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REPRODUCTIVE HEALTH *at a* GLANCE

ZIMBABWE

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Country Context

Zimbabwe's real annual GDP growth rate declined by two-fifths cumulatively in the last decade, the health and education sectors lost many skilled workers who out-migrated, and the country experienced food insecurity and overall poverty.[1] Exacerbating this was the cholera outbreak of 2008/09 and the national HIV/AIDS pandemic.[1]

Zimbabwe's large share of youth population (40 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend in the medium to long term. But for this opportunity to result in accelerated growth, the government needs to invest in the human capital formation of its youth.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3]

In Zimbabwe, the literacy rate among females ages 15 and above is 89 percent. Fewer girls are enrolled in secondary schools compared to boys with a ratio of female to male secondary enrollment of 92 percent.[2] Only 35 percent of girls make it to upper secondary education. Three-fifths of adult women participate in the labor force[2] that mostly involves work in agriculture and are more likely to not receive cash payment for their work.[4] Gender inequalities are reflected in the country's human development ranking; Zimbabwe ranks 130 of 157 countries in the Gender-related Development Index.[5]

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3] The Reproductive Health Department in the Ministry of Health and Child Welfare and the Zimbabwe National Family Planning Council (ZNFPC) working with other development partners provide reproductive health services including family planning.

Zimbabwe: MDG 5 status

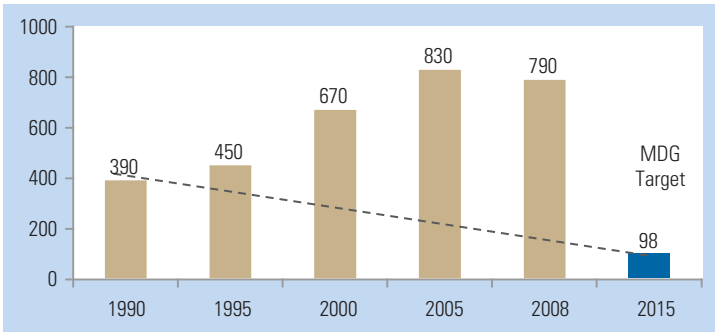
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	790
Births attended by skilled health personnel (percent)	59.8
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	64.9
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	64
Antenatal care with health personnel (percent)	93.4
Unmet need for family planning (percent)	12.8

Source: Table compiled from multiple sources.
[a] Official estimate of 725 maternal deaths per 100,000 live births.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Zimbabwe has not made progress over the past two decades on maternal health and is not yet on track to achieve its 2015 targets.[6]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Zimbabwe

The Bank's new ***Interim Strategy Note*** under preparation (P122495) is scheduled to be approved by the Executive Board.

Current Projects:
P111031 Zimbabwe: Strengthening Health Care Service Delivery Capacity, Monitoring and Evaluation, and Accountability in MIssion Hospitals

Pipeline Project:
P125229 Zimbabwe Health Results Based Financing

Previous Health Project:
None

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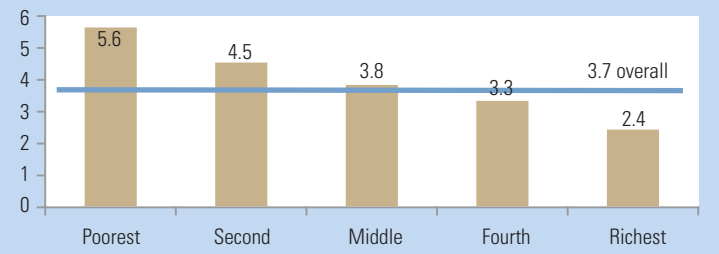
Key Challenges

High fertility

Fertility has been declining over time but remains high among the poorest. Total fertility rate (TFR) declined from 5.5 births per woman in 1988 to 4.0 births per woman in 1999 to 3.7 in 2009.[1] Fertility remains high among the poorest Zimbabweans at 5.6 in contrast to 2.4 among the wealthiest (Figure 2). Similarly, TFR is 3.3 among women with secondary education or higher compared to 4.8 among women with no formal education. It is also lower among urban women at 2.6, compared to rural women at 4.4 births per woman.[4]

Figure 2 ▪ Total fertility rate by wealth quintile

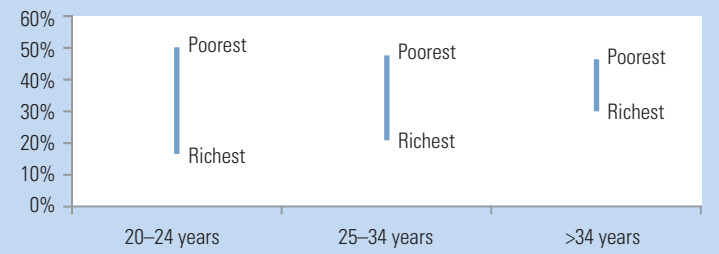


Source: MIMS Preliminary Report, Zimbabwe 2009.

Adolescent fertility adversely affects not only young women's health, education and employment prospects but also that of their children. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 7] In Zimbabwe, adolescent fertility rate is high at 64 reported births per 1,000 women aged 15–19 years. Incorrect knowledge about pregnancy among young girls and economic pressures contribute to the high fertility rates amongst adolescent girls.

Early childbearing is more prevalent among the poor. While 50 percent of the poorest 20–24 years old women have had a child before reaching 18, only 17 percent of their richer counterparts did (Figure 3).

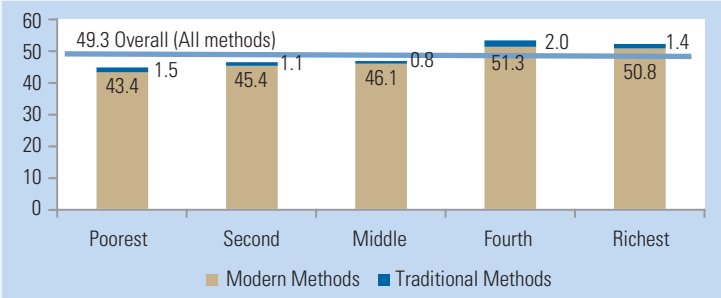
Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile



Source: DHS Final Report, Zimbabwe 2005–06 (author's calculation).

Use of modern contraception is increasing. Current use of contraception among married women was 38 percent in 1988, 54 percent in 1999[4] and 65 percent in 2009.[1] More married women use modern contraceptive methods than traditional methods (63 percent and 2 percent, respectively). The pill is the most commonly used method (50 percent), followed by the injectables (8 percent).[1] Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: modern contraceptive use is 68 percent among women in the wealthiest quintile and 55 percent among those in the poorest quintile (Figure 4).[1] Similarly, just 48 percent of women with no education use modern contraception as compared to 67 percent of women with secondary education or higher, and 61 percent for rural women versus 67 percent for urban women.[1]

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: MIMS Preliminary Report, Zimbabwe 2009.

Unmet need for contraception is 13 percent[4] indicating that women may not be achieving their desired family size.[8]

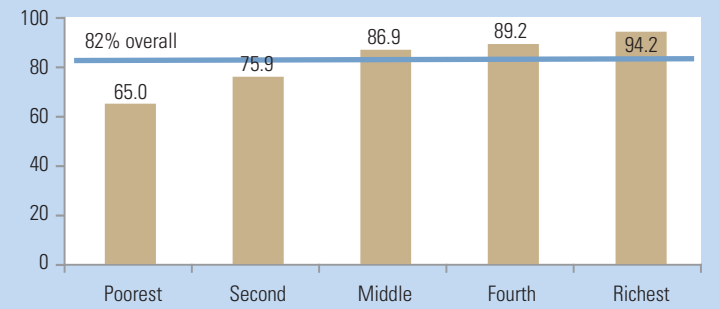
Religious prohibition, fear of side effects and health concerns are the predominant reasons women do not intend to use modern contraceptives in future, not including fertility related reasons (such as menopause and infecundity). Eleven percent not intending to use contraception cited religious prohibition, 9 percent cited fear of side effects and 6 percent cited health concerns as the main reason.[4] Cost (0.8 percent) and access (0.1 percent) are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

While the majority of pregnant women use antenatal care, institutional deliveries are less common. Over nine-tenths of pregnant women receive antenatal care from skilled medical personnel (doctor, nurse, or midwife).[1] However, a smaller proportion, 60 percent deliver with the assistance of skilled medical personnel. While 92 percent of women in the wealthiest quintile delivered with skilled health personnel, only 38 percent of women in the poorest quintile obtained such assistance (Figure 5).[1] 40 percent of women overall, and half of all rural women, deliver at home,[1] a figure which has increased from 23 percent in 1999.[4] This took place in the context of Zimbabwe's socio-economic challenges and a weakened health delivery system.[1] Further, 19

percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[9]

Figure 5 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: MIMS Preliminary Report, Zimbabwe 2009.

Among all women ages 15–49 years who had given birth, 46 percent had no postnatal care within 6 weeks of delivery.[4]

Nearly 3 out of 5 women report getting money needed for treatment as a serious problem in accessing health care for themselves when they are sick (Table 1).[4] Further, nearly half of women report the concern that no drugs would be available as a serious problem in accessing health care.

Table 1 ▪ Reasons for not delivering in a health facility (women age 15–49)

Reason	%
At least one problem accessing health care	79.4
Concern no drugs available	57.8
Concern no provider available	47.5
Getting money for treatment	42.1
Distance to health facility	41.3
Having to take transport	22.8
Not wanting to go alone	22.6
Concern no female provider available	9.8
Getting permission to go for treatment	6.6

Source: DHS final report, Zimbabwe 2005–06.

Human resources for maternal health are limited with only 0.16 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.72 per 1,000 population.[2] A challenge the Government is addressing is the need to upgrade skills of Primary Care Nurses to enable them to provide maternal health services at the primary level of care instead of referring to higher levels of care.

The high maternal mortality ratio at 790 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[6]

HIV prevalence has decreased in Zimbabwe in the past seven years

HIV prevalence is high in Zimbabwe and women are one of the most vulnerable groups. In 2009, the percentage of adult population aged 15–49 years who had HIV was 14 percent, ranking Zimbabwe among the four highest prevalence rates in the world.[1] However, the prevalence has declined from 25 percent in 2003, the first decline of this type in Southern Africa.[1] Of the total population ages 15 years and older with HIV, 57 percent are women.[2]

Knowledge of HIV prevention methods is high. More than three-quarters of Zimbabweans know that condoms can help reduce risk of transmission. Further, knowledge of mother-to-child transmission through breastfeeding has increased from around one third of people in 1999 to 80 percent in 2005–06.[4] The number of Zimbabweans who know that the risk of transmission from mother-to-child can be reduced by using medication is 57 percent for females and 46 percent for males.[4] Overall, 76 percent of women aged 15–49 years knew two ways to prevent HIV transmission, 69 percent correctly identified 3 misconceptions about HIV transmission, and 55 percent knew both.[1]

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

National policies and strategies that have influenced reproductive health

National Health Strategy 2009–2013

Investment Case for Health 2010–2012

National New Born Child Survival Strategy

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls especially in secondary education. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and childbearing and promote delayed sexual debut.
- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups. Strengthen and revitalize the role of ZNFPC Community Based Distributors (CBD) who provided family planning services within communities.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.

Reducing maternal mortality

- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Promote institutional delivery through provider incentives and implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Generate demand for the service and address the perception that it not necessary to deliver at a health facility. This will require a combination of Behavior Change Communication (BCC) programs via mass media and community outreach as well as deploying midwives to assist women with home deliveries. During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Focus HIV/AIDS providing information, education and communication efforts on adolescents, youth, married women, and other high risk groups including IDUs, sex workers and their clients, and migrant workers.

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ZIMBABWE REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2009	3.7	Population, total (million)	2008	12.5
Adolescent fertility rate (births per 1,000 women ages 15–19)	2008	63.5	Population growth (annual %)	2008	0.1
Contraceptive prevalence (% of married women ages 15–49)	2009	64.9	Population ages 0–14 (% of total)	2008	40.2
Unmet need for contraceptives (%)	2005/06	12.8	Population ages 15–64 (% of total)	2008	55.7
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	4
Median age at marriage (years)	2005/06	19.4	Age dependency ratio (% of working-age population)	2008	79.4
Mean ideal number of children for all women	—	—	Urban population (% of total)	2008	37.3
Antenatal care with health personnel (%)	2009	93.4	Mean size of households	2005/06	4
Births attended by skilled health personnel (%)	2009	59.8	GNI per capita, Atlas method (current US$)	2005	360
Proportion of pregnant women with hemoglobin <110 g/L	2008	18.8	GDP per capita (current US$)	2005	274
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	390	GDP growth (annual %)	2005	–5.3
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	450	Population living below US$1.25 per day	—	—
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	670	Labor force participation rate, female (% of female population ages 15–64)	2008	60.8
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	830	Literacy rate, adult female (% of females ages 15 and above)	2008	88.8
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	790	Total enrollment, primary (% net)	2006	90.5
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	98	Ratio of female to male primary enrollment (%)	2006	99.0
Infant mortality rate (per 1,000 live births)	2008	62	Ratio of female to male secondary enrollment (%)	2006	92.4
Newborns protected against tetanus (%)	2008	76	Gender Development Index (GDI)	2008	130
DPT3 immunization coverage (% by age 1)	2009	66.6	Health expenditure, total (% of GDP)	2007	8.9
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	8.6	Health expenditure, public (% of GDP)	2007	4.1
Prevalence of HIV, total (% of population ages 15–49)	2009	13.7	Health expenditure per capita (current US$)	2007	78.6
Female adults with HIV (% of population ages 15+ with HIV)	2007	56.7	Physicians (per 1,000 population)	2004	0.16
Prevalence of HIV, female (% ages 15–24)	2007	7.7	Nurses and midwives (per 1,000 population)	2004	0.72

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	MIMS	2009	5.6	4.5	3.8	3.3	2.4	3.7	3.2	2.3
Current use of contraception (Modern method)	MIMS	2009	55.3	62.0	61.2	67.7	67.6	63.0	–12.3	0.8
Current use of contraception (Any method)	MIMS	2009	58.1	64.2	62.8	68.9	69.5	64.9	–11.4	0.8
Unmet need for family planning (Total)	DHS	2005/06	20.2	14.8	12.5	9.4	7.6	12.8	12.6	2.7
Births attended by skilled health personnel (percent)	MIMS	2009	38.2	45.1	55.5	80.5	92.0	59.8	–53.8	0.4

Development partners support for reproductive health in Zimbabwe

WHO: Reproductive health and HIV/AIDS

European Commission: Health systems strengthening, HIV/AIDS, human resources for health

UNFPA: Reproductive health and rights

UNICEF: Child protection; under-5 mortality, health systems strengthening, PMTCT, pediatric HIV, supply chain management

USAID: Health systems strengthening; skilled birth attendance, quality of care, pediatric HIV

DFID: Maternal and new born services, child protection, health systems strengthening,

SIDA: Women's rights; girls' education

CIDA: Human resources for health

JSI: Supply chain management family planning products

MCHIP: Maternal and child health

LATH : Maternal and newborn services

Marie Stopes International: FP training; contraception distribution

Population Services Zimbabwe: FP training, contraception services