal/Local Clinic	15,2	9,4	10,4	5,1	9,9	13,3	2,5	1,6	5,6
Rural Council Clinic	16,7	5,4	9,5	6,8	5,7	12,1	2,2	1,6	6,8
Commerce/Industry	0,3	0,1	0,5	0,3	0,0	0,4	0,0	0,0	0,1
Mission/Church	2,0	4,9	5,0	4,1	2,7	1,7	7,7	4,4	1,4
School	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	2,8
Private Doctor/Pharmacy	1,8	9,3	8,0	14,1	27,6	5,3	8,3	13,8	6,9
Friends/Relatives	0,1	0,0	0,0	0,0	0,4	0,2	0,0	0,1	16,5
Traditional Healer	0,0	0,0	0,0	0,0	0,0	0,1	0,3	0,3	0,1
Other	1,5	1,2	1,5	1,5	0,9	2,1	0,6	0,7	10,3
Nowhere	0,0	0,1	0,9	0,0	0,0	0,1	0,1	0,0	5,4
Don't Know	4,4	12,7	9,1	17,2	8,8	13,5	6,5	11,2	9,3
Missing	0,1	0,2	0,0	0,3	0,2	0,4	0,1	0,1	1,3
Total	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Number of Women	3 931	2 169	2 612	588	3 566	222	2 086	688	1 182

CBD = ZNFPC community-based distribution worker

(1) Includes a few women who reported that they would obtain the method from a community-based
    worker other than the ZNFPC CBD

4.2 OTHER OBSTACLES TO FAMILY PLANNING USE

Perceived Problems in Using Methods

While lack of information about a specific contraceptive method or about a service provider offering the method are obvious barriers to use of the method, there are many other factors, including concerns about side effects or the effectiveness of the method, which can stand in the way of a woman adopting a particular method. To obtain information on other obstacles to use, women who have heard of a method were asked about the main problem (if any) with using the method. Among those women who have heard of a method, two-fifths say that there is no problem with withdrawal, and one-third feel that there are no problems in using the pill, injection, condom, foam/jelly/foaming tablets and periodic abstinence (Table 4.4). Roughly a quarter think there are no problems with the diaphragm and male and female sterilisation.

Health concerns were cited as the main problem for the pill (40 percent), the IUD (25 percent) and injection (19 percent). Health concerns also were mentioned as a problem for female sterilisation (15 percent), but the most frequently cited problem for this method, as well as for male sterilisation, was its irreversibility. Almost a third of the women were concerned with the permanent nature of sterilisation. The possibility that using injection might result in a woman's being unable to have children later was also perceived as a problem by some women (17 percent).

Ineffectiveness was the most commonly cited problem with periodic abstinence (30 percent) and withdrawal (19 percent). Husband disapproval was rarely perceived as problem, except for withdrawal (14 percent) and, to a lesser degree, the condom (7 percent), possibly due to the need for the husband's active involvement in the use of these methods. Periodic abstinence, withdrawal,

Table 4.4 Percent Distribution of Women Who Know a Contraceptive Method by Main Problem Perceived in Using the Method, According to Specific Method, Zimbabwe DHS, 1988

Main Problem	Pill	IUD	Injec-tion	Dia-phragm	Foam/ Jelly/ Foaming Tablets	Con-dom	Female Steril-isation	Male Steril-isation	Peri-odic Absti-nence	With-drawal
No Problem	30,6	19,6	30,1	26,2	31,3	35,2	25,0	25,1	30,7	42,5
Health Concerns	40,5	25,0	19,3	7,3	10,8	2,8	15,1	8,3	0,1	0,7
Method Permanent	3,5	1,1	16,7	0,2	1,4	0,5	31,3	29,4	0,4	0,5
Inconvenient to Use	3,0	8,8	2,9	8,7	13,8	10,2	1,7	2,3	19,1	10,4
Not Effective	2,5	6,3	1,0	6,0	9,7	9,6	0,4	1,0	29,9	19,3
Access/Availability	0,1	0,3	0,5	0,7	0,5	0,2	0,0	0,1	0,0	0,0
Costs Too Much	0,0	0,1	0,4	0,3	0,7	0,0	0,1	0,1	0,0	0,0
Husband Disapproves	0,6	0,6	0,7	0,7	2,3	7,2	1,3	1,7	2,5	14,2
Other	0,2	0,0	0,2	0,3	0,2	0,2	0,7	1,3	0,3	0,2
Don't Know	18,9	37,9	28,0	49,3	29,0	33,4	24,3	30,5	16,2	11,5
Missing	0,2	0,2	0,0	0,3	0,4	0,7	0,2	0,0	0,7	0,8
Total	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Number of Women	3 931	2 169	2 612	588	3566	3 222	2 086	688	1 182	2 665

foam/jelly/foaming tablets and condom were the methods mentioned most frequently as inconvenient to use. Cost of services and access/availability were not considered problems by many respondents; less than 1 percent report these problems for any method.

For all methods, a substantial proportion of women were not able to name a problem with the method. Those falling into the "don't know" category may not be familiar enough with the methods to be able to specify problems, or they may be embarrassed to discuss problems with using some methods. Therefore, when a large proportion of women report that they do not know about any problem in using a method, this should not be interpreted as evidence that the method is "without problems" for women. Lack of adequate information about a method, including both its advantages and disadvantages, may in itself be the greatest barrier to use.

Husband's Attitude

Husband's disapproval of family planning can be a major obstacle to use for women. The ZDHS found that, among women knowing about family planning, over 70 percent believed their husband approved of family planning, 15 percent felt their husband disapproved and 11 percent were unsure about their husband's attitude (Table 4.5). Older women, women living in rural areas and women who never attended school or had only a primary education were more likely than other women to report that their husband disapproved of family planning or to say that they were unsure of their husband's attitudes. The differential between women with secondary education and women in the other two education groups is particularly large. Around 90 percent of women with a secondary education felt their husband approved of family planning compared with 70 percent of women with a primary education and only 60 percent of women with no education.

Table 4.5 Percent of Currently Married Women Who Know a Contraceptive Method by Husband's Approval of Family Planning, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Disapproves	Approves	Don't Know	Missing	Total Percent	Number of Women
Age						
15-19	10,3	70,9	18,3	0,6	100,0	175
20-24	11,2	79,1	9,3	0,4	100,0	508
25-29	15,5	75,7	8,6	0,2	100,0	556
30-34	15,6	77,8	6,6	0,0	100,0	499
35-39	18,1	70,0	11,6	0,3	100,0	397
40-44	15,4	69,5	15,0	0,0	100,0	246
45-49	19,7	57,9	22,4	0,0	100,0	228
Urban-Rural Residence						
Urban	10,1	83,4	6,3	0,3	100,0	775
Rural	17,2	69,2	13,4	0,2	100,0	1 834
Level of Education						
No Education	18,6	59,5	21,6	0,2	100,0	467
Primary	17,0	72,5	10,4	0,1	100,0	1 591
Secondary or Higher	6,5	88,0	5,1	0,4	100,0	551
Total	15,1	73,4	11,3	0,2	100,0	2 609

Women who said that their husband disapproved of family planning were asked their opinion as to the reason for his attitude. Nearly half pointed to the husband's desire for more children as the reason for his disapproval of family planning. Other reasons mentioned by the women included the husband's fears that the woman would be promiscuous (14 percent), health concerns (10 percent) and religious prohibitions against use of family planning (4 percent) (from survey data not shown in a table in this report).

4.3 OTHER FACTORS FACILITATING USE

Couple Communication about Family Planning

While discussion of family planning by a couple is not required as a prelude to contraceptive use, it is an indicator of the level of interest in family planning on the part of the couple. Table 4.6 shows the number of times currently married women knowing a family planning method reported that they had talked about family planning with their husband in the year before the interview. In view of the length of the recall period, the data are subject to reporting error, particularly with respect to the frequency of the discussions; however, they provide some insight into the prevalence of interspousal communication on the topic of family planning.

Table 4.6   Percent Distribution of Currently Married Women Who Know a
Contraceptive Method by Number of Times Discussed Family Planning
With Husband During the Year Before the Survey, According to
Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Number of Times Discussed Family Planning					Total Percent	Number of Women
	Never	Once	Twice	More Often	Missing		
Age							
15-19	43,4	18,9	7,4	30,3	0,0	100,0	175
20-24	28,3	15,4	8,9	47,2	0,2	100,0	508
25-29	25,2	16,5	7,7	50,5	0,0	100,0	556
30-34	22,8	13,8	8,2	55,1	0,0	100,0	499
35-39	32,2	12,1	7,6	48,1	0,0	100,0	397
40-44	40,2	8,5	6,9	44,3	0,0	100,0	246
45-49	46,1	9,2	4,8	39,9	0,0	100,0	228
Urban-Rural Residence							
Urban	21,0	12,9	8,1	57,8	0,1	100,0	775
Rural	35,1	14,3	7,5	43,2	0,0	100,0	1 834
Level of Education							
No Education	51,4	10,3	7,9	30,2	0,2	100,0	467
Primary	29,4	14,8	6,5	49,3	0,0	100,0	1 591
Secondary or Higher	18,0	14,2	10,7	57,2	0,0	100,0	551
Total	30,9	13,9	7,7	47,5	0,0	100,0	2 609

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Overall, almost half of the women said that they had talked with their husband about family planning more than twice in the preceding year, 20 percent had had one or two conversations and about 30 percent had never discussed family planning with their husband. Couple communication about family planning was more prevalent among women age 20-34, urban women and women with secondary education than other women. Women who had never attended school were the least likely to discuss family planning with their husband; less than half had ever talked about family planning with her husband, and only one in three had had more than two conversations.

Exposure to Mass Media

In Zimbabwe, family planning information is regularly disseminated through the mass media. Information on the coverage of radio, television and print media is, therefore, important for formulating strategies for using these media for family planning education. Table 4.7 summarises information on the exposure of ZDHS respondents to mass media in the week before the survey. Overall, only about one in two women was regularly exposed to any of the media. Coverage was about equal for radio and print media (38 percent and 40 percent, respectively), while television reached far fewer women (16 percent).

Both residence and educational level are related to the likelihood that a woman will have been exposed to any of the media. Over 80 percent of urban women were exposed to either radio, television or a newspaper compared with only 40 percent of rural women. The proportion exposed to any media increases directly with educational level, from 19 percent among women with no formal education to over 80 percent among women with secondary education. Looking at type of

Table 4.7 Percent of All Women Regularly Exposed to Mass Media by Type of Media, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Print Media(1)	Tele- vision(2)	Radio(3)	Exposed to Any Media	Number of Women
Urban-Rural Residence					
Urban	67,7	39,8	69,5	85,6	1 407
Rural	26,4	3,8	22,4	39,2	2 794
Level of Education					
No Education	1,1	3,2	18,0	19,4	566
Primary	31,0	8,6	31,5	47,5	2 349
Secondary or Higher	74,3	34,8	59,3	83,4	1 286
Total	40,2	15,9	38,2	54,7	4 201

(1) Includes those reading a newspaper or magazine at least once a week
(2) Includes those watching television every week
(3) Includes those listening to radio every day

media, it is clear that television reaches a largely urban audience. Even among urban women, however, only 40 percent regularly watches television. Print media and radio reached two-thirds of urban women and one-quarter of rural women. Looking at the differentials for education groups, radio was the media providing the greatest coverage of women with no formal education; however, only 18 percent of women in this group reported regularly listening to radio broadcasts.

Exposure to Family Planning Messages

Data on exposure to family planning information in the month before the interview are shown in Table 4.8. Only 20 percent of women reported that they had read or heard anything about family planning during the month before the survey. Among those exposed to family planning information, radio and interpersonal communication with a health worker are the primary sources of the information. Urban women are more likely to report recent exposure to family planning information than rural women. The likelihood a woman will have heard or read about family planning recently is related to her educational attainment; women with secondary education are three times as likely as women with no formal education to have been exposed to family planning information in the month before the survey. Among those recently exposed to family planning information, the radio and contact with a health worker were the most frequently cited sources among urban women and women with secondary education, while contact with a health worker was the major source of family planning information for other women. Finally, despite the small proportion of women who have heard a family planning broadcast, 95 percent of women believe that it is acceptable to broadcast messages about family planning on radio or television (from survey data not shown in table in this report).

Table 4.8   Percent of All Women Who Heard or Read Any Information about Family
Planning During the Month Before the Survey by the Source of Information,
According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Never Heard or Read Any In- formation	Source of Family Planning Information					Number of Women
		Radio	Health Worker	News- paper	Poster	Other	
Urban-Rural Residence							
Urban	69,2	17,3	10,4	4,5	3,4	3,9	1 407
Rural	84,5	4,3	9,4	1,8	1,8	1,8	2 794
Level of Education							
No Education	90,8	2,3	6,4	0,2	0,7	1,2	566
Primary	81,5	7,4	10,4	1,6	1,3	1,5	2 349
Secondary or Higher	70,5	13,8	10,2	5,8	4,9	4,8	1 286
Total	79,4	8,7	9,8	2,7	2,3	2,5	4 201

Note: Respondents may have cited more than one source of information.

4.4 EVER USE OF FAMILY PLANNING

Experience with using family planning methods is widespread in Zimbabwe, with four out of every five currently married women having used at least one family planning method (Table 4.9). Ever-users are more likely to have adopted modern than traditional methods; 63 percent of married women have used a modern method, while 48 percent have relied on traditional methods. Considering ever use of specific methods, the pill is clearly the most frequently used family planning method; the proportion ever using the pill (57 percent) is more than three times that ever using the condom (17 percent) or injection (14 percent), the other commonly used modern methods. Experience with other supply or clinical methods is limited; 3 percent or less of married women report that they have used the IUD, vaginal methods, female sterilisation or male sterilisation. More than 40 percent of currently married women have relied on withdrawal, the most widely used traditional method.

The likelihood that a woman has used a family planning method varies with the woman's age. Overall, the level of ever use among currently married women increases from 48 percent in

Table 4.9 Percent of All Women and Currently Married Women Who Have Ever Used a Contraceptive Method by Specific Method, According to Age, Zimbabwe DHS, 1988

Age	Any Method	Any Modern Method	Pill	IUD	Injec- tion	Vagi- nals(1)	Con- dom	Sterilisation Female	Sterilisation Male	Any Tradi- tional Method	Perio- dic Absti- nence	With- drawal	Other	Number of Women
All Women
15-19	14,2	11,5	9,9	0,1	0,0	0,1	4,6	0,0	0,0	6,9	2,7	3,9	1,3	1 021
20-24	61,8	53,3	48,3	1,5	1,7	1,9	17,6	0,0	0,0	29,3	6,7	22,0	5,5	840
25-29	80,7	68,9	65,1	3,5	9,1	1,3	20,2	0,4	0,3	44,5	5,9	38,1	7,1	679
30-34	84,9	71,5	64,9	3,9	26,7	1,9	17,1	0,8	0,0	49,6	9,2	41,6	9,3	589
35-39	82,8	63,6	57,8	3,2	22,2	2,2	13,4	4,3	0,6	56,7	7,3	48,1	13,8	464
40-44	75,8	52,8	41,8	3,8	23,9	2,8	7,2	7,9	0,3	53,5	7,9	48,1	11,9	318
45-49	68,6	40,3	31,0	5,2	20,3	2,8	6,2	6,2	0,0	53,1	7,6	44,1	14,5	290
Total	60,4	48,4	43,4	2,5	11,2	1,5	12,8	1,7	0,1	35,6	6,2	29,4	7,3	4 201
Currently Married Women
15-19	48,3	42,2	38,3	0,6	0,0	0,0	16,1	0,0	0,0	22,2	5,6	17,8	3,3	180
20-24	77,2	66,9	61,6	2,1	1,8	2,1	23,0	0,0	0,0	36,8	6,0	30,4	5,8	513
25-29	84,8	71,2	67,6	3,8	8,8	1,4	21,1	0,5	0,4	48,5	6,6	42,0	7,3	559
30-34	85,7	71,0	64,8	4,2	25,6	2,0	18,3	0,8	0,0	52,5	9,3	44,5	9,7	503
35-39	84,6	64,0	57,6	3,2	21,1	2,5	14,1	4,0	0,7	58,1	6,5	50,1	13,4	403
40-44	77,5	52,2	42,3	4,0	23,7	2,8	7,5	9,1	0,4	57,3	7,9	51,4	12,6	253
45-49	70,7	43,5	34,9	5,6	22,4	2,6	7,3	6,9	0,0	54,7	8,2	45,7	15,5	232
Total	79,0	63,0	57,1	3,4	14,5	2,0	17,0	2,3	0,2	48,1	7,2	41,1	9,4	2 643

(1) Includes diaphragm and foam/jelly/foaming tablets

the 15-19 group to 85 percent in the 25-39 groups, before decreasing among older women. Considering only modern methods, the level of ever-use rises from 42 percent among women 15-19 to a peak of 71 percent among women 25-34, before declining to 44 percent in the oldest age group. Use of traditional methods shows a somewhat different pattern with age; the percent ever using a traditional method increases from 22 percent in the youngest age group to 58 percent among women 35-39, with only a slight decrease observed in the rate for the oldest cohorts.

4.5 TIMING OF FIRST USE

Table 4.10 provides information on the number of living children women had at the time they began contracepting. The results indicate that there is a long tradition of initiating contraceptive use in the early stages of childbearing, presumably for spacing purposes. Overall, half of ever-married women--65 percent of all ever users--report that they began using some form of contraception before they had two children. Looking at the age patterns, it is clear that even ever-users in the oldest age cohorts began using family planning early on in the family building process, the majority after only one or two children.
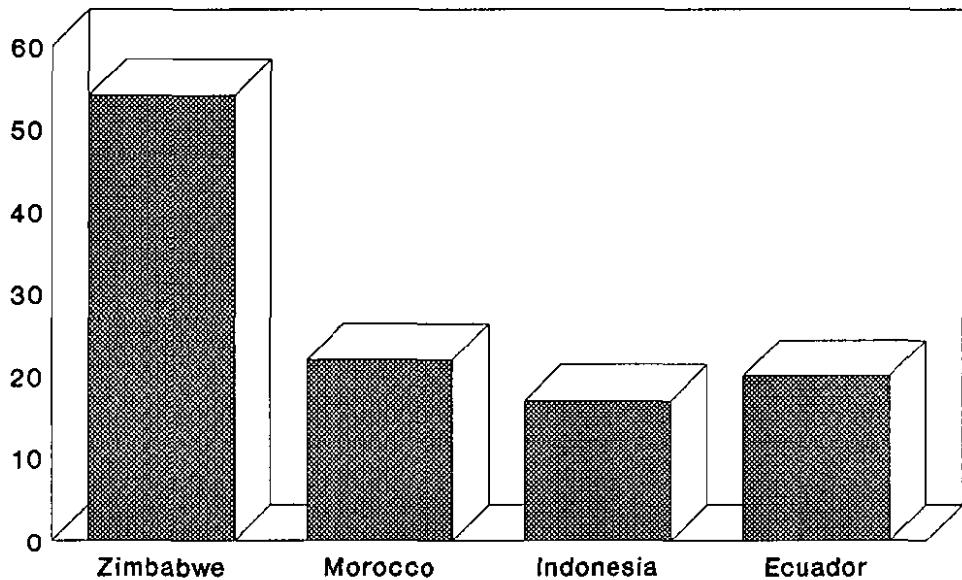
There is evidence of a trend toward increasingly early adoption of family planning; only one in three women in their forties began using family planning when they had fewer than two children compared with more than half of women under 25. To some extent, this trend may simply reflect the fact that modern contraceptive services have been more available to young women, than was the case for older women who had their first births in the 1960s and 1970s when the family planning programme was just beginning. The current availability of modern methods makes it likely that younger women also are initiating family planning with a more effective method (the pill) than their predecessors, who most likely relied on traditional methods such as withdrawal.

Table 4.10 Percent Distribution of Ever-married Women by Number of Living Children at Time of First Use of Contraception, According to Current Age, Zimbabwe DHS, 1988

| Current Age | Never Used | Number of Living Children | | | | | Missing | Total Percent | Number of Women |
		None	1	2	3	4 or More			
15-19	53,0	5,4	39,1	2,5	0,0	0,0	0,0	100,0	202
20-24	22,6	5,7	58,2	10,0	3,0	0,3	0,2	100,0	601
25-29	16,9	4,3	51,0	17,7	6,8	3,3	0,0	100,0	633
30-34	14,5	3,5	48,6	13,1	8,2	12,0	0,2	100,0	574
35-39	16,8	3,3	42,5	12,5	9,2	15,1	0,7	100,0	457
40-44	24,4	3,8	32,7	10,5	8,3	20,3	0,0	100,0	315
45-49	30,8	1,7	37,8	9,8	6,6	13,3	0,0	100,0	286
Total	22,0	4,0	46,8	12,1	6,4	8,6	0,2	100,0	3 068

Figure 4.1
**Percent Who Had Fewer Than Two Children
When They Began Using Contraception**
Percent of Ever-married Women 20-49

The pattern of initiation of contraceptive use in Zimbabwe is quite different from that common in Asian, Near Eastern and Latin American countries. In many of these countries, the movement toward the adoption of family planning--and the transition to lower fertility--began with older, high-parity women seeking to limit births. In Zimbabwe, the desire to space births appears to have been the primary motivation for young, low-parity women to adopt modern contraceptive methods. The contrast in the "spacing" and "limiting" patterns is illustrated in Figure 4.1, which presents the proportion of women 20-49 who initiated contraceptive use when they had fewer than two living children. Only in the last 10-15 years have a substantial proportion of women in Indonesia, Morocco and Ecuador adopted family planning at an early stage of childbearing, a pattern that was common in Zimbabwe 20-30 years ago (Azelmat et al., 1989; CBS and IRD, 1989; and CEPAR and IRD, 1988).

4.6   KNOWLEDGE OF FERTILE PERIOD

A basic understanding of the reproductive cycle, especially an awareness of the fertile period, is important for the successful practice of family planning and particularly of periodic abstinence. Periodic abstinence has been used at some time by 6 percent of all women in Zimbabwe. Table 4.11 presents the distribution of all women and those women who have ever used periodic abstinence by the time during the ovulatory cycle that they think a woman is most likely to get pregnant. To obtain these data, respondents were first asked about when in the monthly cycle a woman has the greatest chance of becoming pregnant. If they did not understand the initial question, an additional probe asked them to identify the days when a women has to be careful to avoid becoming pregnant. It should be noted that the response categories developed for this question are one attempt at dividing the ovulatory cycle into distinct periods. It is possible

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Table 4.11   Percent Distribution of All Women and
              Women Who Have Ever Used Periodic
              Abstinence by Knowledge of the Fertile
              Period During the Ovulatory Cycle,
              Zimbabwe DHS, 1988

Fertile Period	All Women	Periodic Abstinence Users
During Her Period	1,5	1,5
After Period Ended	39,9	55,2
Middle of the Cycle	7,3	10,4
Before Period Begins	8,5	14,7
At Any Time	7,9	4,6
Other	1,2	1,5
Don't Know	33,6	12,0
Missing	0,2	0,0
Total	100,0	100,0
Number of Women	4 201	259

that some women who gave an answer of, say "one week after her period" were coded in the category "just after her period has ended," instead of in the category "in the middle of her cycle". Thus, women may actually have a more accurate understanding of the menstrual cycle than is reflected in Table 4.11.

The results indicate that knowledge of the reproductive cycle is very limited. One-third of all women say that they do not know when the fertile period occurs, while 40 percent think it is just after a menstrual period has ended. Only 7 percent correctly identify the fertile period as occurring in the middle of the cycle. Even among women who have used periodic abstinence, 12 percent could not specify when the fertile period occurs; 56 percent said it is just after the period, and only 10 percent correctly identified it as occurring in the middle of the cycle.

4.7   CURRENT USE OF FAMILY PLANNING

Levels and Differentials

As shown in Table 4.12, 43 percent of currently married women are using contraception in Zimbabwe--36 percent modern methods and 7 percent traditional methods. Figure 4.2 shows that Zimbabwe has the highest level of contraceptive use reported among countries in sub-Saharan Africa for which recent information is available.
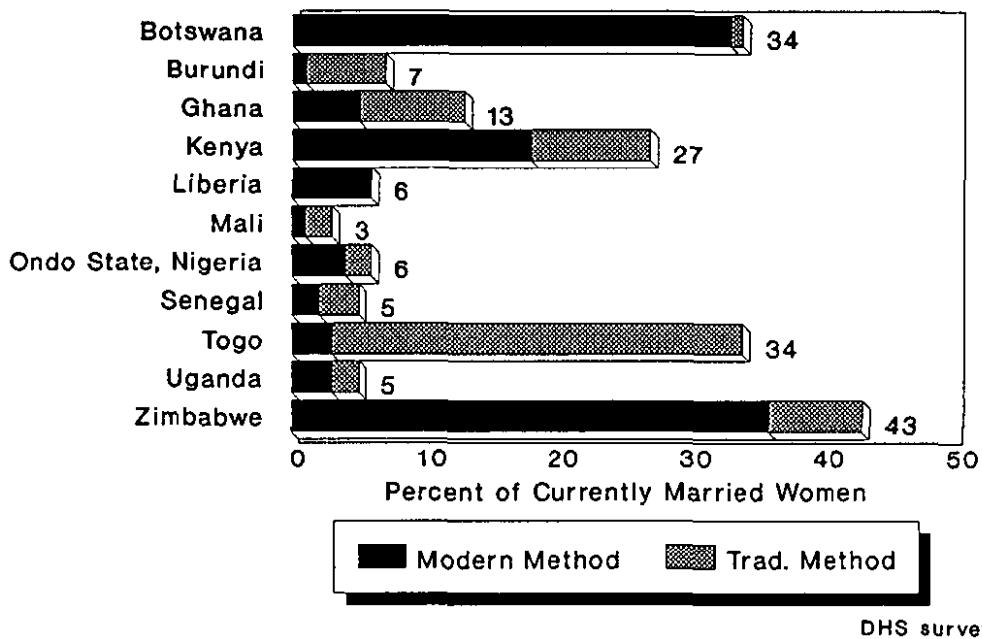
Considering the method mix, the pill (31 percent) is the most commonly used method. Current use of other modern methods is very limited; 2 percent or less are using female sterilisation, the IUD, injection or the condom. The most prevalent traditional method, withdrawal, is currently used by 5 percent of currently married women.

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Table 4.12 Percent Distribution of All Women and Currently Married Women by Contraceptive Method Currently Used, According to Age, Zimbabwe DHS, 1988

Age	Any Method	Any Modern Method	Pill	IUD	Injection	Vaginals(1)	Condom	Sterilisation Female	Sterilisation Male	Any Traditional Method	Periodic Abstinence	Withdrawal	Other	Not Using	Number of Women
All Women															
15-19	8,4	7,1	6,9	0,1	0,0	0,0	0,2	0,0	0,0	1,3	0,7	0,2	0,4	91,6	1 021
20-24	36,1	32,7	31,1	0,2	0,1	0,0	1,3	0,0	0,0	3,3	0,6	1,9	0,8	63,9	840
25-29	47,1	41,5	38,0	1,5	0,1	0,1	1,0	0,4	0,3	5,6	0,1	4,1	1,3	52,9	679
30-34	48,4	41,6	37,9	1,0	0,3	0,0	1,5	0,8	0,0	6,8	0,7	4,6	1,5	51,6	589
35-39	41,2	31,2	23,1	1,3	0,4	0,0	1,5	4,3	0,6	9,9	0,4	7,1	2,4	58,8	464
40-44	34,6	25,5	15,7	0,6	0,9	0,0	0,0	7,9	0,3	9,1	0,0	6,9	2,2	65,4	318
45-49	19,7	14,5	6,9	0,7	0,0	0,0	0,7	6,2	0,0	5,2	0,3	2,8	2,1	80,3	290
Total	32,2	27,2	23,5	0,7	0,2	0,0	0,9	1,7	0,1	5,0	0,5	3,2	1,3	67,8	4 201
Currently Married Women															
15-19	30,0	28,3	27,8	0,6	0,0	0,0	0,0	0,0	0,0	1,7	0,0	1,1	0,6	70,0	180
20-24	45,8	41,5	39,8	0,4	0,0	0,0	1,4	0,0	0,0	4,3	0,4	3,1	0,8	54,2	513
25-29	50,3	43,8	39,7	1,6	0,2	0,2	1,3	0,5	0,4	6,4	0,2	5,0	1,3	49,7	559
30-34	50,5	42,9	39,2	1,2	0,2	0,0	1,6	0,8	0,0	7,6	0,6	5,4	1,6	49,5	503
35-39	41,7	30,8	22,3	1,5	0,5	0,0	1,7	4,0	0,7	10,9	0,2	8,2	2,5	58,3	403
40-44	37,2	26,1	14,6	0,8	1,2	0,0	0,0	9,1	0,4	11,1	0,0	8,7	2,4	62,8	253
45-49	22,8	17,2	8,6	0,9	0,0	0,0	0,9	6,9	0,0	5,6	0,4	3,4	1,7	77,2	232
Total	43,1	36,1	31,0	1,1	0,3	0,0	1,2	2,3	0,2	7,0	0,3	5,1	1,5	56,9	2 643

(1) Includes diaphragm and foam/jelly/foaming tablets

Figure 4.2
Current Use By Type of Method

Country	Value
Botswana	34
Burundi	7
Ghana	13
Kenya	27
Liberia	6
Mali	3
Ondo State, Nigeria	6
Senegal	5
Togo	34
Uganda	5
Zimbabwe	43

Percent of Currently Married Women

■ Modern Method ▨ Trad. Method

DHS surveys: Africa

The level of current use varies with age, peaking at 50 percent among currently married women 25-34 (Table 4.12). However, even among younger and older cohorts, substantial proportions of women are using contraception--over 40 percent in the 20-24 and 35-44 cohorts and 20-30 percent in the 15-19 and 45-49 groups. Looking at the number of living children, there appears to be little interest in postponing the first birth; only 3 percent of married women with no children are using contraception (Table 4.13). Among married women with at least one living child, the proportion using exceeds 40 percent, regardless of the parity category, peaking at 50 percent among women with three children.

The urban-rural differential is fairly large; 52 percent of currently married women in urban areas are using contraception compared to 40 percent of rural women (Table 4.13). Among urban women, the contraceptive prevalence rate is somewhat greater for those living in Harare/ Chitungwiza than in Bulawayo. The rate is considerably lower in Matabeleland North, Matabeleland South and Manicaland than in other provinces. Increasing educational attainment is directly associated with use. For example, among women who have never attended school, only one in three are currently using family planning compared with half of the women with at least some secondary education.

The overwhelming dominance of the pill makes it difficult to discuss differences in the method mix among subgroups. However, there is some tendency for use of methods other than the pill, particularly female sterilisation and traditional methods, to increase with age and with the number of living children. Among urban women, 9 percent are using a modern method other than the pill (primarily female sterilisation or the IUD) compared to 3 percent among rural women, while the prevalence of use of traditional methods is greater among rural (9 percent) than urban

Table 4.13   Percent Distribution of Currently Married Women by Contraceptive Method Currently Used, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Any Method	Any Modern Method	Pill	IUD	Injec- tion	Vagi- nals(1)	Con- dom	Sterilisation Female	Sterilisation Male	Any Tradi- tional Method	Perio- dic Absti- nence	With- drawal	Other	Not Using	Number of Women
Number of Living Children															
None	3,2	1,6	1,6	0,0	0,0	0,0	0,0	0,0	0,0	1,6	0,0	1,1	0,5	96,8	188
1	43,5	40,2	37,2	1,0	0,0	0,0	1,8	0,3	0,0	3,3	0,3	2,0	1,0	56,5	398
2	46,2	42,1	35,5	2,4	0,2	0,2	1,2	1,7	0,7	4,1	0,5	3,4	0,2	53,8	411
3	49,7	42,9	37,6	1,6	0,3	0,0	0,8	2,1	0,5	6,9	0,0	6,1	0,8	50,3	378
4 or More	45,9	36,0	30,0	0,6	0,4	0,0	1,3	3,6	0,1	9,9	0,4	7,0	2,4	54,1	1 268
Urban-Rural Residence															
Urban	51,7	48,8	39,7	2,8	0,5	0,1	1,5	3,6	0,5	3,0	0,5	1,4	1,0	48,3	779
Rural	39,5	30,8	27,4	0,3	0,2	0,0	1,0	1,8	0,1	8,6	0,2	6,7	1,7	60,5	1 864
Place of Residence															
Manicaland	32,1	25,6	22,2	0,3	1,1	0,0	0,9	1,1	0,0	6,5	0,0	5,4	1,1	67,9	352
Mashonaland Central	47,5	40,1	36,4	1,4	0,0	0,0	1,8	0,5	0,0	7,4	0,0	6,9	0,5	52,5	217
Mashonaland East(2)	47,8	43,1	37,5	1,5	0,0	0,0	1,2	2,6	0,3	4,7	0,3	3,2	1,2	52,2	341
Mashonaland West	48,2	43,2	37,8	0,9	0,6	0,0	1,2	2,4	0,3	5,1	0,6	3,0	1,5	51,8	336
Matabeleland North(3)	27,3	18,0	17,2	0,0	0,0	0,0	0,0	0,8	0,0	9,4	0,0	7,0	2,3	72,7	128
Matabeleland South	28,2	21,2	17,3	0,6	0,0	0,0	0,0	2,6	0,6	7,1	0,6	5,1	1,3	71,8	156
Midlands	44,7	35,2	29,6	1,0	0,3	0,0	1,0	3,3	0,0	9,5	0,5	7,8	1,3	55,3	398
Masvingo	47,8	35,3	31,1	0,0	0,0	0,0	2,2	1,9	0,0	12,5	0,0	8,3	4,2	52,2	312
Harare/Chitungwiza	51,5	48,0	41,2	0,5	0,0	0,0	1,0	3,9	1,5	3,4	0,0	3,4	0,0	48,5	204
Bulawayo	43,7	41,2	30,2	5,0	0,0	0,5	1,5	4,0	0,0	2,5	1,0	0,0	1,5	56,3	199
Level of Education															
No Education	32,5	24,9	22,1	0,0	0,0	0,0	0,8	2,0	0,0	7,6	0,2	6,3	1,0	67,5	489
Primary	42,0	34,0	30,4	0,4	0,2	0,0	1,1	1,7	0,1	8,1	0,3	6,1	1,6	58,0	1 601
Secondary or Higher	55,5	52,3	40,7	3,8	0,5	0,2	1,8	4,3	0,9	3,3	0,4	1,3	1,6	44,5	553
Total	43,1	36,1	31,0	1,1	0,3	0,0	1,2	2,3	0,2	7,0	0,3	5,1	1,5	56,9	2 643

(1) Includes diaphragm and foam/jelly/foaming tablets
(2) Excludes Harare/Chitungwiza
(3) Excludes Bulawayo

women (3 percent). Women who have attained the secondary level also are somewhat more likely to be using a modern method other than the pill and somewhat less likely to be using a traditional method than women having less formal education.

Trends in Current Use

A comparison of the findings of the ZDHS with the results of the 1984 Zimbabwe Reproductive Health Survey (ZRHS) highlights some important changes in both the level and the pattern of contraceptive use in Zimbabwe. First, the overall level of contraceptive use among currently married women increased during the four-year period between the two surveys by 5 percentage points, from 38 percent in 1984 to 43 percent (Table 4.14). Considering the change in relative terms, the prevalence rate increased during the period between the surveys by 12 percent.

More importantly, today's users are much more likely to be relying on modern methods than those four years ago. During the period between the surveys, there was a one-third increase in the proportion of women relying on more effective methods; currently, 36 percent of married women are using modern methods, compared with 27 percent in 1984 (Figure 4.3). The increased

Table 4.14   Percent of Currently Married Women by Contraceptive
             Method Currently Used, Zimbabwe DHS, 1988 and RHS, 1984

Contraceptive Method	1988 ZDHS	1984 ZRHS	Absolute Difference
Any Method	43,1	38,4	4,7
Any Modern Method	36,1	26,6	9,5
Pill	31,0	22,6	8,4
IUD	1,1	0,7	0,4
Injection	0,3	0,8	-0,5
Vaginals(1)	0,0	0,1	-0,1
Condom	1,2	0,7	0,5
Female Sterilisation	2,3	1,6	0,7
Male Sterilisation	0,2	0,1	0,1
Any Traditional Method	7,0	11,8	-4,8
Periodic Abstinence(2)	0,3	0,6	-0,3
Withdrawal	5,1	6,5	-1,4
Abstinence	NA	2,1	--
Other Methods(3)	1,5	2,6	-1,1
Number of Women	2 643	2 123	
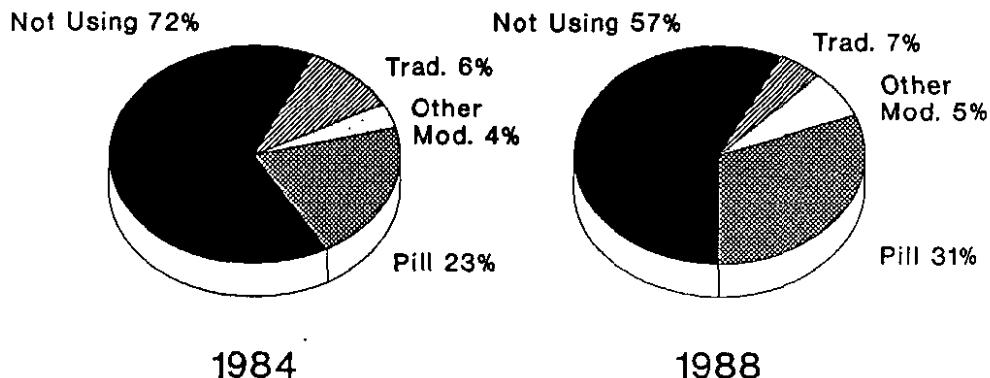
Source: Zimbabwe National Family Planning Council and Westinghouse
        Public Applied Systems, 1985
NA = Not available

(1) Includes diaphragm and foam/jelly/foaming tablets
(2) Reported as rhythm (calendar) in the ZRHS
(3) Reported as folk methods in the ZRHS

Figure 4.3
Current Use of Contraception by Method,
ZRHS 1984 and ZDHS 1988

Not Using 72%   Trad. 6%   Other Mod. 4%   Pill 23%   1984

Not Using 57%   Trad. 7%   Other Mod. 5%   Pill 31%   1988

Zimbabwe DHS 1988

use of modern methods was accompanied by a decline in the use of traditional methods, from 12 percent in 1984 to 7 percent in 1988. As a result of these changes, four in every five users now rely on modern contraceptives, compared with seven in ten users in 1984, suggesting that overall contraceptive practice may be somewhat more effective now than in the past.

Almost all of the increase in the use of modern methods between the two surveys was due to increased use of the pill. The proportion of users relying on the pill increased by a third, from 23 percent in 1984 to 31 percent, while use of all other modern methods grew by only 20 percent (from 4 percent to 5 percent). With use of traditional methods declining, the pill has become even more dominant in the method mix among users. Currently, 72 percent of all users rely on the pill, while in 1984 only 60 percent used the pill.

Table 4.15 shows the changes in the level of contraceptive use that occurred among various subgroups between the ZRHS and the ZDHS. The proportion of married women using contraceptive methods increased in all age groups, except the 40-44 cohort where it remained almost constant. In absolute terms, the largest increases in use are observed for women in the 25-34 cohorts. The prevalence of use of all methods increased by roughly 8 percentage points in the 25-34 age groups, while the use rate for modern methods increased by 14 percentage points. Considering the number of living children, the absolute increase in contraceptive use was greatest for women with 1-2 children.

Between the ZRHS and the ZDHS, significant increases in the use of contraceptive methods occurred for subgroups which had the lowest levels of use in 1984. Among rural women, the prevalence of use of all methods increased from 34 percent in 1984 to 40 percent, while the use of modern methods increased from 20 percent in 1984 to 31 percent. A similar increase

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Table 4.15 Percent of Currently Married Women Currently
Using Any Method And Any Modern Method, by
Selected Background Characteristics, Zimbabwe
DHS, 1988 and RHS, 1984

Background Characteristic	1988 ZDHS		1984 ZRHS	
	Any Method	Any Modern Method	Any Method	Any Modern Method
Age				
15-19	30,0	28,3	24,9	16,2
20-24	45,8	41,5	43,6	34,4
25-29	50,3	43,8	42,3	28,2
30-34	50,5	42,9	42,8	29,1
35-39	41,7	30,8	37,1	22,1
40-44	37,2	26,1	37,6	26,8
45-49	22,8	17,2	21,2	13,9
Number of Living Children				
None	3,2	1,6	7,1	4,8
1-2	44,9	41,2	38,9	28,6
3-5	49,3	42,5	46,9	32,0
6 or More	42,8	29,8	39,0	25,5
Urban-Rural Residence				
Urban	51,7	48,8	46,6	39,4
Rural	39,5	30,8	34,0	19,9
Level of Education				
No Education	32,5	24,9	25,2	16,5
Some Primary	39,8	30,3	37,0	23,0
Completed Primary	46,6	42,5	48,6	35,6
Secondary or Higher	55,5	52,3	48,8	41,4
Total	43,1	36,1	38,4	26,6

Source: Zimbabwe National Family Planning Council and
Westinghouse Public Applied Systems, 1985

occurred for women who never attended school; among these women, the use of all methods increased from 25 percent in 1984 to 32 percent, while the use of modern methods increased from 16 to 25 percent. Despite increased use among these groups, differentials in the level of contraceptive use between subgroups continue to be large. The differential in the contraceptive prevalence rate between urban and rural areas (12 percentage points) is virtually identical to the urban-rural differential in 1984, while the differential between women with no formal education and those with a secondary or higher education (23 percentage points) is almost the same as the differential observed between these groups in 1984.

4.8 SOURCE FOR CONTRACEPTIVE METHODS

Table 4.16 presents the distribution of current users of modern methods according to the source from which they most recently obtained their method. Almost all users rely on government-

Table 4.16 Percent Distribution of Current Users by Most Recent Source for Method, According to Specific Method and Urban-Rural Residence, Zimbabwe DHS, 1988

Source for Method	All Users						Any Method	Urban Users	Rural Users
	Any Supply Method	Pill	Condom	Any Clinic Method	IUD	Female Steril- isation			
CBD(1)	25,3	25,7	21,0	0,0	0,0	0,0	24,5	4,2	36,1
ZNFPC Clinic	13,7	13,8	10,5	7,5	24,1	1,4	13,1	19,9	8,4
MOH Hospital/Clinic	14,8	14,8	10,5	57,5	13,8	74,6	18,8	22,4	16,1
Municipal/Local Clinic	19,1	19,2	18,4	7,5	13,8	4,2	18,0	35,3	5,8
Rural Council Clinic	17,7	18,1	13,2	0,0	0,0	0,0	16,1	5,7	23,4
Commerce/Industry	0,6	0,6	0,0	0,0	0,0	0,0	0,5	0,4	0,6
Mission/Church	1,6	1,7	0,0	3,8	3,4	4,2	1,8	0,4	2,8
Private Doctor/Pharmacy	2,3	1,4	15,8	17,0	31,0	11,3	3,7	7,8	0,7
Friends/Relatives	1,5	1,3	7,9	0,9	3,4	0,0	1,4	1,1	1,8
Traditional Healer	0,5	0,5	0,0	0,0	0,0	0,0	0,5	0,0	0,7
Other	2,8	2,9	0,0	3,8	10,3	1,4	1,4	2,3	3,3
Don't Know	0,1	0,0	2,6	0,0	0,0	0,0	0,1	0,0	0,1
Missing	0,0	0,0	0,0	1,9	0,0	2,8	0,2	0,4	0,0
Total	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Number of Current Users	1 037	989	38	106	29	71	1 143	473	670

CBD = ZNFPC community-based distribution worker
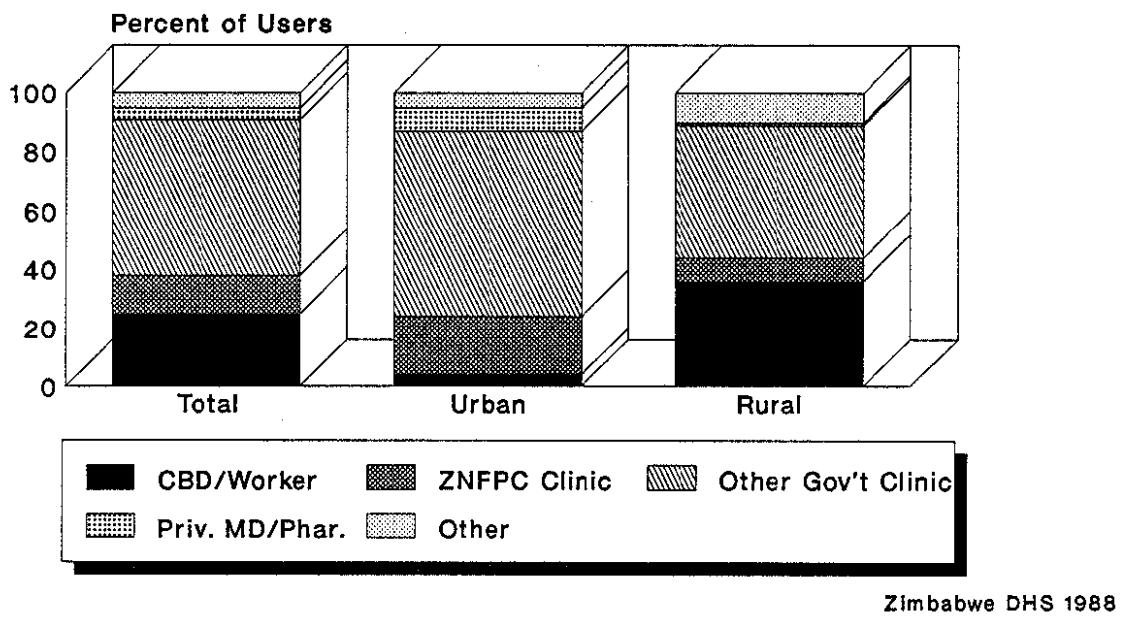
(1) Includes a few women who reported that they obtained their method from a community-based worker other than a ZNFPC CBD (N=10)

sponsored service providers for contraceptive methods. Around one in three users of supply methods (largely the pill) obtained her method from a clinic operated by the Zimbabwe National Family Planning Council (14 percent) or from one of the ZNFPC-sponsored community-based distribution (CBD) workers (25 percent). Most other supply method users relied on clinics operated by the Ministry of Health (MOH) or local government; only 2 percent obtained their supplies from a private doctor or pharmacy.

Government-sponsored outlets are also the principal provider of clinical methods to the small number of users relying on these methods. Three of every four sterilisations were performed at MOH outlets, while ZNFPC clinics were the most frequently cited public sector provider for the IUD. Users of clinical methods are somewhat more likely than users of supply methods to turn to the private sector for services; 17 percent report obtaining their clinical methods from a private doctor, with the small number of IUD users being most likely to report obtaining their method from a private doctor.

The importance of the CBD workers in the providing services to rural users is highlighted in Figure 4.4. Around one-third of rural users rely on the worker for their method (principally the pill). Rural council clinics are the other major providers of contraceptive services in rural Zimbabwe; one-fourth of rural users obtained their methods from these clinics, while 16 percent go to Ministry of Health hospitals or clinics and 14 percent rely on ZNFPC clinics or municipal/

Figure 4.4
Source for Contraceptive Methods Among Current Users by Urban-Rural Residence

Percent of Users

Legend:
- CBD/Worker
- ZNFPC Clinic
- Other Gov't Clinic
- Priv. MD/Phar.
- Other

Zimbabwe DHS 1988

local government clinics. Municipal/local government clinics are the primary providers of methods to urban users, followed by Ministry of Health and ZNFPC facilities.

Most users (95 percent) are satisfied with their service providers (from survey data not shown in table in this report). Only 5 percent indicated that they were not happy with the service they had received. Among these dissatisfied users, common complaints included discourteous staff, long waits, inability to obtain the desired method and the high cost of services.

4.9 PILL USE

The pill is the most popular modern method of contraception in Zimbabwe; more than 80 percent of women using a modern method rely on the pill. To obtain information on the brand of pills being used by women, current users were asked to show the packet of pills they were taking at the time of the interview. Table 4.17 shows that 92 percent of pill users were able to show the interviewer a pill packet.

Looking at the brands used, pill users are fairly evenly divided between

Table 4.17 Percent Distribution of Current Users of the Pill by Brand Used, According to Breastfeeding Status, Zimbabwe DHS, 1988

Pill Brand	Breast-feeding	Not Breast-feeding	All Pill Users
Lo-Femenal	8,6	64,7	41,6
Ovrette	79,9	24,1	47,1
Other	1,2	4,8	3,3
Not Able to Show	9,8	6,0	7,6
Missing	0,5	0,3	0,4
Total	100,0	100,0	100,0
Number of Pill Users	408	581	989

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Lo-Femenal and Ovrette, the two brands available through public sector outlets. In line with programme recommendations, the majority of pill users who are currently breastfeeding use Ovrette (a progestin-only pill which does not reduce milk production), while, among those not breastfeeding, the majority use Lo-Femenal (a low-dose pill). Most pill users pay for their supply; only one-third report receiving the pill free of charge. Among those paying for the pill, almost all pay less than one Zimbabwe dollar for a packet; 50 percent of pill users report paying 20 cents and 10 percent report paying 40 cents (from survey data not shown in table in this report).

In order to study the quality of use of the pill, several questions were included in the ZDHS to determine whether women using the pill comply with instructions to take the pill daily and their actions if they forget to take the pill. To the extent that the questions rely on recall, the responses may tend to understate problems that exist in taking the pill, since users may not remember whether they have been consistent in taking the pill or what they did if they forgot. As Table 4.18 shows, about one-fifth of pill users indicated that they had interrupted use for at least one day during the month prior to the survey. Rural users (22 percent) were only slightly more likely than urban users (19 percent) to say that they had interrupted use. Interruption of use was somewhat more likely to be reported by users who obtained the pill from a CBD worker than by users who relied on other outlets for their supply; the differentials by source are, however, minor, ranging from a low of 15 percent for users obtaining the pill from Ministry of Health hospitals or clinics to 29 percent for the few users obtaining the pill from a private doctor or pharmacy.

Table 4.18 Percent of Current Users of the Pill Saying They Interrupted Use For At Least One Day During the Month Before the Survey by Source Where They Obtained the Pill, According to Urban-Rural Residence, Zimbabwe DHS, 1988

Source	Urban	Rural	Total	Number of Pill Users
CBD(1)	15,0*	25,7	24,8	254
ZNFPC Clinic	16,3	26,0	19,9	136
MOH Hospital/Clinic	17,1	12,9	15,1	146
Municipal/Local Clinic	20,3	29,7	22,1	190
Rural Council Clinic	14,8	23,0	21,8	179
Commerce/Industry	0,0*	0,0*	0,0*	6
Mission/Church	0,0*	18,8*	17,6*	17
Private Doctor/Pharmacy	28,6*	0,0	28,6*	14
Friends/Relatives	50,0*	0,0*	7,7*	13
Traditional Healer	0,0*	0,0*	0,0*	5
Other	37,5*	14,3	20,7	29
Total	18,8	22,3	20,9	989

* Percent based on fewer than 25 cases

(1) Includes a few women who reported that they obtained their method from a community-based worker other than the ZNFPC CBD

Pill users who admitted that they had interrupted use were asked about the reasons for stopping use (Table 4.19). Although most cited only one factor, users were able to give more than one reason for the interruption of use. Forgetting to take a pill or misplacing the packet were mentioned by 79 percent as a reason for the interruption in use, while 6 percent said that they ran out of pills. Only 7 percent said that they were bothered by side effects (including spotting and bleeding), and another 5 percent said that they did not take the pill because they were not sexually active at the time.

Since forgetting to take the pill appears to be one of the main reasons for interrupting use, it is important to know what action pill users take when they forget to take a pill. When asked what they did the last time that they missed taking a pill, slightly more than one-third said they had never forgotten to take a pill (Table 4.20). Among the users who said they had forgotten at least once, the most common--and correct--action was to take two pills the next day; 30 percent of pill users fell into this category. However, a roughly similar proportion of pill users indicated that when they forgot the pill, they either did nothing (5 percent) or took only one pill the following day (24 percent).

The results suggest that the majority of pill users in Zimbabwe are taking the pill consistently and correctly. The effectiveness of the pill may be reduced, however, for a significant minority of users who do not take appropriate action when they fail to take the pill for at least a day. Providers need to stress what to do when the pill is forgotten, misplaced or unavailable--by far the most common reasons for interruption of use--and to remind clients that alternate methods are available if they are bothered by side effects or have intercourse only infrequently. The family planning programme may also want to broaden access to methods like the IUD and female sterilisation that may be more suitable for women who are seeking to limit rather than to space births. The number of women wanting to limit births appears to be increasing in Zimbabwe, according to the data on reproductive intentions presented in Chapter 5.

Table 4.19 Percent of Current Users of the Pill Who Interrupted Use For At Least One Day During the Month Before the Survey by Reason for Interrupting Use, Zimbabwe DHS, 1988

Reason for Interrupting Use	
Side Effects/Illness	5,8
Spotting/Bleeding	1,0
Period Did Not Come	0,5
Ran Out of Pills	6,3
Forgot/Misplaced Pills	78,7
Not Sexually Active	4,8
Other	2,4
Number of Pill Users	207

Note: Users may have given more than one reason for interrupting use.

Table 4.20 Percent Distribution of Current Users of the Pill by Action Taken If Pill Forgotten, Zimbabwe DHS, 1988

Action Taken if Pill Forgotten	
Took One Pill Next Day	24,1
Took Two Pills Next Day	30,7
Used Another Method	0,5
Did Nothing	5,0
Abstained	0,4
Other	1,9
Never Forgot	37,2
Missing	0,2
Total	100,0
Number of Pill Users	989

4.10 ATTITUDES ABOUT PREGNANCY AND REASONS FOR NONUSE

Although the use of contraceptives and especially of modern methods, is widespread in Zimbabwe, there remains a substantial number of women who are not currently using although they are in immediate need of contraception to prevent an unplanned pregnancy. Overall, 52 percent of married women are sexually active, not currently pregnant and not contracepting. When women in this group were asked about their reaction to the possibility of becoming pregnant in the next few weeks, more than one-third said that a pregnancy would pose problems (Table 4.21). The proportion who felt that a pregnancy would pose problems increases with the number of children the woman already has, peaking at 46 percent among women with four or more living children. Even among women with no living children, however, one in four said that a pregnancy would pose problems. When asked for the reason a pregnancy would pose problems, women were most likely to mention already having other young children (29 percent), the belief a pregnancy would be unhealthy (21 percent) or being unable to afford another child (18 percent) (from survey data not shown in table in this report).

For women who stated that a pregnancy in the next few weeks would pose problems, a further question was asked why they were not using contraception. Unlike the information presented earlier in this chapter on the main problems with methods, the responses here are personal, reflecting the reason that the woman herself has for not using any method of contraception, rather than the obstacles or barriers that she perceives might keep other women from using a specific method. The reasons for nonuse presented in Table 4.22 suggest that somewhat more than one-fifth of the women are not using because they consider themselves to be at limited risk of pregnancy, largely since they have sexual intercourse infrequently.

Among the remaining women, the reasons for nonuse are diverse, but about six in ten women cite as reasons for nonuse variables which the family planning programme in Zimbabwe can address. A key issue is the availability of methods. Around one in five of these women points to

Table 4.21 Percent Distribution of Non-pregnant Women Who Are Sexually Active and Not Using Any Contraceptive Method, by Attitude Toward Becoming Pregnant in the Next Few Weeks, According to Number of Living Children, Zimbabwe DHS, 1988

Number of Living Children	Would Pose Problems	Would Not Matter Very Much	Don't Know	Missing	Total Percent	Number of Women
None	26,6	63,5	8,8	1,1	100,0	274
1	30,2	63,5	5,9	0,5	100,0	222
2	36,4	59,9	3,7	0,0	100,0	187
3	34,2	60,1	5,1	0,6	100,0	158
4 or more	45,8	44,6	8,3	1,3	100,0	552
Total	37,0	55,1	7,0	0,9	100,0	1 393

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Table 4.22  Percent Distribution of Non-pregnant Women Who
           Are Sexually Active and Not Using Any Contra-
           ceptive Method and Who Say that It Would Pose
           Problems if They Became Pregnant by Main
           Reason for Nonuse, According to Age,
           Zimbabwe DHS, 1988
```

Reason for Nonuse	Age		
	15-29	30-49	Total
Opposed to Family Planning	4,9	4,9	4,9
Husband Disapproves	9,7	8,1	8,7
Others Disapprove	1,5	0,6	1,0
Religious Objections	5,8	3,6	4,5
Infrequent Sex	17,5	20,7	19,4
Postpartum/Breastfeeding	3,9	1,6	2,5
Menopausal/Subfecund	0,5	0,3	0,4
Health Concerns	2,9	3,2	3,1
Lack of Knowledge	9,7	3,9	6,2
Inconvenient to Use	0,5	20,7	12,6
Access/Availability	23,3	14,6	18,1
Costs Too Much	2,9	3,9	3,5
Fatalistic	1,0	1,6	1,4
Other	10,7	10,7	10,7
Don't Know	5,3	1,0	2,7
Missing	0,0	0,6	0,4
Total	100,0	100,0	100,0
Number of Women *	206	309	515

lack of access (18 percent) or cost (4 percent) as the main reason for nonuse. Women under 30 are more likely than older women to mention access problems. A substantial proportion of older women (21 percent), but almost no women under 30, say they are not contracepting because they find methods inconvenient to use. Lack of knowledge about family planning is given by 6 percent as the reason for not using, with younger women mentioning it more often than older women. An additional 14 percent say that either their husband or others disapprove, or they themselves are opposed to family planning, and 4 percent mention religious prohibitions against contraception. Only 3 percent mention health concerns as a reason for nonuse, although health concerns were cited frequently as the main problem in using contraceptive methods, especially the pill (see Table 4.4).

· These findings raise issues which the family planning programme in Zimbabwe can address. Of key concern is the problem of improving access to contraceptive services, particularly in rural areas. Currently, services are not readily available for many rural women. According to the results of the Catchment Area Survey conducted by the ZNFPC, only 29 percent of the rural population are covered by the CBD programme (Zimbabwe National Family Planning Council, 1987). Moreover, many health facilities serving rural areas do not offer family planning services. The lack of ready access to services is compounded by the fact that some nonusers perceive the methods most readily available--primarily the pill and the condom--as inconvenient to use. Expanding the range of methods offered by providers would address the increasing need for methods appropriate for limiting rather than spacing births, a topic discussed further in the next chapter.

Table 4.23 Percent Distribution of Currently Married Women Who Are Not Currently Using Any
          Contraceptive Method by Intention to Use in the Future, According to Number of
          Living Children, Zimbabwe DHS, 1988

Intention to Use in the Future	Number of Living Children(1)							
	None	1	2	3	4	5	6 or More	Total
Intend to Use in Next 12 Months	13,4	36,4	36,9	35,3	40.8	42,8	34,5	35,2
Intend to Use Later	17,0	16,3	11,6	10,0	5,6	7,6	4,0	9,4
Intend to Use, Unsure about When	9,8	7,9	6,7	7,5	3,9	4,8	3,7	5,9
Unsure about Whether to Use	10,7	10,9	6,2	6,0	11,2	6,2	7,4	8,2
Does Not Intend to Use	49,1	28,0	37,8	39,8	36,9	37,9	48,4	40,1
Missing	0,0	0,4	0.9	1,5	1,7	0,7	2,0	1,2
Total	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Number of Women	112	239	225	201	179	145	403	1 504

(1) Includes current pregnancy

4.11   INTENTION TO USE IN THE FUTURE

An important indicator of the potential demand for family planning is the extent of interest among nonusers in using contraception in the future. When asked about their intention to use contraception, more than 50 percent of currently married nonusers said that they plan to use a method, 40 percent do not intend to use a method, and 8 percent are unsure. Among those intending to use, around 70 percent said that they intended to begin using a method in the next 12 months.

There is generally little variation in the proportion intending to use with the number of living children (including current pregnancies) (Table 4.23). Among childless nonusers and those with six or more children, around 40 percent reported that they plan to use a contraceptive method in the future. Among women with 1-5 living children, the proportion reporting that they intend to use in the future varies from 50 to 60 percent.

Among nonusers who say that they will use in the future, the proportion saying that they will adopt soon is positively associated with parity. Around one-half of those with no children who plan to adopt a method say that they will use soon compared with 60 percent or more of those with 1-2 children and 70 percent or more of women with 3 or more children.

As anticipated, in view of the predominance of the pill in the method mix among users, the method of choice among nonusers who plan to use in the future is the pill. Two-thirds of nonusers intending to adopt a method prefer the pill (Table 4.24). There is significant demand for long-term or permanent methods; one in five nonusers intending to use in the future prefers injection (10 percent), the IUD (4 percent) or female sterilisation (5 percent).

Table 4.24 Percent Distribution of Currently Married
Women Who Are Not Using Any Contraceptive
Method but Who Intend to Use In the Future
by Preferred Method, According to Whether
They Intend to Use in the Next 12 Months
or Later, Zimbabwe DHS, 1988

Preferred Method	Intend to Use in Next 12 Months	Intend to Use Later	Total
Pill	66,2	67,4	66,5
IUD	3,8	5,0	4,0
Injection	9,1	13,5	10,0
Diaphragm/Foam/Jelly	0,8	0,7	0,7
Condom	2,5	0,7	2,1
Female Sterilisation	5,7	4,3	5,4
Periodic Abstinence	0,8	0,7	0,7
Withdrawal	4,3	0,7	3,6
Other	3,2	4,3	3,4
Don't Know	3,6	2,8	3,4
Missing	0,2	0,0	0,1
Total	100,0	100,0	100,0
Number of Women	530	141	671

Chapter 5

FERTILITY PREFERENCES

This chapter examines information from the ZDHS on the fertility preferences and family size norms of Zimbabwean women. A special focus is placed on the women who want to stop childbearing or to delay the next birth but are not using family planning. This unmet need for contraception represents the existing unserved demand for contraceptive services. Meeting this need will be an ongoing challenge for the family planning programme, a primary objective of which is to assist couples to have the number of children they want and to achieve the spacing of births that they desire.

5.1   DESIRE FOR ADDITIONAL CHILDREN

To obtain information on the desire for children, currently married women were asked whether or not they would like to have another child, and if so, how long they would like to wait before the birth of that child.[1] Using their responses, women are classified by their preferences as follows: those who want no more children, those who want another child, those who are undecided and those who believe they are unable to have a child. Women who want another child are further classified as follows: those who want a child within the next two years, those who would like to wait two or more years from the time of the survey, and those who are unsure about when they would like to have their next child.[2]

Three-fifths of currently married women want to have more children, as Figure 5.1 shows. Among these women, however, a strong interest in spacing the next birth is expressed; one-third of all currently married women want to wait at least two years before having another child. Almost all of the remaining women who want a child would like a birth soon (within two years).
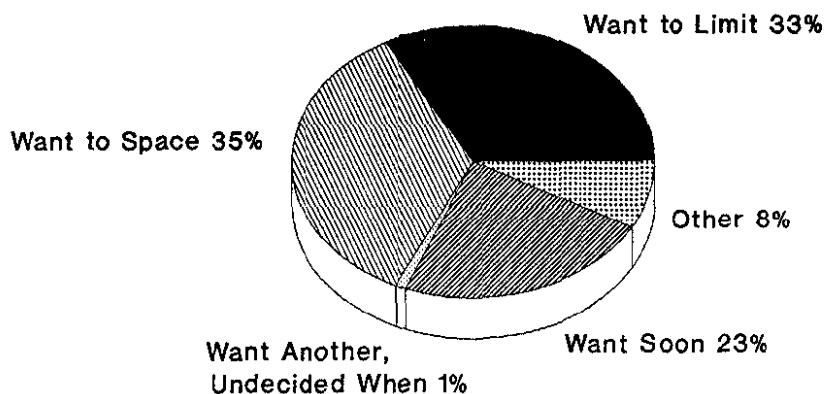
Although the majority want another child, many Zimbabwean women are satisfied with the size of their family. In the ZDHS, one in three currently married women expressed a desire to have no more children. This represents a one-third increase in the proportion of women wanting to limit childbearing since the Zimbabwe Reproductive Health Survey in 1984, when only one in four currently married women reported that she wanted no more children (Zimbabwe National Family Planning Council and Westinghouse Public Applied Systems, 1985, p.58).

Whether or not a woman wants to have another child is likely to depend on how many children she already has. Table 5.1 shows the future childbearing preferences of currently married

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[1]   Women who had no children were asked if they would like to have a child, and pregnant women were asked whether they would like another child after the one they were expecting.

[2]   Women who declare themselves as unable to have children are not classified into any of these categories.

Figure 5.1
Desire for Children
Currently Married Women

Want to Limit 33%

Want to Space 35%

Other 8%

Want Soon 23%

Want Another,
Undecided When 1%

Zimbabwe DHS 1988

Table 5.1   Percent Distribution of Currently Married Women by Desire for Children and Timing,
            According to Number of Living Children, Zimbabwe DHS, 1988

Desire for Children and Timing	Number of Living Children(1)							
	None	1	2	3	4	5	6 or More	Total
Want Another Within 2 Years	72,0	33,0	28,7	25,7	16,4	16,0	8,1	22,6
Want Another After 2 or More Years	2,5	59,2	48,9	46,5	42,7	26,0	11,3	35,3
Want Another, Unsure When	3,4	1,0	1,9	1,0	0,5	1,1	0,7	1,1
Undecided	4,2	1,9	3,9	5,9	7,1	8,9	8,1	5,9
Want No More(2)	2,5	4,4	15,4	19,3	31,8	46,1	68,9	32,7
Unable to Have Child	12,7	0,5	0,7	1,3	1,4	1,5	2,8	2,0
Missing	2,5	0,0	0,5	0,3	0,0	0,4	0,0	0,3
Total Percent	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Number of Women	118	412	415	389	365	269	675	2 643

(1) Includes current pregnancy
(2) Includes sterilised women

Table 5.2 Percent Distribution of Currently Married Women by Desire for Children and Timing, According to Age, Zimbabwe DHS, 1988

Desire for Children and Timing	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Want Another Within 2 Years	34,4	19,5	26,3	23,9	23,6	16,2	14,2	22,6
Want Another After 2 or More Years	54,4	64,1	47,2	30,6	16,4	5,9	3,0	35,3
Want Another, Unsure When	1,1	1.0	1,8	1,6	0,7	0,4	0,4	1,1
Undecided	3,3	4,7	6,4	6,8	7,9	5,9	4,3	5,9
Want No More(1)	3,9	9,7	17,9	36,4	48,6	65,2	70,7	32,7
Unable to Have Child	1,7	0,6	0,0	0,8	2,5	6,3	7,3	2,0
Missing	1,1	0,4	0,4	0,0	0,2	0,0	0,0	0,3
Total Percent	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Number of Women	180	513	559	503	403	253	232	2 643

(1) Includes sterilised women

women according to the number of living children they already have.[3] The distribution of preferences by parity can be easily summarised. More than three-quarters of the women who have no children would like to have a child, and most of these women would like that birth soon. The most frequently expressed preference among women with 1-4 children is to have another child, but to delay its birth for two or more years from the time of interview, while the modal preference for women with five or more children is to have no more children at all.

Table 5.2 shows the distribution of currently married women by their fertility preference, according to age. The modal preference for women under age 30 is to have another child after two or more years. The proportion of women desiring to limit childbearing steadily increases with age. This is to be expected since parity rises with age. However, even among older women, the proportion expressing a desire for no more children reaches a majority only among women in their forties.

An inverse relationship between parity and the desire to have no more children is shown among all subgroups in Table 5.3. A desire to limit births on the part of a significant proportion of currently married women is evident, however, at much lower parities among urban than rural women. For example, more than one in five urban women with two children wants no more, compared with one in ten rural women. At parity four or higher, the urban-rural differential diminishes, with more than half of the women in each residential category expressing a preference to limit further births. The fact that, in the population as a whole, similar proportions of urban and rural women would prefer to have no more children is due to the proportionately greater number of rural women than urban women at higher parities.

Table 5.3 also shows the variation in the percent of currently married women who want no more children by educational attainment. Overall, it appears that women with secondary education are less likely to be interested in limiting births than women with no formal schooling. Again this

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[3] A current pregnancy is counted as one child toward the total number of living children since a pregnant woman was asked whether she wanted to have another child after the one she was expecting.

Table 5.3   Percent of Currently Married Women Who Want No More Children by Number of Living Children, According to Selected Background Characteristics, Zimbabwe DHS 1988

Background Characteristic	Number of Living Children(1)					
	None	1	2	3	4 or More	Total
Urban-Rural Residence						
Urban	5,9	3,8	22,9	31,1	58,1	34,5
Rural	1,2	4,6	10,4	13,0	52,5	32,0
Level of Education						
No Education	4,8*	8,3	13,2	12,3	44,6	32,5
Primary	1,7	3,8	5,7	14,5	55,8	34,3
Secondary or Higher	2,6	4,1	33,1	40,8	64,6	28,4
Total	2,5	4,4	15,4	19,3	53,9	32,7

Note: Sterilised women are included among women wanting no more children.

(1) Includes current pregnancy
* Percentage based on fewer than 25 cases

pattern is due to parity differences between education groups; women with secondary education tend to be younger and have fewer children than women in the other two education categories, and, thus, on aggregate, they are more likely to want another child. When parity is controlled, the expected inverse relationship between educational attainment and the desire to limit is observed at parity two and above. Among women with four or more children, for example, only 45 percent of those with no formal education want to limit childbearing, compared with 65 percent of women with a secondary education.

In summary, the ZDHS data on future childbearing desires indicate that two-thirds of women in Zimbabwe want to avoid or delay the next birth. Young, low-parity women primarily want to space births. Interest in limiting births becomes more predominant among women in their thirties; however, it is only among women in their forties, who are nearing the end of childbearing, that the majority indicate that they are satisfied with the size of their families and want no more children. Significant numbers of urban women and women with secondary education express a desire to limit childbearing when they have two or three children, while, for rural women and less educated women, the preference for limiting begins to emerge strongly only among women with four or more children.

5.2   PREFERRED NUMBER OF CHILDREN

The first part of this chapter focused on the respondent's current childbearing desires, which are influenced by the number of children that she already has. In Table 5.4, which presents the distribution of all women according to the number of living children, attention shifts from the immediate desire for a child to an indicator of the woman's preferred family size. The measure of ideal (preferred) family size was obtained by asking the respondent about the number of children

Table 5.4 Percent Distribution of All Women by Ideal Number of Children and Mean Ideal Number of Children for All Women and Currently Married Women, According to Number of Living Children, Zimbabwe DHS, 1988

Ideal Number of Children	Number of Living Children(1)							
	None	1	2	3	4	5	6 or More	Total
None	0,7	0,2	0,6	0,2	0,2	0,0	0,1	0,4
1	1,3	3,2	1,4	0,2	1,0	0,7	0,1	1,2
2	17,4	13,0	12,2	3,1	4,3	2,9	1,5	9,4
3	13,0	15,2	6,9	8,9	2,4	2,6	1,1	8,3
4	40,0	36,1	38,0	30,4	27,0	17,0	14,7	30,8
5	14,0	11,7	13,9	14,7	11,3	13,7	7,6	12,3
6 or More	12,0	17,2	20,8	36,0	45,1	50,3	56,7	30,3
Non-numeric Response	1,6	3,5	6,2	6,4	8,7	12,7	18,2	7,4
Total Percent	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Number of Women	1 144	632	518	450	415	306	736	4 201
Mean (All Women)	3,9	4,1	4,4	5,2	5,5	5,9	6,7	4,9
Base (All Women)	1 126	610	486	421	379	267	602	3 891
Mean (Currently Married Women)	4,9	4,2	4,5	5,2	5,6	5,9	6,8	5,4
Base (Currently Married Women)	114	397	388	365	332	238	553	2 387

(1) Includes current pregnancy

she would have if she could begin the childbearing period again and have exactly the number that she wanted. This more abstract question proved difficult for some respondents; overall, 7 percent were unable to give numeric answers, with the majority of those unable to state a preferred number concentrated among high-parity (older) women.

The results in Table 5.4 show that the majority of women in Zimbabwe prefer large families. Women want five children, on average. Only one in five women wants three children or less. Three in four want at least four children, and one in three wants six or more children.

The mean preferred number of children increases as the number of children the women actually have increases, from just under four children among childless women to slightly under seven children among women who currently have six or more children. There are several reasons for this pattern. First, to the extent that women implement their preferences, those who want larger families will tend to achieve larger families. Second, it is possible that women with larger families, who are on average older than women with smaller families, have preferences for larger families based on attitudes they acquired 20 to 30 years ago. Finally, some women may report the actual number of children as the preferred number because they find it difficult to admit that they would not have some of their children if they could begin again.

Although most women have not yet had the number of children they would prefer to have, there is a minority of women in every parity group who have already had more children than their

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Table 5.5   Mean Ideal Number of Children for All Women by Age, According to Selected
Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Urban-Rural Residence								
Urban	3,4	3,7	4,2	4,6	5,0	5,3	5,6	4,2
Rural	4,1	4;6	5,3	5,9	6,3	6,6	7,4	5,3
Level of Education								
No Education	5,0*	5,3	5,6	6,8	7,3	6,4	7,4	6,3
Primary	4,2	4,7	5,2	5,4	5,9	6,5	7,0	5,2
Secondary or Higher	3,6	3,7	3,6	4,4	4,5	4,0	4,8*	3,8
Total	3,9	4,2	4,9	5,4	5,9	6,2	6,9	4,9

* Mean based on fewer than 25 cases

preferred family size. Among women with five or more children, the proportion whose actual number of children is greater than their preferred number exceeds 20 percent.

Table 5.5 shows that the desired number of children steadily increases with age, varying from between three or four children among women under 25 to six or seven children among the oldest women interviewed. Urban women of all ages prefer, on average, to have one child fewer than rural women. Preferences vary the most by educational level; women with secondary and higher education prefer to have one child fewer than women with primary education, and more than two children fewer than women with no education.

5.3   FUTURE NEED FOR FAMILY PLANNING

Combining information on current contraceptive behavior and future childbearing preferences, it is possible to estimate the extent of the unmet need for family planning. In Table 5.6, women are considered to be potentially in need of contraception if they either want no more children, want to delay their next birth for two or more years, or are uncertain about having another child, and are not contracepting. By taking into account the intention to use family planning, the final three columns in Table 5.6 provide some insight into the level of motivation to contracept already present among the women in need of family planning.

In considering the results in Table 5.6, it is important to note that, for some of these women, the need for contraception is not immediate: they may not be currently exposed to the risk of pregnancy because they are amenorrhoeic, living apart from their husbands, or are already pregnant. Thus, the results in Table 5.6 represent an estimate of the maximum need for services, including both women who are currently exposed to the risk of a mistimed or unwanted pregnancy and those who will become at risk in the near future.

Overall, one-third of currently married women in Zimbabwe can be considered to be in need of contraception. These women are almost evenly divided between those in need for stopping

Background Characteristic	In Need(1)			In Need and Intend to Use			Number of Women
	Want No More	Want to Space/ Undecided	Total	Want No More	Want to Space/ Undecided	Total	
Urban-Rural Residence							
Urban	15,1	13,4	28,5	8,0	9,9	17,8	779
Rural	18,6	17,9	36,5	7,9	11,5	19,4	1 864
Level of Education							
No Education	20,0	14.5	34,6	7,0	8,7	14,9	489
Primary	19,4	16,7	36,1	8,8	10,7	19,6	1 601
Secondary or Higher	10,1	18,1	28,2	6,1	14,6	20,8	553
Total	17,6	16,6	34,2	7,9	11,0	19,0	2 643

(1) Includes women who are not using a method of family planning and who (a) want no more births, (b) want to postpone their next birth for two or more years, or (c) are undecided about if or when to have a birth.

purposes (18 percent) and those in need because they want to space or they are undecided about whether or when to have another child (20 percent). The proportion in need of contraception is somewhat greater among rural women and women with less than secondary education. However, even among urban women and women with a secondary education, more than one in four can be considered in need of family planning.

From the point of view of providing services, not all need will be equally easy to meet. Those already expressing an interest in using will presumably be easier to motivate to adopt a family planning method than those who are not currently interested in using. The proportion of women who say they intend to use family planning in the future, therefore, provides an estimate of the potential demand for family planning among women in need. Table 5.6 shows that 56 percent of women who are in need of family planning say they intend to use family planning in the future. Those interested in delaying childbearing are more likely to intend to use family planning than those who want to stop childbearing. Rural women in need are less likely than urban women to say that they plan to use in the future. Among women in need, those with no education may be hardest to motivate to use as they are the least likely to express an intention to contracept in the future.

In summary, although over 40 percent of Zimbabwean women are practicing contraception, the need for family planning is high. One in three currently married women want to delay or stop childbearing or are uncertain about if or when to have another child and are not currently contracepting. Half of these women already say they intend to use family planning. By providing permanent methods for limiting childbearing, as well as temporary methods for spacing, the family planning programme can help couples achieve and maintain their desired family size.

5.4   NEED FOR FAMILY PLANNING AMONG HIGH RISK GROUPS

The health risks of pregnancy for mothers and their children have been shown to be highest when pregnancies occur:

- before age 19 (too young);
- after age 35 (too old);
- after five births (too many);
- less than two years apart (too soon).

As Table 5.7 shows, seven in ten Zimbabwean women fall in one or more of these risk groups. Motivating these women to use family planning would contribute significantly to improving the health and well-being of mothers and children in Zimbabwe. Information on fertility desires and the current pattern of contraceptive use suggests that there is strong interest in limiting or delaying births and substantial unmet need for family planning among these women.

Table 5.7 Number and Percent of Women For Whom a Pregnancy Is Considered to Involve High Morbidity and Mortality Risk for Mother and Child by Risk Category, Zimbabwe DHS, 1988		
Risk Category	Percent	Number of Women
18 Years or Less	4,4	117
35 Years and Over	33,6	888
5 Births or More	40,1	1 060
Less than 15 Months Postpartum	29,6	782
Any Risk Factor	69,7	1 842

Childbearing Desires among High Risk Groups

Table 5.8 looks at the childbearing desires of women in high risk categories. For this purpose, women who are 35 and over or who have five or more births are grouped together into one category, old/high parity, while those who are age 18 or less or who are age 19-34 and less than 15 months postpartum are grouped into another category, young/space (Radloff et al., 1989). The results indicate that most women in these high risk groups are in need of family planning if they are to achieve their reproductive goals. In the old/high parity group, almost all women want to limit (55 percent) or to space (16 percent) or are ambivalent about if or when to have another child (9 percent); only 17 percent want another child immediately. In the young/space group, two-thirds would like to delay the next birth for at least two years, and 13 percent want no more children. Even in this group of younger, low-parity women, less than 15 percent are sure that they want another child immediately.

Current Contraceptive Use among Risk Groups

Table 5.9 shows the pattern of contraceptive use among women in the high risk groups. Overall, two in every five women who fall in a risk group are using a contraceptive method. Use levels are considerably higher for women in the young/space group (51 percent) than in the old/high parity group (39 percent). Comparing the use levels in the two groups at the time of the ZDHS with the rates reported in the 1984 ZRHS, there was a small increase in use among women in both groups. More significantly, there was a substantial increase in the proportion of users in the two groups employing a modern method. Equally encouraging is the fact that, among women in the two groups who were not using, there appeared to have been a substantial increase in the level of experience with family planning. Among nonusers in the young/space group, only about

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Table 5.8 Percent Distribution of Currently Married Women in
Young/Space or Old/Parity Risk Categories by Desire
for Children and Timing, According to Risk Category,
Zimbabwe DHS, 1988

Desire for Children and Timing	Young/ Space(1)	Old/High Parity(2)
Want Another Within 2 Years	14,3	17,1
Want Another After 2 or More Years	67,6	16,2
Want Another, Unsure When	0,5	0,9
Undecided	4,0	7,7
Want No More(3)	12,7	54,7
Declared Infecund	0,2	3,4
Missing	0,7	0,1
Total Percent	100,0	100,0
Number of Women	568	1 274

(1) Includes women who are age 18 and under or who are age
19-34 and less than 15 months postpartum
(2) Includes women who are age 35 and over or who have 5 or
more children
(3) Includes sterilised women

Table 5.9 Percent Distribution of Currently Married Women in
Young/Space or Old/Parity Risk Categories, by
Contraceptive Use Status, According to Risk
Category, Zimbabwe DHS, 1988 and RHS, 1984

Contraceptive Use Status	1988 ZDHS		1984 ZRHS	
	Young/ Space(1)	Old/High Parity(2)	Young/ Space	Old/High Parity
Currently using	51,1	39,2	47,3	37,5
Pill	41,9	23,2	31,3	17,6
Other Supply	1,9	1,5	1,6	2,1
IUD	0,9	0,8	0,6	0,9
Sterilisation	0,2	4,7	0,4	3,1
Traditional	6,2	9,1	13,5	13,7
Used in Past	22,5	42,9	12,1	34,3
Never Used	26,4	17,8	40,6	28,2
Total Percent	100,0	100,0	100,0	100,0
Number of Women	568	1 274	506	945

(1) Includes women who are age 18 and under or who are age
19-34 and less than 15 months postpartum
(2) Includes women who are age 35 and over or who have 5 or
more children

one in four had had any experience in using a method in 1984, while, in 1988, 45 percent had used a method at some time. Among nonusers in the old/high parity group, the proportion with experience in using contraceptive methods increased from 55 percent to 70 percent between the two surveys.

Not surprisingly, in view of the dominance of the pill in the method mix among Zimbabwean users, two-thirds of current users in high risk groups at the time of the survey were using the pill, 13 percent were using other modern methods (largely female sterilisation) and the remainder were relying on traditional methods (primarily withdrawal). While the pill is an entirely appropriate method for the young/space group, where use is largely motivated by desire to delay a wanted birth, it is less appropriate among the old/high parity group, where use is most frequently motivated by a desire to limit births. The ZDHS results suggest that the family planning programme in Zimbabwe needs to explore ways to improve the appropriateness of the method mix among users in the old/high parity risk group, including increasing access to the IUD and female sterilisation.

Chapter 6

MORTALITY AND HEALTH

Zimbabwe is currently the home of more than 1,4 million children under the age of five. This chapter focuses on factors relating to the health and survival of these children. The first section describes recent levels, trends and differentials in infant and child mortality. ZDHS findings related to use of maternal health services are reviewed. Attention then turns to information concerning the prevalence and treatment of diarrhoeal and respiratory infections. Finally, the nutrition status of children in the age range 3 to 60 months is examined, using ZDHS height and weight data.

6.1 INFANT AND CHILD MORTALITY

The estimates of infant and child mortality are based on data collected in the ZDHS birth histories; for each reported live birth, information is available on the date of birth, sex, survivorship status and, among those who died, age at death. These retrospective data are used to calculate period probabilities of dying using the life table methodology described by Rutstein (1984). In examining trends in mortality, rates are presented for three periods, 1973-1977, 1978-1982 and 1983-1988. The earlier periods cover exactly five calendar years; the most recent period covers almost six years since it includes information for the months in 1988 and 1989 up to the month of interview. In looking at differentials, the rates are shown for the period 1978-1988. In all cases, the mortality rates are presented for three age intervals:

Infant mortality - the probability of dying between birth and exact age one;
Childhood mortality - the probability of dying between age one and age five;
Under-five mortality - the probability of dying between birth and exact age five;

Birth History Survivorship Data

Estimates of infant and child mortality based on retrospective survey data are subject to several technical limitations. First of all, the estimates are influenced by data collection errors, including underreporting of births, misreporting of birth date and misreporting of age at death. Mortality levels are affected by the underreporting of births who later die, while errors in the reporting of birth dates can distort trends in mortality over time. Misreporting of the age at death can bias the age pattern of mortality; for example, an overestimate of child mortality relative to infant mortality may result if children dying during the first year of life are reported as having died at age one or older. Because respondent recall is likely to be better for the recent past, reporting errors of all types are generally less serious for time periods close to the survey. An examination of the internal consistency of the ZDHS mortality data indicates there is no apparent gross underreporting of deaths during the time periods for which the mortality rates are estimated and that, although there is some evidence of heaping in the age at death data at one year, the bias in the infant and child mortality rates arising from this heaping is negligible.

The examination of mortality trends is also affected by the fact that the rates become progressively more truncated further back in time because women age 50 and over who were bearing children during those periods were not included in the survey. For example, for the period 1973-1977 (11-15 years before the survey), the rates do not include any births for women 40-49 since these women were 51-60 at the time of the survey and not eligible for interview. Since these excluded births to older women who were likely to be at a somewhat greater risk of dying than births to younger women, the mortality levels for the period may be slightly underestimated. The rates for later periods are less affected by truncation bias since fewer older women are excluded.

Finally, in looking at differentials in mortality rates, attention should be paid to the number of events on which the rates are based. For some subgroups, the rates are based on a small number of events and, thus, are subject to greater sampling variability.

Mortality Levels and Trends

Table 6.1 presents the estimates of early childhood mortality for the calendar period 1983-1988, immediately preceding the survey date, and for two earlier five-year time periods (1978-1982 and 1973-1977). The trend in the rates over the three periods is not regular, with mortality levels during the period 1973-1977 being somewhat lower than the rate for the period 1978-1982. Although a temporal rise in mortality in the late 1970s is possible, it is more likely that the rates for the 1973-1977 period are too low, probably due to a combination of the effects of errors in the dating of events and of the truncation bias.

Table 6.1 Infant and Childhood Mortality for the Calendar Periods 1983-1988, 1978-1982 and 1973-1977, Zimbabwe DHS, 1988

Period	Infant Mortality (1q0)	Childhood Mortality (4q1)	Under-five Mortality (5q0)
1983-1988(1)	52,7	23,7	75,1
1978-1982	63,7	42,5	103,6
1973-1977	53,6	40,2	91,6

(1) Includes events in the calendar year of survey up to but excluding month of interview.

Suggesting that mortality levels have been declining sharply, child mortality is substantially lower during the most recent period than during the two earlier periods. Under-five mortality (5q0) during the period 1983-1988 was 75 deaths per thousand compared to a level of over 90 per thousand that prevailed during the 1970s and early 1980s. The decline in under-five mortality has been driven largely by a sharp fall in mortality among children 12-59 months; the current childhood mortality rate (24 deaths per thousand) is around 40 percent lower than the rate observed during the period 1973-1982. Infant mortality also appears to have declined recently, but at a much slower pace. The level estimated in the ZDHS for the period 1983-1988 (53 per thousand) is somewhat lower than the infant mortality rate estimated from the results of the 1987 ICDS (61 per thousand) for the 12-month period before the survey (Johansson, 1989).

Socio-Economic Differentials

Table 6.2 shows differentials in mortality during the ten-year period before the survey according to the mother's current place of residence and level of education. The survival prospects for children living in urban areas are much better than for rural children. Overall, under-five

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Table 6.2 Infant and Childhood Mortality for the Calendar
          Period 1978-1988 by Selected Socio-economic
          Characteristics of the Mother, Zimbabwe DHS, 1988

Socio-economic Characteristic	Infant Mortality (1q0) 1978-1988(1)	Childhood Mortality (4q1) 1978-1988	Under-five Mortality (5q0) 1978-1988
Urban-Rural Residence			
Urban	37,8	17,8	54,9
Rural	64,5	36,4	98,6
Level of Education			
No Education	77,0	52,0	124,9
Primary	55,0	28,9	82,3
Secondary or Higher	39,9	7,9	47,5
Total	57,4	31,3	86,9

(1) Includes events in the calendar year of survey up to but
    excluding the month of interview

mortality in rural areas is almost double that in urban areas. The urban-rural differential is somewhat greater in the case of the child mortality rate than the infant mortality rate. The higher rural than urban child mortality is likely related to a number of factors, including greater availability of health services in urban areas and the higher educational attainment of urban mothers.

Maternal education has a profound effect on levels of both infant and child mortality. Overall, under-five mortality for children of women with at least a secondary level of education was less than half that of children whose mothers had no formal education. The education effect is most pronounced for childhood mortality; the risk of dying during early childhood is six times greater for children of women with no formal education than for children of women with secondary education. Several factors help to explain this extremely strong negative relationship between mother's education and child mortality. Higher educational attainment for the mother is, first of all, likely to be associated with greater awareness of appropriate health practices and, consequently, better general health habits. It is also usually directly related to income, and, consequently, to greater access to health care services, better diet for the child and a safer living environment.

Demographic Differentials

Table 6.3 examines the relationship between infant and childhood mortality and various bio-demographic factors. It is well-established that male children are at increased mortality risk both before and shortly after birth, presumably due to genetic factors. Zimbabwean boys are 30 percent more likely to die in the first year of life than girls. There is, however, no significant sex differential in mortality risk for the 12-59 age group.

The association of infant mortality with maternal age at birth exhibits the expected pattern; the highest mortality risk occurs for children of very young mothers and mothers nearing the end of their reproductive lives. The effect on child mortality is not as pronounced, although it follows

Table 6.3 Infant and Childhood Mortality for the Calendar
Period 1978-1988 by Selected Demographic
Characteristics, Zimbabwe DHS, 1988

Demographic Characteristic	Infant Mortality (1q0) 1978-1988(1)	Childhood Mortality (4q1) 1978-1988	Under-five Mortality (5q0) 1978-1988
Sex of Child			
Male	64,9	30,2	93,1
Female	49,7	32,5	80,5
Mother's Age at Birth			
Less than 20	78,4	36,3	111,9
20-29	47,8	31,3	77,6
30-39	62,0	27,2	87,5
40-49	67,1	37,1	101,7
Birth Order			
First	63,5	31,3	92,9
2-3	53,2	31,3	82,8
4-6	48,7	28,6	75,9
7 or Higher	75,4	37,2	109,8
Interval Since Previous Birth			
Less than 2 Years	78,9	53,5	128,2
2-3 Years	47,9	23,4	70,2
4 Years or More	42,8	25,1	66,8

(1) Includes events in the calendar year of survey up to but
excluding month of interview.

the same general pattern. Since birth order of the child and maternal age are highly correlated, it is not surprising to find mortality risks to be greatest among first births (which are generally to young mothers) and births of order seven or higher (which are generally to older mothers). The differentials in mortality risks by birth order are greater for infants than for older children.

The strong influence of preceding birth interval length on childhood mortality is well-established. In Table 6.3, the most significant differentials in both infant and child mortality are associated with the length of the preceding birth interval. The under-five mortality rate for intervals under two years is almost twice the rate for intervals of four years or more. The infant mortality rate varies from nearly 80 per thousand for birth intervals of less than two years to around 40 per thousand for birth intervals of four years or more. These differentials suggest that mortality risks for Zimbabwean children would be substantially reduced if birth intervals were increased.

Proportion Dead Among Children Ever Born

Additional insights into the issue of child mortality are provided by Table 6.4, which shows the mean number of children ever born, surviving and dead to all women, and the proportion dead

Table 6.4 Mean Number of Children Ever Born, Surviving and Dead, and Proportion Dead Among Children Ever Born by Age of Mother, Zimbabwe DHS, 1988

| Age of Woman | Mean Number of Children | | | Proportion Dead | Number of Women |
	Ever Born	Surviving	Dead		
15-19	0,19	0,17	0,01	0,07	1 021
20-24	1,30	1,21	0,09	0,07	840
25-29	2,89	2,64	0,25	0,09	679
30-34	4,35	3,99	0,35	0,08	589
35-39	5,54	4,98	0,56	0,10	464
40-44	6,40	5,69	0,71	0,11	318
45-49	6,87	5,98	0,90	0,13	290
Total	2,95	2,66	0,29	0,10	4 201

among children ever born, according to the age of the mother. The data summarise the lifetime effect on child survivorship of the mortality levels prevailing throughout the period during which women 15-49 have been bearing children. Overall, about one-tenth of the children ever born to women have died. The proportion dead increases with the age of the mother. This pattern reflects the shorter exposure to the risk of dying among children of younger mothers as well as the decline in child mortality in the recent past.

6.2 MATERNAL CARE INDICATORS

The health care that a mother receives during pregnancy and at the time of delivery is important to the survival and well-being of both the mother and the child. A primary objective of the Ministry of Health is to ensure that all pregnant mothers receive antenatal care and that their children are born in health facilities under conditions of safety for both the mother and the baby. The health system is graded into hierarchies of care, with each lower level referring difficult cases to the next higher level. At the bottom of the formal health care system are clinics and rural health centers (RHC). These facilities, which collectively can be called primary care facilities, are staffed by nurses and nurse-midwives. They refer difficult cases to district hospitals, which have both nurses and doctors. The district hospitals in turn refer patients to provincial hospitals, which ultimately refer to central hospitals.

To obtain information on the maternity care that women receive, ZDHS respondents who had given birth in the five years before the interview were asked whether they had seen anyone for a check on the pregnancy and who had assisted with the delivery. For those receiving antenatal care or delivery assistance from more than one provider, the most qualified provider was recorded by the interviewer. Since neonatal tetanus continues to be a major cause of death among infants during the first month of life, respondents were also asked for each birth if they had received an injection during the pregnancy to prevent the baby from getting tetanus ("convulsions") after birth. The accuracy of the mother's response to this question depends on her recall of events during the pregnancy and, particularly, her ability to distinguish tetanus toxoid injections (given on the

shoulder) from other injections. Moreover, the failure of a mother to be immunised during pregnancy does not necessarily mean that a baby is exposed to the risk of tetanus; some protection may be given by tetanus toxoid injections received prior to the pregnancy.

Antenatal Care
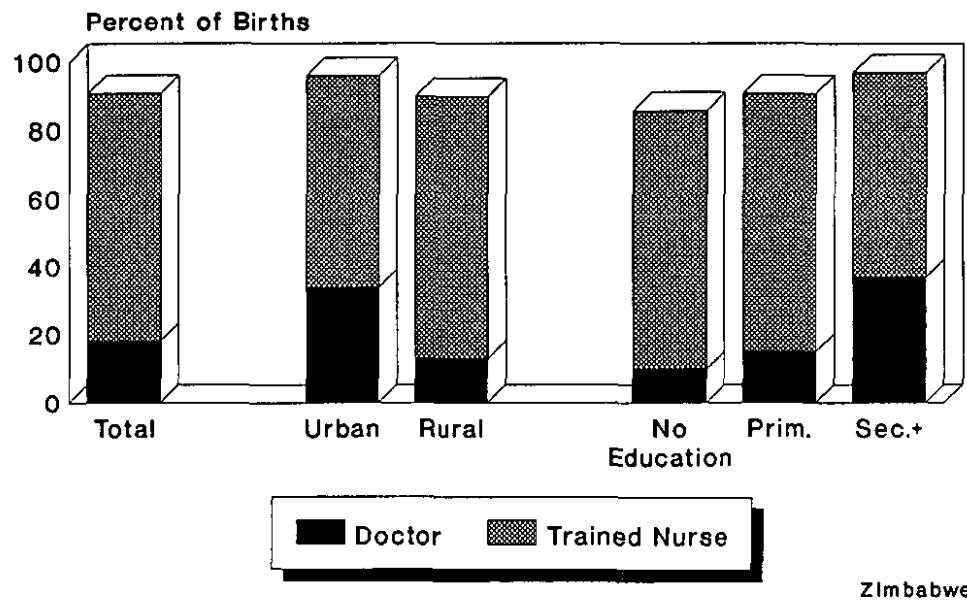
Safe childbearing begins with antenatal care. Table 6.5 shows that, for 91 percent of births, the mother received some form of antenatal care, provided by trained medical personnel (doctors and nurses). The PHC/MCH/ARI survey conducted by the Ministry of Health in October 1988 also found antenatal care to be almost universal among pregnant women, with trained medical personnel providing care during pregnancy for 92 percent of births in the year preceding the survey (Ministry of Health, 1988, p.7). The ZDHS shows that most contact with trained medical personnel during pregnancy is with nurses; among births preceded by antenatal care provided by trained personnel, four in five mothers saw a nurse for such care. Since the majority of mothers attend antenatal clinics at primary care facilities, this is to be expected, as these facilities are staffed by nurses.

There are minor differences among subgroups in the prevalence of antenatal care. Even among women with no education, who are the least served group, mothers report having an antenatal check from trained medical personnel for 86 percent of their births. However, some women are more likely to have a doctor check on their pregnancy than other women (Figure 6.1). For example, among births for which care during the pregnancy was received from trained personnel, the mother was checked by a doctor during pregnancy for one in three urban births

Table 6.5 Among Births in the Five Years Before the Survey, Percent Distribution by Person Providing Antenatal Care for the Mother and Percent Whose Mother Received a Tetanus Toxoid Injection, According to Selected Background Characteristics, Zimbabwe DHS, 1988

| Background Characteristic | No One | Antenatal Care Provider | | | | | Total Percent | Received Tetanus Toxoid Injection | Number of Women |
		Doctor	Trained Nurse	Birth Attendant	Other	Missing			
Age									
15-29	6,2	19,5	72,4	0,4	0,4	1,0	100,0	81,3	1 863
30-49	6,7	16,9	73,7	0,4	0,9	1,4	100,0	75,5	1 471
Urban-Rural Residence									
Urban	3,0	33,9	62,3	0,0	0,3	0,5	100,0	80,7	886
Rural	7,7	12,7	76,8	0,6	0,7	1,5	100,0	78,0	2 448
Level of Education									
No Education	11,7	10,4	75,7	0,0	0,3	1,9	100,0	74,4	617
Primary	6,3	14,9	76,2	0,7	0,8	1,2	100,0	79,6	2 081
Secondary or Higher	1,9	37,3	59,9	0,0	0,5	0,5	100,0	80,2	636
Total	6,4	18,3	73,0	0,4	0,6	1,2	100,0	78,7	3 334

Figure 6.1
Percent Receiving Antenatal Care
From Medical Personnel

Zimbabwe DHS 1988

compared with one in seven rural births. Greater access to doctors in urban areas probably explains this differential; there are far more doctors in urban areas than in rural areas, both in public service and in private practice.

The likelihood of contact with a doctor during pregnancy also increases directly with the mother's educational attainment, with mothers with secondary or higher education more than three times as likely to been seen during pregnancy by a doctor as mothers with no education. Overall, doctors provided the care in only 10 percent of births to mothers with no education compared with 15 percent of those to mothers with primary education and 37 percent of those to mothers with secondary education. Again, greater access to doctors likely explains these differential. Women with secondary education are likely to be financially better off than other women and, thus, better able to afford antenatal visits to private doctors; also, they are more likely to live in urban areas where doctors are more available.

Tetanus Toxoid Injection

Tetanus toxoid injections are an important component of antenatal care. Table 6.5 shows that tetanus toxoid coverage was high in the last five years, but not universal. Almost 80 percent of births were to mothers who reported receiving a tetanus toxoid injection during pregnancy. While coverage by age, residential, and educational status varies in the expected directions--higher coverage among babies born to young, urban, higher educated mothers--the differences are slight. Among women with no education, where the tetanus toxoid immunisation rate was the lowest, 74 percent of babies were born to mothers who reported having had an injection during pregnancy.

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Assistance at Delivery

Proper care during labor and delivery is another important measure in reducing morbidity and mortality risks for both mothers and babies. In Zimbabwe, the majority of mothers receive assistance from health care personnel at the time of delivery. Table 6.6 shows that medical personnel attended 70 percent of births in the five years before the ZDHS. This figure is supported by the results of a survey conducted in October 1988 by the Ministry of Health, which found that 73 percent of births in the year preceding that survey had been attended by trained medical personnel (Ministry of Health, 1988). Nurses provide most delivery care; among the medically supervised deliveries reported in the ZDHS, more than 80 percent were attended by nurses. Among the births not assisted by medical personnel, most were attended by relatives; less than 3 percent of all births were unattended.

Table 6.6 shows that there is greater variability across subgroups in the proportion of deliveries attended by medical personnel than in the other maternity care indicators. For example, only around three in every five births to rural mothers were assisted by a doctor or nurse compared to more than nine in ten urban births. Women with no formal education are least likely to have medically supervised deliveries; only 46 percent of the births to mothers in this group were attended by a doctor or nurse, while two-thirds of the births occurring to mothers with primary education and more than 90 percent of the births to mothers with secondary education were assisted by medical personnel. As was the case with prenatal care, births to urban mothers and mothers with a secondary education are much more likely than other births to be supervised by doctors. Again, this probably reflects greater access on the part of these groups to physicians, who are concentrated in urban areas.

Table 6.6   Among Births in the Five Years Before the Survey, Percent Distribution by the Person Assisting the Mother at the Delivery, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	No One	Doctor	Trained Nurse	Birth Attendant	Relative	Other	Missing	Total Percent	Number of Births
Age									
15-29	1,3	11,5	61,2	5,9	18,5	0,6	1,0	100,0	1 863
30-49	4,1	10,2	55,5	6,9	20,6	1,4	1,4	100,0	1 471
Urban-Rural Residence									
Urban	1,0	22,1	68,4	1,6	6,0	0,5	0,5	100,0	886
Rural	3,1	6,9	55,2	8,0	24,3	1,1	1,5	100,0	2 448
Level of Education									
No Education	5,2	4,4	42,0	1,5	33,2	1,8	1,9	100,0	617
Primary	2,3	8,3	61,7	6,1	19,6	0,9	1,2	100,0	2 081
Secondary or Higher	0,6	25,9	65,3	1,9	5,5	0,3	0,5	100,0	636
Total	2,5	10,9	58,7	6,3	19,4	0,9	1,2	100,0	3 334

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6.3 IMMUNISATION

The Zimbabwe Expanded Programme of Immunisation (ZEPI) was begun in 1982 and is aimed at protecting children against tuberculosis (BCG), whooping cough, diphtheria and tetanus (DPT), poliomyelitis (Polio) and measles. The programme operates throughout the country and has as its goal universal child immunisation. All children are issued a Child Health Card, on which is recorded all the immunisations received by a child and the dates they were given.

Coverage Levels

In the ZDHS, women with children under age five were asked if the child had a Child Health Card (CHC). If a CHC was available for a child, the interviewer copied from the card the dates on which the child had received various immunisations. If a child had no card or the interviewer was unable to examine the card, the mother was asked if the child had ever received an immunisation; however, when the CHC was not seen, no information was collected on specific vaccinations the children had received because of doubts about the reliability of the mother's recall.

Table 6.7 shows that cards were seen for nearly three-quarters of all children under five. The proportion of children for whom the CHCs were available peaks at 88 percent for children 6-11 months of age, before gradually decreasing for older children, possibly because cards are more likely to be misplaced after the child has passed the first birthday (when the primary course of immunisation described above should be completed).

Table 6.7 Among Children Under Age 5, Percent with Health Card, Percent Who Are Immunised as Recorded on a Health Card or Reported by the Mother and, Among Children With Health Cards, Percent for Whom BCG, DPT, Polio and Measles Immunisations Are Recorded on the Health Card by Age (in Months), Zimbabwe DHS, 1988

| | Among Children Under Age 5, Percent With: | | | Among Children with Health Cards, Percent Who Received: | | | | | | | | | |
| | | | | | DPT | | | Polio | | | | All | Number |
Age	Health Card	Immuni- sation Recor- ded on Card	Immuni- sation Reported by Mother	BCG	1	2	3+	1	2	3+	Mea- sles	Immuni- sations	of Children
< 6	82,1	77,7	8,8	94,7	36,9	12,9	3,1	36,4	13,3	3,1	0,9	0,0	274
6-11	87,5	87,5	8,5	99,6	96,5	86,8	63,2	96,1	86,8	64,7	28,7	23,3	295
12-17	80,3	80,3	17,0	98,1	98,5	97,0	91,1	98,5	97,4	90,7	92,9	84,8	335
18-23	74,5	74,1	20,7	97,3	98,6	96,8	94,1	98,6	97,3	94,1	92,7	87,2	294
24-59	67,9	67,1	26,4	95,7	97,7	95,8	90,8	97,8	95,9	91,7	93,5	86,6	1 942
Total	72,9	72,0	21,7	96,5	91,8	86,9	79,4	91,7	87,1	80,0	76,9	70,8	3 140

The results in Table 6.7 show that immunisation coverage in Zimbabwe is quite good; 94 percent of children under five are reported to have received at least one immunisation--72 percent according to information recorded from the CHC and 22 percent according to the mother. Considering only children with CHCs for whom information on individual vaccines is available, it appears that around 85 percent of children 12-59 months--for whom the primary course of immunisation should be completed--have received all the required vaccinations. This represents a maximum estimate of coverage. A minimum estimate can be derived by assuming that the children for whom interviewers did not see a health card have not completed the primary course of immunisation. Based on this assumption, it is estimated that a minimum of 60 percent of the children 12-59 months have completed the primary course of immunisations.

Timeliness of Immunisations

The recommended age schedule for immunising children in the Zimbabwe EPI programme is as follows:

- BCG - at birth or soon after birth;
- DPT1 and Polio1 - at age 3 months;
- DPT2 and Polio2 - at age 4 months;
- DPT3 and Polio3 - at age 5 months;
- Measles - at age 9 months or soon thereafter.

The ZDHS results suggest that most children under five had contact with the health system early in life. Over 90 percent of the children for whom health cards were available had a BCG immunisation during the first three months of life (Table 6.8). DPT coverage is less comprehensive; only three in four children with health cards had the first dose of DPT vaccine at the appropriate age, and only one in two children received the final DPT dose at or close to the recommended age. With regard to measles immunisations, about two-thirds of children received the vaccine at or shortly after the prescribed age of nine months. One in ten measles immunisations was given too early.

Table 6.8 Among Children Under Age 5, Percent Given Vaccination At or Around Recommended Ages by Type of Immunisation, Zimbabwe, DHS, 1988

Immunisation	Percent Given At or Around ¬Recommended Ages
BCG	91 (2-4 months)
DPT1	71 (2-4 months)
DPT3	48 (4-6 months)
Measles	10 (< 9 months)
	66 (9-11 months)

Coverage Differentials

Table 6.9 focuses on children 12-23 months in examining differentials in the child immunisation indicators. Data on immunisation coverage for this group, who should just recently have completed the required course of immunisation, provides an indication of the current level of success of Zimbabwe's EPI programme. Focusing on children 12-23 months also allows the ZDHS results to be compared with the results of the regular series of immunisation coverage surveys carried out by the Ministry of Health. Children 12-23 months are the target group for the

Table 6.9 Among Children 12-23 Months, Percent with Health Card, Percent Who Are Immunised as Recorded on a Health Card or Reported by the Mother and, Among Children With Health Cards, Percent for Whom BCG, DPT, Polio and Measles Immunisations Are Recorded on the Health Card by Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Among All Children 12-23 Months, Percent With:			Among Children With Health Cards, Percent Who Received:									
	Health Card	Immuni-sation Recor-ded on Card	Immuni-sation Reported by Mother	BCG	DPT			Polio			Mea-sles	All Immuni-sations	Number of Children
					1	2	3+	1	2	3+			
Sex of Child													
Male	76,9	76,9	18,6	97,8	98,7	96,0	91,5	98,7	96,9	92,4	91,9	84,8	290
Female	78,2	77,9	18,9	97,7	98,5	97,7	93,2	98,5	97,7	92,1	93,6	86,8	339
Urban-Rural Residence													
Urban	71,8	71,3	25,9	96,0	99,2	98,4	96,8	99,2	98,4	96,8	96,0	90,4	174
Rural	79,8	79,8	16,0	98,3	98,3	96,4	90,9	98,3	97,0	90,6	91,7	84,3	455
Level of Education													
No Education	83,0	83,0	14,3	98,9	98,9	96,8	89,2	98,9	96,8	89,2	89,2	80,6	112
Primary	80,0	80,0	15,1	97,0	98,3	96,3	92,9	98,3	97,0	92,2	92,9	.85,5	370
Secondary/Higher	67,3	66,7	31,3	99,0	99,0	99,0	93,9	99,0	99,0	94,9	96,0	91,9	147
Total	77,6	77,4	18,8	97,7	98,6	96,9	92,4	98,6	97,3	92,2	92,8	85,9	629

Figure 6.2
Immunisation Coverage Among Children
12-23 Months With Health Cards

Percent Receiving All Immunisations*

* BCG, 3+ doses DPT and polio, and measles

Zimbabwe DHS 1988

MOH surveys, the most recent of which was conducted in October 1988 when the ZDHS was also in the field.

Overall, in the ZDHS, Child Health Cards were available for 78 percent of the children 12-23 months. In contrast, in the MOH survey, 94 percent of children 12-23 months had cards. The difference in card availability may be a consequence of the different sampling methods employed in the two surveys and to possible differences in the coverage of children 12-23 months.[1] Estimates of the proportion of children with CHCs who have completed the full course of immunisation are more similar in the two surveys although the ZDHS figure--86 percent--is somewhat higher than the MOH figure (80 percent).

Table 6.9 shows that there are minor differences in the proportion of children 12-23 months with health cards who have completed the full course of immunisation. Among children whose mothers have never attended school, the group where coverage is lowest, 80 percent have had all the required immunisations. Coverage is highest among children whose mothers have had a secondary education, with 92 percent reported as having had the full course of immunisation (Figure 6.2).

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[1] In selecting the areas to be covered in the survey, the MOH used the WHO-recommended cluster-sampling method, while the ZDHS used a random sampling method. Some of the differential may also be traced to the fact that the ZDHS sample was a sample of women while the MOH survey focused on children. If a child was not living with the mother at the time of the ZDHS interview, it is unlikely that the mother would have the child's health card. In the MOH survey, information was collected on card possession regardless of whether or not the mother was present in the household.

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Although urban/rural and educational differences are not great, there is an interesting pattern. Children of rural women and women with less education were more likely to have health cards; but among children who had cards, children of urban women and better educated women were more likely to have received complete immunisation coverage.

6.4 PREVALENCE AND TREATMENT OF DIARRHOEA

Diarrhoea is a major contributing cause of death among infants and children in many developing countries. The ZDHS collected information on occurrence of diarrhoea in children and the treatment practices for those episodes of diarrhoea. Of particular interest was the level of use of oral rehydration therapy (ORT) in treating diarrhoeal episodes. Since diarrhoea kills primarily through causing severe dehydration, ORT is an effective and simple treatment that can sharply reduce the number of deaths associated with diarrhoea.

Table 6.10 shows the prevalence of episodes of diarrhoea in children under five years of age. No attempt has been made to estimate the incidence of diarrhoea since no information was

Table 6.10 Among Children Under Age 5, Percent Reported by the Mother As Having Diarrhoea in the Past 24 Hours and the Past Two Weeks by Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Percent Reported by the Mother as Having Diarrhoea in:		Number of Children
	Past 24 Hours	Past 2 Weeks	
Age			
Under 6 months	8,0	15,3	274
6-11 months	20,7	41,4	295
12-17 months	14,3	33,1	335
18-23 months	9,5	32,0	294
24-59 months	6,0	12,9	1 942
Sex			
Male	9,2	20,5	1 574
Female	8,3	19,0	1 566
Urban-Rural Residence			
Urban	6,7	15,3	851
Rural	9,5	21,4	2 289
Level of Education			
No Education	10,6	21,2	566
Primary	8,4	19,4	1 963
Secondary or Higher	8,2	19,6	611
Total	8,8	19,7	3 140

(1) Includes children having diarrhoea in the past 24 hours

collected regarding the date on which an episode started, nor on its duration. The point prevalence rates are shown for two time periods: (a) the proportion of children under five who had diarrhoea in the 24 hours preceding the survey and (b) the proportion who had diarrhoea in the two weeks preceding the survey. While it is unlikely that a mother would fail to report an episode occurring in the 24 hours before the survey, she may have failed to report an episode that occurred in the 2 weeks before the survey, either because she forgot about the episode or thought that it occurred more than 2 weeks before the interview; thus, the prevalence estimate based on the last two weeks may be too low. Finally, it is important to remember that the diarrhoeal prevalence varies seasonally; at the time of the ZDHS fieldwork (September 1988 through January 1989), diarrhoea levels were expected to be moderate to high.

Among children under five, 9 percent were reported to have had diarrhoea in the 24 hours before the ZDHS and 20 percent in a two-week period preceding the survey. Diarrhoea prevalence was highest among children 6-23 months. Children in this age group are in the process of developing their immune system as they are weaned from the mother's breast milk and initially exposed to disease agents in the food and water they receive as they are weaned. Children less than 6 months are more likely to be exclusively or almost exclusively breastfed and, thus, still largely protected by maternal antibodies, while those older than 2 years have developed through exposure greater immunity to the disease.

Diarrhoea prevalence varies little across subgroups. There is virtually no difference in rates by the sex of the child, and only minor differences among education groups. Rural children were, however, more likely to experience an episode of diarrhoea than urban children. About 10 percent of rural children had an episode of diarrhoea in the 24 hours before the survey and 21 percent in the two weeks before the survey. The corresponding rates for urban children are 7 percent and 15 percent, respectively. The rural-urban differential is likely due to the fact that the water supply, sanitation facilities and environmental hygiene are better in urban than rural areas.

Table 6.11 shows the type of treatment that was sought for diarrhoea episodes. Early treatment of diarrhoea is critical as a child survival intervention, both to prevent dehydration and the complications of dehydration. In Zimbabwe, parents are encouraged to start giving their children a sugar, salt and water solution at home once a child has started diarrhoea, in order to prevent dehydration. They are also encouraged to bring their children to a health facility early on in the episode. The ZDHS obtained information for all children having a diarrhoeal episode during the two weeks before the interview on whether the mother consulted a health facility during the episode and on the treatment used. The figures in Table 6.11 are not mutually exclusive, since mothers may have gone to a health facility as well as used one or more treatments. In one-third of the diarrhoeal episodes, mothers consulted a health facility and, for 70 percent of the cases, they used a sugar, salt and water solution. Mothers rarely used other treatments, and only about one in four did nothing to treat the diarrhoea. The figure for the use of a sugar, salt and water solution is slightly lower than that obtained in the MOH survey of October 1988 (77 percent).

There were only minor differences by sex or by the educational level in the mother's treatment. However, urban residents were somewhat more likely to consult a health facility than rural residents (38 percent vs. 32 percent) and were more likely to use a sugar, salt and water solution as a treatment (81 percent vs. 67 percent).

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Table 6.11 Among Children Under Age 5 Who Had Diarrhoea in the Two Weeks Before the Survey, Percent Consulting a Health Facility, Percent Receiving Different Treatments as Reported by the Mother and Percent Not Consulting a Health Facility and Not Receiving Treatment, by Selected Background Characteristics, Zimbabwe DHS, 1988

| Background Characteristic | Percent Consulted Health Facility | Percent Treated with: | | | | Percent Having No Consultation or Treatment | Number of Children |
		Sugar/ Salt/Water Solution	Herbs	Other Treatments	No Treatment		
Age							
Under 6 months	23,8	45,2	7,1	9,5	38,1	0,0	42
6-11 months	37,7	67,2	2,5	8,2	27,9	0,8	122
12-17 months	35,1	73,0	6,3	8,1	22,5	0,0	111
18-23 months	29,8	73,4	6,4	9,6	18,1	0,0	94
24-59 months	33,5	72,9	8,0	8,0	19,9	0,0	251
Sex							
Male	33,5	68,3	5,6	9,3	25,2	0,3	322
Female	33,2	71,8	7,0	7,4	20,5	0,0	298
Urban-Rural Residence							
Urban	38,5	80,8	3,8	8,5	15,4	0,0	130
Rural	32,0	67,1	6,9	8,4	24,9	0,2	490
Education							
No Education	33,3	68,3	5,8	5,0	26,7	0,0	120
Primary	32,6	70,5	6,6	8,4	22,1	0,3	380
Secondary or Higher	35,8	70,0	5,8	11,7	21,7	0,0	120
Total	33,4	70,0	6,3	8,4	22,9	0,2	620

Information about the use of a homemade solution of sugar, salt and water in treating diarrhoea was obtained only from women whose child had had an episode of diarrhoea. In order to obtain an indication of the overall level of awareness of ORT, women whose child had not had a diarrhoea episode were asked whether they knew about the sugar, salt and water solution. Table 6.12 shows that knowledge of the solution is practically universal, with rural mothers and those without formal education as knowledgeable as urban and secondary educated mothers. The level of knowledge is similar to that in the MOH survey, where 94 percent knew the correct recipe for the solution.

Table 6.12 Among Mothers of Children Under Age 5, Percent Who Know About Sugar, Salt and Water Solution by Level of Education, According to Urban-Rural Residence, Zimbabwe DHS, 1988

| Urban-Rural Residence | Level of Education | | | |
	No Education	Primary	Secondary or Higher	Total
Urban	95,6	98,4	98,9	98,4
Rural	93,5	98,1	96,6	96,9
Total	93,7	98,1	97,9	97,4

Note: The percent is based on women using the solution to treat a recent diarrhoea episode and women who did not use the solution but said that they knew about it.

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6.5 PREVALENCE AND TREATMENT OF ACUTE RESPIRATORY INFECTION

Acute respiratory infection (ARI) is a major child health problem in many developing countries. The ZDHS attempted to obtain a rough estimate of the prevalence of respiratory illness by asking mothers whether any of their children under the age of five had a cough in the four weeks prior to the survey. As with diarrhoea, no attempt is made to estimate incidence, and the data are subject to recall errors.

Table 6.13 shows that 46 percent of children under five had a cough in the four weeks preceding the survey. Children 6-17 months were more likely to have had a cough than any other age group. Again, this is related to the fact that children in this age group are in the process of developing immunity to disease agents; infants less than 6 months are still protected by maternal antibodies, and older children have begun to develop their own immunity. Urban/rural, educational, and sex differences in the rates are slight.

Table 6.13 also shows the type of treatment given to those children who had had a cough. The results show that a health facility was consulted in more than half the cases. With regard to treatment, 23 percent received an injection (probably an antibiotic) and 26 percent were given antibiotics orally. About two-thirds of children were given cough mixtures. Home remedies are fairly common, with 30 percent of children receiving them.

There is little evidence of a sex bias, with boys actually being somewhat less likely than girls to benefit from medical advice. Rural residents were less likely than urban residents to report a health facility was consulted (52 percent vs. 66 percent) and that the cough was treated with antibiotics. They were slightly more likely to use home remedies (31 percent vs. 25 percent) and also more likely to have used cough syrup than urban residents (66 percent vs. 56 percent). Again these differentials may be a result of more limited access to health facilities among rural residents. If rural residents find it hard to get to health facilities, they may be more likely to use other treatments.

Mothers with a secondary school education were more likely to say medical facilities were consulted and to treat the cough with antibiotics than primary school educated or uneducated mothers. There was no significant difference in the use of home remedies between educated and uneducated mothers.

6.6 NUTRITION STATUS

One of the major contributions of the ZDHS to the study of child health status is the anthropometric data collected for children age 3-60 months. Both weight and height measurements were obtained for each child using a Salter scale. Employing this information, the following nutritional status indicators are obtained:

- Height-for-age;
- Weight-for-height;
- Weight-for-age;
- Height-for-age by weight-for-height.

Table 6.13 Among Children Under Age 5, Percent Who Are Reported by the Mother as Having Cough in the Past Four Weeks, and, Among Children Who Suffered from a Cough, Percent Consulting a Health Facility, Percent Receiving Various Treatments and Percent Not Consulting a Health Facility and Not Receiving Treatment, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Percent With Cough	Percent With Cough Consulting a Health Facility	Percent With Cough Treated by:							Percent Having No Consultation or Treatment	Number of Children
			Home Remedy	Injection	Oral Antibiotics	Other Tablets	Cough Syrup	Other Treatment	No Treatment		
Age											
Under 6 months	51,8	44,4	28,9	11,3	18,3	24,6	65,5	12,7	7,7	1,4	274
6-11 months	60,0	65,0	32,8	27,1	22,6	37,9	61,0	11,3	11,9	1,7	295
12-17 months	57,3	62,0	32,3	24,5	25,5	35,4	59,4	7,3	18,8	4,7	335
18-23 months	47,3	52,5	26,6	30,2	24,5	35,3	58,3	11,5	11,5	4,3	294
24-59 months	41,6	53,7	29,4	22,4	28,0	33,6	65,1	10,5	9,7	3,5	1 942
Sex											
Male	48,4	53,1	29,4	22,4	26,0	34,5	62,9	10,6	10,1	3,1	1 574
Female	44,4	57,3	30,4	23,5	25,5	32,7	63,6	10,4	12,2	3,5	1 566
Urban-Rural Residence											
Urban	42,2	65,7	25,1	29,5	30,6	29,2	56,3	8,9	18,1	5,6	851
Rural	48,0	51,6	31,4	20,8	24,1	35,1	65,5	11,0	8,8	2,6	2 289
Level of Education											
No Education	46,5	54,4	27,8	21,3	19,4	36,9	65,4	9,5	10,6	3,0	566
Primary	46,8	52,4	30,1	22,2	26,6	33,2	63,9	10,9	10,9	3,3	1 963
Secondary/Higher	45,0	64,7	30,9	26,9	29,1	32,0	58,9	10,2	12,4	3,6	611
Total	46,4	55,1	29,9	22,9	25,7	33,6	63,2	10,5	11,1	3,3	3 140

Height-for-age is a measure of past nutritional status. Low height-for-age, also known as "stunting", is due to chronic inadequate food intake. **Weight-for-height** is a measure of current nutritional status. Low weight-for-height, also referred to as "wasting", indicates current/acute malnutrition, and is dependent on the current food intake. Weight is a measure of both the skeletal and muscle tissues; **weight-for-age**, therefore, is a composite indicator and does not distinguish between chronic and acute malnutrition. The cross-tabulation of height-for-age by weight-for-height, known as the Waterlow table, highlights the relationship between chronic undernutrition (stunting) and acute undernutrition (wasting). It allows the identification of the most seriously malnourished group in the population--those who are both stunted and wasted.

The nutritional status of children in the survey population is compared against an international reference population defined by the U.S. National Center for Health Statistics (NCHS) and accepted by the U.S. Centers for Disease Control (CDC) and the World Health Organisation (WHO). The use of the international reference population is based on the finding that well-nourished children of all population groups for which data exist follow very similar growth patterns before puberty. The reference population serves as a point of comparison, facilitating the examination of differences in the nutritional status of subgroups in a population or of changes in nutritional status over time. In any large population, there is obviously a natural variation in height and weight. This variation approximates a normal distribution around the median for the reference population with the following percent found in each standard deviation category:

-2.00 or More SD	-1.00 to -1.99 SD	-0.99 to +0.99 SD	+1.00 to +1.99 SD	+2.00 or More SD	Total Percent
2,3	13,6	68,2	13,6	2,3	100,0

Attention will be focused on the percentage of the Zimbabwean children who fall into the category 2 or more standard deviations below the median of the reference population. For any of the nutrition status indicators, the extent to which the percentage of children falling into that category exceeds the expected percentage (2,3 percent) is an indication of the extent to which the population is experiencing serious nutritional deficiencies.

Quality of the Anthropometric Measurements

The quality of the nutrition status information depends on a number of factors, including: (1) the reliability of the measurements, (2) the coverage of children and (3) the accuracy of the data on age for the children measured. As described briefly in Chapter 1, considerable time and resources were devoted to training and supervising the staff responsible for the anthropometric data collection in order to ensure the reliability of the weight and height measurements. A review of the results indicates that the anthropometric data are internally consistent. Only 15 cases were excluded from the tabulations because the measurements were improbable for the child's age, suggesting that they were taken or recorded incorrectly.

Another important factor affecting the anthropometric data is the accuracy of the reporting of the ages of children. Information on a child's exact birth date or age in months is needed for accurate estimation of the anthropometric indices. If a child's true age is a few months younger

than his reported age, his nutritional status may be misclassified. Complete dates of birth were available for all children, suggesting that the age data are generally good.

Finally, the validity of the nutrition data obviously depends on the completeness of the coverage of the population of children. If sick or weak children were systematically not measured, the extent of wasting or stunting may be grossly underestimated. In the ZDHS, coverage of children 3-60 months was not complete. First, some children were not covered because they were not eligible; children were eligible for anthropometric measurements if they were between 3-60 months of age and their mothers were respondents in the survey. Anthropometric measures were not collected for children whose mothers were dead, institutionalised, or, for some other reason, not interviewed in the ZDHS.

Among eligible children, one in five was not measured. Among those not measured, nearly 60 percent were reported as away at the time of the interviewer visit. Only five percent of the children were not measured because they were sick. There was some variation among subgroups in the likelihood that an eligible child was not weighed or measured. Children three years and older, urban children and children whose mothers had a secondary education were somewhat less likely to be measured than other children. There was little variation in the proportion missed by sex.

In summary, the tabulations of height and weight measurements presented below include 2 485 out of a total of 3 098 eligible children. The nutritional status of these children may differ somewhat from that of the children for whom anthropometric measurements are not available. However, the survey results provide a reasonably good picture of the nutritional status of the majority of young children in Zimbabwe.

Height-for-age

Low height-for-age (stunting), indicates chronic malnutrition due to prolonged inadequate food intake. Table 6.14, which shows the proportion of children 3-60 months who fall into various standard deviation categories from the median of the reference population in terms of height-for-age, provides an indication of the prevalence of stunting among Zimbabwean children. The majority of children had normal or near normal height-for-age; however, 20 percent fall into the moderately stunted category, and 9 percent fall into the severely stunted category. The proportion falling into these categories is almost 13 times greater than the proportion observed in the reference population, indicating that chronic malnutrition is a problem for a substantial minority of Zimbabwean children.
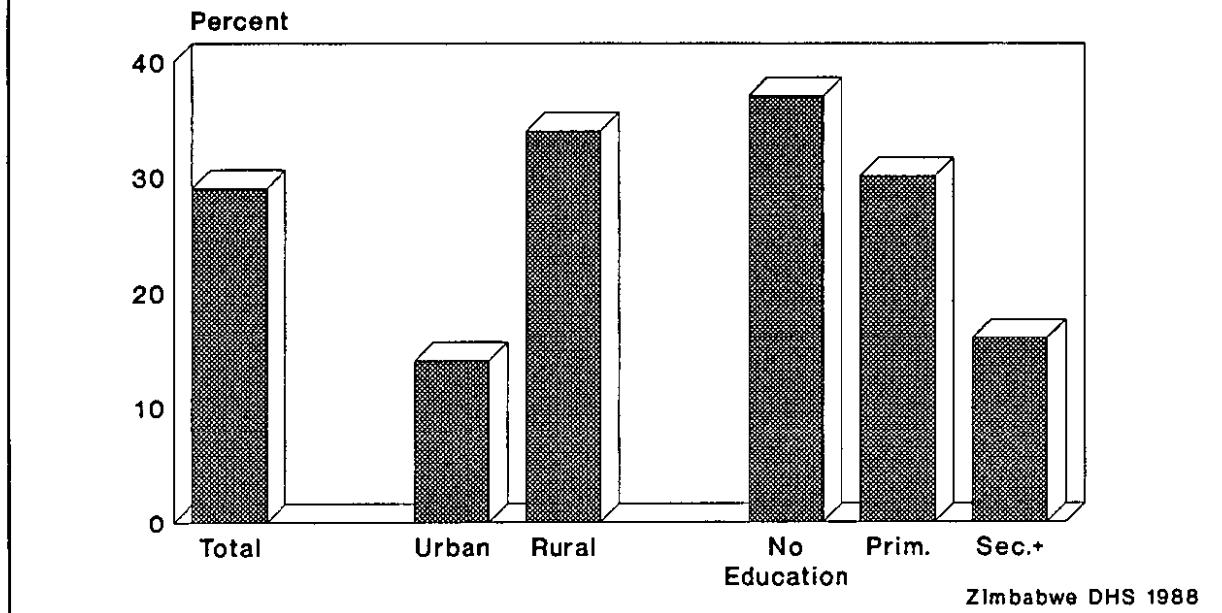
Those less than one year of age show the least stunting (17 percent). Stunting peaks at 36 percent among children 24-35 months. This is the age when mothers complete weaning their babies, leaving them dependent on family meals, which may be nutritionally inadequate. This is also the age when babies become mobile and interested in ingesting whatever is available in their environment, exposing them to disease, especially diarrhoea. The effects of diets low in protein and energy are exacerbated by periods of diarrhoea.

The adverse effect of closely spaced births is again apparent. Children born within two years of the birth of an older sibling are significantly more likely to be stunted than other children

Table 6.14 Percent Distribution of Children 3-60 Months by Standard Deviation Category of Height-for-age Using the NCHS/CDC/WHO International Reference Population, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Standard Deviations from the Median of the NCHS/CDC/WHO Reference Population						Total Percent	Number of Children
	-3.00 or More	-2.00 to -2.99	-1.00 to -1.99	-0.99 to +0.99	+1.00 to +1.99	+2.00 or More		
EXPECTED IN REFERENCE POPULATION	0,1	2,2	13,6	68,2	13,6	2,3	100,0	-
Sex								
Male	9,5	20,4	34,8	33,2	1,4	0,6	100,0	1 249
Female	7,8	20,2	36,1	32,1	2,8	1,0	100,0	1 236
Age								
3-11 Months	4,0	13,1	30,4	48,8	2,7	1,0	100,0	404
12-23 Months	7,6	25,5	41,3	22,7	1,5	1,3	100,0	537
24-35 Months	11,5	24,9	33,5	27,4	1,8	0,9	100,0	555
36-47 Months	12,3	21,4	32,6	30,6	2,4	0,7	100,0	457
48-60 Months	7,3	14,8	37,8	37,8	2,1	0,2	100,0	532
Previous Birth Interval								
First Birth	7,8	18,0	35,0	36,2	2,8	0,2	100,0	472
Less than 2 Years	12,8	22,4	33,9	28,8	1,6	0,5	100,0	375
2-3 Years	8,7	21,2	36,5	31,2	1,8	0,6	100,0	1 295
4 or More Years	5,2	18,1	33,8	37,6	2,6	2,6	100,0	343
Birth Status								
Single Birth	8,4	19,9	35,6	33,2	2,1	0,8	100,0	2 395
Multiple Birth	17,8	31,1	32,2	17,8	1,1	0,0	100,0	90
Diarrhoea Status								
Diarrhoea	10,2	24,6	34,8	28,4	1,1	0,9	100,0	529
No Diarrhoea	8,3	19,4	35,8	33,6	2,1	0,8	100,0	1 922
Urban-Rural Residence								
Urban	4,4	9,9	32,0	47,7	4,2	1,7	100,0	593
Rural	10,0	23,6	36,5	28,0	1,4	0,5	100,0	1 892
Level of Education								
No Education	10,8	26,2	35,6	24,5	1,7	1,1	100,0	461
Primary	9,6	20,8	36,2	31,2	1,6	0,6	100,0	1 587
Secondary or Higher	3,2	12,4	32,7	46,7	3,9	1,1	100,0	437
Total	8,7	20,3	35,5	32,7	2,1	0,8	100,0	2 485

Figure 6.3
Percent Stunted Among
Children 3-60 Months

Zimbabwe DHS 1988

(35 percent). Table 6.14 also shows that first births and children born four or more years after the previous sibling were least likely to fall into the stunted category (26 percent and 23 percent, respectively). Multiple births experience almost double the degree of stunting (49 percent) as single births (28 percent).

Children who had diarrhoea within the two weeks preceding the date of the survey were more likely to be of low height-for-age as compared with those who did not have diarrhoea within that period (35 percent vs. 28 percent). Although height is not affected by current acute illness, the above difference suggests that recurrent diarrhoea could be a contributing factor to chronic malnutrition and hence, stunted growth.

Stunting is particularly serious for rural children. Three-quarters of the children live in rural areas, and these children were twice as likely to be stunted as urban children (34 percent vs. 14 percent) (Figure 6.3). Rural areas were hardest hit by food shortages during the drought of 1986/87.

The level of educational attainment of the mother also is related to the prevalence of stunting. Children of mothers with no education are twice as likely to be stunted as are children of mothers with secondary and higher education (37 percent vs. 16 percent). These results suggest there is a need to simplify child care messages for the benefit of those who either never went to school or have little education. The same mothers could also be encouraged to participate in adult literacy programmes.

Table 6.15 Percent Distribution of Children 3-60 Months by Standard Deviation Category of Weight-for-height Using the NCHS/CDC/WHO International Reference Population, According to Selected Background Characteristics, Zimbabwe DHS, 1988

	Standard Deviations from the Median of the NCHS/CDC/WHO Reference Population							
Background Characteristic	-3.00 or More	-2.00 to -2.99	-1.00 to -1.99	-0.99 to +0.99	+1.00 to +1.99	+2.00 or More	Total Percent	Number of Children
EXPECTED IN REFERENCE POPULATION	0,1	2,2	13,6	68,2	13,6	2,3	100,0	
Sex								
Male	0,2	1,2	10,0	69,3	15,0	4,3	100,0	1 249
Female	0,3	1,0	9,2	71,7	13,3	4,4	100,0	1 236
Age								
3-11 Months	0,0	0,5	4,0	51,0	28,7	15,8	100,0	404
12-23 Months	0,2	1,7	15,8	65,9	12,7	3,7	100,0	537
24-35 Months	0,5	0,5	7,9	78,4	11,4	1,3	100,0	555
36-47 Months	0,0	1,1	9,6	75,9	11,6	1,8	100,0	457
48-60 Months	0,4	1,5	9,4	77,1	9,8	1,9	100,0	532
Previous Birth Interval								
First Birth	0,0	0,6	9,7	68,0	16,3	5,3	100,0	472
Less than 2 Years	0,0	1,6	11,5	72,3	11,7	2,9	100,0	375
2-3 Years	0,4	0,9	9,4	70,8	14,3	4,2	100,0	1 295
4 or More Years	0,3	1,7	8,2	70,8	13,4	5,5	100,0	343
Birth Status								
Single Birth	0,3	1,1	9,5	70,6	14,1	4,5	100,0	2 395
Multiple Birth	0,0	1,1	13,3	68,9	15,6	1,1	100,0	90
Diarrhoea Status								
Diarrhoea	0,0	0,9	13,2	66,0	14,4	5,5	100,0	529
No Diarrhoea	0,3	1,1	8,6	71,7	14,2	4,1	100,0	1 922
Urban-Rural Residence								
Urban	0,3	1,2	8,1	63,9	18,7	7,8	100,0	593
Rural	0,2	1,1	10,1	72,6	12,7	3,3	100,0	1 892
Level of Education								
No Education	0,4	1,5	12,6	73,8	8,7	3,0	100,0	461
Primary	0,3	1,1	9,0	71,8	14,1	3,7	100,0	1 587
Secondary or Higher	0,0	0,5	8,7	62,2	20,4	8,2	100,0	437
Total	0,2	1,1	9,6	70,5	14,2	4,4	100,0	2 485

Weight-for-height

Low weight-for-height (wasting), indicates acute malnutrition due to current food deficit. Wasting can be compounded by childhood illnesses such as diarrhoea, which usually result in rapid weight loss if not controlled. In the ZDHS, less than 2 percent of children 3-60 months were found to be wasted (Table 6.15). The vast majority of children (94 percent) were of normal weight-for-height.

| | Weight-for-height | | | | | |
Height-for-age	Greater than 0 SD	Less than/ Equal to 0 SD	Less than/ Equal to -1 SD	Less than/ Equal to -2 SD	Less than/ Equal to -3 SD	Number of Children
Greater than 0 SD	0,6	7,7	6,4	2,3	1,6	461
Less than/Equal to 0 SD	1,6	22,5	25,1	15,6	5,8	1 752
Less than/Equal to -1 SD	0,4	2,2	3,7	2,2	1,1	239
Less than/Equal to -2 SD	0,2	0,2	0,2	0,3	0,2	27
Less than/Equal to -3 SD	0,0	0,1	0,1	0,0	0,0	6
Number of Children	71	812	881	505	216	2 485

SD = Standard Deviation

While this indicator distinguishes those who are acutely malnourished, it does not identify those who are already stunted and, as a consequence, have weight which is proportional to their stunted height. This could explain the low rate of wasting as opposed to stunting.

Height-for-age by Weight-for-height (Waterlow Table)

Table 6.16 shows the relationship between chronic and acute malnutrition. Children who are both stunted and wasted represent the most malnourished group in the population. As the following summary table shows, less than 1 percent of children 3-60 were both stunted and wasted.

Weight-for height	Height-for-age	
	Not Stunted	Stunted
Not Wasted	70,2%	28,6%
Wasted	0,8%	0,5%

These data also highlight the prevalence of hidden undernutrition. While they are normal in terms of their weight-for-height, more than one-quarter of the children are stunted or short for their age.

Weight-for-age

This composite indicator does not distinguish between acute and chronic malnutrition. Twelve percent of children had low weight-for-age, 87 percent fell into the normal or near normal range and only 1 percent had an above normal weight-for-age (Table 6.17). In Zimbabwe, weights and ages of children under five who visit clinics are recorded on a reporting form, which is forwarded to the central office of the Ministry of Health and used to compile statistics on the

Table 6.17 Percent Distribution of Children 3-60 Months by Standard Deviation Category Category of Weight-for-age Using the NCHS/CDC/WHO International Reference Population, According to Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Standard Deviations from the Median of the NCHS/CDC/WHO Reference Population							
	-3.00 or More	-2.00 to -2.99	-1.00 to -1.99	-0.99 to +0.99	+1.00 to +1.99	+2.00 or More	Total Percent	Number of Children
EXPECTED IN REFERENCE POPULATION	0,1	2,2	13,6	68,2	13,6	2,3	100,0	
Sex								
Male	1,8	9,5	29,1	53,0	5,3	1,3	100,0	1 249
Female	1,5	10,4	31,0	50,2	5,3	1,6	100,0	1 236
Age								
3-11 Months	0,2	4,0	16,3	58,9	15,6	5,0	100,0	404
12-23 Months	1,3	13,8	36,5	42,3	5,4	0,7	100,0	537
24-35 Months	2,7	14,1	30,1	50,1	2,5	0,5	100,0	555
36-47 Months	2,2	9,4	31,5	54,5	1,5	0,9	100,0	457
48-60 Months	1,5	6,8	32,7	54,7	3,4	0,9	100,0	532
Previous Birth Interval								
First Birth	1,1	8,7	28,4	51,5	9,1	1,3	100,0	472
Less than 2 Years	2,9	12,5	30,9	49,6	3,2	0,8	100,0	375
2-3 Years	1,7	10,3	30,1	52,1	4,4	1,3	100,0	1 295
4 or More Years	0,9	7,3	31,2	52,2	5,5	2,9	100,0	343
Birth Status								
Single Birth	1,5	9,8	29,7	52,1	5,4	1,5	100,0	2 395
Multiple Birth	4,4	14,4	38,9	40,0	2,2	0,0	100,0	90
Diarrhoea Status								
Diarrhoea	1,7	14,4	30,8	46,7	4,9	1,5	100,0	529
No Diarrhoea	1,6	8,8	30,0	52,8	5,3	1,5	100,0	1 922
Urban-Rural Residence								
Urban	0,5	4,7	20,4	61,7	9,8	2,9	100,0	593
Rural	2,0	11,6	33,1	48,5	3,9	1,0	100,0	1 892
Level of Education								
No Education	2,8	16,5	31,9	44,7	3,5	0,7	100,0	461
Primary	1,7	9,3	31,9	51,7	4,3	1,2	100,0	1 587
Secondary or Higher	0,2	5,5	21,5	58,8	10,8	3,2	100,0	437
Total	1,6	9,9	30,1	51,6	5,3	1,4	100,0	2 485

nutritional status of children. According to these statistics, 11 percent of children under five who visited the clinics in 1988 were below the third centile (NCHS), i.e, had low weight-for-age. This appears to compare well with the ZDHS survey results.

Chapter 7

AIDS AWARENESS

Acquired immune deficiency syndrome (AIDS), a result of infection with the human immunodeficiency virus (HIV), has emerged in the 1980s as a major public health concern worldwide. The disease, once thought to be largely confined to homosexuals and intravenous drug users, has been shown to be transmitted increasingly through heterosexual contact. In order to combat the spread of the disease, for which there is currently no cure, many countries have established public education programmes to increase the level of awareness of the ways in which AIDS is transmitted and to promote behavioral changes which will help people, especially those in high risk groups, avoid the disease. Although Zimbabwe has an active programme to educate its population about the seriousness of the AIDS epidemic and to familiarise them with the routes of transmission for the disease, only limited information has been available on the knowledge and attitudes of the population towards AIDS to help plan and evaluate the effect of this programme.
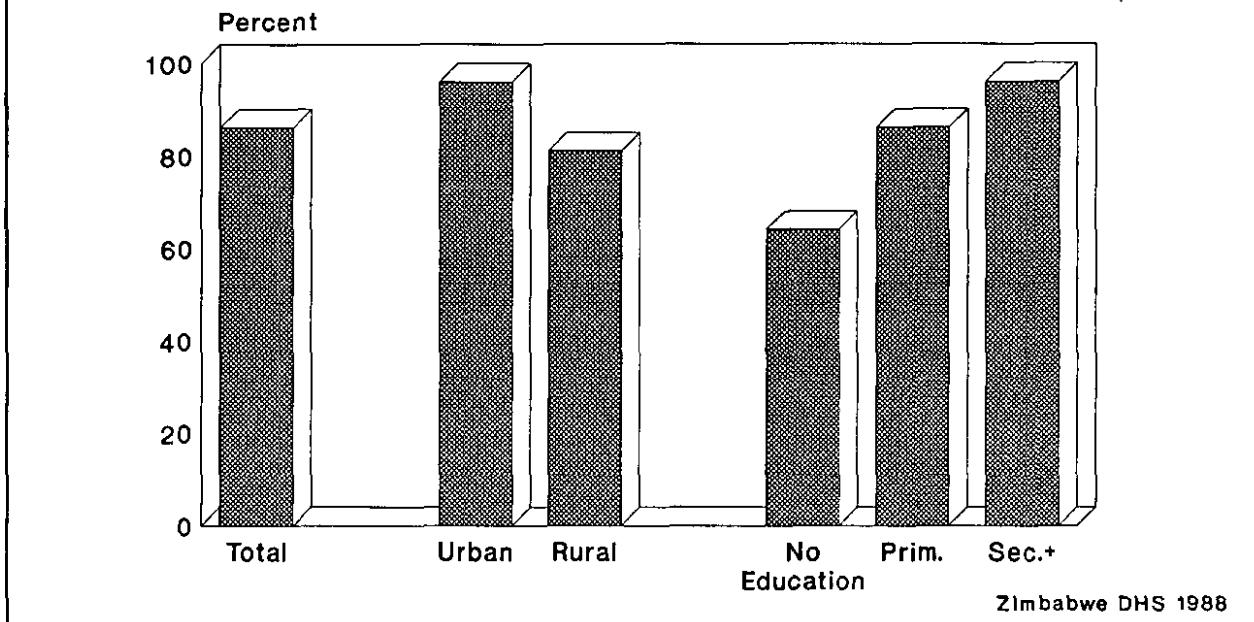
The women interviewed in the ZDHS are, or will shortly be, sexually active and, thus, they represent one of the key target groups for AIDS education efforts. To gauge the extent of AIDS awareness among this key group, the ZDHS included questions designed to ascertain whether the women had heard about AIDS, what they knew about routes of transmission for the disease, and any measures that respondents had taken to avoid contracting AIDS. Information was also collected on attitudes of the women towards persons infected with AIDS, since discrimination against people with AIDS, arising from fears about the disease, particularly misperceptions that AIDS can be contracted by casual contact with a sufferer, may pose serious social problems for those having the disease.

7.1 AWARENESS OF AIDS AND ROUTES OF TRANSMISSION

Awareness of AIDS is widespread among women in Zimbabwe. Of all women interviewed in the ZDHS, 86 percent report that they had heard of AIDS (Table 7.1). While knowledge of the existence of AIDS is high, it is not universal (Figure 7.1). Women who are the least likely to know of the existence of AIDS are those with no education (64 percent), those in polygynous unions (69 percent), those living in rural areas (81 percent) and those in the oldest age cohorts (less than 80 percent).

One of the primary goals of the AIDS education campaign has been to increase awareness of the ways in which the disease is contracted. To obtain information on the transmission routes with which women were familiar, ZDHS respondents who knew about AIDS were asked to tell the interviewer about all the ways in which a person could get the disease. They were encouraged to name more than one transmission route, but, if they did not mention a specific transmission mode, there was no probing. Overall, 80 percent of women who had heard about AIDS reported at least one way in which they thought the disease was spread, 75 percent named at least one correct mode of transmission and more than 50 percent named only correct modes (from survey data not shown in a table in this report).

Figure 7.1
Percent of Women Having
Heard About AIDS

Percent

Zimbabwe DHS 1988

The proportions mentioning various transmission routes are shown in Table 7.1 for women knowing about the disease. Zimbabwean women seem to be aware that AIDS is transmitted through heterosexual contacts, particularly among people having multiple sexual partners. Nearly one in two women say that having sex with many partners exposes a person to AIDS. Other frequently mentioned sexual routes of transmission include having sex with a person with AIDS (32 percent) and having sex with a prostitute (22 percent). Overall, two in three women mention one or more heterosexual modes of transmission of AIDS. Only 3 percent, however, mention homosexual contacts; this is not surprising since homosexual activity is not common in Zimbabwe. Twelve percent mentioned other modes through which AIDS is passed including contact with the blood of an infected person (either through a transfusion or injection with a contaminated needle) or infection of a baby in the uterus.

The AIDS virus is spread through contact with the body fluids of an infected person and not through casual contact with a person having the disease. However, many Zimbabwean women believe incorrectly that AIDS can be spread through casual contact. About one in five cited such contacts as sharing utensils with a person who has AIDS, touching a person with AIDS and wearing the clothing of a person with AIDS as ways in which someone might contract AIDS.

There are no striking differentials in the proportions recognising various AIDS transmission routes among subgroups although younger women, women who have attended school and urban women appear to be somewhat more likely to be aware of correct transmission routes than other women. The fact that never-married women are somewhat more likely than married women to mention that having sex with many partners was a way in which AIDS might be contracted is encouraging since these women, who are primarily young adults, are more likely to have such sexual contacts than older women in stable marital unions.

Table 7.1 Percent of Women Who Have Heard of AIDS and Who Think Someone Can Get AIDS from Various Sources by Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Percent Having Heard of AIDS	Having Sex With: Many Partners	PWA	Pros- titute	Homo- sexual Sex	Receiv- ing Blood from/ Born to PWA	Casual Contact with PWA	Other Incor- rect Modes	Don't Know	Number of Women
Age										
15-19	88,1	43,8	32,3	17,1	3,0	10,4	20,1	7,6	20,6	1 021
20-24	89,5	52,0	34,8	20,5	3,2	13,3	18,6	7,0	16,9	840
25-29	86,7	48,0	34,5	24,1	3,2	12,9	19,0	7,5	19,0	679
30-34	84,9	53,6	30,2	23,4	4,2	16,4	17,8	5,8	20,2	589
35-39	85,8	43,2	31,7	29,1	3,8	11,8	20,1	8,0	19,1	464
40-44	79,2	46,4	27,4	22,2	2,4	11,1	19,4	5,2	23,0	318
45-49	75,5	37,4	27,4	21,0	1,8	9,1	11,4	7,8	33,8	290
Marital Status										
Not in Union	90,1	47,3	33,0	16,3	3,7	12,3	18,9	8,0	18,7	1 558
Monogamous	86,3	48,8	32,3	25,7	3,2	13,3	18,5	7,0	20,0	2 205
Polygynous	69,4	38,2	28,0	22,0	1,3	7,2	19,4	3,3	29,9	438
Urban-Rual Residence										
Urban	95,9	55,4	36,0	18,8	4,7	17,6	17,1	7,9	14,5	1 407
Rural	80,9	42,5	29,9	23,5	2,3	9,2	19,7	6,6	23,8	2 794
Level of Education										
No Education	64,5	32,3	28,5	19,5	0,5	5,5	13,7	3,6	35,9	566
Primary	85,5	44,7	28,1	23,8	1,9	7,2	17,6	4,9	24,9	2 349
Secondary/Higher	96,1	55,8	39,9	19,0	6,1	22,9	22,0	11,7	8,2	1 286
Total	85,9	47,3	32,2	21,7	3,2	12,4	18,7	7,1	20,3	4 201

PWA = Person with AIDS

7.2 KNOWLEDGE OF PREVENTIVE MEASURES

Table 7.2 shows that a large majority of sexually active women (i.e., women who have ever had sexual relations) have never taken any action to avoid getting the disease. Overall, only 14 percent of ZDHS respondents--17 percent of those who have heard about AIDS--indicate that they have ever done anything to avoid AIDS. Since the campaign against AIDS has tended to be moralistic (most posters depict female prostitutes as the source of AIDS), it is possible that in reporting they had done nothing to prevent AIDS, women were giving what they thought was the socially acceptable response.

The proportion taking some preventive measure is highest among the never-married, those attaining at least the secondary level at school and those in urban areas. Even among these groups, however, only about one in three women says that she has done something to avoid AIDS.

Table 7.2 Among Women Who Have Ever Had Intercourse, Percent Who Have Never Heard of AIDS and Percent Who Have Heard of AIDS But Have Done Nothing to Avoid AIDS, and, Among Those Doing Nothing to Avoid AIDS, Percent Giving Various Reasons For Not Doing Anything by Selected Background Characteristics, Zimbabwe DHS, 1988

Background Characteristic	Percent Never Heard of AIDS	Percent Taking Some Action to Avoid AIDS	Percent Taking No Action Because:							Number of Women
			Not Sexually Active	Not at Risk	Using Con- doms	Cannot Avoid AIDS	Other	Don't Know How to Avoid	Don't Know Why	
Age										
15-19	13,7	14,5	3,2	30,6	0,7	13,7	3,5	19,7	16,9	284
20-24	13,3	17,0	2,4	34,0	0,8	15,8	1,9	18,4	16,8	594
25-29	15,7	14,2	1,6	33,6	0,4	17,6	2,3	19,2	13,7	568
30-34	17,2	12,1	1,7	33,9	0,2	16,1	2,3	16,3	15,9	516
35-39	16,2	11,8	1,7	36,3	0,2	17,6	2,0	14,5	14,7	408
40-44	24,5	15,4	6,3	22,7	0,4	17,5	1,9	13,4	16,4	269
45-49	27,6	10,7	3,9	31,9	0,4	11,7	0,4	17,5	12,5	257
Marital Status										
Not in Union	11,1	21,6	10,1	31,3	0,5	15,0	1,8	21,7	11,8	566
Monogamous	15,8	13,2	0,6	34,0	0,4	17,2	2,3	17,3	15,9	1 913
Polygynous	32,1	4,8	1,4	28,3	0,7	12,2	1,4	10,8	17,3	417
Urban-Rual Residence										
Urban	4,8	29,0	2,7	42,2	0,9	13,6	2,2	23,1	12,7	774
Rural	21,8	6,7	2,5	29,2	0,3	17,0	2,0	15,0	16,3	2 122
Level of Education										
No Education	36,7	3,8	2,0	18,2	0,0	15,8	2,2	11,7	16,8	537
Primary	15,3	9,8	2,8	32,6	0,4	16,5	1,7	19,0	15,5	1 814
Secondary/Higher	4,4	31,6	2,4	47,2	1,1	14,9	3,3	16,7	13,4	545
Total	17,2	14,0	2,6	32,7	0,4	16,1	2,1	17,2	15,3	2 896

Note: Respondents may have given more than one reason for not taking action to avoid AIDS.

By far, the most common action is to stay with one partner; four of every five women taking any preventive measure say that they have avoided having sex with multiple partners.

When asked why they had not done anything to avoid AIDS, one-third of the women said they did not think that they were at risk. One in six women were fatalistic, saying that AIDS cannot be avoided, while an equal number said that they did not know any preventive measure to take to avoid AIDS. Fifteen percent could not give a reason.

7.3 BLOOD TRANSFUSION

Transfusion with contaminated blood is one mode of transmission of the AIDS virus. Screening of donated blood for the HIV virus is an important measure in preventing this mode of transmission. Zimbabwe was among the first sub-Saharan African nations to establish HIV blood

Table 7.3 Among Women with At Least One Birth
          in the Last Five Years, Percent Receiving
          a Blood Transfusion with One or More Births
          by Selected Background Characteristics,
          Zimbabwe DHS, 1988

Background Characteristic	Percent Having Blood Transfusion	Number of Women
Age		
15-19	12,3	163
20-24	12,5	568
25-29	8,4	533
30-34	7,9	458
35-39	9,0	311
40-44	11,6	147
45-49	3,0	66
Urban-Rural Residence		
Urban	9,8	653
Rural	9,7	1 593
Level of Education		
No Education	9,8	377
Primary	10,1	1 382
Secondary/Higher	8,8	487
Total	9,8	2 246

screening. The programme, which has been in operation since September 1985, is located in the Harare and Bulawayo Blood Transfusion Services. ZDHS respondents seemed to recognise that blood transfusion is a mode of transmission of the AIDS virus; virtually all women said that a person with AIDS should not donate blood.

In addition to blood screening, health officials also recommend giving transfusions only when absolutely necessary as another means of minimising AIDS transmission. Little population-based information is available, however, on the prevalence of blood transfusion. Although not exhaustive, the ZDHS does provide some data on the prevalence of blood transfusions among women giving birth during the five years before the survey. Table 7.3 shows that, among women who have had at least one birth in the last five years, 10 percent received a blood transfusion with one or more of the births. Women receiving a blood transfusion during delivery constitute around 7 percent of all ZDHS respondents. There is comparatively little variation in the transfusion rate by age (except for women 45-49), education level, or residence.

7.4   SOURCES OF INFORMATION ON AIDS

The two most common sources of information regarding AIDS are: (1) pamphlets or posters and (2) radio. Among those who have heard of AIDS, over 60 percent had heard of the disease by reading a pamphlet or poster, and a similar proportion had heard about it on the radio

Table 7.4 Among Women Who Have Heard of AIDS, Percent Receiving AIDS Information from Various Sources by Selected Background Characteristics, Zimbabwe DHS, 1988 .

Background Characteristic	Percent Receiving AIDS Information from:							Number of Women
	Radio	TV/ Film	News- paper	Pamph- let/ Poster	Health Worker	Friends/ Relatives	Other	
Age								
15-19	54,9	7,3	56,2	67,3	45,0	11,1	9,3	900
20-24	68,2	6,9	58,6	70,1	53,1	11,2	5,5	752
25-29	67,2	5,1	48,4	64,3	54,8	12,6	4,6	589
30-34	66,4	7,6	47,2	63,0	56,8	13,0	3,4	500
35-39	60,3	7,3	44,0	60,8	53,8	12,8	6,0	398
40-44	61,5	6,0	36,5	53,6	47,6	12,7	8,7	252
45-49	61,6	8,2	31,5	47,0	50,2	18,3	6,8	219
Marital Status								
Not in Union	62,5	8,6	59,5	68,1	46,8	10,8	8,1	1 403
Monogamous	63,0	6,3	46,8	62,8	54,9	12,8	5,3	1 903
Polygynous	62,2	2,3	25,7	51,3	50,7	16,4	5,3	304
Urban-Rural Residence								
Urban	79,7	14,9	67,9	75,3	50,8	7,8	4,9	1 349
Rural	52,6	2,1	39,3	57,1	51,7	15,1	7,3	2 261
Level of Education								
No Education	48,5	1,6	8,2	29,6	44,4	18,4	8,5	365
Primary	58,1	3,1	40,3	60,2	51,7	14,7	5,6	2 009
Secondary/Higher	74,5	14,6	78,1	80,0	53,0	6,7	7,0	1 236
Total	62,7	6,9	50,0	63,9	51,4	12,4	6,4	3 610

(Table 7.4). Other primary sources of information are newspapers and health workers. Somewhat more than 50 percent of the women reported hearing about AIDS from a health worker.

There are clear differentials across subgroups in the proportion saying they obtained information on AIDS from particular sources. For example, urban women were more likely than rural women to have heard about AIDS on the radio or television or through a newspaper or pamphlet than were rural women. The more educated a woman is the more likely she is to have heard about AIDS through both broadcast and print media. For instance, the proportion mentioning the radio as a source of AIDS information varies directly with educational attainment, from around 50 percent among women with no education to 75 percent among women who achieved at least the secondary level. Not surprisingly, few women who never attended school cite newspapers as an information source, although nearly 30 percent cite pamphlets/posters, suggesting that these media are successful in reaching some of this largely illiterate group.

7.5 ATTITUDES ABOUT AIDS

The AIDS epidemic has generated considerable fear of the disease and, as a consequence, discriminatory attitudes toward persons infected with the disease. To investigate this issue, women

Table 7.5 Among Women Who Have Heard of AIDS, Percent Who Hold Various Beliefs About Participation of a Person with AIDS in Society, Percent Who Think a Person with AIDS Should Donate Blood and Percent Who Think a Cure for AIDS Exists, by Selected Background Characteristics, Zimbabwe DHS, 1988

	Percent Believing a Person with AIDS Should:				Percent Who Believe a Cure Exists	Number of Women
Background Characteristic	Be Allowed to Go School	Be Allowed in Public Places	Be Quar-antined	Donate Blood		
Age						
15-19	7,7	6,1	78,7	1,8	7,0	900
20-24	10,2	10,2	78,7	1,1	6,4	752
25-29	9,3	9,0	76,1	1,2	6,1	589
30-34	9,0	7,2	81,0	0,2	6,2	500
35-39	6,3	7,0	80,4	1,0	4,5	398
40-44	4,4	5,6	73,0	0,4	7,1	252
45-49	7,8	5,5	71,7	1,4	5,5	219
Urban-Rural Residence						
Urban	13,9	13,3	73,2	1,0	5,1	1 349
Rural	4,9	4,2	80,8	1,2	6,9	2 261
Level of Education						
No Education	2,5	2,2	69,0	1,1	4,9	365
Primary	3,7	3,2	82,4	1,1	6,8	2 009
Secondary/Higher	17,5	16,3	73,3	1,1	5,8	1 236
Total	8,3	7,6	78,0	1,1	6,3	3 610

who said that they knew about AIDS were asked their opinion about whether a person with AIDS should be allowed to attend school or be in public places. These women were also asked whether they believed a person with AIDS should be quarantined. Table 7.5 shows that less than ten percent of the women interviewed thought that a person with AIDS should be allowed to attend school or have other contact with the public. Reflecting again the attitude that a person with AIDS should be isolated, nearly 80 percent agreed with the suggestion that anyone infected should be quarantined. Younger women, urban women and women with secondary education are somewhat more open to the idea of social contact with a person with AIDS than other women; but, even in these groups, most appear to be unwilling to have contact with anyone infected with AIDS. The discriminatory attitudes toward persons with AIDS may stem from a fear of contracting a disease, for which few women (6 percent) think there is a cure.

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Appendix A

SAMPLE DESIGN AND IMPLEMENTATION

Appendix A

SAMPLE DESIGN AND IMPLEMENTATION

The major analytical objective of the Zimbabwe Demographic and Health survey is to obtain data for estimating levels of fertility and mortality, as well as to provide information on the proximate determinants of fertility, particularly contraceptive use, and of basic indicators of maternal and child health. Separate estimates for these variables are needed at the national level and for urban and rural areas.

A.1 DESCRIPTION OF THE SAMPLE DESIGN

To achieve this objective, a nationally representative, self-weighting sample of women 15-49 was selected and interviewed in the survey. The ZDHS sample was drawn from the Zimbabwe Revised Master Sample (ZRMS). The ZRMS was based on the master sample constructed at the initiation of the Zimbabwe National Household Survey Capability Programme (ZNHSCP) and revised for the first round of the Intercensal Demographic Survey in 1987.

The ZRMS can be considered as a two-stage sample, which is self-weighting at the household level. The sample is stratified by eight provinces and six sectors. The sectors, which are determined by land use include: (1) communal lands, (2) large-scale commercial farming areas, (3) small-scale commercial farming areas, (4) urban and semi-urban areas, (5) resettlement schemes, and (6) national parks, forest and other areas.

A subsample of 167 enumeration areas (EAs) from the 273 EAs in the ZRMS was selected for the ZDHS, including 114 in rural areas and 53 in urban areas. The EAs were selected systematically with probability proportional to the number of households in the 1982 census. Household listings prepared prior to the 1987 ICDS were used in selecting the households to be included in the ZDHS from the selected EAs. All women 15-49 present in the households drawn for the ZDHS sample on the night before the interview were eligible for the survey.

A.2 SAMPLING PROBABILITIES

The selection probabilities for the ZDHS sample are calculated as follows:

$$f = P_1 P_2$$

where

f is the overall probability of selection for each household in the ZDHS sample;
P_1 is the overall probability of selection for an EA in the ZDHS sample; and
P_2 is the probability of selection for a household within an EA.

Thus,

$$f = (a_h \; M_{hi} \; / \; M_h) \; (\; 1 \; / \; I_{hi})$$

where

a_h is the number of EAs selected in h-th stratum in the ZDHS;
M_{hi} is the measure of size for the selected i-th EA;
M_h is the measure of size for the h-th stratum; and
I_{hi} is the sampling interval for households within the selected EA.

To obtain the ZDHS sample from the ZRMS, the following procedure was implemented:

$$f = (a_h^* \; M_{hi} \; / \; M_h) \; (\; a_h \; / \; a_h^* \;) \; (\; 1 \; / \; I_{hi})$$

where

a_h^* is the number of EAs selected in the h-th stratum for the Revised Master Sample;

Thus,

$$f = P_1^* \; (\; a_h \; / \; a_h^* \;) \; (\; 1 \; / \; I_{hi})$$

which indicates that a_h EAs were subsampled for ZDHS sample from the a_h^* EAs selected for the master sample. Then, in every selected EA, households were selected for inclusion in the ZDHS, with an interval I_{hi}.

A.3   SAMPLE IMPLEMENTATION

Table A.1 summarizes the outcome of fieldwork in the ZDHS. Out of the 4 789 households selected for the sample, 9 percent were not available for interview at the time of the ZDHS.[1] The percent of households not available for interview varied by geographic area, ranging from 6 percent in Mashonaland Central to 16 percent in Matabeleland North.

Among the available households, 4 107 were successfully interviewed, a household response rate of 95 percent. The household response rate exceeded 90 percent in all geographic areas, except Harare/Chitungwiza, where the rate was only 84 percent.

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[1] Households not available for interview included: (1) households which were not present on the night before the interview; (2) households not found because the dwelling in which they resided at the time of the listing was vacant, no longer used as a dwelling or destroyed; and (3) households not interviewed for other reasons. These households are excluded from the calculation of the household response rate.

Table A.1   Results of the Household and Individual Interviews, by Place of Residence, Zimbabwe DHS, 1988

	Manica-land	Masho-naland Central	Masho-naland East	Masho-naland West	Matabe-leland North	Matabe-leland South	Mid-lands	Mas-vingo	Harare/ Chitung-wiza	Bulawayo	Total
SELECTED HOUSEHOLDS	673	359	631	560	202	230	684	516	555	379	4 789
HOUSEHOLDS NOT AVAILABLE FOR INTERVIEW											
HH absent	16	0	20	17	0	4	19	12	6	10	104
Dwelling vacant	28	15	20	24	23	10	22	36	54	10	242
Dwelling destroyed	2	6	5	14	6	2	5	10	0	0	50
Other	16	1	5	2	4	0	17	1	5	5	56
HOUSEHOLDS AVAILABLE FOR INTERVIEW											
Completed interviews	569	308	555	479	166	212	603	451	413	351	4 107
HH present, no respondent	6	8	10	0	0	0	5	4	62	2	97
Postponed	0	0	0	0	0	0	0	0	1	0	1
Refusal	1	0	1	0	0	0	0	1	11	1	15
Dwelling not found	35	21	15	24	3	2	13	1	3	0	117
HOUSEHOLD RESPONSE RATE	93,1	91,4	95,5	95,2	98,2	99,1	97,1	98,7	84,3	99,2	94,7
ELIGIBLE WOMEN IDENTIFIED	549	293	591	526	193	289	701	528	394	403	4 467
Completed interviews	527	288	543	495	189	282	656	497	345	379	4 201
Not at home	13	5	10	8	2	2	29	17	30	5	121
Postponed	0	0	0	0	0	0	1	0	0	0	1
Refused	2	0	3	0	0	0	0	0	6	1	12
Partly completed	0	0	1	0	0	0	0	1	0	0	2
Other	7	0	34	23	2	5	15	13	13	18	130
INDIVIDUAL RESPONSE RATE	96,0	98,3	91,9	94,1	97,9	97,6	93,6	94,1	87,6	94,0	94,0
OVERALL RESPONSE RATE	89,4	89,8	87,8	89,6	96,2	96,7	90,9	92,9	73,8	93,2	89,1

Note: The household response rate is obtained by dividing the number of households interviewed by the total number of sampled households available for interview at the time of the fieldwork. The individual response rate is obtained by dividing the number of eligible women interviewed by the total number of eligible women identified in the household schedules. The overall response rate is the product of the household response rate by the individual response rate.

A total of 4 467 eligible women were identified in the interviewed households. Individual questionnaires were completed for 4 201 of these women, a response rate of 94 percent. The individual response rate varied from 88 percent in Harare /Chitungwiza to 98 percent in Mashonaland Central, Matabeleland North and Matabeleland South.

The overall response rate, which is the product of the household and individual response rate, was 89 percent for the whole sample. It was 90 percent or higher, except in Manicaland (89 percent), Mashonaland East (88 percent) and Harare/Chitungwiza (74 percent).

Appendix B

SAMPLING ERRORS

Appendix B

SAMPLING ERRORS

Sampling error is defined as the difference between the expected value for any variable measured in a survey and the value estimated by the survey. The estimates from a sample survey are affected by two types of errors: (1) sampling error and (2) non-sampling error. Non-sampling error is the result of mistakes made in carrying out data collection and data processing, including the failure to locate and interview the correct household, errors in the way questions are asked, and data entry errors. Although efforts were made during the implementation of the ZDHS to minimize this type of error, non-sampling errors are impossible to avoid and difficult to evaluate statistically.

Sampling error is a measure of the variability between all possible samples that could have been selected from the same population using the same design and size. For the entire population and for large subgroups, the ZDHS sample is sufficiently large so that the sampling error for most estimates is small. However, for small subgroups, sampling errors are larger and, thus, affect the reliability of the data.

Sampling error is usually measured in terms of the standard error for a particular statistic (mean, percentage, ratio, etc.), i.e., the square root of the variance. The standard error can be used also to calculate confidence intervals within which the true value for the population can reasonably be assumed to fall. For example, for any given statistic calculated from a sample survey, the value of that statistic as measured in 95 percent of all possible samples with the same design will fall within a range of plus or minus two times the standard error for that statistic.

The computations required to provide sampling errors for survey estimates which are based on complex sample designs like those used for the ZDHS survey are more complicated than those based on simple random samples. The software package CLUSTERS was used to assist in computing the sampling errors with the proper statistical methodology. The CLUSTERS program treats any percentage or average as a ratio estimate, $r=y/x$, where y represents the total sample value for variable y and x represents the total number of cases in the group or subgroup under consideration.

To compute the variance the package makes use of the formula:

$$\text{var}(r) = \frac{1-f}{x^2} \sum_{h=1}^{H} \left[\frac{m_h}{m_h - 1} \left(\sum_{i=1}^{m_h} z_{hi}^2 - \frac{z_h^2}{m_h} \right) \right]$$

where:

$z_{hi} = y_{hi} - rx_{hi};$

$z_h = y_h - rx_h;$

$H = $ the number of strata;

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n_h = the number of cases in stratum h;

y_{hi} = the sum of the values of variable y in cluster i in the h-th stratum;

x_{hi} = the sum of the number of cases in cluster i in the h-th stratum; and

f = the overall sampling fraction, which is so small that the CLUSTERS program ignores it.

In addition to the standard errors, CLUSTERS computes the design effect (DEFT) for each estimate, which is defined as the ratio between the standard error using the given sample design and the standard error that would result if a simple random sample had been used. A DEFT value of 1,0 indicates that the sample design is as efficient as a simple random sample, while a value greater than 1,0 indicates the increase in the sampling error due to the use of a more complex and less statistically efficient design. CLUSTERS also computes the relative error and confidence limits for estimates.

Sampling errors are presented below for selected variables considered to be of major interest. Results are presented for the whole country, urban and rural areas, three broad age groups and three educational levels. For each variable, the type of statistic (mean, proportion) and the base population are given in B.1. For each variable, Tables B.2-B.5 present the value of the statistic, its standard error, the number of unweighted and weighted cases, the design effect, the relative standard errors, and the 95 percent confidence limits.

The relative standard error for most estimates for the country as a whole is small, which means that the ZDHS results are reliable. There are some differentials in the relative standard error for the estimates by region and age groups. For example, for the variable, the proportion ever using a contraceptive method, the relative standard error as a percent of the estimated proportion for the whole country, for urban areas and for rural areas is 1,2 percent, 1,8 percent and 1,5 percent, respectively.

The confidence interval has the following interpretation. The mean number of children ever born among all women is 2,953 and its standard error is 0,045. Therefore, to obtain the upper bound of the 95 percent confidence limit, twice the standard error, i.e., 0,09, is added to the sample mean. To obtain the lower bound, the same amount is subtracted from the mean. There is a high probability (95 percent) that the true mean ideal number of children falls within the interval of 2,862 and 3,044.

Table B.1   List of Variables for Which Sampling Errors Are Presented,
             Zimbabwe DHS, 1988

Name	Estimate	Variable	Base Population
RESI	Proportion	Resident in urban area	All women
EDUCAT	Proportion	Attended school	All women
CUNION	Proportion	Currently married	All women
MBEF20	Proportion	Married before 20	All women
PREG	Proportion	Pregnant	All women
CEB	Mean	Children ever born	All women
FCHILD	Proportion	First child before 20	All women
CEB40	Mean	Children ever born	All women 40-49
KNW	Proportion	Know method	Currently married women
KNWMOD	Proportion	Know modern method	Currently married women
EVUS	Proportion	Ever used method	Currently married women
CURUSE	Proportion	Currently using method	Currently married women
CURUSM	Proportion	Currently using modern method	Currently married women
WANTNM	Proportion	Want no more children	Currently married women
WANT2	Proportion	Want to delay the next birth 2 or more years	Currently married women
IDEAL	Mean	Ideal number of children	All women
CSUR	Mean	Surviving children	All women
CDED	Proportion	Dead children	All women
TETANU	Proportion	Mother received tetanus toxoid injection during pregnancy	Births in last 5 years
ATTE	Proportion	Doctor/nurse assisting at birth	Births in last 5 years
WCARD	Proportion	With health card	Children 12-23 months
FULLIM	Proportion	Full immunised	Children 12-23 months with card
DIAR	Proportion	With diarrhoea in last 2 weeks	Children 1-59 months
MTREAT	Proportion	Received medical treatment	Children 1-59 months with diarrhoea
COUGH	Proportion	With cough in last 2 weeks	Children 1-59 months
TREATC	Proportion	Received medical treatment	Children 1-59 months with cough
HAGE	Proportion	Height-for-age less than 2 SD	Children 3-60 months
WAGE	Proportion	Weight-for age less than 2 SD	Children 3-60 months
WHEIGH	Proportion	Weight-for-height less than 2 SD	Children 3-60 months

Table B.2 Sampling Errors for the Total Population, Zimbabwe DHS, 1988

	Value	Stan-dard Error	Number	Design Effect	Relative Error	Confidence Limits R-2SE	Confidence Limits R+2SE
RESI	0,335	0,019	4 201	2,612	0,057	0,297	0,373
EDUCAT	0,865	0,009	4 201	1,732	0,011	0,847	0,884
CUNION	0,629	0,008	4 201	1,061	0,013	0,613	0,645
MBEF20	0,626	0,012	3 180	1,430	0,020	0,602	0,651
PREG	0,089	0,003	4 201	0,788	0,039	0,082	0,096
CEB	2,953	0,045	4 201	0,991	0,015	2,862	3,044
FCHILD	0,547	0,011	3 180	1,256	0,020	0,524	0,569
CEB40	6,625	0,127	608	0,982	0,019	6,371	6,879
KNW	0,987	0,003	2 643	1,291	0,003	0,981	0,993
KNWMOD	0,978	0,004	2 643	1,261	0,004	0,971	0,985
EVUS	0,790	0,010	2 643	1,221	0,012	0,771	0,810
CURUSE	0,431	0,011	2 643	1,135	0,025	0,409	0,453
CURUSM	0,361	0,011	2 643	1,196	0,031	0,339	0,384
WANTNM	0,327	0,011	2 643	1,247	0,035	0,305	0,350
WANT2	0,353	0,010	2 643	1,096	0,029	0,333	0,373
IDEAL	4,886	0,048	3 891	1,327	0,010	4,790	4,983
CSUR	2,664	0,038	4 201	0,935	0,014	2,588	2,741
CDED	0,289	0,013	4 201	1,244	0,046	0,262	0,315
TETANU	0,787	0,011	3 334	1,304	0,014	0,765	0,810
ATTE	0,109	0,009	3 334	1,376	0,080	0,092	0,127
WCARD	0,776	0,020	629	1,198	0,026	0,736	0,816
FULLIM	0,859	0,017	488	1,046	0,019	0,826	0,892
DIAR	0,197	0,009	3 140	1,175	0,043	0,180	0,215
MTREAT	0,329	0,019	620	0,983	0,059	0,290	0,368
COUGH	0,471	0,012	3 140	1,252	0,026	0,446	0,496
TREATC	0,552	0,017	1 479	1,181	0,031	0,518	0,587
HAGE	0,290	0,013	2 485	1,301	0,044	0,264	0,316
WAGE	0,116	0,009	2 485	1,334	0,077	0,098	0,134
WHEIGH	0,013	0,002'	2 485	0,937	0,162	0,009	0,018

Table B.3.1 Sampling Errors for the Urban Population, Zimbabwe DHS, 1988

	Value	Stan- dard Error	Number	Design Effect	Relative Error	Confidence Limits	
						R-2SE	R+2SE
RES1	1,000	0,000	1 407	0,000	0,000	1,000	1,000
EDUCAT	0,936	0,009	1 407	1,358	0,009	0,918	0,954
CUNION	0,554	0,015	1 407	1,128	0,027	0,524	0,584
MBEF20	0,544	0,024	1 084	1,573	0,044	0,497	0,592
PREG	0,083	0,007	1 407	0,952	0,084	0,069	0,097
CEB	2,284	0,070	1 407	1,101	0,031	2,144	2,425
FCHILD	0,503	0,022	1 084	1,455	0,044	0,459	0,547
CEB40	5,195	0,242	164	1,099	0,047	4,711	5,680
KNW	0,995	0,003	779	1,121	0,003	0,989	1,001
KNWMOD	0,988	0,005	779	1,386	0,005	0,978	0,999
EVUS	0,840	0,015	779	1,117	0,018	0,810	0,869
CURUSE	0,517	0,018	779	1,008	0,035	0,481	0,553
CURUSM	0,488	0,018	779	1,011	0,037	0,452	0,524
WANTNM	0,345	0,027	779	1,575	0,078	0,292	0,399
WANT2	0,357	0,021	779	1,234	0,059	0,314	0,399
IDEAL	4,166	0,077	1 334	1,496	0,018	4,012	4,319
CSUR	2,141	0,064	1 407	1,080	0,030	2,013	2,269
CDED	0,143	0,013	1 407	1,112	0,091	0,117	0,169
TETANU	0,807	0,021	886	1,381	0,027	0,764	0,850
ATTE	0,221	0,024	886	1,443	0,109	0,173	0,270
WCARD	0,718	0,037	174	1,096	0,052	0,643	0,793
FULLIM	0,904	0,021	125	0,791	0,023	0,862	0,946
DIAR	0,153	0,018	851	1,403	0,118	0,117	0,189
MTREAT	0,385	0,047	130	1,071	0,122	0,291	0,479
COUGH	0,428	0,027	851	1,421	0,062	0,375	0,481
TREATC	0,657	0,029	364	1,062	0,043	0,600	0,714
HAGE	0,143	0,017	593	1,097	0,115	0,110	0,176
WAGE	0,052	0,008	593	0,885	0,154	0,036	0,068
WHEIGH	0,015	0,004	593	0,873	0,287	0,006	0,024

Table B.3.2 Sampling Errors for the Rural Population, Zimbabwe DHS, 1988

	Value	Stan-dard Error	Number	Design Effect	Relative Error	Confidence Limits	
						R-2SE	R+2SE
RESI	0,000	0,000	2 794	0,000	0,000	0,000	0,000
EDUCAT	0,830	0,013	2 794	1,807	0,015	0,804	0,855
CUNION	0,667	0,009	2 794	0,992	0,013	0,649	0,685
MBEF20	0,669	0,013	2 096	1,256	0,019	0,643	0,695
PREG	0,092	0,004	2 794	0,713	0,042	0,085	0,100
CEB	3,290	0,050	2 794	0,841	0,015	3,189	3,390
FCHILD	0,569	0,012	2 096	1,097	0,021	0,545	0,593
CEB40	7,153	0,127	444	0,844	0,018	6,900	7,407
KNW	0,984	0,004	1 864	1,313	0,004	0,976	0,992
KNWMOD	0,974	0,005	1 864	1,253	0,005	0,964	0,983
EVUS	0,770	0,012	1 864	1,219	0,015	0,746	0,794
CURUSE	0,395	0,013	1 864	1,108	0,032	0,370	0,420
CURUSM	0,308	0,012	1 864	1,141	0,040	0,284	0,333
WANTNM	0,320	0,012	1 864	1,069	0,036	0,297	0,343
WANT2	0,351	0,011	1 864	1,030	0,032	0,329	0,374
IDEAL	5,262	0,058	2 557	1,239	0,011	5,146	5,378
CSUR	2,928	0,042	2 794	0,802	0,014	2,843	3,012
CDED	0,362	0,017	2 794	1,161	0,047	0,328	0,396
TETANU	0,780	0,013	2 448	1,275	0,017	0,754	0,806
ATTE	0,069	0,006	2 448	0,966	0,082	0,058	0,080
WCARD	0,798	0,024	455	1,256	0,030	0,750	0,846
FULLIM	0,843	0,021	363	1,099	0,025	0,801	0,885
DIAR	0,214	0,010	2 289	1,128	0,046	0,194	0,234
MTREAT	0,314	0,021	490	,971	0,068	0,271	0,357
COUGH	0,487	0,014	2 289	1,206	0,029	0,459	0,515
TREATC	0,518	0,020	1 115	1,210	0,039	0,477	0,559
HAGE	0,336	0,015	1 892	1,247	0,044	0,307	0,365
WAGE	0,136	0,011	1 892	1,309	0,079	0,114	0,157
WHEIGH	0,013	0,002	1 892	0,959	0,194	0,008	0,018

Table B.4.1 Sampling Errors for the Population 15-24, Zimbabwe DHS, 1988

	Value	Stan-dard Error	Number	Design Effect	Relative Error	Confidence Limits R-2SE	R+2SE
RESI	0,353	0,023	1 861	2,032	0,064	0,308	0,398
EDUCAT	0,954	0,007	1 861	1,414	0,007	0,941	0,968
CUNION	0,372	0,013	1 861	1,182	0,036	0,346	0,399
MBEF20	0,531	0,017	840	0,999	0,032	0,497	0,565
PREG	0,086	0,006	1 861	0,954	0,072	0,074	0,098
CEB	0,689	0,028	1 861	1,177	0,040	0,634	0,745
FCHILD	0,489	0,018	840	1,014	0,036	0,454	0,524
CEB40	0,000	0,000	0	0,000	0,000	0,000	0,000
KNW	0,986	0,005	693	1,029	0,005	0,976	0,995
KNWMOD	0,980	0,005	693	0,930	0,005	0,970	0,990
EVUS	0,697	0,021	693	1,180	0,030	0,656	0,738
CURUSE	0,417	0,024	693	1,289	0,058	0,369	0,465
CURUSM	0,381	0,025	693	1,330	0,064	0,332	0,430
WANTNM	0,082	0,010	693	1,000	0,127	0,061	0,103
WANT2	0,616	0,019	693	1,016	0,030	0,579	0,654
IDEAL	4,034	0,043	1 811	1,137	0,011	3,948	4,120
CSUR	0,643	0,025·	1 861	1,157	0,039	0,592	0,693
CDED	0,047	0,007	1 861	1,316	0,151	0,033	0,061
TETANU	0,828	0,016	1 015	1,168	0,020	0,795	0,861
ATTE	0,135	0,013	1 015	1,103	0,099	0,108	0,162
WCARD	0,753	0,029	231	1,014	0,038	0,696	0,811
FULLIM	0,856	0,025	174	0,938	0,029	0,806	0,906
DIAR	0,237	0,015	962	1,096	0,065	0,206	0,268
MTREAT	0,325	0,029	228	0,898	0,088	0,267	0,382
COUGH	0,511	0,018	962	1,022	0,034	0,476	0,547
TREATC	0,608	0,025	492	1,036	0,040	0,559	0,657
HAGE	0,267	0,020	693	1,119	0,075	0,227	0,307
WAGE	0,104	0,013	693	1,114	0,130	0,077	0,131
WHEIGH	0,012	0,004	693	0,999	0,350	0,003	0,020

Table B.4.2 Sampling Errors for the Population 25-34, Zimbabwe DHS, 1988

	Value	Stan- dard Error	Number	Design Effect	Relative Error	Confidence Limits	
						R-2SE	R+2SE
RESI	0,349	0,019	1 268	1,439	0,055	0,310	0,387
EDUCAT	0,823	0,013	1 268	1,230	0,016	0,797	0,850
CUNION	0,838	0,010	1 268	0,990	0,012	0,817	0,858
MBEF20	0,676	0,015	1 268	1,137	0,022	0,646	0,706
PREG	0,118	0,008	1 268	0,898	0,069	0,102	0,135
CEB	3,569	0,063	1 268	1,154	0,018	3,442	3,695
FCHILD	0,588	0,016	1 268	1,159	0,027	0,555	0,620
CEB40	0,000	0,000	0	0,000	0,000	0,000	0,000
KNW	0,993	0,003	1 062	1,117	0,003	0,988	0,999
KNWMOD	0,987	0,004	1 062	1,171	0,004	0,979	0,995
EVUS	0,852	0,013	1 062	1,229	0,016	0,825	0,879
CURUSE	0,504	0,018	1 062	1,163	0,035	0,468	0,539
CURUSM	0,434	0,018	1 062	1,196	0,042	0,398	0,470
WANTNM	0,266	0,015	1 062	1,075	0 055	0,237	0,296
WANT2	0,394	0,017	1 062	1,107	0,042	0,360	0,427
IDEAL	5,143	0,075	1 177	1,159	0,015	4,993	5,293
CSUR	3,268	0,056	1 268	1,114	0,017	3,156	3,380
CDED	0,300	0,022	1 268	1,258	0,073	0,257	0,344
TETANU	0,783	0,015	1 559	1,212	0,019	0,753	0,814
ATTE	0,099	0,012	1 559	1,342	0,125	0,075	0,124
WCARD	0,804	0,025	286	1,055	0,031	0,754	0,855
FULLIM	0,865	0,026	230	1,143	0,030	0,814	0,917
DIAR	0,186	0,011	1 470	1,026	0,058	0,164	0,207
MTREAT	0,326	0,030	273	0,972	0,091	0,267	0,385
COUGH	0,457	0,017	1 470	1,167	0,038	0,423	0,492
TREATC	0,536	0,023	672	1,062	0,043	0,489	0,582
HAGE	0,294	0,018	1 206	1,254	0,062	0,257	0,330
WAGE	0,116	0,011	1 206	1,175	0,098	0,093	0,139
WHEIGH	0,012	0,003	1 206	0,992	0,263	0,006	0,018

Table B.4.3 Sampling Errors for the Population 35-49, Zimbabwe DHS, 1988

	Value	Standard Error	Number	Design Effect	Relative Error	Confidence Limits	
						R-2SE	R+2SE
RESI	0,287	0,020	1 072	1,475	0,071	0,247	0,328
EDUCAT	0,760	0,019	1 072	1,489	0,026	0,721	0,799
CUNION	0,828	0,013	1 072	1,129	0,016	0,802	0,854
MBEF20	0,643	0,018	1 072	1,262	0,029	0,606	0,680
PREG	0,061	0,007	1 072	0,965	0,116	0,047	0,075
CEB	6,154	0,093	1 072	1,039	0,015	5,968	6,340
FCHILD	0,543	0,017	1 072	1,139	0,032	0,508	0,578
CEB40	6,625	0,127	608	0,982	0,019	6,371	6,879
KNW	0,981	0,006	888	1,351	0,006	0,968	0,993
KNWMOD	0,966	0,008	888	1,270	0,008	0,951	0,982
EVUS	0,789	0,014	888	1,006	0,017	0,762	0,817
CURUSE	0,355	0,016	888	1,010	0,046	0,322	0,387
CURUSM	0,259	0,015	888	1,046	0,059	0,228	0,290
WANTNM	0,591	0,018	888	1,102	0,031	0,555	0,628
WANT2	0,099	0,011	888	1,091	0,110	0,077	0,121
IDEAL	6,262	0,102	903	1,149	0,016	6,058	6,467
CSUR	5,460	0,084	1 072	1,065	0,015	5,292	5,628
CDED	0,694	0,035	1 072	1,096	0,050	0,625	0,763
TETANU	0,742	0,022	760	1,158	0,030	0,698	0,786
ATTE	0,096	0,013	760	1,021	0,134	0,070	0,122
WCARD	0,750	0,044	112	1,056	0,059	0,661	0,839
FULLIM	0,845	0,042	84	1,063	0,050	0,761	0,929
DIAR	0,168	0,013	708	0,954	0,080	0,141	0,195
MTREAT	0,345	0,045	119	1,000	0,131	0,254	0,435
COUGH	0,445	0,021	708	1,018	0,047	0,403	0,486
TREATC	0,502	0,038	315	1,190	0,076	0,425	0,578
HAGE	0,311	0,023	586	1,133	0,074	0,265	0,356
WAGE	0,130	0,016	586	1,117	0,122	0,098	0,161
WHEIGH	0,019	0,006	586	1,002	0,300	0,008	0,030

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Table 8.5.1   Sampling Errors for the Population with No Education, Zimbabwe
               DHS, 1988

	Value	Stan-dard Error	Number	Design Effect	Relative Error	Confidence Limits	
						R-2SE	R+2SE
RESI	0,159	0,027	566	1,724	0,167	0,106	0,212
EDUCAT	0,000	0,000	566	0,000	0,000	0,000	0,000
CUNION	0,864	0,015	566	1,072	0,018	0,833	0,895
MBEF20	0,730	0,021	540	1,084	0,028	0,688	0,771
PREG	0,099	0,011	566	0,879	0,112	0,077	0,121
CEB	4,935	0,156	566	1,210	0,032	4,622	5,247
FCHILD	0,628	0,021	540	1,025	0,034	0,585	0,670
CEB40	6,727	0,267	176	1,051	0,040	6,194	7,260
KNW	0,955	0,012	489	1,304	0,013	0,931	0,979
KNWMOD	0,941	0,014	489	1,297	0,015	0,913	0,968
EVUS	0,689	0,025	489	1,178	0,036	0,640	0,739
CURUSE	0,325	0,023	489	1,091	0,071	0,279	0,371
CURUSM	0,249	0,023	489	1,187	0,093	0,203	0,296
WANTNM	0,325	0,023	489	1,107	0,072	0,278	0,372
WANT2	0,256	0,018	489	0,891	0,069	0,220	0,291
IDEAL	6,342	0,150	459	1,130	0,024	6,041	6,643
CSUR	4,272	0,131	566	1,175	0,031	4,009	4,535
CDED	0,663	0,053	566	1,246	0,079	0,557	0,768
TETANU	0,744	0,021	617	1,011	0,029	0,701	0,787
ATTE	0,044	0,010	617	1,002	0,226	0,024	0,064
WCARD	0,830	0,033	112	0,893	0,040	0,764	0,897
FULLIM	0,806	0,041	093	1,005	0,051	0,724	0,889
DIAR	0,212	0,020	566	1,123	0,093	0,172	0,252
MTREAT	0,333	0,043	120	0,943	0,128	0,248	0,418
COUGH	0,472	0,027	566	1,132	0,057	0,418	0,526
TREATC	0,543	0,033	267	0,926	0,060	0,478	0,609
HAGE	0,371	0,024	461	0,926	0,064	0,323	0,418
WAGE	0,193	0,019	461	1,017	0,100	0,155	0,232
WHEIGH	0,020	0,006	461	0,938	0,311	0,007	0,032

Table B.5.2 Sampling Errors for the Population with Primary Education, Zimbabwe
DHS, 1988

	Value	Stan-dard Error	Number	Design Effect	Relative Error	Confidence Limits	
						R-2SE	R+2SE
RES1	0,255	0,019	2 349	2,113	0,074	0,217	0,293
EDUCAT	1,000	0,000	2 349	0,000	0,000	1,000	1,000
CUNION	0,682	0,010	2 349	1,080	0,015	0,661	0,702
MBEF20	0,709	0,012	1 862	1,148	0,017	0,685	0,734
PREG	0,096	0,005	2 349	0,884	0,056	0,085	0,107
CEB	3,461	0,072	2 349	1,173	0,021	3,318	3,605
FCHILD	0,617	0,011	1 862	0,985	0,018	0,595	0,639
CEB40	6,856	0,144	382	0,910	0,021	6,567	7,145
KNW	0,994	0,002	1 601	0,974	0,002	0,990	0,998
KNWMOD	0,984	0,003	1 601	0,954	0,003	0,978	0,990
EVUS	0,811	0,011	1 601	1,089	0,013	0,790	0,833
CURUSE	0,420	0,013	1 601	1,040	0,031	0,395	0,446
CURUSM	0,340	0,012	1 601	0,975	0,034	0,317	0,363
WANTNM	0,343	0,014	1 601	1,150	0,040	0,316	0,370
WANT2	0,347	0,013	1 601	1,106	0,038	0,320	0,373
IDEAL	5,237	0,063	2 169	1,322	0,012	5,111	5,363
CSUR	3,136	0,065	2 349	1,182	0,021	3,006	3,266
CDED	0,325	0,015	2 349	1,048	0,047	0,294	0,356
TETANU	0,796	0,014	2 081	1,258	0,017	0,769	0,823
ATTE	0,083	0,009	2 081	1,263	0,107	0,065	0,101
WCARD	0,800	0,027	370	1,283	0,033	0,747	0,853
FULLIM	0,855	0,023	296	1,101	0,026	0,810	0,900
DIAR	0,194	0,010	1 963	1,064	0,050	0,174	0,213
MTREAT	0,318	0,025	380	1,014	0,080	0,268	0,369
COUGH	0,475	0,015	1 963	1,207	0,032	0,445	0,505
TREATC	0,526	0,020	933	1,101	0,039	0,486	0,567
HAGE	0,304	0,015	1 587	1,245	0,051	0,273	0,335
WAGE	0,110	0,010	1 587	1,246	0,094	0,089	0,130
WHEIGH	0,014	0,003	1 587	0,970	0,204	0,008	0,020

Table B.5.3 Sampling Errors for the Population with Secondary or Higher Education, Zimbabwe DHS, 1988

	Value	Stan-dard Error	Number	Design Effect	Relative Error	Confidence Limits R-2SE	R+2SE
RESI	0,558	0,026	1 286	1,845	0,046	0,506	0,609
EDUCAT	1,000	0,000	1 286	0,000	0,000	1,000	1,000
CUNION	0,430	0,014	1 286	1,035	0,033	0,401	0,459
MBEF20	0,356	0,022	778	1,304	0,063	0,311	0,401
PREG	0,072	0,006	1 286	0,881	0,088	0,060	0,085
CEB	1,152	0,049	1 286	1,003	0,042	1,054	1,249
FCHILD	0,321	0,020	778	1,186	0,062	0,282	0,361
CEB40	4,500	0,351	50	1,001	0,078	3,799	5,201
KNW	0,996	0,003	553	0,998	0,003	0,991	1,001
KNWMOD	0,995	0,002	553	0,583	0,002	0,991	0,998
EVUS	0,819	0,018	553	1,108	0,022	0,783	0,855
CURUSE	0,555	0,021	553	1,014	0,039	0,512	0,598
CURUSM	0,523	0,023	553	1,088	0,044	0,476	0,569
WANTNM	0,284	0,027	553	1,423	0,096	0,229	0,339
WANT2	0,458	0,025	553	1,179	0,055	0,408	0,507
IDEAL	3,755	0,048	1 263	1,142	0,013	3,659	3,852
CSUR	1,095	0,048	1 286	1,043	0,043	0,000	1,190
CDED	0,057	0,007	1 286	0,867	0,119	0,043	0,070
TETANU	0,802	0,027	636	1,473	0,033	0,749	0,855
ATTE	0,259	0,026	636	1,279	0,102	0,207	0,312
WCARD	0,673	0,039	147	0,979	0,057	0,596	0,751
FULLIM	0,919	0,027	99	0,998	0,030	0,864	0,974
DIAR	0,196	0,018	611	1,076	0,091	0,161	0,232
MTREAT	0,358	0,045	120	0,977	0,125	0,269	0,448
COUGH	0,457	0,024	611	1,099	0,052	0,410	0,504
TREATC	0,649	0,031	279	1,041	0,048	0,587	0,711
HAGE	0,156	0,016	437	0,954	0,106	0,123	0,189
WAGE	0,057	0,012	437	1,073	0,208	0,033	0,081
WHEIGH	0,005	0,003	437	0,991	0,700	-0,002	0,011

Appendix C

SURVEY QUESTIONNAIRES

ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY
HOUSEHOLD SCHEDULE COVER SHEET
CENTRAL STATISTICAL OFFICE

IDENTIFICATION	
PLACE NAME _____	☐
PROVINCE _____	☐
STRATA..	☐
DHS SEGMENT NUMBER............................	☐☐☐
HOUSEHOLD NUMBER..............................	☐☐☐☐

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	___	___	___	MONTH ☐☐ YEAR ☐☐
INTERVIEWER'S NAME	___	___	___	☐☐
RESULT*	___	___	___	☐
NEXT VISIT: DATE	___	___		TOTAL NUMBER OF VISITS ☐
TIME	___	___		

*RESULT CODES:

1 COMPLETED
2 HOUSEHOLD PRESENT BUT NO COMPETENT RESP. AT HOME
3 HOUSEHOLD ABSENT NIGHT BEFORE INTERVIEW
4 POSTPONED
5 REFUSED
6 DWELLING VACANT OR ADDRESS NOT A DWELLING
7 DWELLING DESTROYED
8 DWELLING NOT FOUND
9 OTHER _____
        (SPECIFY)

TOTAL IN HOUSEHOLD ☐☐

TOTAL ELIGIBLE WOMEN ☐☐

LANGUAGE		FIELD EDITOR	OFFICE EDITOR	KEYED BY	KEYED BY
SHONA......1	NAME	___	___	___	☐☐
NDEBELE....2 ENGLISH....3 OTHER____.4	DATE	___	___	___	

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HOUSEHOLD SCHEDULE

E-Now we would like some information about the people who usually live in your household or who are staying with you now.

S-Iye zvino ndinoda kukubvunzai mibvunzo maererano nezve vanhu vano wanzo gara pano mazuva ose, kana vari kugara nemi iye zvino?

N-Okwamanje sicela lisitshele amabizo abantu abajwayele ukuhlala kumbe abahlala endlini yakho khathesi.

NO.	USUAL RESIDENTS AND VISITORS	RESIDENCE		SEX	AGE	ELIGIBILITY
E	Please give me the names of the persons who usually live in your household and visitors who stayed with you last night starting with the head of household.	Does (NAME) usually live here?	Did (NAME) sleep here last night?	Is (NAME) male or female?	How old was (NAME) at his/her last birthday?	CIRCLE LINE NUMBER OF WOMEN ELIGIBLE FOR INDIVIDUAL
S	Mungandipewo here mazita evanhu vano-wanzo gara pano mazuva ose, neevaenzi vakarara pano. Tangai kundipa zita remunhu anoona nezreurongwa hwevanhu vepano.	(ZITA) Ano-wanzo gara pano here?	(ZITA) Aka-rara pano here usiku hwapfuura?	(ZITA) Murume here kana ku-ti mukadzi?	(ZITA) Ane ma-kore mangani akazara oku-berekwa?	INTERVIEW: SLEPT HERE LAST NIGHT,
N	Ngicela ungitshele amabizo abantu abaj-wayele ukuhlala lapha, kanye lezetheke-li ezilele khonapha, uqale ngebizo lom-ninindlu nxa ejwayele ukuhlala lapha onguye obona ngamalungiselelo abantu	U (IBIZO) ujwayele uk-uhlala lapha yini?	U (IBIZO) ulele khona-pha yini ub-usuku obed-luleyo?	U (IBIZO) ngowesilisa yini kumbe ngowesintwa-na?	U (IBIZO) seleminyaka emingaki egc-weleyo?	FEMALE 15-49
(1)	balapha. (2)	(3)	(4)	(5)	(6)	(7)
		YES NO	YES NO	M F	IN YEARS	
01	_____	1 2	1 2	1 2		01
02	_____	1 2	1 2	1 2		02
03	_____	1 2	1 2	1 2		03
04	_____	1 2	1 2	1 2		04
05	_____	1 2	1 2	1 2		05
06	_____	1 2	1 2	1 2		06
07	_____	1 2	1 2	1 2		07
08	_____	1 2	1 2	1 2		08
09	_____	1 2	1 2	1 2		09
10	_____	1 2	1 2	1 2		10

TICK HERE IF CONTINUATION SHEET USED ☐   TOTAL NUMBER OF ELIGIBLE WOMEN ON THIS SHEET ☐☐

E
S Just to make sure that I have a complete listing:
N Kuti ndive nechokwadi kut ndanyora vanhu vose:
Ukuthi ngibone sibili ukuthi abantu bonke balotshiwe:

E 1) Are there any other persons such as small children or infants that we have not listed?
S Hapane vanhu vakaita sevana vadiki vatisina kunyora here? YES ☐ → ENTER IN TABLE NO ☐
N Bakhona yini abanye abantu abanjenga bantwana esinga babhalanga?

E 2) In addition, are there any other people such as domestic servants, lodgers or friends who usually live here and cook with your household?
S Hapana here vamwe vanhu vakaita sevashandi, marodger, kana dzimwe shamwari dzenyu dzamunogara nadzo muchibika pamwe chete? YES ☐ → ENTER IN TABLE NO ☐
N Bakhona yini abanye abantu abanjenge zisebenzi, abangani kanye lamaloja abajwayele ukuhlala, lipheka lisidla ndawonye khonapha egumeni lenu?

E 3) Do you have any guests or temporary visitors staying here, or anyone else who slept here last night?
S Mune vaenzi here vari kugara pano kwemazuva mashomanana, kana mumwe munhu akarara pano usiku hwapfuura? YES ☐ → ENTER IN TABLE NO ☐
N Lile zethekheli yini kumbe abantu bemzini abalele lapha ubusuku obedluleyo?

CONTINUATION SHEET FOR HOUSEHOLD SCHEDULE

NO.	USUAL RESIDENTS AND VISITORS	RESIDENCE		SEX	AGE	ELIGIBILITY
E	Please give me the names of the persons who usually live in your household and visitors who stayed with you last night starting with the head of household.	Does (NAME) usually live here?	Did (NAME) sleep here last night?	Is (NAME) male or female?	How old was (NAME) at his/her last birthday?	CIRCLE LINE NUMBER OF WOMEN ELIGIBLE FOR INDIVIDUAL INTERVIEW:
S	Mungandipewo here mazita evanhu vano-wanzo gara pano mazuva ose, neevaenzi vakarara pano. Tangai kundipa zita remunhu anoona nezreurongwa hwevanhu vepano.	(ZITA) Ano-wanzo gara pano here?	(ZITA) Aka-rara pano here usiku hwapfuura?	(ZITA) Murume here kana ku-ti mukadzi?	(ZITA) Ane ma-kore mangani akazara oku-berekwa?	SLEPT HERE LAST NIGHT,
N	Ngicela ungitshele amabizo abantu abaj-wayele ukuhlala lapha, kanye lezetheke-li ezilele khonapha, uqale ngebizo lom-ninindlu nxa ejwayele ukuhlala lapha onguye obona ngamalungiselolo abantu	U (IBIZO) ujwayele uk-uhlala lapha yini?	U (IBIZO) ulele khona-pha yini ub-usuku obed-luleyo?	U (IBIZO) ngowesilisa yini kumbe ngowesintwa-na?	U (IBIZO) seleminyaka emingaki egc-weleyo?	FEMALE 15-49
(1)	balapha. (2)	(3)	(4)	(5)	(6)	(7)
		YES NO	YES NO	M F	IN YEARS	
11	_____	1 2	1 2	1 2		11
12	_____	1 2	1 2	1 2		12
13	_____	1 2	1 2	1 2		13
14	_____	1 2	1 2	1 2		14
15	_____	1 2	1 2	1 2		15
16	_____	1 2	1 2	1 2		16
17	_____	1 2	1 2	1 2		17
18	_____	1 2	1 2	1 2		18
19	_____	1 2	1 2	1 2		19
20	_____	1 2	1 2	1 2		20
21	_____	1 2	1 2	1 2		21
22	_____	1 2	1 2	1 2		22

TOTAL NUMBER OF ELIGIBLE WOMEN ON THIS SHEET

TOTAL NUMBER OF ELIGIBLE WOMEN ON BOTH SHEETS

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+-----------------------------------------------------------------------------+
|            |                                                                |
|            |                    AGE DETERMINATION TABLE                     |
|            |                                                                |
|            |   To find the person's age, locate the decade of their year    |
|            |   of birth on the left hand column, and the last number of     |
|            |   their year of birth in the row which goes across the top.    |
|            |   If that person has had a birthday already this year          |
|            |   before the date of the interview, their age is the number    |
|            |   in the upper left corner of the box.  If they have not       |
|            |   yet had a birthday in the year of the interview, their       |
|            |   age is the lower of the two numbers in the box.              |
|            |----------------------------------------------------------------|
|            |        |                                                        |
|FIRST THREE |        |        LAST DIGIT OF THE YEAR OF BIRTH                 |
|DIGITS OF   |--------+-----+-----+-----+-----+-----+-----+-----+-----+--------|
|THE YEAR    |   0    |  1  |  2  |  3  |  4  |  5  |  6  |  7  |  8  |   9    |
|OF BIRTH    |        |     |     |     |     |     |     |     |     |        |
```

FIRST THREE DIGITS OF THE YEAR OF BIRTH	0	1	2	3	4	5	6	7	8	9
193·	----	----	----	----	----	----	----	----	·· 49	49 48
194·	48 47	47 46	46 45	45 44	44 43	43 42	42 41	41 40	40 39	39 38
195·	38 37	37 36	36 35	35 34	34 33	33 32	32 31	31 30	30 29	29 28
196·	28 27	27 26	26 25	25 24	24 23	23 22	22 21	21 20	20 19	19 18
197·	18 17	17 16	16 15	15 14	14 13	13 12	12 11	11 10	10 09	09 08
198·	08 07	07 06	06 05	05 04	04 03	03 02	02 01	01 00	00 ··	·· --

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CENTRAL STATISTICAL OFFICE

IDENTIFICATION	
PLACE NAME _____	
PROVINCE _____	☐
STRATA..	☐
DHS SEGMENT NUMBER..	☐☐☐
HOUSEHOLD NUMBER..	☐☐☐☐
LINE NUMBER OF WOMAN..	☐☐

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	MONTH ☐☐ YEAR ☐☐
INTERVIEWER'S NAME	_____	_____	_____	☐☐
RESULT*	_____	_____	_____	☐
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS ☐
TIME	_____	_____		

*RESULT CODES:
1 COMPLETED
2 NOT AT HOME
3 POSTPONED
4 REFUSED
5 PARTLY COMPLETED
6 OTHER _____
          (SPECIFY)

LANGUAGE		FIELD EDITOR	OFFICE EDITOR	KEYED BY	KEYED BY
SHONA......1	NAME	_____	_____	_____	☐☐
NDEBELE....2					
ENGLISH....3	DATE	_____	_____	_____	
OTHER_____.4					

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
101	RECORD THE TIME.	HOUR........................ ☐☐ MINUTES..................... ☐☐	
102 S N	How long have you been residing continuously in (NAME OF VILLAGE, TOWN, CITY)? Mava nenguva yakadii muchigara mu village, town, city (musina kumbobva)? Usuhlale okwesikhathi esingakanani khonapha e (ibizo lesigaba, idolobho)?	MONTHS..................... ☐☐ YEARS...................... ☐☐ SINCE BIRTH...................95 VISITOR.......................96	
103 S N	In what month and year were you born? Makazvarwa mwedzi upi uye mugore ripi? Uzelwe ngayiphi inyanga njalo kuwuphi umnyaka?	MONTH..................... ☐☐ DK MONTH.......................98 YEAR............... .... ☐☐ DK YEAR.......................98	
104 S N	How old were you at your last birthday? Mava nemakore mangani akazara okuberekwa? Uleminyaka emingaki egcweleyo? COMPARE AND CORRECT 103 AND/OR 104 IF INCONSISTENT.	AGE IN COMPLETED YEARS..... ☐☐ IS SHE SURE? YES NO ☐ ☐	
105 S N	Have you ever attended formal school? Makambo pinda chikoro here? Wake wangena esikolo na?	YES.............................1 NO............... ....2———>108	
106 S N	Are you currently enrolled in school full-time? Muri kudzidza kwezuva rose here iye zvino? Okwakhathesi, uyafunda yini uqobo?	YES.............................1 NO............... 2	
107 S N	What was the highest grade of school you completed? Makapedza grade, standard, form ripi kuchikoro? Wacina ngaluphi ugwalo esikolo? CIRCLE CODES FOR LEVEL AND GRADE.	LEVEL GRADE NONE.......00 PRIMARY....1 1 2 3 4 5 6 7 SECONDARY..2 1 2 3 4 5 6 HIGHER.....3 1 2 3 4 5 6	
108 S N	Can you read a letter or newspaper in any language? Munokwanisa kuverenga tsamba kana pepanhau here? Uyenelisa ukubala incwadi loba iphephandaba kungakhatha-lekile ukuthi ilotshwe kumbe lilotshwe ngolimi bani na?	YES.............................1 NO..............................2———>110	
109 S N	Do you read a newspaper or magazine at least once a week? Munomboverenga pepanhau here kana magazine kamwe chete zvako pasvondo? Uyabala iphephandaba kumbe imagazini kanye ngeviki na?	YES.............................1 NO..............................2	
110 S N	Do you watch television every week? Munotarisa terevizheni here svondo rega rega? Uyabukela iTV amaviki wonke na?	YES............... ....1 NO..............................2	
111 S N	Do you listen to a radio every day? Munoteerera radio mazuva ose here? Uyalalela iradio insuku zonke yini?	YES.............................1 NO..............................2	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
112	Does your household have: **S** Mumba menyu mune: **N** Lilezo yini izinto ezilandelayo? A radio? Radio? iRadio? A television? TV? iTV? A refrigerator? Refridgerator? iFriji? A telephone? Telephone? iTelephone?	YES NO RADIO......................1 2 TELEVISION.................1 2 REFRIGERATOR...............1 2 TELEPHONE..................1 2	
113 S N	What is the major source of drinking water for members of your household? Munowanzotora kupi mvura yekunwa? Ananzi okunatha liwathola ngaphi?	PIPED INTO RESIDENCE..........01 PRIVATE TAP IN YARD OR PLOT....02 COMMUNAL TAP..................03 PROTECTED WELL................04 UNPROTECTED WELL..............05 BOREHOLE......................06 PROTECTED SPRING..............07 UNPROTECTED SPRING............08 RIVER/STREAM..................09 MUFUKU........................10 TANKER........................11 RAINWATER.....................12 OTHER _____.13 (SPECIFY)	
114 S N	How far away is this drinking water? Kure zvakadii kwamunotora mvuro yekunwa? Akhatshana okunganani la amanzi eliwanathaya?	ON PREMISES...................01 < 5 METRES....................02 6 - 30 METRES.................03 31 - 100 METRES...............04 101 - 500 METRES..............05 501 M - 1 KM..................06 >1 - 3 KM.....................07 >3 - 5 KM.....................08 >5 KM.........................09	
115 S N	During periods of drought, where do members of your household obtain drinking water? Munguva yokushaikwa kwemvura, mvura yokunwa maiiwana kupi? Ngesikhathi sokuhlupha kwamanzi, liwathola ngaphi amanzi okunatha? Did this area experience drought?	PIPED INTO RESIDENCE..........01 PRIVATE TAP IN YARD OR PLOI....02 COMMUNAL TAP..................03 PROTECTED WELL................04 UNPROTECTED WELL..............05 BOREHOLE......................06 PROTECTED SPRING..............07 UNPROTECTED SPRING............08 RIVER/STREAM..................09 MUFUKU........................10 TANKER........................11 RAINWATER.....................12 OTHER _____.13 (SPECIFY) DID NOT HAVE DROUGHT...........96	
116 S N	What is the major source of water for household use other than drinking (e.g., clothes washing, cooking) for members of your household? Munowanzowara kupi mvura yokushandisa zvimwe zvakaita, sekubika ne kugeza mbatya? Ngaphandle kwamanzi okunatha, liwathola ngaphi amanzi awokwenza izinto ezifana lokuwatsha kumbe lokupheka lokunye nje okufuna amanzi?	PIPED INTO RESIDENCE..........01 PRIVATE TAP IN YARD OR PLOT....02 COMMUNAL TAP..................03 PROTECTED WELL................04 UNPROTECTED WELL..............05 BOREHOLE......................06 PROTECTED SPRING..............07 UNPROTECTED SPRING............08 RIVER/STREAM..................09 MUFUKU........................10 TANKER........................11 RAINWATER.....................12 OTHER _____.13 (SPECIFY)	
117 S N	How far away is this household water? Kure zvakadii kwamunowana mvura iyi? Akhatshana okungakanani amanzi la?	ON PREMISES...................01 < 5 METRES....................02 6 - 30 METRES.................03 31 - 100 METRES...............04 101 - 500 METRES..............05 501 M - 1 KM..................06 >1 - 3 KM.....................07 >3 - 5 KM.....................08 >5 KM.........................09	
118 S N	What kind of toilet facility do members of your household use? Munosevenzesa chimbuzi chakaita sei? Lisebenzisa mhlobo bani wesambuzi konapha ekhaya?	FLUSH TOILET..................1 BLAIR TOILET..................2 PIT LATRINE...................3 OTHER _____.4 (SPECIFY) NO FACILITIES.................5——>120	

3

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
119 S N	Is this toilet facility used by members of your household alone, shared with neighbors, or is it communal? Chimbuzi ichi chinoshandiswa nevemhuri yenyu vega here, kana kuti munoshandisa nevavakidzani, kana kuti neruzhinji rwevanhu? Isambuzi senu lesi sisetshenziswa yini lodwa kumbe liyasihlanganyela labomakhelwana, kumbe njalo ngesikazulu wonke?	HOUSEHOLD ALONE..................1 SHARED WITH NEIGHBORS..........2 COMMUNAL.......................3	

120	Does any member of your household own:	S Mumhuri yenyu pane ane:	N Ukhona yini khonapha ngakwakho olalezizinto ezilandelayo:		YES	NO
	A bicycle? A motorcycle? A car? A tractor? A scotch cart? Cattle? Goat? Sheep?	Bhasikoro? Mudhudhudhu? Motokari? Tarakita? Chikochikari? Mombe? Mbudzi? Hwai?	Ibhasikili? Umdududu? Imota? Italakita? Inqola? Inkomo? Imbuzi? Izimvu?	BICYCLE....................1 MOTORCYCLE.................1 CAR........................1 TRACTOR....................1 SCOTCH CART................1 CATTLE.....................1 GOAT.......................1 SHEEP......................1		2 2 2 2 2 2 2 2

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
121 S N	What kind of fuel does your household mainly use for cooking? Munowanzo shandisa moto wakaitaseyi pakubika? Libaseni nxa lipheka?	WOOD..................... ....01 PARAFFIN.........................02 ELECTRICITY......................03 GAS..............................04 CHARCOAL, COAL........... .....05 DUNG.............................06 OTHER _____.07 (SPECIFY)	
122 S N	What kind of fuel does your household mainly use for lighting? Kuti mumba mujeke munosenzesa chii? Likhanyisa ngani lapha ekhaya?	PARAFFIN.........................1 ELECTRICITY......................2 GAS..............................3 CANDLES..........................4 OTHER _____.5 (SPECIFY)	
123	MAIN MATERIAL OF THE FLOOR IN SLEEPING ROOM. RECORD OBSERVATION, OR ASK IF YOU CANNOT SEE IT.	PARQUET OR POLISHED WOOD.......01 VINYL OR ASPHALT STRIPS........02 CERAMIC TILES............. ....03 WOOD PLANKS.....................04 CEMENT...........................05 POLISHED CLAY...................06 EARTH/SAND............... .....07 DUNG..... ....08 OTHER _____.09 (SPECIFY)	
124 S N	IF RURAL: RECORD OBSERVATION (CODE 01-05) IF URBAN: Is this place owned by a member of the household or is it rented? (CODE 06 OR 07) IF URBAN:Imba ino ndeyenyu here? (CODE 06 OR 07) IF URBAN: Indlu le ngeyenu na? (CODE 06 OR 07)	RURAL: TRADITIONAL.. ....01 MIXED.. .. ..02 DETACHED..... .. ..03 SEMI-DETACHED...... . ...04 URBAN: OWNED............................06 RENTED...........................07 OTHER _____.08 (SPECIFY) OWNED BY A RELATIVE............09 FREE RENT......................10	
125 S N	What is your religion? Chitendero chenyu ndechipi? Lingabaliphi ibandla kwezokholo?	TRADITIONAL......................1 SPIRITUAL........................2 CHRISTIAN........................3 OTHER _____.4 (SPECIFY)	
126	RECORD ETHNICITY.	BLACK............................1 WHITE............................2 COLOURED.........................3 ASIAN............................4 OTHER _____.5 (SPECIFY)	

4

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
201	Now I would like to talk with you about pregnancy and child-birth. Have you ever given birth?	YES.......................1	
S	Iye zvino ndinoda kumbokurukura nemi maererano nezve kuita pamuviri nekuzvarwa kwevana. Makamboita mwana here?	NO........................2——>206	
N	Okwamanje ngizaxoxa lawe ngendaba zokuzithwala lezokukhulu-leka. Sewake wazala na?		
202	Do you have any sons or daughters you have given birth to who are now living with you?	YES.......................1	
S	Mune vana vakomana kana vasikana vamakabereka vamuri kugara navo iye zvino here?	NO........................2——>204	
N	Ulamadodana kumbe amadodakazi azalwa nguwe njalo ohlala lawo na?		
203	How many sons live with you? How many daughters live with you?		
S	Vakomana vangani vamuri kugara navo? Vasikana vangani vamuri kugara navo?	SONS AT HOME........	
N	Mangaki amadodana ohlala lawo? Mangaki amadodakazi ohlala lawo? IF NONE ENTER '00'.	DAUGHTERS AT HOME....	
204	Do you have any sons or daughters you have given birth to who are alive but do not live with you?	YES.......................1	
S	Mune vana vakomana kana vasikana vamakabereka vapenyu vamusin-gagare navo here?	NO........................2——>206	
N	Akhona yini amadodana lamadodakazi azalwa nguwe angahlali lawe?		
205	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you?		
S	Vakomana vangani vapenyu vamusingagare navo? Vasikana vangani vapenyu vamusingagare navo?	SONS ELSEWHERE.......	
N	Mangaki amadodana aphilayo, ongahlali lawo? Mangaki amadoda-kazi aphilayo, ongahlali lawo? IF NONE ENTER '00'.	DAUGHTERS ELSEWHERE..	
206	Have you ever given birth to a boy or a girl who was born alive but later died? IF NO, PROBE: Any (other) boy or girl who cried or showed any sign of life but only survived a few hours or days?	YES.......................1 NO........................2——>208	
S	Makambobereka mwana mukomana kana musikana akararama akazo-shaika hake pava paye here? IF NO PROBE: Hapana mwana muko-mana kana musikana wamakabereka akachema, kana kurarama kwen-nguva diki zvayo, kana kurarama kwemazuva mashoma?		
N	Sewake wakhululeka umntwana ongumfana kumbe oyinkazana, et-shengisa ukuthi uyaphila kodwa wabuye wafa yini? IF NO, PROBE: (Umntwana lo angabe wezwakala ekhala kumbe wabonakala edhikiza, njalo waphila okwemizuzu kumbe amahola kumbe ama-langa athize.)		
207	How many boys have died? And how many girls have died?		
S	Vakomana vakashaika vangani? Vasikana vakashaika vangani?	BOYS DEAD............	
N	Mangaki amadodana afayo? Mangaki amadodakazi afayo? IF NONE ENTER '00'.	GIRLS DEAD...........	
208	SUM ANSWERS TO 203, 205, AND 207, AND ENTER TOTAL. IF NONE ENTER '00'.	TOTAL...............	
209	In total, then, how many live births have you had? _____		
S	Vana vamakazvara panwe chete vangani? _____		
N	Nxa sihlanganisa abantwana abazalwa bephila sibala labo asebafayo, bangaki anbantwana owabazala bephila? _____ COMPARE HER ANSWER WITH TOTAL IN 208: NUMBERS ARE THE SAME ☐ NUMBERS ARE DIFFERENT ☐ → PROBE AND CORRECT 201-209 AS NECESSARY		
210	CHECK 208: ONE OR MORE BIRTHS ☐ NO BIRTHS ☐		——>220

5

211 Now I would like to talk to you about all of the children you have given birth to, whether still alive or not, starting with the first one you had.

S Iye zvino ndinoda kubvunza nezve vana venyu vose vapenyu nevakashaika tichalanga kubvunza nezve mwana wenyu wekutanga.

N Khathesi ngizaxoxa lawe mayelana labantwana bonke owabazalayo, abaphilayo kumbe abafayo. Ngizaqala ngezibulo lakho.

(RECORD NAMES OF ALL THE BIRTHS IN 212. RECORD TWINS ON SEPARATE LINES AND CONNECT NAMES WITH A BRACKET.
RECORD DEAD TWIN BEFORE LIVE TWIN.)

212 What name was given to your (first, next) baby? / Dangwe renyu rinonzi (rain- zi) ani? Ano- teera? / Izibulo lenu ngubani ibizo lakhe? Olande- layo ke?	213 Is (was) (NAME) a boy or a girl? / (ZITA) (Aive) mu- komana here kana kuti musikana? / U (IBIZO) (waye) yin- kazana kum- be umfana?	214 In what month and year was (NAME) born? PROBE: In what season is his/her birthday? / (ZITA) Akaberekwa gore ripi mwedzi upi? PROBE: Mungazive kuti akazvarwa munguva ipi yegore? U (IBIZO) uzelwe kuyiphi inyanga njalo ngawuphi umnyaka? PROBE: Uzelwe Ngasiphi isikha- thi somnyaka?	215 Is (NAME) still alive? / (ZITA) achiri mupenyu here? / U (IBIZO) usaphila yini?	216 IF DEAD: How old was (NAME) when he/she died? RECORD IN DAYS IF LESS THAN 1 MONTH, IN MONTHS IF LESS THAN 2 YEARS, OR IN YEARS. IF DEAD: (ZITA) Akanga ave nemakore mangani paakushaika? IF DEAD: U (IBIZO) wafa seleminyaka emin- yaki?	217 IF ALIVE: How old was (NAME) at his/ her last birthday? RECORD AGE IN COMPLETED YEARS. IF ALIVE: (ZITA) Ave ne- makore mangani akazara okube- rekwa? IF ALIVE: U (IBIZO) ulemi- nyaka emingaki engcweleyo?	218 IF ALIVE: Is he/she living with you? IF ALIVE: (ZITA) Ari- kugara nemi here? Nxa ephila uhlala laye na?
01 ___ (NAME)	BOY GIRL 1 2	MONTH... ☐☐ YEAR.... ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.....1 ☐☐ MONTHS...2 YEARS....3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS.. KNOWS AGE? YES☐ NO☐	YES NO 1 2
02 ___ (NAME)	BOY GIRL 1 2	MONTH... ☐☐ YEAR.... ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.. ...1 ☐☐ MONTHS...2 YEARS....3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS . KNOWS AGE? YES☐ NO☐	YES NO 1 2
03 ___ (NAME)	BOY GIRL 1 2	MONTH... ☐☐ YEAR.... ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.....1 ☐☐ MONTHS...2 YEARS....3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS . KNOWS AGE? YES☐ NO☐	YES NO 1 2
04 ___ (NAME)	BOY GIRL 1 2	MONTH... ☐☐ YEAR.... ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.....1 ☐☐ MONTHS...2 YEARS.. .3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS.. KNOWS AGE? YES☐ NO☐	YES NO 1 2
05 ___ (NAME)	BOY GIRL 1 2	MONTH. . ☐☐ YEAR . . ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.....1 ☐☐ MONTHS. 2 YEARS....3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS.. KNOWS AGE? YES☐ NO☐	YES NO 1 2
06 ___ (NAME)	BOY GIRL 1 2	MONTH... ☐☐ YEAR.... ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.....1 ☐☐ MONTHS...2 YEARS....3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS.. KNOWS AGE? YES☐ NO☐	YES NO 1 2
07 ___ (NAME)	BOY GIRL 1 2	MONTH... ☐☐ YEAR.... ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.....1 ☐☐ MONTHS...2 YEARS....3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS.. KNOWS AGE? YES☐ NO☐	YES NO 1 2
08 ___ (NAME)	BOY GIRL 1 2	MONTH... ☐☐ YEAR.... ☐☐	YES NO 1 2→ (GO TO 217)	DAYS.....1 ☐☐ MONTHS...2 YEARS....3 (GO TO NEXT BIRTH)	AGE IN ☐☐ YEARS.. KNOWS AGE? YES☐ NO☐	YES NO 1 2

6

142

212	213	214	215	216 IF DEAD:	217 IF ALIVE:	218 IF ALIVE:
What name was given to your next baby?	Is (was) (NAME) a boy or a girl?	In what month and year was (NAME) born? PROBE: In what season is his/her birthday?	Is (NAME) still alive?	How old was (NAME) when he/she died? RECORD IN DAYS IF LESS THAN 1 MONTH, IN MONTHS IF LESS THAN 2 YEARS, OR IN YEARS.	How old was (NAME) at his/her last birthday? RECORD AGE IN COMPLETED YEARS.	Is he/she living with you?
S Dangwe renyu rinonzi (rain-zi) ani? Ano-teera?	(ZITA) (Aive) mu-komana here kana kuti musikana?	(ZITA) Akaberekwa gore ripi mwedzi upi? PROBE: Mungazive kuti akazvarwa munguva ipi yegore?	(ZITA) achiri mupenyu here?	IF DEAD: (ZITA) Akanga ave nemakore mangani paakushaika?	IF ALIVE: (ZITA) Ave ne-makore mangani akazara okube-rekwa?	IF ALIVE: (ZITA) Ari-kugara nemi here?
N Izibulo lenu ngubani ibizo lakhe? Olande-layo ke?	U (IBIZO) (waye) yin-kazana kum-be umfana?	U (IBIZO) uzelwe kuyiphi inyanga njalo ngawuphi umnyaka? PROBE: Uzelwe Ngasiphi isikha-thi somnyaka?	U (IBIZO) usaphila yini?	IF DEAD: U (IBIZO) wafa seleminyaka emin-yaki?	IF ALIVE: U (IBIZO) ulemi-nyaka emingaki engcweleyo?	Nxa ephila uhlala laye na?

09 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO NEXT BIRTH)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2
10 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO NEXT BIRTH)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2
11 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO NEXT BIRTH)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2
12 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO NEXT BIRTH)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2
13 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO NEXT BIRTH)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2
14 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO NEXT BIRTH)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2
15 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO NEXT BIRTH)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2
16 ___ (NAME)	BOY GIRL 1 2	MONTH... ▦ YEAR.... ▦	YES NO 1 2—→ (GO TO 217)	DAYS.....1 ▦ MONTHS...2 ▦ YEARS....3 ▦ (GO TO 219)	AGE IN YEARS.. ▦ KNOWS AGE? YES☐ NO☐	YES NO 1 2

219 COMPARE 208 WITH NUMBER OF BIRTHS IN HISTORY ABOVE AND MARK:

NUMBERS ARE SAME ☐   NUMBERS ARE DIFFERENT ☐—→ (PROBE AND RECONCILE)

7

143

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

220
S
N

Are you pregnant now?

Mune pamuviri here iye zvino?

Uzithwele yini khathesi?

YES..............................1
NO...............................2
UNSURE...........................8
→229

221
S
N

For how many months have you been pregnant?

Pamuviri penyu pane mwedzi mingani?

Ungabe usulenyanga ezingaki uzithwele?

MONTHS..................... ☐☐

222
S
N

Did you see anyone for a check on this pregnancy?

Kubva zvamakaita pamuviri makambonotariswa here?

Usuke wabonana lomunye umuntu wakuhlola na?

YES..............................1
NO...............................2 →224

223
S
N

Whom did you see?

Makatariswa naani?

Ngubani owakuhlolayo?

PROBE FOR TYPE OF PERSON AND RECORD MOST QUALIFIED.

DOCTOR...........................1
TRAINED NURSE/MIDWIFE...........2
TRADITIONAL MIDWIFE.............3
OTHER _____.4
(SPECIFY)

224

S

N

Do you have a health card with a record of any tetanus injections you might have had since becoming pregnant? IF YES: May I see it, please?

Makambo baiwa jekiseni rekudzivirira chiomesa shaya here muine pamuviri pamuinapo iye zvino? Mune card here rekusikero. IF YES: Ndingariwone wo here?

Ulegwaliba elitshengisa ukuthi wahlatshwa ijekiseni eyo-kuvikela umkhuhlane omisa imihlathi (tetanus) kusukela uzithwala na? IF YES: Ngicela ukulibona?

YES, CARD SEEN...................1
YES, CARD NOT SEEN..............2
NO CARD.........................8 →226

225

RECORD INJECTION DATES FROM CARD.

IF INJECTION WAS NOT GIVEN, CIRCLE '1'.

	NOT GVN	DA	MO	YR	
TETANUS 1	1				
TETANUS 2	1				→228

226

S

N

Since you have been pregnant, have you been given any injection to prevent the baby from getting tetanus, that is, convulsions after birth?

Kubvira pamakaita pamuviri apa makambobaiwa majekiseni ekudzivirira mwana kuti asaite chirwere chekuoma shaya, kana kuti buka rinoitwa mwana achangozvarwa?

Kusukela ekuzithwaleni kwakho usuke wahlatshwa yini ij-ection yokuvikela umkhuhlane wamaketane (tetanus), lo obangela ukukhwinta kwenisipha ngemva kokuzalwa kwakhe umntwana?

YES..............................1
NO...............................2
DK...............................8 →230

227

S

N

How many tetanus injections have you received during this pregnancy?

Makabaiwa majekiseni mangani ekudzivirira chirwere che-kuomesa shaya mava nepamuviri pamuinapo?

Sewahlatshwa amajekiseni amangaki awokuvikela umkhuhlane we (tetanus)?

ONE..............................1
TWO..............................2
DK..............................8

8

144

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
228 S N	Where did you go to get the (last) tetanus injection? Wakabaiwa kupi jekiseni rekupedzisira rekudzivirira chiomesa shaya? Ijekiseni yokucina wayihlatshelwa ngaphi?	GOVERNMENT HEALTH FACILITY......1 PRIVATE DOCTOR/CLINIC..........2 CBE WORKER.....................3 OTHER _____ ..4 (SPECIFY) DK.............................8	→230
229 S N	How long ago did your last menstrual period start? Sezvamunoziva kuti munhukadzi anogeza mwedzi wega wega. Paane nguvo yakadini kubvira pamakatanga kugeza kekupedzisira kusvika parizvino? Ucine nini ukungena esifhathini sokegeza kwabomama? IF LESS THAN 2 MONTHS, RECORD ANSWER IN DAYS OR WEEKS.	DAYS AGO................1 WEEKS AGO...............2 MONTHS AGO..............3 YEARS AGO...............4 BEFORE LAST BIRTH.............995 NEVER MENSTRUATED............996	
230 S N	When during her monthly cycle do you think a woman has the greatest chance of becoming pregnant? PROBE: What are the days during the month when a woman has to be careful to avoid becoming pregnant? Inguva ipi yepamwedzi yamunofunga kuti munhukadzi anga-bate pamuviri? PROBE: Mazuva api epamwedzi akafanirwa kuti mukadzi achenjerere kuita pamuviri? Ngolwazi lwakho, yisiphi isikhathi umama angathatha isisu kalula? PROBE: Yiwaphi amalanga umama amele ananzelele ukuze angathathi isisu?	DURING HER PERIOD (1-5).........1 JUST AFTER PERIOD (6-10)........2 MIDDLE OF THE CYCLE (11-17).....3 JUST BEFORE PERIOD BGNS(18-28)..4 AT ANY TIME.....................5 OTHER_____.6 (SPECIFY) DK..............................8	
231	PRESENCE OF OTHERS AT THIS POINT.	YES NO CHILDREN UNDER 10..........1 2 HUSBAND....................1 2 OTHER MALES................1 2 OTHER FEMALES..............1 2	

9

TRANSLATIONS FOR CONTRACEPTION SECTION:

302 Have you ever heard of (METHOD)? READ DESCRIPTION.

 S Mati mambonzwa here nezve (METHOD)?

 N Usuke wezwa ngendlela yokuvikela na, okunjenge (METHOD)?

303 Have you ever used (METHOD)?

 S Matimamboshandisa (METHOD) here?

 N Usuke wasebenzisa enye yezindlela zokuvikela na, okunjenge (METHOD)?

304 Where would you go to obtain (METHOD) if you wanted to use it?

 S Kwanungawane (METHOD) ndokupi kanamuchida kuishandisa?

 N Nxa ufuna ukusebenzisa i (NDELELA ungayithola ngaphi)? (CODES BELOW)

305 In your opinion, what is the main problem, if any, with using (METHOD)?

 S Zvii zvamunofunga kuti zvinganetse pakushandisa (METHOD)?

 N Ngokunakana kwakho okuhluphayo kakhulu nxa kukhona, ngalindlela yikuphi?
    (RECORD HER WORDS)

CODES FOR 304	CODES FOR 305
01 MOH HOSPITAL/CLINIC	C2 NOT EFFECTIVE
02 ZNFPC CLINIC	C3 HUSBAND DISAPPROVES
03 MUNICIPALITY/	C4 HEALTH CONCERNS
LOCAL GOVT CLINIC	05 ACCESS/AVAILABILITY
04 COMMERCE/INDUSTRY	06 COSTS TOO MUCH
05 MISSION/CHURCH	07 INCONVENIENT TO USE
06 PRIVATE DR/PHARMACY	09 METHOD PERMANENT
07 RURAL COUNCIL CLINIC	11 OTHER (SPECIFY)
08 FRIEND/RELATIVE	12 NONE
09 TRADITIONAL HEALER	98 DK
10 OTHER (SPECIFY)	
11 NOWHERE	
98 DK	

10

301 Now I would like to talk about a different topic. There are various ways or methods that a couple can use to delay or avoid a pregnancy. Which of these ways or methods have you heard about?

S Regai ndichimbotaura neimwe nyaya yakatisiyane nedzatanga tichitaura-nadzo kune nzira dzakasiyana siyana dzinoshandi swa kudzivirira kuita pamuviri, pane dzamati mambonzwa here?

N Khathesi sengizake ngixoxe lawe ngendaba eyehlukileyo. Kulendlela ezitshiyeneyo ezingase tshenziswa yizithandani ukuze owesifazana angathathi isisu kalula. Yiziphi zalezizindlela osuke wazizwa?

INTERVIEWER: CIRCLE CODE 1 IN 302 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN THE COLUMN, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 2 IF METHOD IS RECOGNIZED, AND CODE 3 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 OR 2 CIRCLED IN 302, ASK 303-305 BEFORE PROCEEDING TO THE NEXT METHOD.

TRANSLATIONS FOR 302-305 ARE ON OPPOSITE PAGE	302 Have you ever heard of (METHOD)? READ DESCRIPTION.	303 Have you ever used (METHOD)?	304 Where would you go to obtain (METHOD) if you wanted to use it? (CODES OPPOSITE)	305 In your opinion, what is the main problem, if any, with using (METHOD)? (CODES OPPOSITE)
01 PILL Women can take a pill by mouth every day. MAPIRITSI Piritsi rinonwiwo nevanhukadzi mazuva ose. AMAPHILISI Omama bangaginya iphilisi insuku zonke.	YES/SPONT........1 YES/PROBED.......2 NO..............3	YES..... ....1 NO..........2	OTHER _____	OTHER _____
02 LOOP Women can have a loop or IUD inserted in their wombs by a doctor or a nurse. RUPU Inoiswa muchibereko chaamai nanesi kanachiremba. ILUPHU Omama bangasebenzisa i "loop" loba IUD abayifakwa esinyeni ngudokotela loba ngunesi.	YES/SPONT........1 YES/PROBED.......2 NO..............3	YES..........1 NO..........2	OTHER _____	OTHER _____
03 INJECTIONS Women can have an injection by a doctor or nurse which stops them from becoming pregnant for several months. JEKISENI Vakadzi vanobaiwa majekiseni nachiremba kanananesi kuti vadzivirire kuita pamuviri jekiseni iri rinoshandq kwemwedzi yakati wande. IJEKISENI Omama bangahlatshwa amajekiseni abavikela ukuzithwala okwenyanga ezithize.	YES/SPONT........1 YES/PROBED......2 NO..............3	YES..........1 NO...... .. .2	OTHER _____	OTHER _____
04 DIAPHRAGM Women can place a diaphragm or pessary inside them before intercourse. DIAPHRAGM Vakadzi vanokwanisa kupfeka capi kana vasati vasangana nevanhurume. DIAPHRAGM Omama bangavunula i "diaphragm" bengakahlangani labobaba.	YES/SPONT........1 YES/PROBED.......2 NO..............3	YES..........1 NO..........2	OTHER _____	OTHER _____
05 CONDOM OR DUREX Men can use a rubber during sexual intercourse. CONDOM OR DUREX Varume vanokwanisa kupfeka durex vasati vasangana nevanhukadzi. CONDOM OR DUREX Abesilisa bangavunula ama "condom" kumbe ama "durex" bengakahlangani labomama.	YES/SPONT........1 YES/PROBED.......2 NO..............3	YES..........1 NO..........2	OTHER _____	OTHER _____
06 FEMALE STERILIZATION Women can have an operation to avoid having any more children. FEMALE STERILIZATION Vakadzi vanokwanisa kuitwa operesheni yekuthi vasaite vana zvachose. FEMALE STERILIZATION Omama banga valwa ukuze bangazali futhi ngamadokotela.	YES/SPONT........1 YES/PROBED.......2 NO..............3	YES..........1 NO..........2	OTHER _____	OTHER _____

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	302 Have you ever heard of (METHOD)? READ DESCRIPTION.	303 Have you ever used (METHOD)?	304 Where would you go to obtain (METH-OD) if you wanted to use it? (CODES OPPOSITE)	305 In your opinion, what is the main problem, if any, with using (METHOD)? (CODES OPPOSITE)
07 MALE STERILIZATION Men can have an operation to avoid having any more children. MALE STERILIZATION Varume vanosungwa chubhu kuti vasaitise pamuviri. MALE STERILIZATION Abesilisa banga valwa ngamadokotela ukuze bangazali futhi.	YES/SPONT........1 YES/PROBED.......2 NO...............3	YES..........1 NO...........2	☐☐ OTHER _____	☐☐ OTHER _____
08 SAFE PERIOD Couples can avoid avoid having sexual intercourse on certain days of the month when the woman is more likely to become pregnant. SAFE PERIOD Vakadzi vanoverenga mazuva avanofungidzirwa kuti vangabate pamuviri vorega kusangana nevanhurume. SAFE PERIOD Izithandani zingema ukuhlangana ngezinye izinsuku lapho owesifazana engathatha isisu kalula.	YES/SPONT........1 YES/PROBED.......2 NO........ 3	YES..........1 NO.. 2	Where would you go to obtain instructions for using the safe period? ☐☐ OTHER _____ Mungaende kupi kunodzidziswa nezvekuverenga mazuva? Ungaqonda ngaphi lapha ongathola khona isicebiso sokuke lingahlangani okwalezo insukwana?	☐☐ . _____
09 WITHDRAWAL Men can be careful and pull out before ejaculation. WITHDRAWAL Baba vanokwanisa kurasira kunze. WITHDRAWAL Owesilisa angakhipha nje khonokho esefuna ukucitha.	YES/SPONT........1 YES/PROBED.......2 NO........ 3	YES. .. .. 1 NO..... 2	⟶ OTHER _____	☐☐
10 FOAM/JELLY/FOAMING TABLETS Women can insert foam or jelly or foaming tablets inside them before intercourse. FOAM/JELLY/FOAMING TABLETS Vakadzi vanogona kupfeka mapiritsi anoita furo, kana kuisa jeri vasati vasangana nemurume. FOAM/JELLY/FOAMING TABLETS Omama bangavunula iphilisi efomayo kumbe ijeli phambi kokubana bahlangane labobaba.	YES/SPONT........1 YES/PROBED. .. ..2 NO...... 3	YES....... ..1 NO........ ..2	☐☐ OTHER _____	☐☐ OTHER _____
11 ANY OTHER METHODS? Have you heard of any other ways or methods that women or men can use to avoid pregnancy? PANE DZIMWE NZIRA HERE? Matimambonzwa here nezvedzimwe nzira dzingaseenzeswa nevanhukadzi kana nevanhurume kudzivirira kuita pamuviri. ANY OTHER METHODS? Ingabakhona enye indlela osewake wayizwa engavikela ukuthatha isisu na? zithwala?	YES/SPONT........ 1 NO... 3	YES..........1 NO...... 2	☐☐ OTHER_____	☐☐ OTHER _____

(SPECIFY)

306 CHECK 303: EVER USED A METHOD:
NO--NOT A SINGLE YES ☐
YES--AT LEAST ONE YES ☐ ⟶ SKIP TO 309.

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
307 S N	Have you ever used anything or tried in any way to delay or avoid getting pregnant? Mati mamboshandisa nzira yokudzivirira kuita pamuviri here. Kana kuedza chimwe chinhu? Sewake wazama iloba yiliphi nje icebo lokuthi ungaze wa-zithwala na? MARK THE APPROPRIATE RESPONSE.	YES............................ ☐ NO............................. ☐	→335
308 S N	What have you used or done? Makashandisa nzira ipi? Wasebenzisani kumbe wenzani? CORRECT 302-303 AND OBTAIN INFORMATION FOR 304 TO 306 AS NECESSARY.		
309 S N	When you first started using a method to avoid getting pregnant, how many living children did you already have? Makatanga kushandisa nzira yokudzivirira pamuviri muine vana vangani vapenyu? Bangaki abantwana abaphilayo, nxa bekhona owawusulabo ngesikhathi uqalisa ukusebenzisa indlela yokuvikela ukuzithwala? IF NONE ENTER '00'.	NUMBER OF CHILDREN......... ☐☐	
310	CHECK 220: NOT PREGNANT ☐ PREGNANT ☐ OR UNSURE		→335
311	CHECK 303: WOMAN NOT ☐ WOMAN ☐ STERILIZED STERILIZED		→313A
312 S N	Are you currently doing something or using any method to avoid getting pregnant? Iye zvino pane chamuri kuiita here kana kushandisa kud-zivirira kuita pamuviri? Okwazolezi insuku ukhona yini omunye umzamo owenzayo ukuze ungazithwali?	YES............................1 NO.............................2	→329
313 S N 313A	Which method are you using? Muri kushandisa nzira ipi? Yiphi indlela oyisebenzisayo? CIRCLE '06' FOR 'FEMALE STERILIZATION'.	PILL...........................01 IUD............................02 INJECTIONS....................03 DIAPHRAGM....................04 CONDOM.......................05 FEMALE STERILIZATION..........06 MALE STERILIZATION............07 SAFE PERIOD...................08 WITHDRAWAL....................09 FOAM/JELLY....................10 OTHER _____.11 (SPECIFY)	→320 →319 →320B →323 →320 →323
314 S N	Please show me the package of pills you are now using. Mungandiratidzewo pakiti remapiritsi amuri kushandisa iye zvino? Ngicela ungitshengise iphakethi lamaphilisi owasebenzi-sayo khathesi. (RECORD NAME OF BRAND.)	BRAND NAME ☐☐ NOT ABLE TO SHOW..............96	
315 S N	How much does one packet (cycle) of pills cost you? Pakiti rimwe chete rinoita marii? Iphakethi elilodwa libiza malini? IF MORE THAN $9.90, ENTER 9.90.	COST................. ☐ ☐☐ FREE...........................996 DK.............................998	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
316 S N	At any time in the past month, have you interrupted use of the pill for at least one day? Mumwedzi wapfuura makambokanganwa kushandisa mapiritsi kwezuva rimwe zvaro here? Kuyonale inyanga edluleyo sewake weqhisa yini ukuginya iphilisi okwelango elilodwa?	YES.............................1 NO.........-....................2——>318	
317 S N	Why did you miss a pill or pills? PROBE: Any other reasons? Sei makaregera kunwa (piritsi) mapiritsi? PROBE: Pane zvimwe here? Weqhisa ukunatha iphilisi kumbe amaphilisi ngenxa yani? PROBE: Okunye ke? CIRCLE ALL REASONS MENTIONED.	SIDE EFFECTS OR ILLNESS.........1 SPOTTING/BLEEDING...............1 PERIOD DID NOT COME.............1 RAN OUT OF PILLS................1 FORGOT/MISPLACED................1 NOT SEXUALLY ACTIVE.............1 OTHER_____.1 (SPECIFY)	
318 S N	Sometimes people forget to take the pill. What did you do the last time that you forgot to take the pill? Dzimwe nguva vanhu vanokanganwa kunwa mapiritsi. Makaita sei pamakakanga nwa kunwa mapiritsi? Abanye abantu bayake bakhohlwe ukunatha iphilisi. Wena wenzani uze ukhohlwe ukunatha iphilisi?	NEVER FORGOT....................1— TOOK ONE PILL THE NEXT DAY......2 TOOK TWO PILLS THE NEXT DAY.....3 OTHER_____4 (SPECIFY) DID NOTHING.... ....5—	>320
319 S N	In what month and year did you (he) have the operation? Mumwedzi upi gore ripi ramakaitwa (ravakaitwa) operesheni? Kwakungayiphi inyanga njalo kuwuphi umnyaka mhlazana uhlinzwa?	DATE MONTH.................. ... YEAR..................	>320A
320 S N 320A S N 320B S N	Where did you last visit to obtain (method)? Makapedzisira kunotora kupi (METHOD)? Ucine uyithatha ngaphi indlela yokuvikela? Where did the sterilization take place? Makaitwa (vakaitwa) operesheni kupi? Wavalelwa ngaphi inzalo? Where did you obtain instructions for using the safe period? Makadzidziswa kupi kushandisa n_ira yokuverenga mazuva? Walithatha ngaphi lelocebo kumbe iziqhondiso zokunanzelela isikhathi esingela ngozi yokuthatha isisu?	MOH HOSPITAL/CLINIC... ......01 ZNFPC CLINIC........... .. ....02 MUNICIPALITY/LOCAL GOVT. ......03 COMMERCE/INDUSTRY.. .. ..04 MISSION/CHURCH..................05 PRIVATE DOCTOR/PHARMACY..... ..06 RURAL COUNCIL CLINIC... ....07 FRIEND/RELATIVE.............. ..08— TRADITIONAL HEALER...... .....09 OTHER_____.10 (SPECIFY) DK........ .. ..98—	>322
321 S N	Was there anything you particularly disliked about the services you received there? IF YES: What? Pane chamusina ku'arira pane zvamakapiwa; kana kubatwa kwamakaitwa ikoko here? IF YES: Chii? Kukhona yini okunye ongazange ukuthande ngendlela abakuphatha ngayo kuleyondawo? IF YES: Kuyini owakusolayo?	WAIT TOO LONG......... ....1 STAFF DISCOURTEOUS......... ....2 SERVICES TOO EXPENSIVE ....3 DESIRED METHOD UNAVAILABLE......4 OTHER_____.5 (SPECIFY) NO COMPLAINTS....... 6	
322	CHECK 313: HE/SHE ☐┐ CURRENTLY ┌─┐ STERILIZED ☐┘ USING ANOTHER ☐ METHOD		>324
323 S N	For how long have you been using (CURRENT METHOD) continuously? Mava nenguva yakadii muchishandisa (CURRENT METHOD) musina kumbomira? Indlela le usuyisebenzise okwesikhathi esingakanani ungazange ume kumbe weqhise?	DURATION MONTHS................. YEARS.................	
324 S N	Have you experienced any problems from using (CURRENT METHOD)? Pane zviri kukunetsai here pakushandisa (CURRENT METHOD)? Indlela le oyisebenzisayo kuiezi insuku isike yakuhlupha na?	YES.............................1 NO..................... ....2——>326	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
325 S N	What is the main problem you experienced? Chii chiri kunetsa? Luhlupho bani osuke wahlangana lalo?	METHOD FAILED...................02 HUSBAND DISAPPROVED...........03 HEALTH CONCERNS................04 ACCESS/AVAILABILITY...........05 COST TOO MUCH..................06 INCONVENIENT TO USE...........07 OTHER _____.11 (SPECIFY) DK............................98	
326	CHECK 313: NEITHER ☐ HE/SHE ☐ STERILIZED STERILIZED		>338
327 S N	At any time during the same month, do you regularly use any method other than (CURRENT METHOD)? Mumwedzi mumwechete munonyanyo shandisa imwe nzira here isiri (CURRENT METHOD)? Ngaphandle kwale indlela oyisebenzisayo kulezi insuku, ikhona yini enye indlela oyisebenzisayo kunyanganye?	YES............................1 NO.............................2	>338
328 S N	Which method is that? Inzira ipi? Yiphi leyondlela? (END OF SECTION FOR CURRENT USERS)	PILL..........................01 IUD...........................02 INJECTIONS....................03 DIAPHRAGM.....................04 CONDOM........................05 SAFE PERIOD...................08 WITHDRAWAL....................09 FOAM/JELLY....................10 OTHER _____.11 (SPECIFY)	>338
329	(BEGIN SECTION FOR PREVIOUS USERS) CHECK 208: ANY BIRTHS? YES ☐ NO ☐		>331
330 S N	Since your last birth have you done anything or used any method to avoid getting pregnant? Kubvira pamakazvara mwana wenyu wokupedzisira pane chamati mamboita here, kana kushandisa kudzivirira kuita pamuviri? Ngemuva kokukhululeka ocine ngakho, usuke wasebenzisa indlela kumbe elinye nje icebo lokuvikela ukuthatha isisu na?	YES............................1 NO.............................2	>335
331 S N	Which was the last method you used? Inzira ipi yamakapedzisira kushandisa? Yiphi indlela yokuvikela ocine uyisebenzisa?	PILL..........................01 IUD...........................02 INJECTIONS....................03 DIAPHRAGM.....................04 CONDOM........................05 MALE STERILIZATION............07 SAFE PERIOD...................08 WITHDRAWAL....................09 FOAM/JELLY....................10 OTHER _____.11 (SPECIFY)	
332 S N	In what month and year did you start using that method (last time)? Mumwedzi upi gore ripi pamakatanga kushandisa (METHOD) nguva yapfuura? Waqhalisa kuyiphi inyanga njalo kuwuphi umnyaka ukusebenzisa indlela ocine uyisebenzisa?	DATE MONTH...................... ☐☐ YEAR....................... ☐☐	
333 S N	For how long had you been using (LAST METHOD) before you stopped using it (last time)? Makashandisa (LAST METHOD) kwenguva yakadii nguva yapera? Wawusulesikathi eside okunganani usebenzisa indlela ocine uyisebenzisa?	DURATION MONTHS.................... ☐☐ YEARS.................... ☐☐	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
334 S N	What was the main reason you stopped using (LAST METHOD) then? Chii chikonzero chakaita kuti muregedze kushandisa (LAST METHOD)? Kuyini okwabangela ukuthi uyekele ukuyisebenzisa leyondlela?	TO BECOME PREGNANT............01 METHOD FAILED.................02 HUSBAND DISAPPROVED...........03 HEALTH CONCERNS...............04 ACCESS/AVAILABILITY...........05 COST TOO MUCH.................06 INCONVENIENT TO USE...........07 INFREQUENT SEX................08 FATALISTIC....................10 OTHER _____.11 (SPECIFY) DK............................98	
335 S N	Do you intend to use a method to avoid pregnancy at any time in the future? Muchade kushandisa nzira yokudzivirira kuita pamuviri here munguva inotevera? Ngokubona kwakho, uzasebenzisa yini indlela yokuvikela ukuthatha isisu ngesikhathi esizayo?	YES...........................1 NO............................2 DK............................8	>338
336 S N	Which method would you prefer to use? Mungade kushandisa nzira ipi? Yiphi indlela oyibona ingcono kuwe ukusebenzisa?	PILL..........................01 IUD...........................02 INJECTIONS....................03 DIAPHRAGM.....................04 CONDOM........................05 FEMALE STERILIZATION..........06 MALE STERILIZATION............07 SAFE PERIOD...................08 WITHDRAWAL....................09 FOAM/JELLY....................10 OTHER_____.11 (SPECIFY) UNSURE........................98	
337 S N	Do you intend to use (PREFERRED METHOD) in the next 12 months or will you wait longer than that? Munotarisira kushandisa (PREFERRED METHOD) mumwedzi gumi nemiviri inotevera here, kana kuti kudarika? Ubona uzayisebenzisa yini indlela le oyibona ingcono phakathi kwezinyanga ezilitshumi lambili ezilandelayo?	YES...........................1 NO............................2 DK............................8	
338 S N	In the last month, have you heard or read any information about family planning? Mumwedzi wapfuura makambonzwa here, kana kuverenga nezvekurongwa kwemhuri? Kunyanga edlulileyo, usuke wezwa kumbe wabala mayelana ngezokondla imhuli na?	YES...........................1 NO............................2	>340
339 S N	Where did you hear or see the information? Makazvinzwa kana kuzviona kupi? Wakuzwa kumbe wakubala ngaphi lokhu? RECORD ALL SOURCES MENTIONED.	RADIO.........................1 HEALTH WORKER.................1 NEWSPAPER.....................1 POSTER/PAMPHLET...............1 OTHER:_____.1 (SPECIFY)	
340 S N	Would you be interested in learning about family planning at some time in the future ? Mungafarire here kudzidza nezvekurongwa kwemhuri munguva inotevera? Ungathanda ukufunda ngezokondla imhuli ngesikhathi esizayo na?	YES...........................1 NO............................2	

NO.		S	N	ACCEPT-ABLE	NOT ACCEPT-ABLE	DK
341	Is it acceptable or not acceptable to you for family planning information to be provided	Munobvumira here kuti zvekurongwa kwemhuri zvibudiswe?	Kulungile kumbe kakulunganga kuwe ukuthi imfundiso yezokondla imhuli ikhutshwe kuhlele			
	On the radio? On television?	paRadio? paTelevision?	Lwe radio? Lwe television?	RADIO............1 TELEVISION........1	2 2	8 8

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401 CHECK 214: ONE OR MORE LIVE BIRTHS SINCE JAN. 1983	NO LIVE BIRTHS SINCE JAN. 1983 ☐ → (SKIP TO 501)			
402 RECORD LINE NUMBER AND DATE OF BIRTH FROM P. 6. ☐☐ M Y —/—	☐☐ M Y —/—	☐☐ M Y —/—	☐☐ M Y —/—	
RECORD TWINS IN SEPARATE COLUMNS. ASK QUESTIONS ABOUT ALL BIRTHS SINCE JAN. 1983.	LAST BIRTH NAME _____ ALIVE ☐ DEAD ☐	FIRST FROM LAST BIRTH NAME _____ ALIVE ☐ DEAD ☐	SECOND-FROM-LAST NAME _____ ALIVE ☐ DEAD ☐	THIRD-FROM-LAST NAME _____ ALIVE ☐ DEAD ☐
403 When you were pregnant with (NAME), did you see anyone for a check on this pregnancy? IF YES: Whom did you see? S-Pamaiva nepamuviri pa (ZITA) makamboenda kunotariswa here? IF YES: Mokatariswa naani? N-Ulesisu sika (IBIZO) wake wabonana lomuntu wakuhlola na? IF YES: Wahlolwa ngubani? PROBE FOR THE TYPE OF PERSON AND RECORD THE MOST QUALIFIED.	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........ 2 TRAD'L MIDWIFE....3 OTHER ____.4 (SPECIFY) NO ONE..........5⌐ (SKIP TO 405)<⌐	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........2 TRAD'L MIDWIFE....3 OTHER ____.4 (SPECIFY) NO ONE..........5⌐ (SKIP TO 405)<⌐	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........2 TRAD'L MIDWIFE....3 OTHER ____.4 (SPECIFY) NO ONE..........5⌐ (SKIP TO 405)<⌐	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........2 TRAD'L MIDWIFE....3 OTHER ____.4 (SPECIFY) NO ONE..........5⌐ (SKIP TO 405)<⌐
404 When you were pregnant with (NAME) were you given any injection to prevent the baby from getting tetanus, that is, convulsions after birth? S-Pamaiva nepamuviri pa (ZITA) makabaiwa majekiseni okudzivirira mwana chirwere chekuomesa shaya chinoitisa buka mwana achangozvarwa? N-Ulesisu sika (IBIZO) wahlatshwa yini ukuvikela umkhuhlane we 'tetanus'?	YES.............1 NO..............2 DK..............8	YES.............1 NO..............2 DK..............8	YES.............1 NO..............2 DK..............8	YES.............1 NO..............2 DK..............8
405 Where did the delivery take place? S-Makasunungukira kupi? N-Wabelethela ngaphi?	CENTRAL HOSP......1 PROVINCIAL HOSP...2 DISTRICT HOSP.....3 RURAL HOSP........4 RHC CLINIC........5 HOME..............6 OTHER____.7 (SPECIFY)	CENTRAL HOSP......1 PROVINCIAL HOSP...2 DISTRICT HOSP.....3 RURAL HOSP........4 RHC CLINIC........5 HOME..............6 OTHER____ 7 (SPECIFY)	CENTRAL HOSP......1 PROVINCIAL HOSP...2 DISTRICT HOSP.....3 RURAL HOSP........4 RHC CLINIC........5 HOME..............6 OTHER____.7 (SPECIFY)	CENTRAL HOSP......1 PROVINCIAL HOSP...2 DISTRICT HOSP.....3 RURAL HOSP........4 RHC CLINIC........5 HOME..............6 OTHER____.7 (SPECIFY)
406 Did you receive any blood transfusions with the birth of (NAME)? S-Makapamhidzirwa ropa here pamakasununguka (ZITA)? N-Wengezelelwa igazi ngemva kokubeletha u (IBIZO) yini?	YES.............1 NO..............2	YES.............1 NO..............2	YES.............1 NO..............2	YES.............1 NO..............2
407 Who assisted with the delivery of (NAME)? S-Makasunungutswa nani? N-Wabelethiswa ngubani ku (IBIZO)? PROBE FOR THE TYPE OF PERSON AND RECORD THE MOST QUALIFIED.	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........2 TRADL MIDWIFE.....3 RELATIVE.........4 OTHER ____.5 (SPECIFY) NO ONE..........6	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........2 TRADL MIDWIFE.....3 RELATIVE.........4 OTHER ____.5 (SPECIFY) NO ONE..........6	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........2 TRADL MIDWIFE.....3 RELATIVE.........4 OTHER ____.5 (SPECIFY) NO ONE..........6	DOCTOR..........1 TRAINED NURSE/ MIDWIFE........2 TRADL MIDWIFE.....3 RELATIVE.........4 OTHER ____.5 (SPECIFY) NO ONE..........6
408 Did you ever feed (NAME) at the breast? S-Makamboyamwisa (ZITA) here? N-U (IBIZO) wamunya yini?	YES.............1⌐ (SKIP TO 410)<⌐ NO..............2	YES.............1⌐ (SKIP TO 411)<⌐ NO..............2	YES.............1⌐ (SKIP TO 411)<⌐ NO..............2	YES.............1⌐ (SKIP TO 411)<⌐ NO..............2

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409 Why did you never feed (NAME) at the breast? S-Makaregererei kuyamwisa (ZITA)? N-Kungani engazange amunye?	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK..03 BABY REFUSED.....04 BABY DIED........05 BABY SICK........06 MOTHER SICK......07 OTHER_____.08 (SPECIFY) (ALL SKIP TO 414)<	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK..03 BABY REFUSED.....04 BABY DIED........05 BABY SICK........06 MOTHER SICK......07 OTHER_____.08 (SPECIFY) (ALL SKIP TO 414)<	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK..03 BABY REFUSED.....04 BABY DIED........05 BABY SICK........06 MOTHER SICK......07 OTHER_____.08 (SPECIFY) (ALL SKIP TO 414)<	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK..03 BABY REFUSED.....04 BABY DIED........05 BABY SICK........06 MOTHER SICK......07 OTHER_____.08 (SPECIFY) (ALL SKIP TO 414)<
410 Are you still breast-feeding (NAME)? S-Muchirikuyamwisa (ZITA) here? N-Ulokhe emunya yini? (IF DEAD, CIRCLE '2')	YES...............1 (SKIP TO 413)< NO (OR DEAD)......2			
411 How many months did you breastfeed (NAME)? S-Makamuyamwisa kwemwedzi mingani (ZITA)? N-U (IBIZO) wamunya okwen-yanga ezingaki?	MONTHS.......[ ][ ] UNTIL DEATH......96 (SKIP TO 413)<	MONTHS.......[ ][ ] UNTIL DEATH......96 (SKIP TO 413)<	MONTHS.......[ ][ ] UNTIL DEATH......96 (SKIP TO 413)<	MONTHS.......[ ][ ] UNTIL DEATH......96 (SKIP TO 413)<
412 Why did you stop breastfeeding (NAME)? S-Makazoregererei kuyamwisa (ZITA)? N-Wamkhuphelani ebeleni?	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK..03 BABY REFUSED.....04 BABY DIED........05 BABY SICK........06 BY HAD DIARRHEA..07 BY WEANING AGE...08 MOTHER SICK......09 BECAME PREGNANT..10 COSMETIC REASONS.11 OTHER_____.12 (SPECIFY)	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK..03 BABY REFUSED.....04 BABY DIED........05 BABY SICK........06 BY HAD DIARRHEA..07 BY WEANING AGE...08 MOTHER SICK......09 BECAME PREGNANT..10 COSMETIC REASONS.11 OTHER_____.12 (SPECIFY)	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK..03 BABY REFUSED.....04 BABY DIED........05 BABY SICK........06 BY HAD DIARRHEA..07 BY WEANING AGE...08 MOTHER SICK......09 BECAME PREGNANT..10 COSMETIC REASONS.11 OTHER_____.12 (SPECIFY)	INCONVENIENT.....01 HAD TO WORK......02 INSUFFICNT MILK. 03 BABY REFUSED.... 04 BABY DIED.. .....05 BABY SICK...... ..06 BY HAD DIARRHEA..07 BY WEANING AGE...08 MOTHER SICK......09 BECAME PREGNANT .10 COSMETIC REASONS.11 OTHER_____.12 (SPECIFY)
413 How old was (NAME) when you first gave supple-mental food or liquid? S-(ZITA) Anga ave nemwedzi mingani pamakatanga ku-mupa zvekudya zvimwe kana zvinwiwa? N-Wayesekhule okunganani u (IBIZO) ngesikhathi umni-ka okunye ukudla kumbe o-kunathwayo okungasi chago lwakho?	MONTHS.......[ ][ ] NOT YET GIVEN....95 CHILD DIED FIRST.96	MONTHS.......[ ][ ] CHILD DIED FIRST.96	MONTHS.......[ ][ ] CHILD DIED FIRST.96	MONTHS.......[ ][ ] CHILD DIED FIRST 96
414 How many months after the birth of (NAME) did your period return? S-Pamakasununguka (ZITA) makazogeza kwapera mwedzi mingani? N-Kwakuthatha inyanga ezin-gaki ukuthi upinde ugeze ngemva kokubeletha u (BIZO)?	MONTHS.......[ ][ ] NOT RETURNED.....96	MONTHS.......[ ][ ] NEVER RETURNED...96	MONTHS.......[ ][ ] NEVER RETURNED...96	MONTHS.......[ ][ ] NEVER RETURNED ..96
415 Have you resumed sexual relations since the birth of (NAME)? S-Matimatanga kusangana nababa here kubvira pama-kasununguka (ZITA)? N-Usuqalisile yini ukuhlan-gana lowesilisa ngemuva kokuzalwa kuka (IBIZO)?	YES (OR PREGN.)...1 NO................2 (GO TO NEXT COL)<			
416 How many months after the birth of (NAME) did you resume sexual relations? S-Makapedza mwedzi mingani musati masangana nababa kubvira pamakasununguka (ZITA)? N-Wahlala inyanga ezingaki ungakahlangani lowesilisa ngemuva kokuzalwa kuka (IBIZO)?	MONTHS.......[ ][ ] (GO TO NEXT COLUMN)	MONTHS.......[ ][ ] (GO TO NEXT COLUMN)	MONTHS.......[ ][ ] (GO TO NEXT COLUMN)	MONTHS.......[ ][ ] (GO TO 417)

18

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

417 CHECK 410 FOR LAST BIRTH:

LAST CHILD STILL BREASTFED ☐   ALL OTHERS ☐   IF DEAD/LIVING, AWAY ☐ ─────→423
                ─────→420

▼

418 How many times did you breastfeed last night between sundown and sunrise?

S Makayamwisa kangani nezuro kubvira kudoka kwezuva kusyika kubuda kwaro?

N Kusukela ilanga litshona lize liphume lamuhla umunyise kangaki u (BIZO)?

NUMBER OF TIMES........... ☐☐

AS OFTEN AS CHILD WANTED.......96

419 How many times did you breastfeed yesterday during the daylight hours?

S Makayamwisa kangani nezuro kubvira zuva richibuda kusvikira radoka?

N Umunyise kangaki kusukela ilanga liphuma lize liyetshona izolo?

NUMBER OF TIMES........... ☐☐

AS OFTEN AS CHILD WANTED.......96

420 At any time in the last 24 hours, was (NAME OF LAST CHILD) given any of the following:

S Panguva ipi zvayo mumaawa makumi maviri nemana apfuura (ZITA) akapiwa zvinotevera here?

N Kusukela ngalesi sikhathi izolo kusiyo fika khathesi u (IBIZO) uphiwe yini okunye kwalez' zinto ezilandelayo:

	S	N		YES	NO
Plain water?	Mvura?	Amanzi okunatha?	PLAIN WATER...............1		2
Juice?	Zvinwiwa zvemichero?	Umhluzi (juice)?	JUICE.....................1		2
Powdered milk	Mukaka hweupfu?	Uchago lwempuphu?	POWDERED MILK.............1		2
Cow's or goat's milk?	Mukaka wemombe kana wembudzi?	Uchago lwenkomo lobo olwembuzi?	COW'S OR GOAT'S MILK.......1		2
Formula?	Formula (Selactogeni)?	I'Formula (njenge ilactogeni)?	FORMULA...................1		2
Porridge?	Bota?	Ilambazi?	PORRIDGE..................1		2
Sadza?	Sadza?	Isitshwala?	SADZA.....................1		2
Sour milk?	Mukaka wakakora?	Isawa?	SOUR MILK 1		2
Fruit?	Michero?	Izithelo?	FRUIT.....................1		2
Potatoes?	Mbatatisi?	Amagwili?	POTATOES. 1		2
Egg?	Mazai?	Iqanda?	EGG.......................1		2
Any other liquid?	Zvimwe zvinwiwa?	Loba okunye nje okunathwayo?	ANY OTHER LIQUID _____ ..1		2
			(SPECIFY)		
Any other solid or mushy food?	Zvimwe zvekudya zvakaomarara	Loba okunye nje okujiyileyo?	ANY OTHER SOLID OR MUSHY FOOD....................1		2

421 CHECK 420:

WAS GIVEN FOOD OR LIQUID ☐   NO FOOD OR LIQUID GIVEN ☐ ─────→423

▼

422 How were these foods and/or liquids given? PROBE: What implements were used to feed the baby in the last 24 hours?

S Makamupa sei zvokudya izvi kana zvinwiwa? (zvamakapa mwana) PROBE: Makashandisa chii pakupa mwana zvokudya mumaawa makumi maviri nemana apfuura?

N Ukudla kumbe okunathwayo lokhu ubumupha njani? PROBE: Ubusebenzisa zinto bani ukumfunza kumbe ukumnathisa kumahola angamatshumi amabili lamane adluleyo?

CIRCLE '1' FOR EACH ITEM MENTIONED.

CUP AND SPOON...................1
PLATE..........................1
BOTTLE.........................1
BY HAND........................1
OTHER _____.1
      (SPECIFY)

19

423 ENTER THE NAME, LINE NUMBER, AND SURVIVAL STATUS OF EACH BIRTH SINCE JAN. 1983 BELOW. BEGIN WITH THE LAST BIRTH. THE HEADINGS IN THE TABLE SHOULD BE EXACTLY THE SAME AS THOSE AFTER Q. 402. DO NOT ASK QUESTIONS ABOUT DEAD CHLORN.

	LAST BIRTH	NEXT-TO-LAST BIRTH	SECOND-FROM-LAST	THIRD-FROM-LAST
RECORD LINE NUMBER AND DATE OF BIRTH.	☐☐ M Y _/_	☐☐ M Y _/_	☐☐ M Y _/_	☐☐ M Y _/_
ASK QUESTIONS ONLY FOR LIVING CHILDREN	NAME_____ ALIVE ☐ DEAD ☐ →	NAME_____ ALIVE ☐ DEAD ☐ →	NAME_____ ALIVE ☐ DEAD ☐ →	NAME_____ ALIVE ☐ DEAD ☐ (GO TO 439)
424 Do you have a health card for (NAME)? IF YES: May I see it, please? S-Mune kadhi ra(ZITA) reutano hwake here? IF YES: Ndingariona here? N-U (IBIZO) ulegualiba lesibhedlela na? IF YES: Ngicela uku-libona?	YES, SEEN...........1 YES, NOT SEEN.......2⌐ (SKIP TO 428)<—— NO CARD.............3⌐	YES, SEEN...........1 YES, NOT SEEN.......2⌐ (SKIP TO 428)<—— NO CARD.............3⌐	YES, SEEN...........1 YES, NOT SEEN.......2⌐ (SKIP TO 428)<—— NO CARD.............3⌐	YES, SEEN...........1 YES, NOT SEEN.......2⌐ (SKIP TO 428)<—— NO CARD.............3⌐
425 RECORD BIRTH WEIGHT FROM BACK OF HEALTH CARD. ENTER 9,996 IF NOT GIVEN ON THE CARD.	WEIGHT IN KG. ☐,☐☐☐	WEIGHT IN KG. ☐,☐☐☐	WEIGHT IN KG. ☐,☐☐☐	WEIGHT IN KG. ☐,☐☐☐
426 RECORD DATE OF BIRTH FROM BACK OF HEALTH CARD. ENTER 96 IF NOT GIVEN	DAY MONTH YEAR ☐☐|☐☐|☐☐	DAY MONTH YEAR ☐☐|☐☐|☐☐	DAY MONTH YEAR ☐☐|☐☐|☐☐	DAY MONTH YEAR ☐☐|☐☐|☐☐

427 RECORD DATES OF IMMUNIZATIONS FROM HEALTH CARD.

	NOT GIVEN DA MO YR	NOT GIVEN DA MO YR	NOT GIVEN DA MO YR	NOT GIVEN DA MO YR
TB/BCG	1	1	1	1
POLIO 1	1	1	1	1
DPT 1	1	1	1	1
POLIO 2	1	1	1	1
DPT 2	1	1	1	1
POLIO 3	1	1	1	1
DPT 3	1	1	1	1
MEASLES	1	1	1	1
POLIO BSTR	1	1	1	1
DPT BSTR	1	1	1	1
	(SKIP TO 429)	(SKIP TO 429)	(SKIP TO 429)	(SKIP TO 429)

428 Has (NAME) ever had a vaccination to prevent him/her from getting diseases? S-(ZITA) Ati ambobayiwa majekiseni okudzivi-rira zvirwere here? N-U (IBIZO) wahlatshwa yini ukuthi angabanjwa yimikhuhlane?	YES.................1 NO..................2	YES.................1 NO..................2	YES.................1 NO..................2	YES.................1 NO..................2
429 Has (NAME) had diarrhea, that is, 3 or more loose or runny stools in the last 24 hours? S-(ZITA) akamboita man-yoka here mumaawa ma-kumi maviri nemana ap-fuura akabudisa katatu here achiita tsvina yakaita mvura mvura? N-U (IBIZO) ukewahuda kathathu kumbe kanengi phakathi kwamahola an-gamatshumi amabili la-mane adluleyo na?	YES.................1⌐ (SKIP TO 431) <—⌐ NO..................2 DK..................8	YES.................1⌐ (SKIP TO 433) <—⌐ NO..................2 DK..................8	YES.................1⌐ (SKIP TO 433) <—⌐ NO..................2 DK..................8	YES.................1⌐ (SKIP TO 433) <—⌐ NO..................2 DK..................8

20

430 Has (NAME) had diarrhea in the last two weeks? S-(ZITA) akamboita manyoka here mumasvondo maviri apfuura? N-U (IBIZO) ukewahuda phakathi kwamaviki amabili adluleyo na?	YES.................1 NO..................2 (SKIP TO 436) <— DK..................8	YES................1 (SKIP TO 433) <— NO..................2 (SKIP TO 436) <— DK..................8	YES................1 (SKIP TO 433) <— NO..................2 (SKIP TO 436) <— DK..................8	YES................1 (SKIP TO 433) <— NO..................2 (SKIP TO 436) <— DK..................8
431 CHECK 410: LAST CHILD STILL BREASTFED?	YES ☐ NO ☐ (SKIP TO 433)			
432 Did you breastfeed (NAME) when he/she had dirrrhea then? S-Makayamwisa here (ZITA) paaiva nemanyoka? N-U (BIZO) ubemunya yini ngesikhathi ehuda?	YES.................1 NO..................2			
433 Was (NAME) given anything special for the diarrhea? IF YES: What? CIRCLE ALL MENTIONED. S-Pane chaakapiwa here kuti manyoka apere? IF YES: Makamupa chii? N-Kukhona yini okwaphiwa U (IBIZO) okwelapha umkhuhlane wokuhuda? IF YES: Kuyini akuphiwayo?	SUGAR-SALT-WATER SOLUTION..........1 (SKIP TO 435)<— HERBS...............1 OTHER_____.1 (SPECIFY) NOTHING SPECIAL.....1	SUGAR-SALT-WATER SOLUTION..........1 (SKIP TO 435)<— HERBS...............1 OTHER_____.1 (SPECIFY) NOTHING SPECIAL.....1	SUGAR-SALT-WATER SOLUTION..........1 (SKIP TO 435)<— HERBS...............1 OTHER_____.1 (SPECIFY) NOTHING SPECIAL.....1	SUGAR-SALT-WATER SOLUTION..........1 (SKIP TO 435)<— HERBS...............1 OTHER_____.1 (SPECIFY) NOTHING SPECIAL.....1
434 The last time (NAME) had diarrhea, was he/she given a sugar-salt-water solution? S-(ZITA) paakaita manyoka nguva yapfuura akapiwa here mvura yesugar nemunyu (sauti)? N-Ngesikhathi leso u (IBIZO) ehuda wanikwa yini amanzi ahlanganiswe letshukela letshwayi?	YES.................1 NO..................2 DK..................8	YES................1 NO..................2 DK..................8	YES................1 NO..................2 DK..................8	YES................1 NO..................2 DK..................8
435 Was (NAME) taken to health facility, a private doctor, a community-based extension worker or to any other person or place to treat the last episode of diarrhea? IF YES: Where was he/she taken? S-Makaendesa here (ZITA) kunorapwa, kwaDoctor, kwa CBEW kana kumwewo kunorapwa? IF YES: Akaropwa kupi? N-U (IBIZO) lamusa esibhedlela, kumbe kudhokotela, kumbe emuntwini obona ngezempilo kuyonale indawo kumbe komunye nje umuntu ukuze elatshwe umkhuhlane wokuhuda na? IF YES: Lamusa ngaphi?	HEALTH FACILITY.....1 PRIVATE DOCTOR......2 CBEW................3 TRAD'L MIDWIFE......4 TRADL HEALER........5 OTHER_____.6 (SPECIFY) CHILD NOT TAKEN.....7	HEALTH FACILITY.....1 PRIVATE DOCTOR......2 CBEW................3 TRAD'L MIDWIFE......4 TRADL HEALER........5 OTHER_____.6 (SPECIFY) CHILD NOT TAKEN.....7	HEALTH FACILITY.....1 PRIVATE DOCTOR......2 CBEW................3 TRAD'L MIDWIFE......4 TRADL HEALER........5 OTHER_____.6 (SPECIFY) CHILD NOT TAKEN.....7	HEALTH FACILITY.....1 PRIVATE DOCTOR......2 CBEW................3 TRAD'L MIDWIFE......4 TRADL HEALER........5 OTHER_____.6 (SPECIFY) CHILD NOT TAKEN.....7
436 In the last 4 weeks has (NAME) suffered from: Cough? Fast or difficult breathing? Noisy breathing? Blocked/runny nose? Sore throat? Earache or discharge? Fever? S N Rash?	YES NO DK COUGH.........1 2 8 FAST/DIFFICULT BREATHING...1 2 8 NOISY BREATHG.1 2 8 RUNNY NOSE....1 2 8 SORE THROAT...1 2 8 EARACHE.......1 2 8 FEVER.........1 2 8 RASH..........1 2 8	YES NO DK COUGH.........1 2 8 FAST/DIFFICULT BREATHING...1 2 8 NOISY BREATHG.1 2 8 RUNNY NOSE....1 2 8 SORE THROAT...1 2 8 EARACHE.......1 2 8 FEVER.........1 2 8 RASH..........1 2 8	YES NO DK COUGH.........1 2 8 FAST/DIFFICULT BREATHING...1 2 8 NOISY BREATHG.1 2 8 RUNNY NOSE....1 2 8 SORE THROAT...1 2 8 EARACHE.......1 2 8 FEVER.........1 2 8 RASH..........1 2 8	YES NO DK COUGH.........1 2 8 FAST/DIFFICULT BREATHING...1 2 8 NOISY BREATHG.1 2 8 RUNNY NOSE....1 2 8 SORE THROAT...1 2 8 EARACHE.......1 2 8 FEVER.........1 2 8 RASH..........1 2 8

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157

S-Ko (ZITA) akamborati-
dzika kuti aive nez-
vi**** zvinotevera here
munasvondo maviri ap-
fuura?

	YES NO DK	YES NO DK	YES NO DK	YES NO DK
Chikosoro?	COUGH.........1 2 8	COUGH.........1 2 8	COUGH.........1 2 8	COUGH.........1 2 8
Kuzarirwa?	DFCLT BRTHG...1 2 8	DFCLT BRTHG...1 2 8	DFCLT BRTHG...1 2 8	DFCLT BRTHG...1 2 8
Kufemereka?	NOISY BREATHG.1 2 8	NOISY BREATHG.1 2 8	NOISY BREATHG.1 2 8	NOISY BREATHG.1 2 8
Dzihwa?	RUNNY NOSE....1 2 8	RUNNY NOSE....1 2 8	RUNNY NOSE....1 2 8	RUNNY NOSE....1 2 8
Maronda epahuro?	SORE THROAT...1 2 8	SORE THROAT...1 2 8	SORE THROAT...1 2 8	SORE THROAT...1 2 8
Kurwadziwa nenzeve kana kubuda hurwa?	EARACHE.......1 2 8	EARACHE.......1 2 8	EARACHE.......1 2 8	EARACHE.......1 2 8
Kupindwa nechando?	FEVER.........1 2 8	FEVER.........1 2 8	FEVER.........1 2 8	FEVER.........1 2 8
Tumhezi?	RASH..........1 2 8	RASH..........1 2 8	RASH..........1 2 8	RASH..........1 2 8

N-U (IBIZO) sewake wagu-
la omunye wemikhuhlane
elandelayo yini pha-
kathi kwamaviki amane
adluleyo:

	YES NO DK	YES NO DK	YES NO DK	YES NO DK
Ukukwehlela?	COUGH.........1 2 8	COUGH.........1 2 8	COUGH.........1 2 8	COUGH.........1 2 8
Ukugcwalelana?	DFCLT BRTHG...1 2 8	DFCLT BRTHG...1 2 8	DFCLT BRTHG...1 2 8	DFCLT BRTHG...1 2 8
Ukuhoqa ephefumula nzima?	NOISY BREATHG.1 2 8	NOISY BREATHG.1 2 8	NOISY BREATHG.1 2 8	NOISY BREATHG.1 2 8
Umvimbano?	RUNNY NOSE....1 2 8	RUNNY NOSE....1 2 8	RUNNY NOSE....1 2 8	RUNNY NOSE....1 2 8
Amalonda?	SORE THROAT...1 2 8	SORE THROAT...1 2 8	SORE THROAT...1 2 8	SORE THROAT...1 2 8
Ubuhlungu kumbe ukubhibhidla indlebe?	EARACHE.......1 2 8	EARACHE.......1 2 8	EARACHE.......1 2 8	EARACHE.......1 2 8
Uquqo?	FEVER.........1 2 8	FEVER.........1 2 8	FEVER.........1 2 8	FEVER.........1 2 8
Ukuqhubuka?	RASH..........1 2 8	RASH..........1 2 8	RASH..........1 2 8	RASH..........1 2 8

436A CHECK 436:
CHILD HAD ANY SYMPTOMS
--AT LEAST ONE YES?

YES ☐ NO ☐ →Go to next col.	YES ☐ NO ☐ →Go to next col.	YES ☐ NO ☐ →Go to next col.	YES ☐ NO ☐ →439
V	V	V	V

437 Was (NAME) taken to
health facility, a
private doctor, a
community-based exten-
sion worker or to any
other person or place
to treat the problem?
IF YES: Where was he/
she taken?
S-Makamboenda here na-
(ZITA) kunorapwa, kwa
Doctor, kana kwa CBEW,
kana kumwewo kunorapwa?
IF YES: Akarapwa kupi?
N-U (IBIZO) lamusa esib-
hedlela, kumbe kudho-
kotela, kumbe emuntwi-
ni obona ngezempilo
kuyonale indawo kumbe
komunye nje umuntu uk-
uze elatshwe umkhuhla-
ne lo?
IF YES: Lamusa ngaphi?

HEALTH FACILITY.....1	HEALTH FACILITY.....1	HEALTH FACILITY.....1	HEALTH FACILITY.....1
PRIVATE DOCTOR......2	PRIVATE DOCTOR......2	PRIVATE DOCTOR......2	PRIVATE DOCTOR......2
CBEW................3	CBEW................3	CBEW................3	CBEW................3
UNTRAINED TRADL MW..4	UNTRAINED TRADL MW..4	UNTRAINED TRADL MW..4	UNTRAINED TRADL MW..4
TRADL HEALER........5	TRADL HEALER........5	TRADL HEALER........5	TRADL HEALER........5
OTHER_____.6	OTHER_____..6	OTHER_____.6	OTHER_____..6
(SPECIFY)	(SPECIFY)	(SPECIFY)	(SPECIFY)
CHILD NOT TAKEN.....7	CHILD NOT TAKEN.....7	CHILD NOT TAKEN.....7	CHILD NOT TAKEN.....7

438 As treatment, for
problem(s) did (NAME)
receive:

	YES NO DK	YES NO DK	YES NO DK	YES NO DK
Home remedies?	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8
Injection (penicln)?	INJECTION.....1 2 8	INJECTION.....1 2 8	INJECTION.....1 2 8	INJECTION.....1 2 8
Oral antibiotics?	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8
Other tablets?	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8
Anything else? IF YES: What else?	OTHER_____.1 2 8	OTHER_____.1 2 8	OTHER_____.1 2 8	OTHER_____.1 2 8
	(SPECIFY)	(SPECIFY)	(SPECIFY)	(SPECIFY)
	(ALL GO TO NEXT COL)	(ALL GO TO NEXT COL)	(ALL GO TO NEXT COL)	(ALL GO TO 439)

S-Mwana wenyu (ZITA)
paairatidzika kunge
anezvirwere izvi, aka-
pihwa here zvimwe zve-
zvinotevra izvi:

	YES NO DK	YES NO DK	YES NO DK	YES NO DK
Mishonga inogadzirwa pamba?	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8
Jekiseni?	INJECTION.....1 2 8	INJECTION.....1 2 8	INJECTION.....1 2 8	INJECTION.....1 2 8
Mapiritsi ekunwa ano-dzivirira hutachiwana?	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8
Mamwewo zvawo mapiri-tsi?	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8
Pane zvimwe here? IF YES: Ndezvipi?	OTHER_____.1 2 8	OTHER_____.1 2 8	OTHER_____.1 2 8	OTHER_____.1 2 8
	(SPECIFY)	(SPECIFY)	(SPECIFY)	(SPECIFY)
	(ALL GO TO NEXT COL)	(ALL GO TO NEXT COL)	(ALL GO TO NEXT COL)	(ALL GO TO 439)

N-Ngesikhathi u (BIZO)
etshengisela ukuba
lale imkhuhlane wathola
lokhu okulandelayo na:

	YES NO DK	YES NO DK	YES NO DK	YES NO DK
Imithi yangekhaya?	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8	HOME REMEDIES.1 2 8
Ijekiseni?	INJECTION.....1 2 8	INJECTION.....1 2 8	INJECTION.....1 2 8	INJECTION.....1 2 8
Amaphilisi okuvikela imkhuhlane?	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8	ORAL ANTIBIO..1 2 8
Amanye amaphilisi ke?	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8	OTHER TABLETS.1 2 8
Okunye-ke? IF YES: Kuyini?	OTHER_____.1 2 8	OTHER_____.1 2 8	OTHER_____.1 2 8	OTHER_____.1 2 8
	(SPECIFY)	(SPECIFY)	(SPECIFY)	(SPECIFY)
	(ALL GO TO NEXT COL)	(ALL GO TO NEXT COL)	(ALL GO TO NEXT COL)	(ALL GO TO 439)

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
439	CHECK 433 AND 434: S-S-W GIVEN TO ANY CHILD? NO/DEAD ☐ YES ☐		→441
440 S N	Have you ever heard about a sugar-salt-water solution you can give to children who have diarrhea? Mati mambonzwa nezvemvura yakasanganiswa neshuga nesauti inopiwa mwana kana aine manyoka here? Usuke wezwa ngamanzi ahlanganiswa letshukela letswayi abesenathiswa abantwana na?	YES...............................1 NO................................2	→501
441 S N	Where did you first learn about sugar-salt-water solution? Makatanga kuzvidzidza kupi izvi zvemvura yakasanganiswa neshuga nesauti? Waqalisa ngaphi ukufunda ngamanzi la?	HEALTH FACILITY.................1 PRIVATE DOCTOR..................2 CBEW............................3 MASS MEDIA......................4 POSTER..........................5 FRIEND/RELATIVE.................6 OTHER_____.7 (SPECIFY DK..............................8	
442 S N	How much water should one use to prepare the solution? Munoda mvura yakawanda zvakadii kuti mugadzire mvura iyi? Kufuneka amanzi amanengi ckungakanani?	750 ML..........................1 ONE MAZOE BOTTLEFUL.............2 ONE COOKING OIL BOTTLEFUL.......3 ONE LARGE COKE BOTTLEFUL........4 OTHER_____.5 (SPECIFY) DK..............................8	
443 S N	How much sugar should one use to prepare the solution? Munoshandisa shuga yakawanda zvakadii? Kufuneka itshukela elinengi okungakanani?	6 LEVEL TEASPOONS...............1 6 TEASPOONS.....................2 OTHER_____.3 (SPECIFY) DK..............................8	
444 S N	How much salt should one use to prepare the solution? Munoshandiso sauti yakawanda zvakadii? Kufuneka itswayi elinengi okungakanani?	1/2 TEASPOON....................1 1/4 TEASPOON....................2 OTHER_____.3 (SPECIFY) DK..............................8	
445 S N	How often should the solution be given to a child with diarrhea? Mwana anemanyoka angapiwa kangani musanganiswa uyu? Umntwana ohudayo unikwa kangaki amanzi la?	WITH EACH LOOSE BOWEL MOVEMENT..1 AS OFTEN AS CHILD WILL DRINK....2 THREE TIMES PER DAY.............3 ONCE PER DAY....................4 OTHER_____.5 (SPECIFY) DK..............................8	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
501 S N	Have you ever been married? Makamboroorwa here? Sewake wenda yini?	YES...............................1 NO................................2	>510
502 S N	Are you now married or are you widowed, divorced or separated? Iye zvino makaroorwa here, kana kuti muri chirikadzi here, kana kuti makarambana here, kana kuti hamusi kugara mose? Okwamanje wendile, kumbe ungumfelokazi kumbe sewehlukana lomkakho?	MARRIED...........................1 WIDOWED...........................2 DIVORCED/SEPARATED................3	>507
503 S N	Does your husband stay here? Murume wenyu arikugara pano here? Umkakho uhlala laye yini?	YES...............................1 NO................................2	>505
504 S N	For how long has your husband been living away continuously? Murume wenyu ava nenguva yakadii asipo? Umkakho uselesikhathi eside okungakanani engabuyi ekhaya? (RECORD IN DAYS OR MONTHS OR YEARS)	DURATION DAYS.....................1 MONTHS...................2 YEARS....................3	
505 S N	Does your husband have any other wives beside yourself? Murume wenyu ane mumwe mudzimai here kunze kwenyu? Umkakho ulesithembo na?	YES...............................1 NO................................2 DK................................8	>507
506 S N	What is your rank? PROBE: Are you the first, second, or which wife? Imi muri wechingani? PROBE: Muri wekutanga, kana wechipiri here kana wechikangani? Wena ungowesingaki? PROBE: Ungowokuqala, kumbe owesibili na?	FIRST.............................1 SECOND............................2 THIRD.............................3 HIGHER............................4 DK................................8	
507 S N	Have you been married or lived with a man only once, or more than once? Makamboroorwa here kana kugara nemurume kamwe zvako, kana kakawanda? Sewake wendela kwenye indoda yini?	ONCE..............................1 MORE THAN ONCE....................2	
508 S N	In what month and year did you start living with your (first) husband? Mumwedzi upi gore ripi apo makatanga kugara nomurume? (apo makatanga kugara nomurume wenyu wekutanga) Waqala ngayiphi inyanga njalo kuwuphi umnyaka ukuhlala lomkakho wakuqala? IF SHE KNOWS THE YEAR, MARK HER ANSWER AND SKIP TO 511.	MONTH................ ☐☐ DK................................98 YEAR................. ☐☐ DK YEAR...........................98	>511
509 S N	How old were you when you started living with him? Makanga maane makore mangani pamakatanga kugara nemurume wenyu? Wawuleminyaka emingaki yokuzalwa usenda?	AGE................. ☐☐	>511
510 S N	Now we need some details about your sexual activity in order to get a better understanding of contraception and fertility. Have you ever had sexual intercourse? Iye zvino tinoda kunzwa maererano nezvekusangana kwenyu nevanhurume kuitira kuti zvitibatsire nezvekudzivirira kuita pamuviri kana kuzvarwa kwevana. Matimambosangana nemunhurume here? Khathesi kuyaswelakala ukuthi sazi mayelana lendaba zokuhlangana labesilisa njalo langokuzithwala kwakho. Sewake wahlangana lowesilisa na?	YES...............................1 NO................................2	>511A >518

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
511	Now we need some details about your sexual activity in order to get a better understanding of contraception and fertility. How old were you when you first had sexual intercourse?		
S	Iye zvino tinoda kunzwa maererano nezvekusangana kwenyu nevanhurume kuitira kuti zvitibatsire nezvekudzivirira kuita pamuviri kana kuzvarwa kwevana. Makabiswa humhandara muine makore mangani?		
N	Khathesi kuyaswelakala ukuthi sazi mayelana lendaba zokuhlangana labesilisa njalo langokuzithwala kwakho. Sewake wahlangana lowesilisa na? Wawusuleminyaka emingaki ngesikhathi uqalisa ukuhlangana lowesilisa?		
511A	How old were you when you first had sexual intercourse?	AGE.........................☐☐	
S	Makabiswa humhandara muine makore mangani?		
N	Wawusuleminyaka emingaki ngesikhathi uqalisa ukuhlangana lowesilisa?		
512	When was the last time you had sexual intercourse?	DAYS AGO.................1 ☐☐	
S	Makapedzisira kusangana nemurume riini?	WEEKS AGO................2	
N	Ucine nini ukuhlangana lowesilisa?	MONTHS AGO..............3	
	IF LESS THAN 2 MONTHS, RECORD IN DAYS OR WEEKS.	YEARS AGO................4	
		BEFORE LAST BIRTH.............996——>518	
513	CHECK 220: NOT PREGNANT OR UNSURE ☐ PREGNANT ☐————————————————>518		
514	CHECK 312 AND 313: NOT USING CONTRACEPTION ☐ USING CONTRACEPTION ☐————————————————>518		
515	If you felt pregnant in the next few weeks, would it pose any problems for you or would it not matter very much?	YES, POSE PROBLEMS..............1 NO, NOT MATTER..................2— DK.............................8—┘>518	
S	Mukabata pamuviri pamasvondo maviri anotevera zvingakupinzai munjodzi here kana kuti kwete?		
N	Nxa kungenzeka ukuthi uthathe isisu phakathi kwamaviki amalutshwane alandelayo, kungakubangela udubo yini kumbe hatshi kakungezake kukuhluphe kangako?		
516	What sort of problems would it cause?	CAN'T AFFORD IT.................0: CHILDREN ARE YOUNG.............02 UNHEALTHY TO HAVE MORE........03 CAN'T CARE FOR MORE............04 MENOPAUSAL....................05 NO PARTNER....................06 OTHER_____.07 (SPECIFY) DK............................98	
S	Chii chingakunetsai?		
N	Zingaba zinhlupho bani lezo?		
517	What is the main reason that you are not using a method to avoid pregnancy?	LACK OF KNOWLEDGE.............01 OPPOSED TO FAMILY PLANNING.....02 HUSBAND DISAPPROVES...........03 OTHERS DISAPPROVE.............04 HEALTH CONCERNS...............05 ACCESS/AVAILABILITY...........06 COSTS TOO MUCH................07 INCONVENIENT TO USE...........08 INFREQUENT SEX................09 FATALISTIC....................10 RELIGION......................11 POSTPARTUM/BREASTFEEDING.......12 MENOPAUSAL/SUBFECUND..........13 OTHER _____.14 (SPECIFY) DK............................98	
S	Chii chikonzero chiri kuita kuti musashandise nzira yokudzivirira kuita pamuviri?		
N	Yisiphi isizatho esikhulu esikwenza ungaze wasebenzisa indlela yokuvikela ukuthatha isisu?		
518	PRESENCE OF OTHERS AT THIS POINT.	YES NO CHILDREN UNDER 10..........1 2 HUSBAND....................1 2 OTHER MALES................1 2 OTHER FEMALES.............1 2	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
519 S N	Now I have a few questions about a very important topic. Have you ever heard of an illness called AIDS? Lye zvino ndinemibvunzo mishoma shoma yakakosha chaizvo. Matimabonzwa nezvechirwere chinonzi AIDS? Khathesi ngilombuzo emilutshwana mayelana lendaba eqakathekileyo kakhulukazi. Sewake wezwa yini ngomkhuhlane okuthiwa yi "AIDS"?	YES.............................1 NO..............................2	───>601
520 S N	Please tell me all the ways that a person can get AIDS/ HIV infection. Any other ways? Munganditaurirewo here nzira dzose idzo munhu angabate nadzo chiwere cheAIDS/HIV? Pane dzimwe here? Ngicela ungitshele indlela zonke ezingenza umuntu abanjwe ngomkhuhlane we "AIDS" kumbe i"HIV". Ezinye ke? CIRCLE ALL WAYS MENTIONED.	SEX WITH A PERSON WITH AIDS.....1 SEX WITH A PROSTITUTE...........1 MANY SEX PARTNERS...............1 HOMESEXUAL SEX..................1 TOUCHING A PERSON WITH AIDS.....1 SHARING UTENSILS WITH A PWA.....1 BLOOD TRANSFUSION...............1 BEING BORN TO A WOMAN WITH AIDS.1 DONATING BLOOD..................1 MOSQUITO BITES..................1 INJECTION WITH A DIRTY NEEDLE...1 OTHER_____.1 OTHER_____.1 (SPECIFY) DK..............................1	
521			YES NO
	Have you heard about AIDS on the	**S** Matimambonzwa here nezve AIDS pa	**N** Sewake wezwa yini ngomkhuhlane okuthiwa yi AIDS?	
	Radio? From a health worker? In the newspaper? On a pamphlet or poster? Any other ways?	Radio? Kubva kunevashandi vezve utano? Mupepanhau? Patumapepa kana mapepa akanamirwa pamudhuri? Pane kumwe here kwamakazvinzwa?	KuRadio? Kwabezempilo abahambela izigaba? Kuphephandaba? Emabhukwaneni kumbe emagwalibeni ananyathiselwa emidhulini (posters) Enye ke?	RADIO.......................1 2 HEALTH WORKER...............1 2 NEWSPAPER...................1 2 PAMPHLET/POSTER.............1 2 OTHER_____1 2 (SPECIFY)
522 S N	What should a person with AIDS do for treatment? Anything else? Munhu ane AIDS angaita seyi kuti arapwe? Pane zvimwe here? Umuntu ole"AIDS" angenzani ukuze elatshwe? Okunye ke? CIRCLE ALL THINGS MENTIONED.	GO TO NANGA.....................1 GO TO HOSPITAL..................1 GO TO CLINIC....................1 DO NOTHING......................1 TAKE HERBS......................1 OTHER_____.1 (SPECIFY) DK..............................1	
523 S N	Is there a cure for AIDS? AIDS inorapika here? I"AIDS" iyelapheka yini?	YES.............................1 NO..............................2 DK..............................8	
524 S N	If a person has AIDS, is it alright for them to: Continue to go to school? Be permitted in public places? Donate blood? Be quarantined (isolated)? Kana munhu aine AIDS anga rambe achienda kuchikoro here? Angabvumirwa panzvimbo dzinosangana vanhu vakawanda here? Anobvumirwa kupa ropa here? Anga iswa mumba make ega here? Nxa umuntu elomkhuhlane we "AIDS": Angaqubeka esiya esikolo na? Angavunyelwa ukuhlangana labanye abantu na? Angapha igazi na? Kumbe angahlaliswa yedwa na?	YES NO DK GO TO SCHOOL............1 2 8 BE IN PUBLIC............1 2 8 DONATE BLOOD............1 2 8 BE QUARANTINED.........1 2 8	

525	CHECK 510: EVER HAD INTERCOURSE? YES OR 510 ☐ NEVER HAD ☐ NOT ASKED SEX		──>609
526 S N	Have you done anything to avoid getting AIDS? Pane zvamakamboita here kudzivirira chirwere che AIDS? Usuke wenza umzano wokwenqabela ukubanjwa ngumkhuhlane othiwa yi AIDS?	YES...............................1 NO................................2	──>528

527
 	
S
 	
N
	What have you done? Anything else?
	
	   CIRCLE EVERYTHING MENTIONED.
	
	Chii chamakaita? Pane zvimwe here?
	
	Wenzani? Okunye ke?
		USED CONDOMS.....................1
		STAY WITH ONE PARTNER............1
		AVOID MULTIPLE PARTNERS.........1
		AVOID BARS.......................1
		TAKE HERBS.......................1
		OTHER_____.1
		OTHER_____.1
		        (SPECIFY)
			──>601

528
 	
S
 	
N
	Why not? Any other reasons?
	
	   CIRCLE EVERYTHING MENTIONED.
	
	Makaregererei?
	
	Wekelelani?
		NOT AT RISK......................1
		NOT HAVING SEX...................1
		ALREADY USING CONDOMS...........1
		CANNOT AVOID AIDS...............1
		OTHER_____.1
		OTHER_____.1
		        (SPECIFY)
		DK...............................1	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
601	CHECK 502: □ CURRENTLY MARRIED NOT CURRENTLY MARRIED □		>609
602 S N	Now I have some questions about the future. Lye zvino ndinemubvunzo maereraro neramangwana. Khathesi ngifuna ukubuza ngelakusasa. CHECK 220 AND MARK BOX. NOT PREGNANT OR UNSURE □ PREGNANT □ > READ 602B v READ 602A		
602A S N	Would you like to have a (another) child or would you prefer not to have any (more) children? Muchada kuzoita mumwe mwana here kana kuti hamuchadi mumwe mwana? Uyafuna yini ukuba lomntwana kumbe ukuba lomunye umntwana, kumbe njalo kawusafuni ukuzala abanye abantwana?	HAVE ANOTHER....................1 NO MORE.........................2 SAYS SHE CAN'T GET PREGNANT.....3 UNDECIDED OR DK.................8	>605
602B S N	After the child you are expecting, would you like to have another child or would you prefer not to have any (more) children? Kana masun) unguka mwana wamurikutarisira, muchada kuzoita mumwe mwoana here. (Vomwe vana here)? Kana kuti kwete. Ngemva kokubeletha lo omthweleyo uzafisa yini ukuba labanye kumbe bazabe sebenele?		
603 S N	How long would you like to wait from now before the birth of a (another) child? Mungade kupedza nguva yakadii musati maita mumwe mwana? Ufuna ukuma okwesikhathi esinganani ungakamelamisi lo umntwana olaye?	DURATION MONTHS..................1 □□ YEARS...................2 RIGHT AWAY....................996 DK............................998	>605 >605
604 S N	CHECK 215: How old would you like your youngest child to be before you have another child? Mungamire kusvika mwana wenyu mudiki ave nemakore mangani? Omncane olaye uyabe esemdala okunganani? IF NO LIVING CH._DREN, CIRCLE '96'.	AGE OF YOUNGEST YEARS..................□□ NO LIVING CHILDREN.............96 DK............................98	
605 S N	Does your husband approve or disapprove of women using family planning to delay or avoid pregnancy? Murume wenyu anobvumira here kana kuti haabvume kuti vanhukadzi vashandise nzira dzokuronga mhuri? Umkakho uyavuma kumbe njalo uyala ukuthi omama basebenzise indlela zokuvikela ukuthatha isisu kumbe ukwelamisela khatshana na?	APPROVES........................1 >607 DISAPPROVES.....................2 DK.............................8 >607	
606 S N	Why does he disapprove? Sei asingabvumire? Ukwalelani lokho?	WOMAN WILL BE PROMISCUOUS.......1 WANTS MORE CHILDREN.............2 HEALTH CONCERNS.................3 OTHER_____.4 (SPECIFY) DK.............................8	
607 S N	Have you ever discussed family planning with your husband? Matimambokurukura nezvekurongwa kwemhuri nemurume wenyu here? Sewake waxoxa lomkakho mayelana ngendaba yokondla imhuli na?	YES.............................1 NO..............................2 >609	
608 S N	How many times have you discussed it in the last year? Makakurukura kangani mugore rapfuura? Layixoxa kangaki lindaba kumnyaka ophelileyo?	NONE............................1 ONCE............................2 TWICE...........................3 THREE OR MORE...................4	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
609	CHECK 202 AND 204: NO LIVING CHILDREN ☐ HAS LIVING CHILDREN ☐ READ 609A READ 609B		
609A	If you could choose exactly the number of children to have in your whole life, how many would that be?		
S	Dai zvainzi sarudzai kuti mungade vana vangani muhupenyu hwenyu hwose, vangava vangani?	NUMBER.................. ☐☐	
N	Nxa kungathiwa khetha inani labantwana ofuna ukuba laba empilweni yakho, ungakhetha abangaki?		
609B	If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be?	OTHER ANSWER _____ (SPECIFY)	
S	Mukafunga nguva yamaiva musati mave nemwana, maida vana vangani muhupenyu hwenyu hwose?		
N	Asithi awulabantwana, kubesekuthiwa zikhethele inani labantwana obafunayo, ungakhetha abangaki empilweni yakho yonke?		
	RECORD NUMBER OR OTHER ANSWER.		

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
701	CHECK 501: EVER ☐ ALL OTHERS ☐ MARRIED ASK QUESTIONS ABOUT CURRENT OR MOST RECENT HUSBAND.		──>710
702 S N	Now I have some questions about your (most recent) husband. Did your husband ever attend formal school? Iye zvino ndinoda kubvunza nezve murume wenyu. (Wamaiva naye) Murume wenyu akamboenda kuchikoro here? Okwakhathesi ngilemibuzo mayelana lomkakho olaye khathesi. Umkakho wake waya esikolo na?	YES.............................1 NO.............................2──>704	
703 S N	What was the highest grade of school he completed? Vakagumira mustandard grade form ani? Wacina kuluphi ugwalo? CIRCLE LEVEL AND GRADE.	LEVEL GRADE DK NONE.......00 PRIMARY....1 1 2 3 4 5 6 7 8 SECONDARY..2 1 2 3 4 5 6 8 HIGHER.....3 1 2 3 4 5 6 8 DK........98	
704 S N	Can (could) he read a letter or newspaper in any language? Vanokwanisa (vaikwanisa) here kuverenga tsamba kana pepanhau? Umkakho uyanelisa ukubala incwadi kumbe iphephandaba na?	YES.............................1 NO.............................2	
705 S N	What kind of work does (did) your husband mainly do? Murume wenyu anowanzoita basa rei? Umkakho wenza msebenzi bani?	───── ─☐☐☐☐☐ ───── ─────	
706	CHECK 705: DOES (DID) NOT ☐ WORKS ☐ WORK IN AGRI- (WORKED) CULTURE IN AGRICULTURE		──>708
707 S N	Does (did) he earn a regular wage or salary? Anotambira (aitambira) mari svondo rega rega here kana pamwedzi? Uyahola kulo msebenzi maviki wonke kumbe nyanga zonke na?	YES.............................1 NO ....2 DK.............................8	}─>710
708 S N	Does (did) your husband work mainly on his or family land, on someone else's land, or on communal lands? Murume wenyu anowanzo (aiwanzo) shanda mumunda menyu here, kana memumwe munhu kana mumaruwa? Umkakho usebenza ikakhulu ensimini yenu, kumbe uyaqatshwa ukusebenza emasimini abanye abantu kumbe njalo usebenza emapulazi na?	HIS/FAMILY LAND.................1──>710 SOMEONE ELSE'S LAND.............2 COMMUNAL LANDS..................3	
709 S N	Does (did) he work mainly for money or does (did) he work for a share of the crops? Anowanzo (vaiwanzo) shandira mari here kana kugovana mbesa navamwe munhu? Uyahola kumbe vayabelana kungavunwa?	MONEY..........................1 A SHARE OF CROPS...............2	
710 S N	Aside from their usual housework, many women work in order to earn money. Are you currently doing any work for money? Kunze kwebasa repamba, madzimai mazhinji vanoshanda kuti vahore mari iye zvino murikushanda basa rinokupai mari here? Ngaphandle kokwenza imisebenzi yendlini, omama abanengi sebesebenza imisebenzi ebapha imali. Wena ukhona umsebenzi owenzayo okupha imali na?	YES.............................1 NO.............................2──>721	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
711	What kind of work do you do?	☐☐☐☐	
S	Munoita basa rei?		
N	Wenza msebenzi bani?		
712	CHECK 711: WORKS IN AGRICULTURE ☐ DOES NOT WORK IN AGRICULTURE ☐		→715A
713	Do you work mainly on your (or your husband's) family's land, on someone else's land, or on communal lands?	HER/FAMILY LAND.................1──→721 SOMEONE ELSE'S LAND.............2 COMMUNAL LANDS..................3	
S	Munowanzoshanda mununda (memurume wenyu here) menyu here, kana memumwewo munhu, kana mumaruwa?		
N	Wena usebenza ikakhulu emasimini enu, kumbe uyaqatshwa ukusebenza emasimini abanye abantu kumbe njalo usebenza emapulazi na?		
714	Do you work mainly for money or do you work for a share of the crops?	MONEY..........................1──→719 A SHARE OF CROPS...............2	
S	Munowanzo shandira mari here, kana kuti munozogovana mbesa?		
N	Uyahola kumbe liyabelana kungavunwa?		
715	Do you sell the crops for money or use them mainly for subsistence?	SELL FOR MONEY.................1──→719 USE FOR SUBSISTENCE...........2──→721	
S	Munotengesa here zvirimwa zvamunenge makohwa, kana kuti munoshandisa zvose?		
N	Amabele la owatholayo uyawathengisa kumbe njalo ngawokudla ngekhaya?		
715A	Who runs the place where you work: yourself, your family, or someone else?	HERSELF........................1 HER FAMILY.....................2 SOMEONE ELSE...................3	
S	Ndiani anotungamirira pamunosevenza, ndimi here, kana kuti vemhuri yenyu, kana kuti mumwe munhuwo hake?		
N	Ngubani umphathi emsebenzini wakho: nguwe, yimhuli yakho, kumbe njalo ngomunye umuntu?		
716	During most weeks of the year, do you usually work at this job five or more days per week, four or fewer days, or do you work seasonally or irregularly?	5+ DAYS........................1 UP TO 4 DAYS...................2 SEASONALLY.....................3 IRREGULARLY....................4 OTHER _____.5 (SPECIFY)	
S	Masvondo mazhinji epagore munowanzo shanda kwemazuva mashanu here kana kupfuura pasvondo rega rega, mazuva mana kana kuti mashoma, kana kuti mwaka nemwaka kana kuine basa?		
N	Phakathi komnyaka, uvame ukusebenza lo umsebenzi okwamalanga amahlanu kumbe adlula amahlanu ngeviki, kumbe amane, kumbe angaphansi kwamane, kumbe ngesikhathi sokulima, kumbe esokuvuna kumbe njalo usebenza nxa umsebenzi ungavuka?		
717	On a typical day when you are doing this work, how many hours do you spend working at this job?	HOURS................☐☐	
S	Pazuva ramunoshanda munosevenza maawa mangani pabasa iri?		
N	Ngelanga ubona engathi usebenza okwamahora amangaki?		
718	On a typical working day, how long does it take you to travel to the place where you work? PROBE: About how many minutes or hours?	MINUTES.................1 ☐☐ HOURS...................2 ☐☐ WORKS AT HOME...............996	
S	Pazuva ramunoshanda munotora nguva yakadii kuenda kwamunosevenzera? PROBE:		
N	Kukuthatha isikhathi esinganani ukuthi uyefika emsebenzini? PROBE: Kungaba imizuzo kumbe abahola amangaki?		

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
719	In a typical day, week or month, how much do you earn for this work?	AMOUNT	
S	Pazuva, pasvondo, pamwedzi, munowana marii pabasa renyu iri?	PER HOUR.....,....................1	
N	Uhola malini ngelanga, ngeviki kumbe ngenyanga kulo umsebenzi owenzayo?	PER DAY.........................2 PER WEEK........................3 PER MONTH.......................4 PER YEAR........................5	
	RECORD IN THE SMALLEST UNIT OF TIME POSSIBLE.		
720	When you are working for money, do you decide how all of the money you earn will be used, how some of it will be used, or does someone else decide how your earnings will be used?	DECIDES ABOUT ALL...............1 DECIDES ABOUT SOME..............2 SOMEONE ELSE DECIDES............3	>723
S	Kana muchishandira mari, ndimi munofunga nezvemashandisirwo emari here, kana kuti pane mumwe anokurongerai mashandisirwo emari?		
N	Nxa usebenzela imali, nguwe yini ophawula ukuthi imali yonke oyiholayo izasebenza njani kumbe uphawula inxhenye yale imali kumbe njalo ukhona ophawula ukuthi iholo lakho lonke lizasebenza njani na?		
721	Have you ever worked regularly--that is, for six months or more, to earn money, other than on a farm or in a business run by your family?	YES.............................1 NO..............................2	>723
S	Matimamboshanda here kwemwedzi mitanhatu kana kudarika musina kumbomira, muchishandira mari pasiri papurazi kana pabhizimisi remhuri yenyu?		
N	Usuke waqatshwa usebenzela imali, njalo wasebenza ungazange umiswe ekwezinyanga eziyisithupha ngaphandle kokusebenza emasimini kumbe kubizimusi yemhuli yakho na?		
722	What kind of work did you do last?	▢▢▢▢	
S	Maiita basa rei?		
N	Wacina ngokusebenza umsebenzi bani?		
723	CHECK 710: WOMAN IS WORKING ▢ WOMAN IS NOT WORKING ▢		>727
724	CHECK 217 AND 218: HAS CHILDREN AGE 5 AND UNDER LIVING AT HOME ▢ NO CHILDREN AGE 5 AND UNDER LIVING AT HOME ▢		>727
725	While you are working, are your children who are age 5 and under with you most of the time, some of the time, or never?	MOST OF THE TIME................1 SOMETIMES.......................2 NEVER...........................4	>727
S	Pamunenge muchishanda vana venyu vanemakore mashanu nevadiki vanenge vainemi nguva zhinji, kana kuti dzimwe nguva, kana kuti kwete?		
N	Nxa usemsebenzini, abantwabakho abaleminyaka emihlanu kumbe abaleminyaka engaphansi kwemihlanu, uyabe ulabo emsebenzini isikathi esinengi, kumbe ngesinye isikhathi, kumbe kakujwayelekanga kumbe njalo kawuzake ubelabo?		
726	Who usually takes care of these children while you are working?	HUSBAND........................01 RESPONDENT HERSELF.............02 OTHER CHILDREN.................03 OTHER RELATIVES................04 NEIGHBORS/FRIENDS..............05 DOMESTIC HELP..................06 CHILDREN ARE AT SCHOOL.........07 NURSERY/DAY CARE CENTER........08 OTHER _____.09 (SPECIFY)	
S	Ndiani anochengeta vana pamunenge muchishanda?		
N	Ngubani ojwayele ukubagcina lababantwana nxa usemsebenzini?		
727	RECORD THE TIME.	HOUR.....................▢▢ MINUTES..................▢▢	

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INTERVIEWER: IN 801-803, RECORD THE LINE NUMBERS, NAMES, AND BIRTH DATES OF ALL LIVING CHILDREN
BORN SINCE JANUARY 1, 1983, STARTING WITH THE YOUNGEST CHILD. CHECK AGE IN 804
TO IDENTIFY CHILDREN 3-60 MONTHS OF AGE. RECORD WEIGHT AND LENGTH IN 805 AND 806.

	|1| YOUNGEST LIVING CHILD	|2| NEXT-TO-YOUNGEST LIVING CHILD	|3| SECOND-TO-YOUNGEST LIVING CHILD
801 LINE NO. FROM 212	☐☐	☐☐	☐☐
802 NAME FROM 212	(NAME)	(NAME)	(NAME)
803 DATE OF BIRTH FROM 214	MONTH........... ☐☐ YEAR............ ☐☐	MONTH........... ☐☐ YEAR............ ☐☐	MONTH........... ☐☐ YEAR............ ☐☐
804 CHECK AGE: 3-60 MONTHS?*	YES ☐ NO ☐ → v	YES ☐ NO ☐ → v	YES ☐ NO ☐ v
805 WEIGHT (in kgs)	☐☐.☐	☐☐.☐	☐☐.☐
806 LENGTH (in cms)	☐☐☐.☐	☐☐☐.☐	☐☐☐.☐
807 STATE REASON IF UNABLE TO RECORD	CHILD SICK.................1 CHILD AWAY.................2 MOTHER REFUSED.............3 CHILD ASLEEP...............4 NO MEASURERS...............5 OTHER_____.6 (SPECIFY)	CHILD SICK.................1 CHILD AWAY.................2 MOTHER REFUSED.............3 CHILD ASLEEP...............4 NO MEASURERS...............5 OTHER_____.6 (SPECIFY)	CHILD SICK.................1 CHILD AWAY.................2 MOTHER REFUSED.............3 CHILD ASLEEP...............4 NO MEASURERS...............5 OTHER_____.6 (SPECIFY)
808 NAME OF MEASURER: _____ ☐☐		NAME OF ASSISTANT: _____ ☐☐	

* IF UNABLE TO DETERMINE DUE TO MISSING OR CONTRADICTORY INFORMATION, MEASURE CHILD.

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INTERVIEWER'S OBSERVATIONS
(To be filled in after completing interview.)

Person Interviewed: _____

_____

_____

Specific Questions: _____

_____

_____

Other Aspects: _____

_____

Name of Interviewer: _____ Date: _____

SUPERVISOR'S OBSERVATIONS

_____

_____

_____

_____

Name of Supervisor: _____ Date: _____

EDITOR'S OBSERVATIONS

_____

_____

_____

_____

Name of Field Editor: _____ Date: _____

Name of Keyer: _____ Date: _____

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