

Zimbabwe

Worldwide, over 500,000 women and girls die of complications related to pregnancy and childbirth each year. Over 99 percent of those deaths occur in developing countries such as Zimbabwe. But maternal deaths only tell part of the story. For every woman or girl who dies as a result of pregnancy-related causes, between 20 and 30 more will develop short- and long-term disabilities, such as obstetric fistula, a ruptured uterus, or pelvic inflammatory disease (see box on page 2).

Zimbabwe's maternal mortality rate continues at an unacceptably high level. While maternal mortality figures vary widely by source and are highly controversial, the best estimates for Zimbabwe suggest that roughly between 1,300 and 2,800 women and girls die each year due to pregnancy-related complications. Additionally, another 26,000 to 84,000 women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each year.¹

The tragedy – and opportunity – is that most of these deaths can be prevented with cost-effective health care services. Reducing maternal mortality

and disability will depend on identifying and improving those services that are critical to the health of women and girls, including antenatal care, emergency obstetric care, adequate postpartum care for mothers and babies, and family planning and STI/HIV/AIDS services. With this goal in mind, the Maternal and Neonatal Program Effort Index (MNPI) is a tool that reproductive health care advocates, providers, and program planners can use to:

- Assess current health care services;
- Identify program strengths and weaknesses;
- Plan strategies to address deficiencies;
- Encourage political and popular support for appropriate action; and
- Track progress over time.

Health care programs to improve maternal health must be supported by strong policies, adequate training of health care providers, and logistical services that facilitate the provision of those programs. Once maternal and neonatal programs and policies are in place, all women and girls must be ensured equal access to the full range of services.

At-A-Glance: Zimbabwe

Population, mid-2001	11.4 million
Average age at first marriage, all women	19 years
Births attended by skilled personnel	73%
Total fertility rate (average number of children born to a woman during her lifetime)	4
Females giving birth by age 20	47%
Children who are exclusively breastfed at ages less than 6 months	11%
Contraception use among married women, 15-49, modern methods	50%
Abortion policy, 2000	Permitted on physical or mental health grounds

Sources: Population Reference Bureau – 2002 *Women of Our World*; 2001 *World Population Data Sheet*; *The World Youth, 2000*; and 1999 *Breastfeeding Patterns in the Developing World* (see <http://www.worldpop.org/datafinder.htm>).

Understanding the Causes of Maternal Mortality and Morbidity

Maternal mortality refers to those deaths which are caused by complications due to pregnancy or childbirth. These complications may be experienced during pregnancy or delivery itself, or may occur up to 42 days following childbirth. For each woman who succumbs to maternal death, many more will suffer injuries, infections, and disabilities brought about by pregnancy or childbirth complications, such as obstetric fistula.² In most cases, however, maternal mortality and disability can be prevented with appropriate health interventions.³

Some of the direct medical causes of maternal mortality include hemorrhage or bleeding, infection, unsafe abortion, hypertensive disorders, and obstructed labor. Other causes include ectopic pregnancy, embolism, and anesthesia-related risks.⁴ Conditions such as anemia, diabetes, malaria, sexually transmitted infections (STIs), and others can also increase a woman's risk for complications during pregnancy and childbirth, and, thus, are indirect causes of maternal mortality and morbidity. Since most maternal deaths occur during delivery and during the postpartum period, emergency obstetric care, skilled birth attendants, postpartum care, and transportation to medical facilities if complications arise are all necessary components of strategies to reduce maternal mortality.⁵ These services are often particularly limited in rural areas, so special steps must be taken to increase the availability of services in those areas.

Efforts to reduce maternal mortality and morbidity must also address societal and cultural factors that impact women's health and their access to services. Women's low status in society, lack of access to and control over resources, limited educational opportunities, poor nutrition, and lack of decision-making power contribute significantly to adverse pregnancy outcomes. Laws and policies, such as those that require a woman to first obtain permission from her husband or parents, may also discourage women and girls from seeking needed health care services – particularly if they are of a sensitive nature, such as family planning, abortion services, or treatment of STIs.

Traditional practices that affect maternal health outcomes include early marriage and female genital cutting. Many women in sub-Saharan Africa marry before the age of 20. Pregnancies in adolescent girls, whose bodies are still growing and developing, put both the mothers and their babies at risk for negative health consequences.

Female genital cutting, also known as female circumcision or genital mutilation, is a practice that involves removing all or part of the external genitalia and/or stitching and narrowing the vaginal opening (which is called infibulation). The practice is common in some parts of Africa and the Middle East. Social, cultural, religious, and personal reasons support the persistence of this practice. Some of these reasons include maintaining tradition and custom, promoting hygiene or aesthetics, upholding family honor, controlling women's sexuality and emotions, and protecting women's virginity until marriage.⁶ Many women and girls who undergo female genital cutting, particularly those who undergo Type III cutting or infibulation, experience health problems including hemorrhage, pain, infection, perineal tears, and trauma during childbirth. They often also experience psychological and sexual problems.

The consequences of maternal mortality and morbidity are felt not only by women but also by their families and communities. Children who lose their mothers are at an increased risk for death or other problems, such as malnutrition. Loss of women during their most productive years also means a loss of resources for the entire society.

Ensuring safe motherhood requires recognizing and supporting the rights of women and girls to lead healthy lives in which they have control over the resources and decisions that impact their health and safety. It requires raising awareness of complications associated with pregnancy and childbirth, providing access to high quality health services (antenatal, delivery, postpartum, family planning, etc.), and eliminating harmful practices.

The Maternal and Neonatal Program Effort Index

In 1999, around 750 reproductive health experts evaluated and rated maternal and neonatal health services as part of an assessment in 49 developing countries.⁷ The results of this study comprise the MNPI, which provides both international and country-specific ratings of relevant services. Using a tested methodology for rating programs and services,⁸ 10 to 25 experts in each country – who were familiar with but not directly responsible for the country’s maternal health programs – rated 81 individual aspects of maternal and neonatal health services on a scale from 0–5. For convenience, each score was then multiplied by 20 to obtain an index that runs from 0–100, with 0 indicating a low score and 100 indicating a high score.

The 81 items are drawn from 13 categories, including:

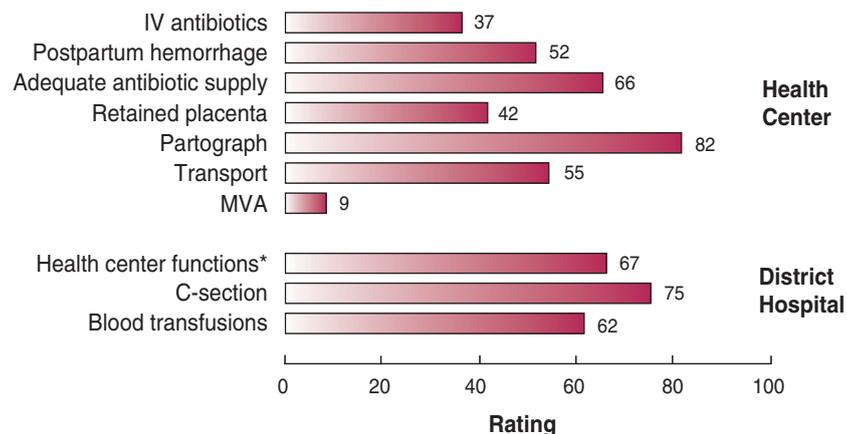
- Health center capacity;
- District hospital capacity;
- Access to services;
- Antenatal care;
- Delivery care;
- Newborn care;
- Family planning services at health centers;
- Family planning services at district hospitals;
- Policies toward safe pregnancy and delivery;
- Adequacy of resources;
- Health promotion;
- Staff training; and
- Monitoring and research.

Items from these categories can be grouped into five types of program effort: service capacity, access, care received, family planning, and support functions. The following five figures, organized by type of program effort, present the significant indicators from the Zimbabwe study.

Service Capacity

Overall, Zimbabwe’s service capacity to provide emergency obstetric care received a rating of 59 out of 100. Figure 1 shows ratings of the capacity of health centers and district hospitals to provide specific services. The least available service among those assessed at health centers is providing vacuum aspiration of the uterus (MVA) for postabortion care (9). Use of the partograph (82) is the most commonly available service at health centers. District hospitals received relatively strong ratings for performing Cesarean-sections (75) and providing a range of health center services (67). Blood transfusions (62) were the least available service among those assessed at district hospitals. While health center services in Zimbabwe generally received higher ratings when compared to services in other countries from the sub-Saharan Africa region, district hospitals generally received lower ratings.

Figure 1. Service capacity of health centers and district hospitals in Zimbabwe

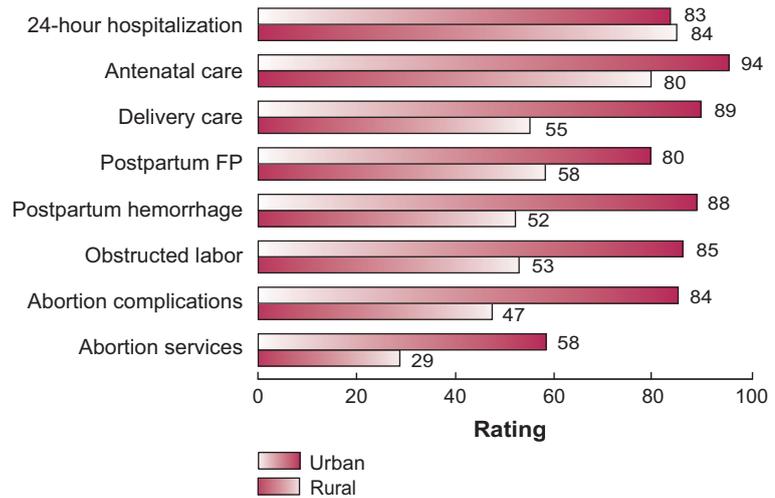


*Refers to all those functions performed by the health center

Access

In most developing countries, access to safe motherhood services in rural areas is more limited than in urban areas. This is particularly important for Zimbabwe considering 68 percent of its population lives in rural areas.⁹ Overall, Zimbabwe received a rating of 70 for access, with an average of 57 for rural access and 83 for urban access. Figure 2 presents the rural and urban access ratings for eight services. With the exception of 24-hour hospitalization, there are large gaps in the ratings for rural and urban access to services. Rural access scores ranged from 29 to 84 – suggesting an urgent need to increase access to a variety of services. Even though urban access received relatively high scores, the ratings still indicate room for improvement, particularly for safe abortion services (58).

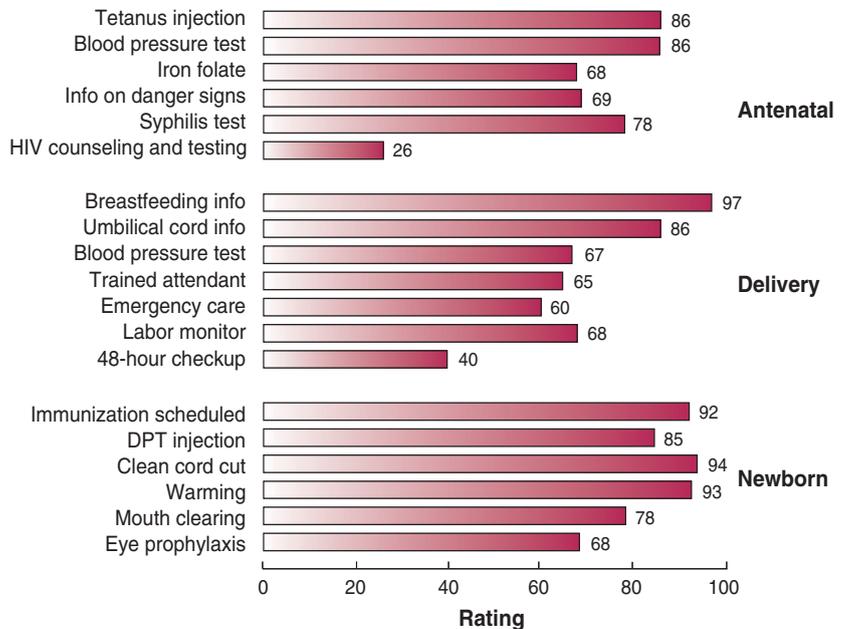
Figure 2. Comparisons of access to services for rural and urban areas in Zimbabwe



Care Received

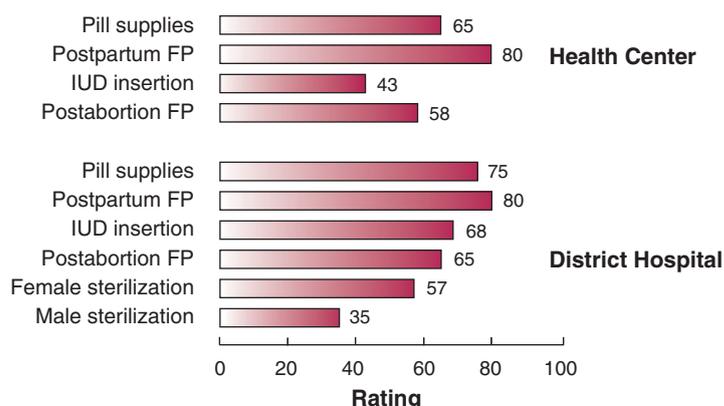
In most countries, newborn services are rated higher than delivery care or antenatal care, and this was the case for Zimbabwe as well. Overall, care received was given a rating of 74, with newborn care receiving an average rating of 85 compared to 69 for both antenatal and delivery care. Figure 3 presents key indicators for each type of care. One of the more important indicators of maternal mortality is the presence of a trained attendant at birth,¹⁰ which received a rating of 65. Other crucial elements that reduce maternal mortality are emergency obstetric care and the 48-hour postpartum checkup, which are rated 60 and 40, respectively. HIV counseling and testing (26) and the 48-hour postpartum checkup (40) were given the lowest ratings for care received, while the provision of breastfeeding advice to pregnant women received the highest rating (97).

Figure 3. Antenatal, delivery and newborn care received in Zimbabwe



Family Planning

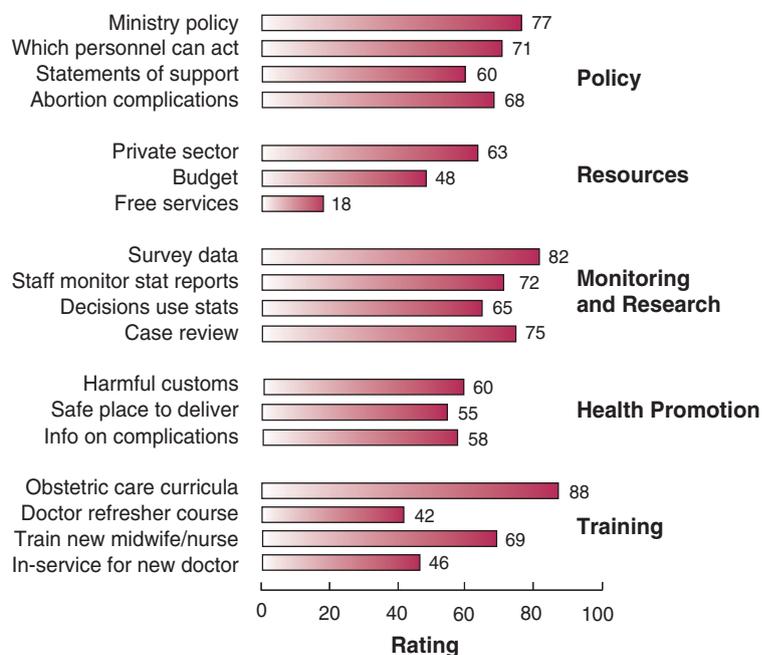
Figure 4. Provision of family planning services at health centers and district hospitals in Zimbabwe



Overall, family planning services provided by health centers and district hospitals in Zimbabwe received a rating of 63. Figure 4 presents the ratings for individual family planning services provided by health centers and district hospitals. These ratings consider facility capacity, access, and care received. Both health centers (65) and district hospitals (75) received relatively high ratings for pill supplies as well as postpartum family planning (both receiving a score of 80). District hospitals also do relatively well when it comes to IUD insertion (68) and postabortion family planning (65). IUD insertion (43) was the lowest rated service for health centers, while male sterilization (35) was the lowest for district hospitals.

Policy and Support Functions

Figure 5. Policy and support functions in Zimbabwe



Policy and support functions in Zimbabwe received an overall rating of 61. Ratings for support functions, shown in Figure 5, are divided into the following categories: policy, resources, monitoring and research, health promotion, and training. Zimbabwe's ministry-level policy on maternal health received a relatively strong rating of 77. Commitment to this policy, however, needs to be reinforced through more frequent statements to the press and public by high-level government officials – an aspect of policy that received a rating of 60. Policies regarding which personnel can provide maternal health care (71) and treatment of abortion complications (68) should also be developed.

Policies, even when they have been adopted, do not automatically translate into quality services at the local level. Many of the support functions in Zimbabwe, including resources, monitoring and research, health promotion, and training, are in need of further development. Ratings of the availability of free services (18) and government budget resources (48) lag behind private sector resources (63). The ratings suggest that Zimbabwe is fairly strong in its monitoring and research capabilities, particularly with regard to recent survey data on maternal events (82).

Health promotion and education of the public are important adjuncts to the provision of health services. Topics such as safe places to deliver (55), pregnancy complications (58), and harmful customs (60) all require attention in Zimbabwe. Mass media should be used to educate the public about safe pregnancy and delivery, and community-based organizations should assist these efforts through systematic programs.

Finally, the education and training of health professionals is an integral part of providing high quality care and preventing maternal death and disability. While ratings suggest that hands-on obstetric care curricula have been developed (88), actual training in Zimbabwe is generally poor, and was found to be weakest in the areas of doctor refresher courses (42) and in-service training for new doctors (46).

Global Comparisons

Overall, the experts gave maternal and neonatal health services in Zimbabwe a rating of 64, compared to an average of 56 for the 49 countries involved in the MNPI study. This rating places services in Zimbabwe sixth among the 49 countries. Among the 13 developing countries studied in the sub-Saharan Africa region,¹¹ services in Zimbabwe rank second. While comparisons across countries should be made with a certain degree of caution – given the subjective nature of expert opinions and evaluations in different countries – these comparisons may help maternal health care advocates and providers in Zimbabwe identify priority action areas. It is also important to keep in mind that average scores may mask the differences among provinces within each country.

Table 1 compares Zimbabwe's scores to the global averages for nine selected items of the MNPI. In many cases, ratings for services in Zimbabwe outpace the ratings from the global assessment. In particular, Zimbabwe received higher ratings than the global average when considering breastfeeding advice (97 vs. 74), rural access to safe motherhood services (57 vs. 39), and urban access (83 vs. 68). Zimbabwe's highest ratings are for breastfeeding advice (97), immunization (88), and urban access (83). The only two areas in which services in Zimbabwe were rated lower than the global average are in the areas of postpartum checkups within 48 hours (40 vs. 41) and voluntary counseling and testing for HIV (26 vs. 30).

Table 1. Comparison of global and Zimbabwe MNPI scores for selected items, 1999

Indicators of Maternal and Neonatal Services	Global Assessment (49 country average)	Zimbabwe
Access to safe motherhood services by pregnant women*		
Rural access	39	57
Urban access	68	83
Able to receive emergency obstetric care	55	60
Provided appointment for postpartum checkup within 48 hours	41	40
Immunization**	76	88
Encouraged to begin immediate breastfeeding	74	97
Offered voluntary counseling and testing for HIV	30	26
Postabortion family planning	54	62
Adequate maternal health policy	72	77
Adequate budget resources	48	48
Overall rating	56	64

*Refers to composite scores for all the rural and urban access items.
**Refers to a composite of three immunization items: maternal tetanus immunization, DPT immunization, and other immunizations scheduled.

Summary

The MNPI ratings indicate that Zimbabwe is considered to have a strong policy on safe motherhood. In addition, monitoring and research capacity and curricula for training health care providers are rated highly. Women and babies have reasonable access to some services, including newborn care, some family planning methods (e.g., pills, IUD), and 24-hour hospitalization in case of emergency. Other aspects of maternal and neonatal care services require strengthening, particularly in rural areas where women and babies have more limited access to services. Moreover, women in all

regions need access to improved delivery care, including skilled attendants at birth, postpartum checkups within 48 hours of delivery, and emergency obstetric care. Voluntary counseling and testing for HIV is very limited, which should be a concern since it is estimated that about one-third (33.7 percent) of Zimbabwe's adult population (age 15-49) is living with HIV/AIDS.¹² Finally, as in most other developing countries, maternal and neonatal health care services in Zimbabwe face resource shortages – from both the public and private sectors – that hamper expansion of services.

Priority Action Areas

The following interventions have been shown to improve maternal and neonatal health and should be considered in Zimbabwe's effort to strengthen maternal and neonatal health policies and programs.

- Increase access to reproductive health, sexual health, and family planning services, especially in rural areas.** Due to the lack of access to care in rural areas, maternal death rates are higher in rural areas than in urban areas. In addition, many men and women in rural and urban areas lack access to information and services related to HIV/AIDS and other STIs.
- Strengthen reproductive health and family planning policies and improve planning and resource allocation.** While the MNPI scores demonstrate that many countries have strong maternal health policies, implementation of the policies may be inadequate. Often, available resources are insufficient or are used inefficiently. In some cases, advocacy can strengthen policies and increase the amount of resources devoted to reproductive health and family planning. In other cases, operational policy barriers – barriers to implementation and full financing of reproductive health and family planning policies – must be removed.
- Increase access to and education about family planning.** Another feature that relates closely to preventing maternal mortality is the provision of family planning. Family planning helps women prevent unintended pregnancies and space the births of their children. It thus reduces their exposure to risks of pregnancy, abortion, and childbirth. Reliable provision of a range of contraceptive methods can help prevent maternal deaths associated with unwanted pregnancies.
- Increase access to high quality antenatal care.** High quality antenatal care includes screening and treatment for STIs, anemia, and detection and treatment of hypertension. Women should be given information about appropriate diet and other healthy practices and about where to seek care for pregnancy complications. The World Health Organization's recommended package of antenatal services can be conducted in four antenatal visits throughout the pregnancy.
- Increase access to skilled delivery care.** Delivery is a critical time in which decisions about unexpected, serious complications must be made. Skilled attendants – health professionals such as doctors or midwives – can recognize these complications, and either treat them or refer women to health centers or hospitals immediately if more advanced care is needed. Women in rural areas live far distances from quality obstetric care, so improvements depend greatly on early recognition of complications, better provisions for emergency treatment, and improved logistics for rapid movement of complicated cases to district hospitals. Increased medical coverage of deliveries, through additional skilled staff and service points, are basic requirements for improving delivery care. Reliable supply lines and staff retraining programs are also critical.
- Provide prompt postpartum care, counseling, and access to family planning.** It is important to detect and immediately manage problems that may occur after delivery, such as hemorrhage, which is responsible for about 25 percent of maternal deaths worldwide. Postpartum care and counseling will help ensure the proper care and health of the newborn. Counseling should include information on breastfeeding, immunization, and family planning.
- Improve postabortion care.** About 13 percent of maternal deaths worldwide are due to unsafe abortion. Women who have complications resulting from abortion need access to prompt and high quality treatment for infection, hemorrhage, and injuries to the cervix and uterus.
- Strengthen health promotion activities.** Mass media should be used to educate the public about pregnancy and delivery, and community-level organizations should assist this through systematic programs. An important step for health promotion, in order to prevent negative maternal health outcomes, is to have the Ministry of Health supply adequate educational materials regarding safe practices.

References

- ¹ The sources used to calculate this range are the 1994 Zimbabwe DHS and the 1995 WHO/UNICEF/UNFPA estimates of maternal mortality. See Central Statistical Office [Zimbabwe] and Macro International Inc. 1995. *Zimbabwe Demographic and Health Survey, 1994*. Calverton, Maryland, USA: Central Statistical Office and Macro International Inc. Also see Hill, K., C. AbouZahr, and T. Wardlaw. 2001. "Estimates of Maternal Mortality for 1995." *Bulletin of the World Health Organization* 79 (3): 182-193.
- ² Obstetric fistula occurs as a result of a prolonged and obstructed labor, which in turn is further complicated by the presence of female genital cutting. The pressure caused by the obstructed labor damages the tissues of the internal passages of the bladder and/or the rectum and, with no access to surgical intervention, the woman can be left permanently incontinent, unable to hold urine or feces, which leak out through her vagina. (UNFPA Press Release, July 2001)
- ³ MEASURE Communication. 2000. *Making Pregnancy and Childbirth Safer*. (Policy Brief) Washington, DC: Population Reference Bureau. Available at <http://www.prb.org/template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm ContentID=2824>
- ⁴ World Health Organization. 2001. *Advancing Safe Motherhood through Human Rights*. Available at http://www.who.int/reproductive-health/publications/RHR_01_5_advancing_safe_motherhood/RHR_01_05_table_of_contents_en.html
- ⁵ Dayaratna, V., W. Winfrey, K. Hardee, J. Smith, E. Mumford, W. McGreevey, J. Sine, and R. Berg. 2000. *Reproductive Health Interventions: Which Ones Work and What Do They Cost?* (Occasional Paper No. 5) Washington, DC: POLICY Project. Available at <http://www.policyproject.com/pubs/occasional/op-05.pdf>
- ⁶ Population Reference Bureau. 2001. *Abandoning Female Genital Cutting: Prevalence, Attitudes, and Efforts to End the Practice*. Washington, DC: Population Reference Bureau. Available at http://www.prb.org/pdf/AbandoningFGC_Eng.pdf
- ⁷ The MNPI was conducted by the Futures Group and funded by the U.S. Agency for International Development (USAID) through the MEASURE Evaluation Project. For more information on the MNPI, see Bulatao, R. A., and J. A. Ross. 2000. *Rating Maternal and Neonatal Health Programs in Developing Countries*. Chapel Hill, NC: MEASURE Evaluation Project, University of North Carolina, Carolina Population Center.
- ⁸ This methodology for rating policies and programs was originally developed for family planning and has also been used for HIV/AIDS. See Ross, J. A., and W. P. Mauldin. 1996. "Family Planning Programs: Efforts and Results, 1972-1994." *Studies in Family Planning* 27 (3):137-147. Also see UNAIDS, USAID, and POLICY Project. 2001. "Measuring the Level of Effort in the National and International Response to HIV/AIDS: The AIDS Program Effort Index (API)." Geneva: UNAIDS.
- ⁹ Population Reference Bureau. 2001. *2001 World Population Data Sheet*. Washington, DC: Population Reference Bureau. Available at http://www.prb.org/Content/NavigationMenu/Other_reports/2000-2002/sheet4.html
- ¹⁰ In the MNPI survey instrument, the term "trained" was used because it is empirically concrete for the respondent, whereas "skilled" is more subjective. Asking respondents about skill levels would require them to judge the probable quality of the original training and the deterioration of skills over time. While knowing about skills is really more critical, it throws more subjectivity into the data and, as a factual matter, skills were not measured.
- ¹¹ Countries in the sub-Saharan Africa region that were included in this index are: Angola, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, South Africa, Sudan, Tanzania, Uganda, Zambia, and Zimbabwe.
- ¹² See UNAIDS. *Report on the Global HIV/AIDS Epidemic, June 2000*. Available at http://www.unaids.org/epidemic_update/report/Epi_report.htm

For More Information

A complete set of results, including more detailed data and information, has already been sent to each of the participating countries. For more information, contact:

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