

# The Impact of Family Planning on Women's Lives: Findings from the Women's Studies Project in Mali and Zimbabwe

Barbara Barnett,<sup>1</sup> Mamadou Konaté,<sup>2</sup> Marvellous Mhloyi,<sup>3</sup> Jane Mutambirwa,<sup>4</sup> Monica Francis-Chizororo<sup>5</sup> and Noah Taruberekeru<sup>3</sup> and Priscilla Ulin<sup>1</sup>

## ABSTRACT

This paper reports on the findings of the Women's Studies Project, a five-year research effort conducted by Family Health International and designed to study the impact of family planning on women's lives. Twenty-six field studies were conducted in ten countries, including the sub-Saharan countries of Mali and Zimbabwe. In Mali, researchers looked at the experiences of first-time contraceptive users and factors that influence decisions to continue or discontinue methods, including spousal approval. In Zimbabwe, studies focused on family planning as a factor in women's participation in the country's economic development process. Researchers concluded that family planning is one of many strategies women can use to exercise autonomy in their lives. However, negative consequences of contraceptive use, such as community disapproval or husband's opposition may discourage women from taking control of their fertility. (*Afr J Reprod Health* 1999;3[1]:27-38)

## RÉSUMÉ

**l'Impact de la planification familiale sur la vie des femmes : Découvertes du Projet d'Étude sur les Femmes au Mali et au Zimbabwe.** Ce document rapporte les découvertes faites par le Projet d'Étude sur les Femmes, une recherche de cinq ans menée par Family Health International et conçue dans le but d'étudier l'impact de la planification familiale sur la vie des femmes. Vingt-six études de terrain avaient été conduites dans dix pays comprenant les deux pays subsaharien que sont le Mali et le Zimbabwe. Au Mali, les chercheurs ont étudié les expériences d'utilisateurs de contraceptifs pour la première fois ainsi que les facteurs influençant la décision de continuer ou d'arrêter la méthode, telles que par exemple l'approbation du conjoint. Au Zimbabwe, les études se sont focalisées sur la planification familiale comme constituant un facteur de la participation de la femme dans le processus de développement de son pays. Les chercheurs ont conclu que la planification familiale est une parmi beaucoup des stratégies possibles que les femmes peuvent utiliser afin d'être autonomes dans leur vie ; cependant, les conséquences négatives de l'usage de la contraception, telles que la désapprobation de la communauté ou l'opposition du mari peuvent décourager les femmes à prendre le contrôle sur leur fertilité. (*Rev Afr Santé Reprod* 1993; 3[1]:27-38)

---

KEY WORDS: *Family planning, women's lives, Mali, Zimbabwe*

---

<sup>1</sup>Women's Studies Division, Family Health International; <sup>2</sup>Centre d'Études et de Recherché sur la Population pour le Développement; <sup>3</sup>Center for Population Studies, University of Zimbabwe; <sup>4</sup>Department of Psychiatry, University of Zimbabwe Medical School; <sup>5</sup>Institute for Development Studies, University of Zimbabwe.

## Introduction

Family planning use in sub-Saharan Africa is as divergent as the continent's landscape. Contraceptive prevalence rates range from highs of nearly 50 per cent of married women of reproductive age in some southeast African countries, to lows of less than 3 per cent in Burundi and Ethiopia. Although two-thirds of the sub-Saharan countries have family planning programmes, contraceptive use throughout the region remains low — roughly 18 per cent — with another 25 per cent of married women saying they want to delay pregnancy but are not using any contraceptive method.

These contradictions provide an interesting setting for research on the impact of family planning on women's lives. The Women's Studies Project (WSP), a five-year effort to explore women's perceptions of the benefits or disadvantages of contraceptive use and non-use, was conducted in two sub-Saharan countries — Mali, a Francophone country in the west, where modern contraception is practised by fewer than 5 per cent of the population, and Zimbabwe in the east, where nearly half the women of reproductive age use modern methods. While Zimbabwe's family planning programme has been in place for several decades, Mali's programme is relatively new. Not only do these two study sites offer contrasts in contraceptive prevalence rates, they also provide settings with differences in cultural and religious norms, access to contraceptive services, rural-urban migration patterns, and HIV prevalence rates. However, the studies explore the common theme of women's empowerment in personal and economic levels.

The studies in Mali and Zimbabwe were among 26 field studies conducted as part of the WSP, which was supported by a cooperative agreement to Family Health International (FHI) from the U.S. Agency for International Development. However, because numerous studies have examined the impact of family planning on maternal and child health status, the Women's Studies Project sought to move beyond this

point. The studies examined how women's family planning experiences — their contraceptive use and non-use, their pregnancies and child-bearing, and their experiences with family planning and reproductive health programmes — affected other aspects of their lives, including their roles as individuals, family members and participants in the larger community.

A goal of the WSP was to put women's concerns at the centre of population research, an idea reinforced at the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women. The ICPD programme of action noted that "the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. In addition, it is essential for the achievement of sustainable development".<sup>1</sup>

Five studies were conducted in sub-Saharan Africa. In Mali, a single qualitative study explored the experiences of first-time contraceptive users, reactions of family members to contraceptive use, and strategies developed by some women to cope with family and community opposition. In Zimbabwe, four studies, combining qualitative and quantitative methodologies, focused on family planning and women's participation are in the development process. In-country colleagues, including researchers, policy-makers and providers, and women's health advocates selected the topics. This "triangle" became a critical component of the research process. Members of the triangle were involved in establishing the research agenda, monitoring the research process and planning dissemination of study findings.

In Mali, Zimbabwe and other WSP countries, women said that family planning offers numerous benefits. It reduces fear of unplanned pregnancy and affords women the freedom to enjoy sexual relationships more fully; it relieves women from the physical and financial stress of caring for a large family; it allows some to pursue an education and possibly gain a measure of economic security; and it also gives them a means

to avoid a pregnancy that, for them, may be too early in life, too late, or too soon following a previous birth.

The WSP also found that family planning complicates women's lives. For some, when family planning is not an accepted religious or community norm, its use carries serious risks, including isolation or divorce. Family planning use can create its own set of anxieties as women worry about physical side-effects and whether those side-effects will alter their ability to work, care for their families, or to go to school. It causes stress for women as they maintain their reproductive roles and also take on new, and sometimes unwanted, productive roles in the workforce.

Following are brief summaries of WSP research findings in Mali and Zimbabwe. These include findings based on women's perceptions of the immediate and long-term consequences of their family planning experiences.

### **Mali: The Risks and Rewards of Contraceptive Use**

Although family planning has been part of official Malian policy since 1972, only 6.7 per cent of married women use any contraceptive method, and fewer than 5 per cent use modern methods, according to the 1996 DHS.<sup>2</sup> Levels of use are higher in urban areas; for example, in Bamako, 16.4 per cent of women subscribe to family planning compared with 8.2 per cent in other cities and only 1.9 per cent in rural areas. Among women who go for family planning, discontinuation is high. An earlier study of nearly 900 women, conducted by the Centre d'Etudes et de Recherche sur la Population pour le Developpement (CERPOD), found that two-thirds quit using a method within 15 months of starting.

Although contraceptive use is minimal, attitudes about family planning among married women are generally positive. Nearly three-quarters of women approve of family planning, reports the 1995 *Enquête sur la Promotion du Logo*

### *National de la Planification Familiale.*

Gender and religious norms may discourage contraceptive use. Mali has a strongly patriarchal culture, which delegates authority and decision-making to men and elder female relatives, especially the mother-in-law. Younger women have little autonomy over their bodies, their mobility and their finances. Polygamy, which is still practised, discourages contraceptive use when wives compete with each other to produce children. According to the DHS, 10 per cent of women said contraceptive use conflicts with Islamic religious beliefs. A 1996 study found that one-fourth of couples said they had never discussed family planning, and one in five couples disagreed about family planning (the husband disapproved but the wife approved).<sup>3</sup>

To learn more about women's contraceptive decision-making process, the WSP worked with CERPOD to conduct a prospective survey of 55 new contraceptive users.<sup>4</sup> Although the study population here is small, researchers believe findings can be used to initiate discussions on changes in health policies and programmes. Women were interviewed during their initial visit to the Association Malienne pour la Protection et Promotion de la Famille (AMPFF), the International Planned Parenthood Federation affiliate. They were then re-interviewed 8 months and 18 months later. After failure to follow-up, 41 women participated in the second round of interviews. Additionally, four focus group discussions (FGDs) were conducted with mothers-in-law, four with experienced contraceptive users, and three with husbands. In each category, separate group discussions were held for educated and non-educated participants.

The study's goals were:

1. to examine differences between what women expected from contraceptive use and their actual experiences;
2. to examine interaction between family members and communication between partners;
3. to explore the relationship between women's use of family planning and their economic

- roles; and
4. to identify strategies women have developed to avoid or minimise negative consequences of family planning use.

Study results showed that in Mali, family planning is considered by women and men to be a woman's domain, but both sexes regard decision-making as the purview of men. "It is he who rules, he is the only decision-maker, he does not need anyone else's opinion," said one male FGD participant. "Only the man has the right to make the decision," said another. This distinction between women's responsibility and men's right creates tension as women seek to plan their families. When interviewed in focus group discussions, less than one-third of men said they would ever need family planning.

Husbands were unanimous in their opinions that women had no right to use contraception without permission. Some said the couple should make the decision jointly, but husbands were adamant that the final decision was theirs. "When the husband says no, it means no," said one man. "The woman can't say anything. She must submit to her husband's decision." Another said: "If my wife makes the decision to use family planning without my consent, I will divorce her."

Most new contraceptive users said they had approached their husbands with logical arguments and examples of how family planning would improve the family's life. However, women also solicited the help of older sisters-in-law to broach the subject with resistant husbands and to encourage husbands' support for contraceptive use. One woman had this to say:

She [my sister-in-law] asked me to speak about it first to my husband and if he refused, to have him talk to her, and she would make him understand. My sisters-in-law tell me to make every effort to go to the planning clinic, that I don't see how much I suffer. ...They also tell me, using jokes, that life is expensive, that they can't afford more baptisms ... to let our little

sisters bring the rest of the babies into the world.

Younger sisters-in-law did not play as critical an advocacy role, and mothers-in-law were considered of little importance in women's contraceptive decision-making. Another woman said:

As for my mother-in-law getting involved, this only concerns my husband and I. He knows how much I have suffered, so no one should be interested more than the two of us.

Yet another woman said:

All she could do would be to argue, and that's it.

Husbands participating in focus group discussions agreed that mothers-in-law should not be involved in couples' contraceptive decisions. Mothers-in-law themselves were reluctant to discuss contraception with daughters-in-law, but some said they would offer opinions in support of family planning if asked. New users often regarded other elder female relatives, such as husband's aunts, as sources of support.

For many women, the anticipated benefits of family planning were worth the anxiety they felt about confronting husbands. For others, contraceptive use became a clandestine activity. Of the 41 new users, 17 did not tell their husbands at the time of their initial visit to the clinic. At the time of the second interview, seven were still keeping contraceptive use a secret, three had abandoned family planning without telling their spouses, and two had told their husbands and encountered no problems. Again, sisters-in-law and female friends and relatives offered encouragement. One woman said:

He is not aware, and I don't want him to learn of it. ... If he learns of it and makes a problem, I'll stop, but if he doesn't ... I won't stop.

Most clandestine users chose injectable contraceptives. Others used oral contraceptives but hid their pill packets in bags and only took them out at night. Others kept pills at a friend's house, while some women kept their pills at work.

A woman said:

On holidays, I am nervous, each time he goes into the room, I tell myself he must have found them [the pills]. My heart beats faster until I take my pill in the morning.

Some women who used family planning without spousal permission said they faced anger, abandonment, divorce, and indifference to side-effects. One clandestine user dropped out of the study when her husband discovered her contraception, threatened divorce, and then refused to let her leave the house.

New users encountered other obstacles, which led them to switch methods or discontinue altogether. Of the 41 new users interviewed 8 months after they began using contraception, 9 had discontinued family planning and 2 had changed methods. Concern about side-effects was one reason. A Norplant user said amenorrhea and weight gain made her want to switch to another method. "Even though they told me... I would go all this time without seeing my period... well, I wasn't really ready for that."

Women's reasons for wanting to use family planning were that too many pregnancies and closely spaced pregnancies were a physical, emotional and economic burden. They described high parity in terms of "suffering," and chose family planning as a remedy. One woman had this to say:

The midwife told me that I should not have any more children, that it is not good for me. This coincides with my tenth pregnancy.

Women also mentioned rest and health of the mother and child as reasons to space pregnancies.

A woman said:

It is the first time I have weaned a baby before having another pregnancy.

Another one said:

The woman who has close pregnancies is exhausted, but when you space your children, you are at peace, it avoids sickness, you are always feeling healthy.

Women said family planning gave them the freedom to work both inside and outside the home. Two women had these to say, respectively:

When you are pregnant, and with a baby on your back, the kitchen is dirty, you cannot clean.

I can do my business as I wish, I can go where I wish.

Husbands and mothers-in-law also cited family planning as a vehicle that allowed women to work, and they approved of women bringing in extra family income.

In addition to financial independence, family planning also offer women another kind of freedom — free time to devote to husbands and children. A woman said:

I have sexual relations now with my husband, and I no longer have in my head that I am going to get pregnant.

Another woman had this to say:

Because you have free time to take care of your husband, you can see the affection reborn. Your children will be well taken care of, they will eat as they should, you won't be tired or anything.

Among women in Mali who had never used family planning, most saw contraception as something that they might try once they had reached their desired family size. One woman said she would not consider family planning until she has had her fourth child. Other non-users said they feared family planning would cause illness and infertility. While non-users supported the idea of family planning, more than half said they had never discussed the issue with a spouse, friend or relative.

## **Zimbabwe: Family Planning, Women and Development**

In Zimbabwe, four research subprojects were conducted to determine if and how family planning affects women as individuals and as participants in the country's development proc-

ess. Markers of participation in development were household decision-making, work in the formal labour sector, and political and community activity.

Among sub-Saharan African countries, Zimbabwe has one of the highest contraceptive use rates. Family planning use increased from 10 per cent in 1980 to 48 per cent in 1994, according to the DHS. Fertility rates dropped from 6.7 children per woman in 1984 to 4.3 in 1994.<sup>5</sup>

With women spending less time in 'reproductive' roles, researchers have theorised that women have more hours to devote in 'productive' or income-generating activities. Yet, women in Zimbabwe remain only marginal players in the country's development process. The WSP in Zimbabwe examined reasons for this limited involvement.

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

To gain insights into women's interest and involvement in development, the WSP conducted a survey of 2,456 women in all the 10 provinces in Zimbabwe.<sup>6</sup> They found that events in reproductive life follow a typical pattern — menarche occurs at age 15, first sexual intercourse at age 18, marriage at 19, and first birth at 21. (As the age of menarche drops, the ages of first intercourse and first birth also decline, researchers found.)

Forty-eight per cent of women in Zimbabwe use family planning, according to the DHS, and WSP research suggests this figure may have been even higher in 1997. However, contraceptive use typically occurs after the first birth, according to the WSP. Only 10 per cent of women studied used family planning at first sexual intercourse and only 8 per cent at marriage. Contraceptive use rose sharply after the first birth (59 per cent of women) and increased again after second and third births (63 and 64 per cent respectively). After the fourth birth, contraceptive use declined (54 per cent). This pattern is similar for urban

and rural women, a reflection of the cultural expectation that a woman must prove her fertility soon after marriage.

Women who used contraception at first sex were more likely than non-users to live in urban areas, to have some secondary schooling, and to have partners with more education. Women's role in contraceptive decision-making appeared to increase with parity. Approximately 30 per cent of women said they jointly made decisions with their partners after first birth, but this figure increased to 36 per cent after the third birth. However, family members often influenced women's contraceptive decisions. Women in Masvingo province said spouses and in-laws wanted them to bear numerous children to extend the family line.

The WSP also found that women's participation in the formal labourforce tended to be low — 32 per cent of women work outside the home, a rate comparable with the percentage working in 1984. However, this finding must be interpreted in the context of Zimbabwe's current high unemployment rate.

Women's workforce participation was typically greater in urban areas than in rural areas. With more children, urban women felt increased pressure to work, while as rural women's parity increased, their labourforce participation declined. Younger women were less likely to work than older women — 26 per cent of women under age 30 worked, compared with the 45 per cent over 30. When compared with women who did not use contraception at first sex, women who did use contraception at first sex or first marriage were significantly more likely to use a method consistently thereafter and to be working.

While women's workforce participation was low, their participation in community activities was even lower. Six per cent of study participants were involved in community activities at the time of first sex, and the figure rose only slightly, to 11 per cent, after the fourth child's birth. Family planning use between births did not affect community participation. However, women

who were involved in community activities at first sex tended to continue their participation intermittently throughout childbearing.

Researchers concluded that family planning has helped women achieve their reproductive goals but has not become a gateway to participation in the development process. In this instance, contraceptive use has helped women to meet their practical (everyday) needs but has not helped them to meet the strategic or long-term need for gender equity.

### **Family Planning and Quality of Life**

In this qualitative study, researchers explored individuals' perceptions of quality of life.<sup>7</sup> Women and men were asked how they would define quality of life; how family planning use/non-use affects the quality of life; and if and how quality of life is related to women's status, including their autonomy in household decision-making, use of time, employment, and involvement in political or civic activities. More than 130 women and men — ages 18 to 40 — living in the Mashonaland East Province participated in 16 focus group discussions. Thirteen focus group discussions were held for women and three for men.

Study participants defined quality of life as satisfaction with one's life and identity, having dreams that are realistic, and hopes and aspirations based on the reality of one's circumstances. However, transcripts show that study participants' definition of quality of life is multifaceted. As study participants grappled with the meaning of the concept in their own lives, their discussions indicated that quality of life has physical, social, cultural, and spiritual dimensions.

Both women and men said quality of life means mutual respect and domestic harmony. Women emphasised marital contentment arising from satisfaction with one's livelihood and the couple's ability to plan and provide for children, as well as having a husband who is a good financial provider for the family. Women placed high value on having the time and ability to raise

and nurture their families.

Men tended to concur, defining quality of life in terms of the woman's responsibility to maintain the home. Men called women, "pillars of the home," and described their role as the most difficult one in the family. Factors that, in men's views, contribute to a family's quality of life include a wife who is well looked after by her husband, who maintains a well-kept home, and who can show that she and her family are in good health. However, some men complained that women's attitudes are changing, and spoke negatively of women who value making money over raising their children. Others said women incorrectly perceive themselves as subservient to men. In general, men expressed empathy and respect for women's roles in childbearing, maintaining the household, and obtaining contraception. Both women and men said that planning a family — the number of children the couple wants and can support — is an important element of quality of life. There is nothing to be gained, they said, from *not* using family planning. They also advised that more methods should be made available and that price subsidies should be offered to help couples afford contraception. Men wanted women to take the lead in discussing family size and family planning, since they are the ones responsible for child rearing. In reproductive decisions, women said they take into account the economic as well as physical consequences of childbearing, stretching limited resources to make contraception part of the household budget.

Women said a benefit of family planning is improved health for the mother and the entire family, more time for rest and leisure, and the ability to devote adequate time and affection to children and husbands. According to the men, the entire family reaps the benefits of contraceptive use. By limiting births, men can adequately provide for their families, women can protect their physical and mental health, and the couple can enjoy more time together. "Having 10 or 11 children may be so bad for the wife's

wellbeing that she feels she is being used as a human-making machine," said one husband.

Women identified several negative consequences of family planning use, including method failure, prolonged menstrual bleeding and headaches. Women's strategies for improving the quality of their experiences with family planning were seeking more information on contraceptive use, including education from other women; ignoring in-laws' comments; visiting a doctor before initiating contraception; and receiving family planning counselling *with* their husbands. Women said they want health providers to be more attentive to their concerns and to listen to their suggestions for improving family planning programmes, including the need of many families for price subsidies. Men said they want women to share problems with them but stressed that confidentiality about contraceptive use is important.

Researchers concluded that peace and wellbeing in the family remain important to both women and men. *Kudzorana* — peaceful negotiation of conflicts within the home — is the ideal. However, because of Zimbabwe's worsening economic situation, the roles of women are changing, while the attitudes of men are in flux. In the past, women took care of their families by cooking for them, cleaning, sewing, etc. Today, women are expanding the definition of 'caring for the family' to include work in the formal sector and additional income-generation activities such as knitting or gardening. While men do not object to women's income, they still want women to be responsible for the traditional roles of home-makers.

### **Influences of Gender on Women's Participation in Development**

The purpose of this qualitative study was to explore women's participation in four domains: the household; education and training; the workforce; and politics.<sup>8</sup> Also, the study sought to understand and compare the perceptions of younger women (under age 40), older women (over 40), and men concerning women's par-

ticipation in the four domains and to explore the influence of family members on family size. Researchers interviewed 40 women, ages 25 to 40 with five or more children, and 40 women with four or fewer children. They also interviewed married men and older women to better understand the social context in which younger women make decisions.

In interviews and focus groups, participants consistently emphasised that husbands are the primary decision-makers regarding family size and family planning. A majority of younger women said they discuss family size with their husbands, and many reported attempts by in-laws to encourage them to bear several children to perpetuate the family line. Some women resisted, saying that decision-making about family size belonged exclusively to the couple. One woman noted:

They [in-laws] might talk but these people do not assist us in providing for the children.

Another woman described intense pressure from their in-laws to bear children:

They suggested that my husband take another wife...

Younger women said they often initiate discussions about family planning with their husbands, and the majority said husbands supported family planning. However, because husbands are the chief financial providers, women acknowledged that men have the right to make final decisions. Although men and older women acknowledged the health and economic benefits of family planning, they also advocated that women prove fertility before using contraception, some fearing that some methods could cause permanent infertility. One man said:

It depends on whether we have reached the number of children I wish to have in life, so that even if the contraceptive pills [permanently] prevent her from having children, I would [already] have had the number of children I want.



As with family planning, household decision-making was, for the most part, men's domain. Women managed routine inexpensive decisions, while men said their status as financial providers gave them decision-making authority. Urban working women claimed more control over household expenditures and said they could use their own earnings to support their parents, pay children's school fees, or make purchases without their husband's consent. Younger women with fewer children also tended to discuss budgeting with their husbands; possibly a reflection of younger men's attitudes that women can have a say in spending although the final decisions remain theirs.

While women and in-laws can influence decisions about children's schooling, men again have the final authority. Both women and men valued education and described it as essential for survival in Zimbabwe's changing economy, and young women agreed that girls should have the same educational opportunities as boys. Older women also agreed that education was important because lucrative jobs could contribute to in-laws' comfort and well-being. Nonetheless, study participants said boys should be given preference over girls during hard economic times. A woman said:

Children should get the same education, but if money is scarce, I would rather send a boy [to school] than a girl who will get married [and move] elsewhere.

Decision-making about expenditures and schooling did not depend on family size. Rather, study participants said decision-making depended upon intelligence and the strength of the couple's marital relationships.

Younger and older women said family size does not affect a woman's ability to acquire skills for a job and work outside the home. Men, however, were more likely to say family size would have an effect, due to increased household expenses to support a larger family (meaning less money would be available for the wife's education). Study participants recognised the eco-

nomie benefits of women's work; however, men and mothers-in-law preferred that younger women devote themselves to child care and other domestic duties. Men were concerned that their wives would have extramarital affairs if they worked outside the home; others were concerned that women would want to assume more control at home. "She may be the boss at work," one rural man observed, "but at home, it has to be a different situation." Most respondents viewed women's participation in political activities as positive, yet few women took on these extra responsibilities. Women voted in national and local elections but did not seek office themselves. A few urban women supported the idea of women's political involvement as a way of improving women's status. However, most young and older women said marriage and politics were incompatible. While rural men suggested that women could have important ideas to contribute, urban men were more reticent. They suggested that increased political involvement would make women harder to control and the travel involved "brings AIDS to the home".

Researchers concluded that, while men and women both hold traditional, conservative attitudes about gender roles, there may be subtle transitions occurring. While women avoided direct confrontation with their husbands, they were willing to circumvent gender norms in indirect ways — younger women who participated in community activities but returned home before their husbands; younger women who worked in offices, but near their husbands; and older women who were reluctant to care for grandchildren when parents could provide adequate financial support.

### **Impact of Family Planning on Young Women's Academic Achievement and Vocational Goals**

For girls in Zimbabwe, sexual activity typically begins in the secondary school or college. Few women use contraception during first intercourse, placing them at risk of unplanned

pregnancies and sexually transmitted diseases.

The purposes of this study were:

1. to determine patterns of sexual activity, contraceptive use, and pregnancy experience among young Zimbabwean women;
2. to compare the academic and vocational goals of sexually inactive students, sexually active students who have never been pregnant, and students who left school because of pregnancy; and
3. to identify relationships between young women's sense of personal control in their lives and pregnancy prevention.<sup>9</sup>

The study began with three focus group discussions, one with college students and two with school dropouts. This became the basis for a survey that was designed and administered to 970 female students at three teacher training colleges — Morgenster (located in Masvingo province), a rural mission college; Belvedere (in Harare) and Marymount (in Mutare), government institutions in urban areas. Belvedere and Marymount provide contraceptive services for students, while Morgenster does not.

In addition to the survey, in-depth interviews were held with 15 women under age 25 who had recently given birth and left school as a result of pregnancy. Interviews were also held with 20 'community mothers,' women of ages 18 to 25, who had been out of school for at least two years, and with six women from each of the three colleges who had returned to school after pregnancy.

Analysis of data revealed that 59 per cent of young girls were sexually active, with 5 per cent reporting first intercourse as early as primary or secondary school. Nearly two-thirds of the women said they did not use a contraceptive the first time they had intercourse. For women who did use contraceptives, condoms were the most popular choice, yet over time, women switched to the pill. College students were able to obtain contraception at public, private or school clinics or at pharmacies. But as secondary pupils, they were discouraged by family planning clinics

from using contraception and had to rely on mothers, sisters or other individuals for information.

A community mother, who had been expelled from school when she became pregnant, explained her unsuccessful attempts to get contraception.

My boyfriend had waited so long, he wanted, and I also wanted, to experience how it [sex] feels. I had tried to get some tablets, but I was chased from the clinic. I think it was because I looked very young at that time. I also tried to ask my big sister to help me ... but instead she discouraged me, saying tablets were not good, as they would make me barren in the future. ... But now I regret it. I could have finished school. Maybe I could have been a teacher like him [my husband], because now when I ask for money he tells me that he went to school alone.

Most of the students, sexually active or not, held high academic aspirations. This was true for many of the community mothers, who expressed regret that they were financially unable to return to school after pregnancy. One woman said:

If I had [had] access to the method of preventing pregnancy, I wouldn't have been pregnant and I would have finished my O-levels. And you never know, I might have passed. And I would be working somewhere in town, and maybe I would be having a better life than this one.

Another woman said:

I wish I could go back to school. You know, I have four subjects (at the) O-level, and I only need one to have a complete certificate. But my husband can't afford it, and I have a family to look after.

## Conclusions and Recommendations

The WSP illustrates that taking control of fertility through the use of family planning is one of many strategies a woman can employ to exercise autonomy in other aspects of her

life. Women view contraceptive use as a means of helping them achieve an end; that is, feeding their family, continuing their own education, seeking employment, or reducing the fear of unplanned pregnancy.

Based on research in Mali, Zimbabwe and other WSP countries, the WSP identified several common themes that emerged from research. Among them:

- Gender norms strongly influence women's family planning experiences.
- Family planning offers freedom from fear of unplanned pregnancy and can improve sexual life, partner relations and family wellbeing.
- Where jobs are available, family planning users are more likely than non-users to take advantage of work opportunities.
- Family planning helps women to meet their practical (everyday) needs and is necessary, but not sufficient, to help them meet their strategic (long-term) need for gender equity.
- Contraceptive side-effects, real or perceived, are a serious concern for many women, more so than providers realise.
- When partners or others are opposed, practising family planning can increase women's vulnerability.
- When women have smaller families, they may lose the security of traditional roles and face new and sometimes difficult challenges, including the burden of multiple responsibilities at home and at work.
- Women reap fewer benefits if family planning is initiated late in reproductive life.
- Men often have a dominant role in family decisions but tend to be marginalised by family planning programmes.

One of the main purposes of the WSP was to encourage the use of research findings to improve the quality of women's reproductive health services, and indeed, the results have clear implications for health policies and programmes. For example:

- Contraceptive counselling must take into account gender norms and the barriers they may pose to family planning.
- Peer networks should be established, in which experienced contraceptive users counsel new users about the everyday realities of method side-effects.
- Men and other key family members, including in-laws, need to be educated about family planning to help them make informed decisions about family planning use and to support women's contraceptive choices.
- Counselling should emphasise the benefits of contraceptive use beyond health and economics, including emphasis on improvement in family relationships.
- Family life education should begin early and women should be encouraged to view family planning use as a component of life-long reproductive health.

The WSP found that while women perceive numerous benefits of family planning use, they also see negative consequences, such as family disapproval and method side-effects, which can discourage them from taking control of their fertility. Women's dual perspectives should be taken into account as researchers, women's advocates, policy-makers, and providers work collaboratively to improve family planning services. By understanding the intricate realities of women's lives and the factors that affect their reproductive health behaviours, family planning programmes can offer services that match women's needs and ultimately help to improve the quality of women's lives.

## **Acknowledgements**

The Women's Studies Project gratefully acknowledges the support of the U.S. Agency for International Development (USAID). A cooperative agreement between USAID and Family Health International made the WSP possible.

## REFERENCES

1. United Nations Population Fund. *International Conference on Population and Development Programme of Action*. New York: UNFPA, 1994.
2. Coulibaly S, Dicko F, Traore SM, Sidibe O, Seroussi M, Barrere B. *Mali Enquete Demographique et de Sante 1995-1996*. Calverton MD: Cellule de Planification et de Stateistique du Ministere dela Sante, Direction Nationale de la Statistique et de l'informatique et Macro International Inc., 1996.
3. Coulibaly S, Dicko F, Traore SM, Sidibe O, Seroussi M, Barrere B. *Enquete Demographique et de Sante Mali 1995-1996*. Cellule de Planification et de Statistique, Ministere de la Sante, de la Solidarite, et des Personnes Agees. Bamako and Calverton, MD: Macro International, Inc., 1996.
4. Centre D' Etudes et de Rescherche sur la Population pour le Developpment, Institure du Sahel. *The impact of family planning on women's lives in Bamako, Mali: results of a two-year prospective study of new users of family planning*. Draft report perpared for the Women's Studies Project, 1998.
5. Central Statistical Office and Macro International Inc., *Zimbabwe Demographic and Health Survey 1994*. Calverton MD: Central Statistical Office and Macron International Inc., 1994.
6. Meoyi M, Mapfumo OM. *Zimbabwe: The Effect of Family Planning on Women's Participation and the Development Process*. Final report prepared for the Women's Studies Project. Research Triangle Park, NC: Family Health International, 1998.
7. Mutambirwa JM, Utete VL, Mutambirwa CC, Maramba PP. *Consequences of family planning on women's lives in Zimbabwe*. Summary report prepared for the Women's Studies Project, 1998.
8. Francis-Chizororo M, Wekwete N, Matshaka M. *Family Influences on Zimbabwean Women's Reproductive Decisions and their Participation in the Wider Society*. Summary report prepared for the Women's Studies Project. Research Triangle Park, NC: Family Health International, 1998.
9. Tshuma NM, Taruberekera N, Zvobgo R. *Impact of family planning on young women's academic achievement and vocational goals*. Draft report prepared for the Women's Studies Project, 1998.