

**AGENCY FOR INTERNATIONAL DEVELOPMENT**  
**BUREAU FOR AFRICA**  
*Health/Population/Nutrition*  
**Country Profile**



**January 1991**

## Key Country Information

### FAMILY PLANNING

Forty-three (43%) percent of the married women are currently using contraception, the highest prevalence use of contraception among the countries in sub-Saharan Africa. Knowledge of contraception is almost universal, with 96% of all women reporting that they have heard about at least one method. The total fertility rate decreased from 7.3 in 1970 to 5.5 in 1990, and will drop further as more couples begin using modern methods of contraception.

### CHILD SURVIVAL

Zimbabwe has had unusual success in establishing wide immunization coverage (over 80% for most vaccines). It is now launching initiatives to eradicate poliomyelitis, and to eliminate measles and neonatal tetanus within Zimbabwe.

Access to oral rehydration salts for the treatment of dehydrating diarrheas have increased in Zimbabwe to 70% in 1988. Although no data is available for use of oral rehydration therapy at this time, the data on access suggests that home management of diarrhea is another area which is achieving programmatic success.

### HIV/AIDS

Although information on HIV/AIDS prevalence has not been available previously due to a lack of political commitment for HIV/AIDS control, it is now estimated that 10% of the general population is infected in both urban and rural areas, with infection rates of 25 to 30% in the workforce (20 to 40 years old) population and high rates in the military (greater than 40% in the Army and greater than 60% in the Air Force). Zimbabwe is an HIV/AIDS high priority country and several USAID-funded activities have been implemented including central and regional projects (including two PVO grants to Save the Children and World Vision), as well as significant amounts of local currencies.

### NUTRITION

Even in this better-endowed country, there still is evidence of malnutrition in selected areas throughout the country.

## Government Policies

President . . . . .	Robert Mugabe
Minister of Health . . . . .	Timothy Stamps

### HEALTH

The Government considers primary health care as a cornerstone of its socio-economic development policies.

### POPULATION

The Government considers the fertility rate to be too high and actively supports family planning interventions. In 1984, the Government established a Population Planning Unit in the Ministry of Economic Planning and Development. In 1990, an interministerial Council on Population was established by President Mugabe.

### HIV/AIDS

The Government, in conjunction with the World Health Organization, has developed a multi-year (three to five years) Medium Term Plan for its National AIDS Control Program. All HIV/AIDS prevention and control activities are coordinated by a National AIDS Committee, which is an inter-ministerial body. The new Minister of Health, Dr. Timothy Stamps, has reversed earlier Government policies whereby HIV/AIDS statistics had been under-reported and the overall program was undermined.

**SOURCES:** Agency for International Development, Bureau for Africa, Office of Technical Resources, Health, Population and Nutrition Division.  
Inventory of Population Projects in Developing Countries Around the World, 1988/89, UNFPA.



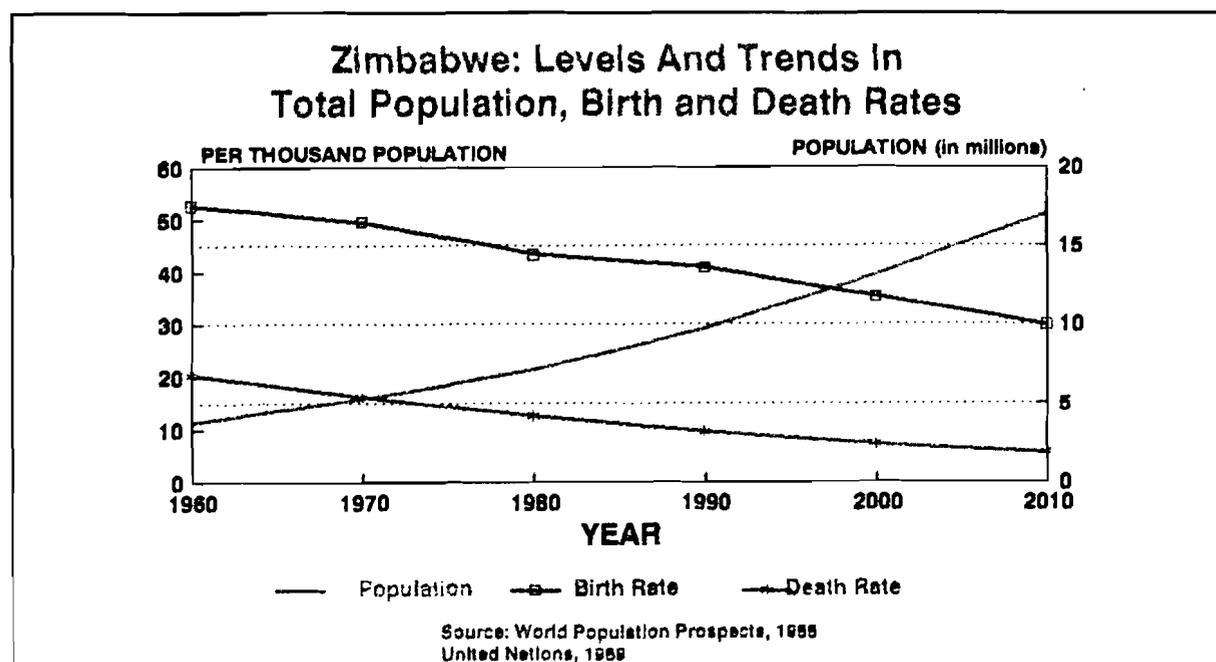
## Basic Population Information

### DEMOGRAPHIC DATA AND PROJECTIONS

ZIMBABWE Indicator	Estimates			Projections		
	1960	1970	1980	1990	2000	2010
Total Population (000)	3,816	5,270	7,138	9,721	13,135	16,984
Population Density (per square mile)	10	13	18	25	34	43
Urban (percent)	12.6	16.9	21.9	27.6	34.6	42.5
Functional Age Groups Percent:						
Young Child (0-4)	20.5	20.0	18.2	17.6	16.1	13.7
Child (5-14)	26.0	29.1	29.6	27.2	27.0	25.1
Youth (15-24)	18.4	17.8	20.3	21.0	19.6	20.5
Elderly (65+)	2.9	2.7	2.6	2.7	2.9	3.2
Women (15-49)	21.9	21.0	21.9	23.4	24.3	25.6
Crude Birth Rate (per 1,000 pop.)	52.7	49.5	43.3	40.8	35.2	28.9
Crude Death Rate (per 1,000 pop.)	20.4	16.1	12.4	9.6	7.2	5.7
Population Growth Rate (Natural Increase)	32.3	33.4	30.9	31.3	28.0	23.2
Total Fertility Rate	7.50	7.34	6.40	5.56	4.63	3.6
Infant Mortality Rate	110	97	83	68	54	40
Life Expectancy: Males	43.7	48.6	53.0	57.8	62.5	66.3
Life Expectancy: Females	46.9	52.0	56.6	61.4	66.3	70.4
Life Expectancy: Both Sexes	45.3	50.3	54.8	59.6	64.4	68.3

SOURCE: World Population Prospects 1988, United Nations, 1989.

## DEMOGRAPHIC INDICATORS

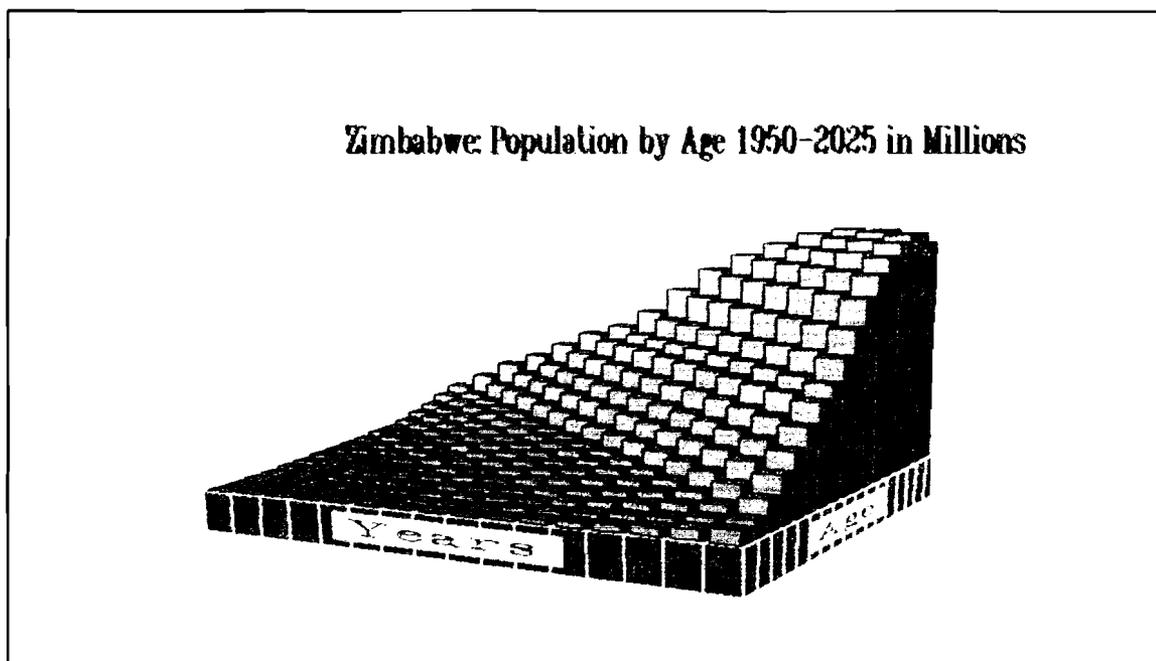


- The population of Zimbabwe increased from 7.1 million in 1980 to an estimated 9.7 million in 1990. Twenty-eight percent of the population live in urban centers. More than half of the urban population is found in the two largest cities, Harare and Bulawayo.
- The 1988 Demographic and Health Survey estimated a total fertility rate of 5.5 births per woman. Urban fertility is lower than rural fertility; at current rates by age group women living in urban areas will average 4.1 live births over their lifetime, while those women living in rural areas will average have 6.2 births.
- Fertility differentials by women's education 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 average less than 4 births.
- While the total fertility rate has been decreasing slowly during the past twenty years from 7.3 in 1970 to 5.5 in 1990; the infant mortality rate has been dropping significantly from 97 deaths per 1,000 live births in 1970 to 68 deaths per 1,000 live births in 1990.
- As a result of the faster decline in infant mortality than in the fertility rate, the natural increase for Zimbabwe is estimated to be 3.2% per year. At this rate the population of Zimbabwe will double in 22 years.

## CONTRACEPTIVE PREVALENCE INDICATORS

- Based on the 1988 Demographic and Health Survey, 43% of the married women are currently using contraception. The pill (31%) is the most commonly used method. Current use of other methods is limited; 2% or less are using female sterilization, the IUD, injection or the condom. The most prevalent traditional method, withdrawal, is used by 5% of currently married women.
- The urban-rural differential is fairly large; 52% are using in urban areas compared with 40% 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.
- Contraceptive knowledge is practically universal, with 96% of all women reporting that they have heard about at least one method.

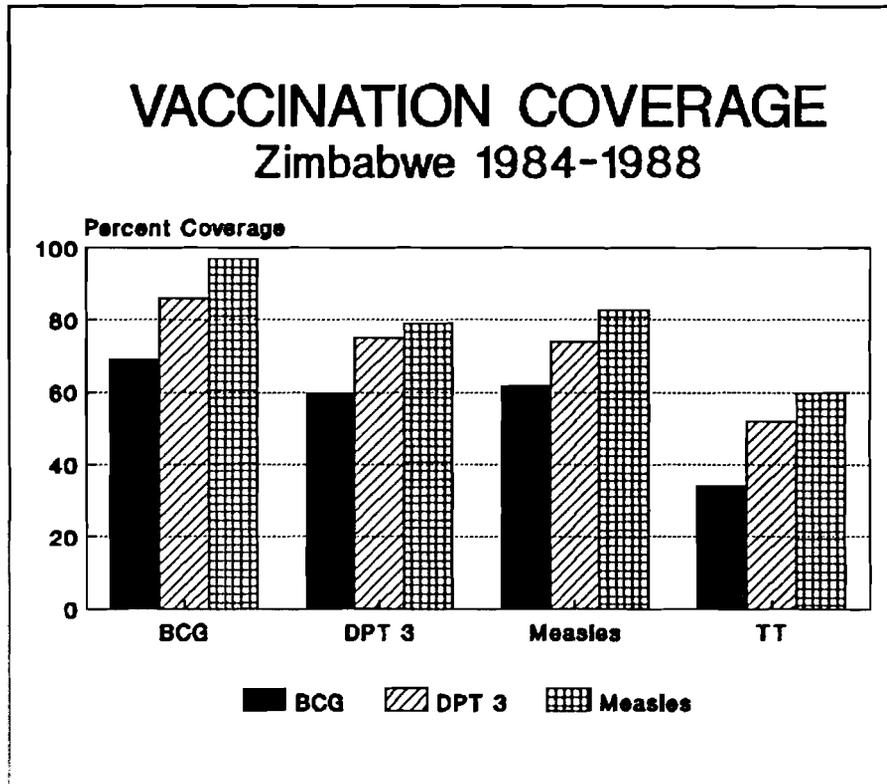
By the year 2025, the population of Zimbabwe is projected to be 22.6 million with 30.5% less than 15 years of age.



SOURCE: World Population Projects 1988, United Nations, 1989.

## Health Characteristics

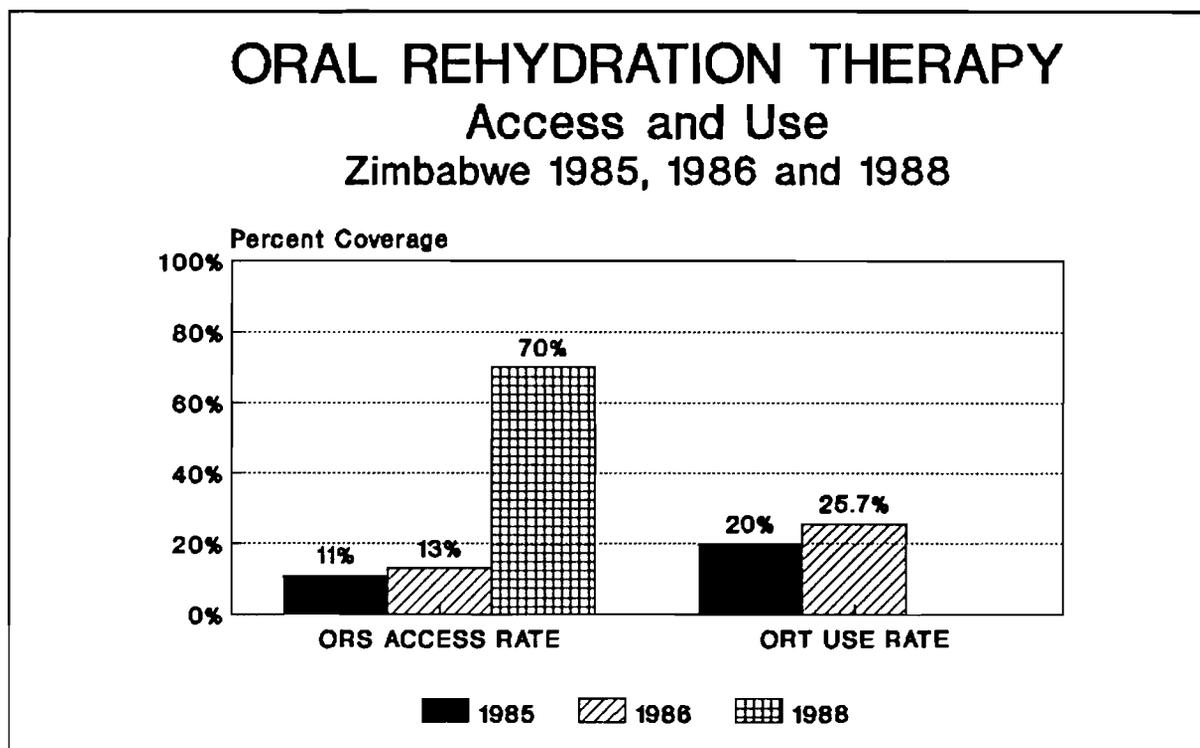
### CHILDHOOD IMMUNIZATIONS



SOURCE: Center for Health Information/ISTI  
1984 and 1986 WHO/EPI Reports  
1988 WHO/EP/GEN/89.2

Zimbabwe has attained high vaccination coverage levels for all of the childhood vaccines, over 80% in most cases. With other neighboring countries in Southern Africa, Zimbabwe is now pushing for eradication of poliomyelitis and elimination of measles and neonatal tetanus.

## ORAL REHYDRATION THERAPY



SOURCE: Center for Health Information/ISTI  
1985 and 1986 WHO/CDD/87.26, 88.28  
1988 WHO/CDD Facsimile (3/27/90)

In Zimbabwe, oral rehydration therapy (ORT) use rates were higher than was access to oral rehydration salts packets in 1985. This probably reflects health workers' success in teaching mothers to prepare homemade salt and sugar solutions for their children with diarrhea. No data on use of ORT in this country is available for 1988. Access rates, however, had improved dramatically, to 70% between 1986 and 1988.

**HIV/AIDS**

Estimates of HIV-1 Seroprevalence by Residence and Risk Factor, for Developing Countries:  
Circa 1989

Region and Country	Capital/Major City		Outside Major City	
	Low Risk	High Risk	Low Risk	High Risk
<b>AFRICA</b>				
Côte d'Ivoire	8.5a	23.8a	3.3a	-
Malawi	23.3	55.9	-	-
*Mali	.4	23.0a	-	-
*Nigeria	.5	4.3a	.0	.5
South Africa	.1	3.2	-	-
Uganda	24.3	86.0b	12.3	76.0b
Zaire	6.0	37.8	.8	17.7
<b>Zimbabwe</b>	<b>3.2c</b>	<b>-</b>	<b>1.4</b>	<b>6.6</b>

Estimates of HIV-2 Seroprevalence by Residence and Risk Factor, for Developing Countries:  
Circa 1989

<b>AFRICA</b>				
Côte d'Ivoire	3.2a	17.2a	2.1a	-
*Mali	1.4	27.4a	-	-
*Nigeria	1.2	3.5a	.1	.3

- No data found

\* HIV-1 and HIV-2 present.

a Rate represents infection with HIV-2 only and dual infection (HIV-1 and HIV-2), therefore, addition of rates from Tables 1 and 2 is not advised.

b Data are best available but are not necessarily reliable due to small sample size (<100).

c Data refer to prior to 1986.

**NOTES:**

**Definition:** High risk -- prostitutes and clients, STD patients or other persons with known risk factors.  
Low risk -- pregnant women, blood donors, or other persons with no known risk factors.

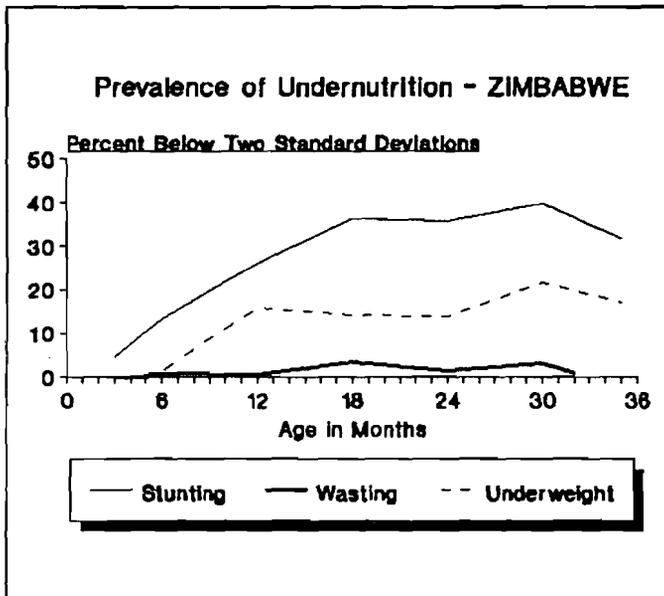
- Very few studies of HIV infection in the general population of Zimbabwe have been published. One study of blood donors shows that infection was already well established in 1985 in the urban population. Behavioral studies have shown that contact with prostitutes and experience with STDs are common among urban males.
- The rural population of Zimbabwe is also at risk of infection. Zimbabwe's well-developed roads facilitate communication and the spread of infection.
- In a study conducted in 1987, pregnant women in one rural area showed a significant level of HIV infection. In this same rural area, STD patients were several times more likely to be infected than pregnant women. Both males and females were at risk.

### **HIV/AIDS PROGRAMS IN ZIMBABWE**

The U.S. response to date has been:

- ▶ Physical expansion of the Blood Transfusion Service centers and laboratory equipment: US \$1,440,068 over several years, mostly through local counterpart currencies.
- ▶ HIV/AIDS Prevention in Africa PVO Grants: US \$419,000/2 years.
  - Save the Children AIDS Education Projects (three impact areas):
    - Knowledge, Attitudes and Practices (KAPs) baseline survey
    - develop curriculum on AIDS education for country adaptation
    - train field staff to train project, MOH and PVO staff in AIDS prevention
    - Local trainers to train parents in skills and attitudes for prevention of HIV transmission
  - World Vision AIDS Awareness Project (Urungwe District):
    - KAP baseline survey of high risk groups
    - train project staff in HIV/AIDS prevention
    - develop/disseminate media messages for HIV/AIDS prevention
    - develop support system for AIDS victims and their families
    - condom distribution at strategic locations
- ▶ Bulawayo prostitute education project: US \$73,500/2 years
  - implemented by the AIDSTECH project
- ▶ Provision of condoms for HIV-related programs: US \$200,160
- ▶ Provision of country-designated funds through the WHO/GPA:
  - US \$150,000 in support of the Medium Term Plan
- ▶ National Institutes of Health Fogarty International Center:
  - Research Training Grants
    - University of California at Berkeley: US \$89,400
    - University of Washington: US \$8,615

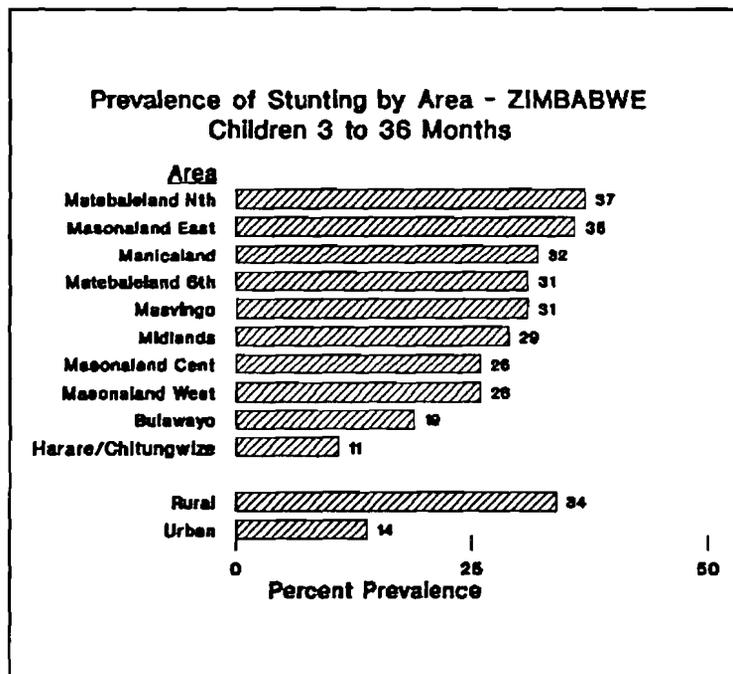
## Nutrition and Feeding Characteristics



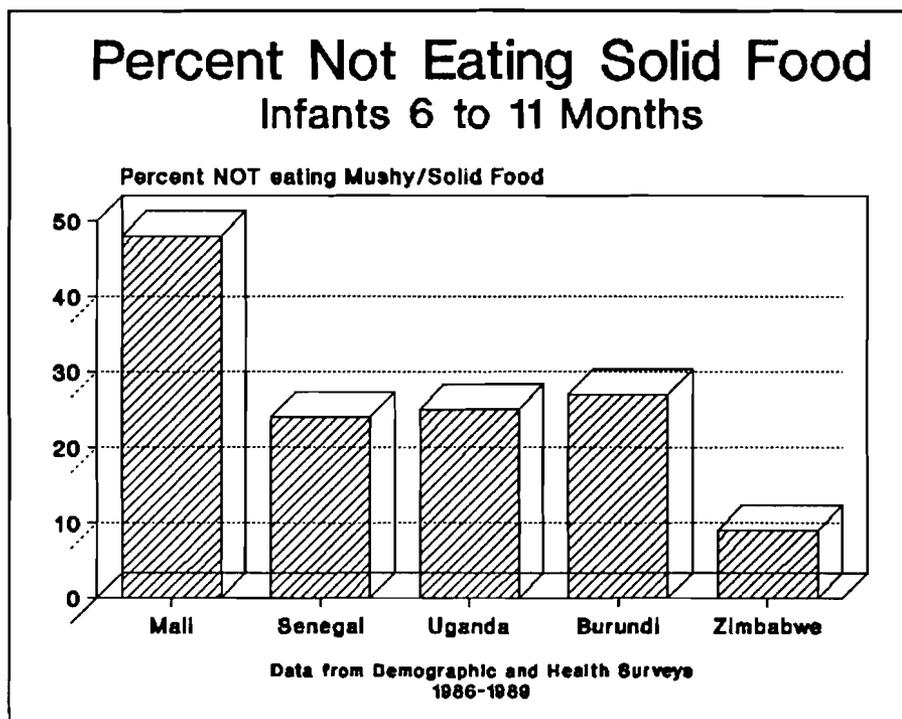
According to the 1988 Health and Demographic Survey, 30% of children 3 to 60 months are stunted (low height for age), an indication of chronic malnutrition due to prolonged inadequate food consumption and/or frequent bouts of diarrhea. Stunting begins for 17% of children before the age of one year and peaks to 36% among children 24 to 35 months of age. Compared to other African countries with comparable DHS nutrition data, Zimbabwe has the lowest level of wasting (low weight for height), an indicator of current acute nutrition problems.

SOURCE: Zimbabwe Demographic Health Survey 1988

There are wide variations between urban and rural levels of stunting. Children 3 to 36 months living in rural areas have twice the level of stunting at 34% as children in urban areas at 14%. Matebeleland with a level of 37%, and Masonaland East at 36% have the highest regional levels of stunting compared to Midlands with 29% and Masonland West with 26%.

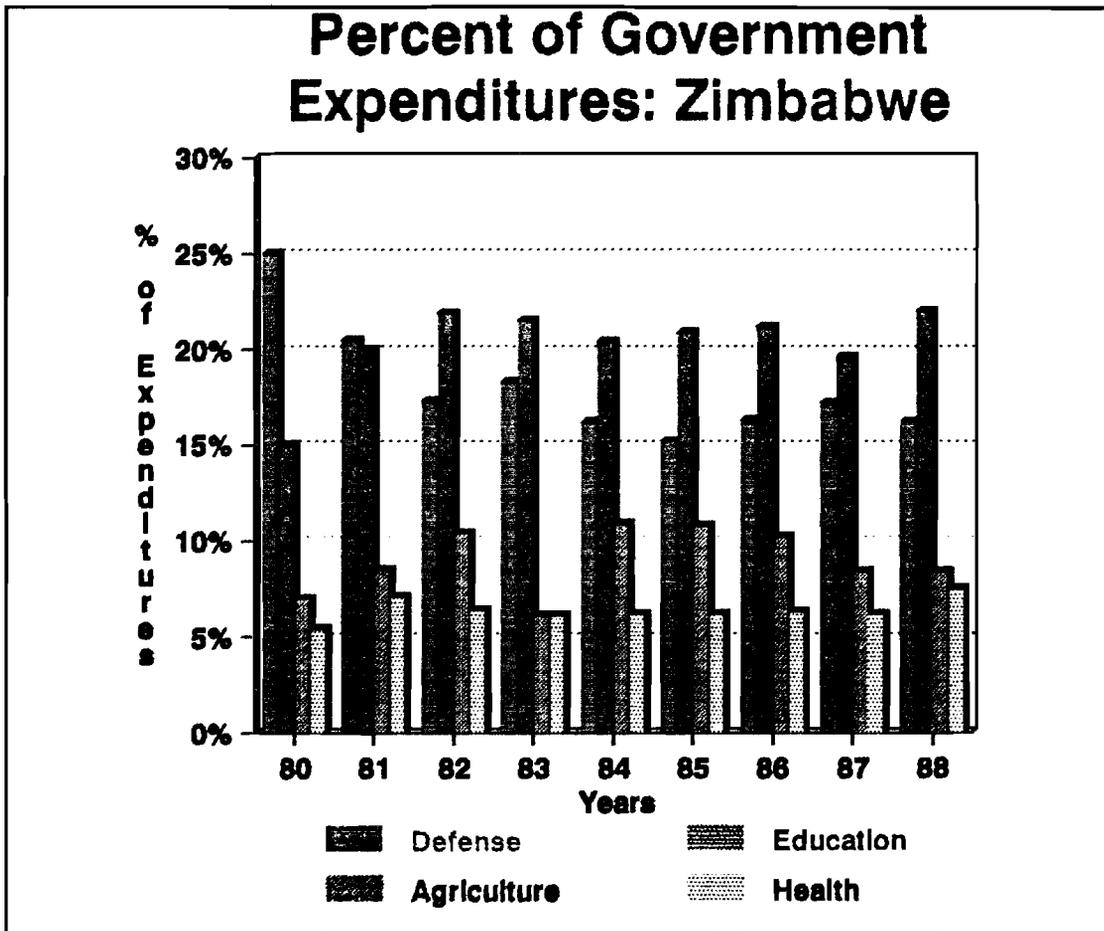


SOURCE: Zimbabwe Demographic Health Survey 1988



Factors contributing to malnutrition in Zimbabwe include nonexclusive breastfeeding, improper weaning practices and frequent episodes of diarrhea. Although most all infants in Zimbabwe are breastfed, only 9% of infants below four months are being exclusively breastfed; a majority of lactating mothers are complementing breastmilk with other liquids. Partial breastfeeding increases the risk of diarrhea, malnutrition and mortality particularly for infants from poor families. In addition, in the Midlands and Matebaliland Sth, 20 to 30% of children 6 to 11 months are not eating solid foods. WHO, UNICEF and A.I.D. all recommend the introduction of breastmilk by the end of a child's sixth month. A child's first food in Zimbabwe is typically made from corn meal and may not have adequate caloric density or protein for optimal child growth and development.

## Economic and Financial Data



Source: African Economic and Financial Data, World Bank, 1990

- Since 1980, the Public Health Sector in Zimbabwe has continuously received the smallest proportion of GOZ expenditures when compared to Defense, Education and Agriculture.
- In 1988, expenditures for Public Health were only 7.5% of total Government Expenditures.