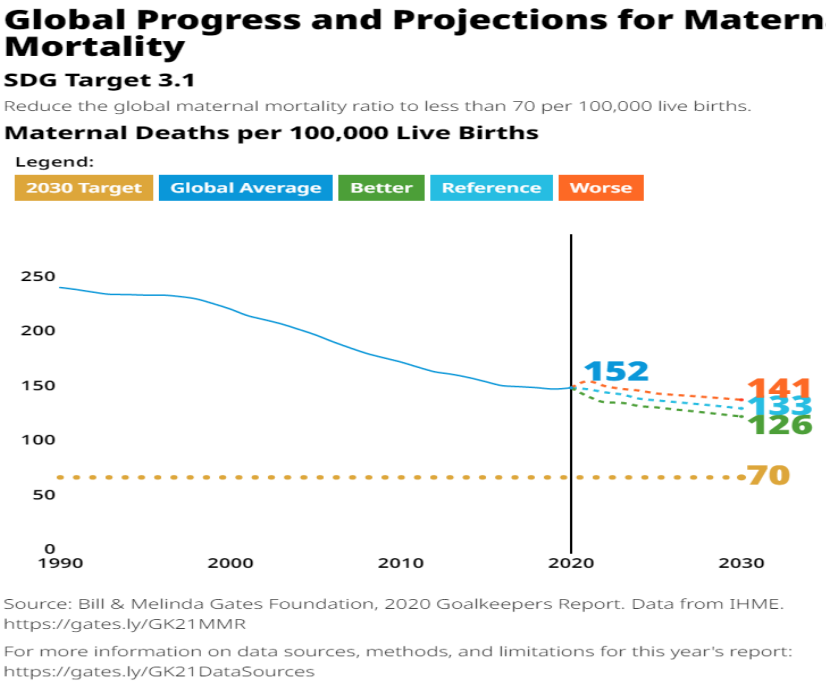
STRATEGIC ENGAGEMENT TO INFORM AFRICA REGIONAL ADVOCACY FOR ACCELERATED ACTION FOR MATERNAL AND NEONATAL MORTALITY REDUCTION TO MEET SDG 3 IN AFRICA

National Baseline Report on Maternal Health in Zimbabwe

Phase 1

INTRODUCTION

Maternal mortality has been a global health challenge which has been decreasing in a decreasing rate. In 2020, the global maternal mortality ratio was 152 deaths per 100,000 live births, up from 151 deaths per 100,000 live births in 2019. This trajectory projects 133 deaths per 100,000 live births in 2030, nearly double the SDG target (Bill and Melinda Gates Foundation, 2021).



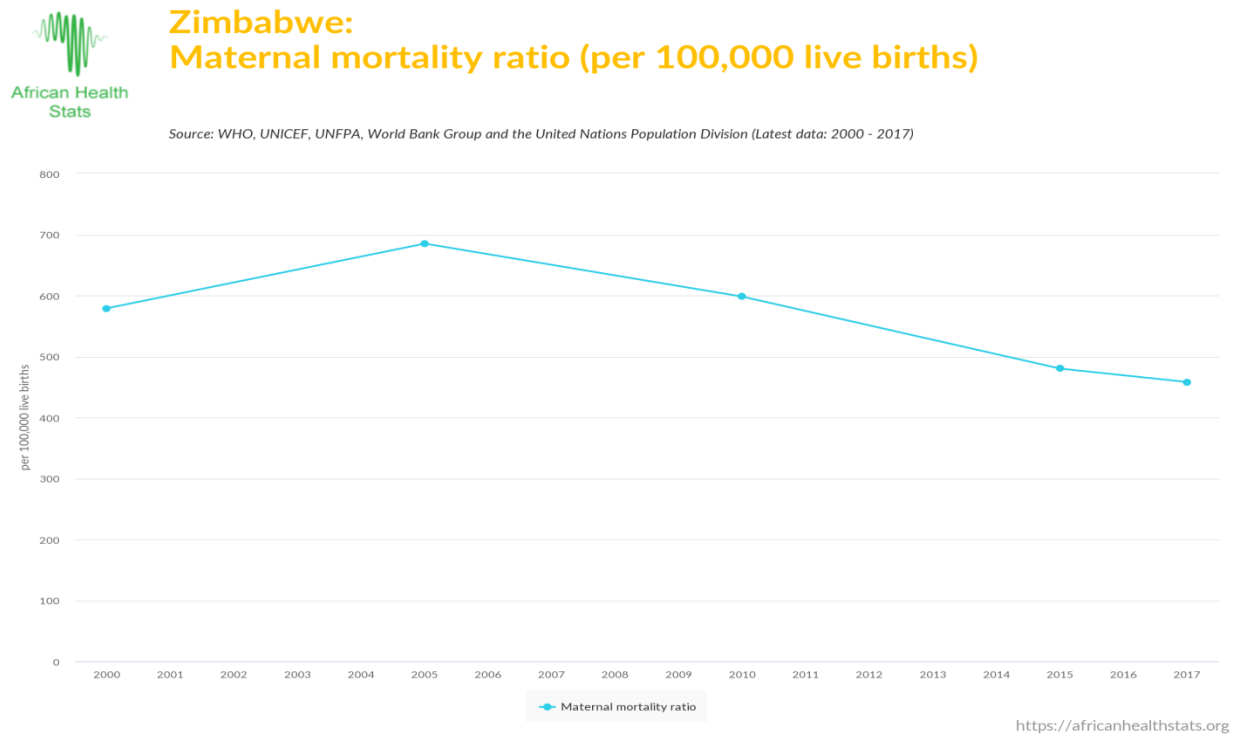
The global position also reflects what is happening in different countries especially in sub-Saharan Africa. The SDG target is to reach a rate of 70 deaths per 100,000 live births in 2030,

which seems to be a long reach considering the situations in different countries which includes Zimbabwe.

ZIMBABWE STATISTICS

Maternal Mortality Ratio

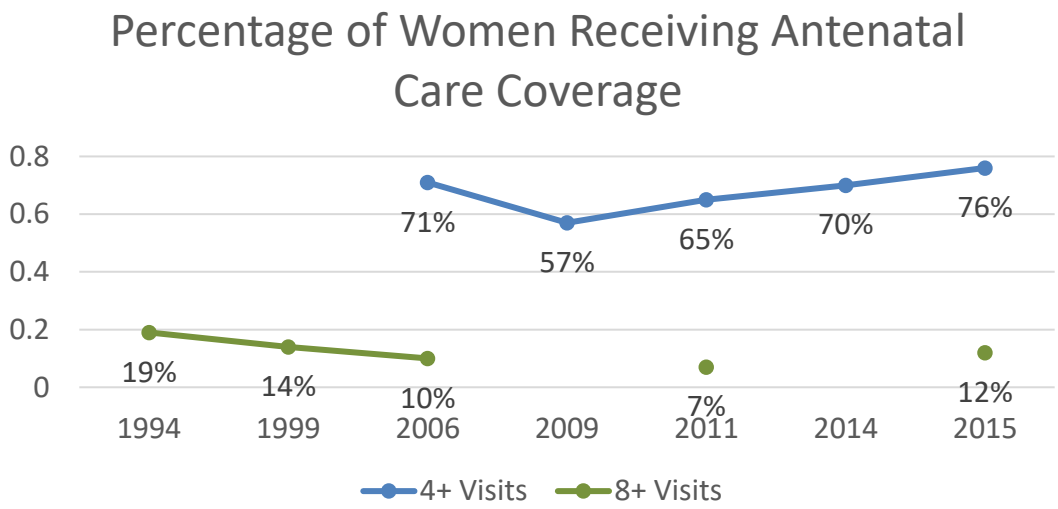
The Maternal Mortality Ratio (MMR) is the rate at which women die from maternal causes and is measured as the number of maternal deaths per every 100,000 live births. As of 2017 the MMR in Zimbabwe is 458 deaths per 100,000 live births (African Health Stats, 2019). At this rate Zimbabwe will reach the SDG target in 2163 which is more than a millennial from 2021.



From 2000 to 2017, the Zimbabwean MMR declined by **20.9%** from 579 to 458 deaths per 100,000 live births. This translates to an average annual rate of reduction of **1.4%.** At this rate Zimbabwe will reach the SDG target in 2163 which is more than a millennial from 2021. In order to reach the target, Zimbabwe's rate of reduction has to increase to 13%, which is only possible if drastic changes are made in the health system of the country.

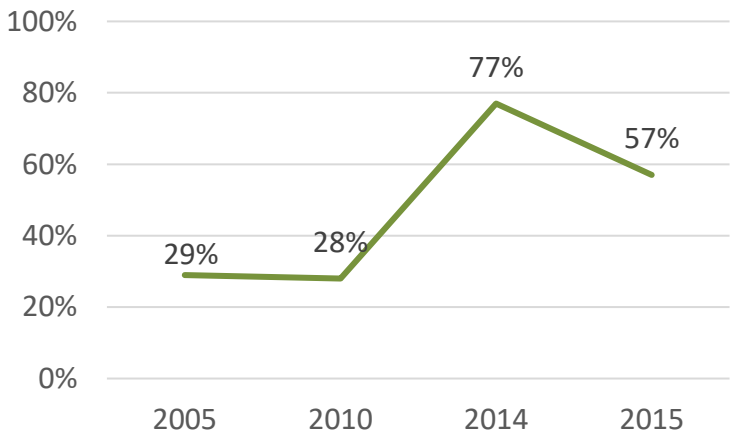
Antenatal Care

Antenatal Care is the health control or health checks that are done routinely to pregnant women to ensure that their health and that of their babies is protected. WHO recommends that a woman should at least have 4 visits for check-ups (antenatal care assessments) over the course of her pregnancy (World Health Organisation, 2007). Over the past years the percentage of women aged 15 to 49 with a live birth who have received antenatal care has been fairly increasing. As of 2015, 76% of the women in Zimbabwe have been receiving the WHO requirement of 4 visits and only 12% have had more than 8 visits (African Health Stats, 2019). The drastic drop in 2009 shows the effect of political and economic instability to the health care system as Zimbabwe was experiencing hyperinflation and it was just after the 2008 elections which had caused political instability within the country.



Postpartum Care Coverage for Mothers

Postpartum Care Coverage for Mothers: This refers to the number of women in the early postnatal period (the first 48 hours after birth) who received a check-up—measured as the proportion of the total number of women aged 15-49 who had a live birth in the last 3 to 5 years prior to the survey.



The statistics in Zimbabwe as of between 2005 and 2015 show us that the postpartum care had increased by a tremendous amount in 2014 and drastically dropped in 2015 by 20% (African Health Stats, 2019). The increase in 2014 can be attributed to the country's efforts to achieve its 2007-2015 National Maternal and Neonatal Health Road Map as it was reaching its deadline without achieving its plan to better the healthcare system for mothers and their babies.

Births Attended by Skilled Health Personnel

Births Attended by Skilled Health Personnel: The percentage of births that take place in the presence of a skilled healthcare worker who is qualified to attend to births (i.e. midwives, nurses, or doctors). Traditional birth attendants are not included.

Year	Percentage of Births Attended by Skilled Health Personnel
1994	69%
1999	73%
2006	69%
2009	60%

2011	66%
2014	80%
2015	78%

The number of births recorded over the years which have been attended by skilled health personnel has been fairly high. However, according to the world bank data as of 2020, 68% of the Zimbabwean population live in the rural areas (The World Bank, 2021). This then leaves a gap in the statistics as many women in rural Zimbabwe have traditional birth attendants, due to religion and the births of their children are only recorded when they are older when they now want to access education.

ZIMBABWE POLICY ENVIRONMENT

The legislation of Zimbabwe has several Acts that protect the maternal health of women and their unborn children (Ministry of Health and Child Care Zimbabwe, 2017)which includes: Medical Dental and Allied Professionals Act, Public Health Act, Termination of Pregnancy Act and Disabled Persons Act. These Acts are further followed up by national policy documents and strategies such as:

1. The National Maternal and Neonatal Health Strategy for 2017 to 2021
2. Guidelines for conducting maternal and perinatal death audits.

3. The National Maternal and Perinatal Death Review Committee which sits every quarter
4. Guidelines on Key Interventions for Improving Perinatal and Neonatal Health Outcomes in Zimbabwe
5. Guidelines on Youth Friendly Clinical SRH Service Provision
6. National Standard Training Manual on ASRH
7. Implementation of the National Cervical Cancer Screening and Management programme through VIAC.
8. Launched the Health Development Fund (HDF) which is supporting implementation of all Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions (including procuring blood and blood related products meant to assist women with pregnant related complications).
9. Developed an electronic Maternal and Perinatal Death Notification System
10. Developed and rolled out production of the Reproductive, Maternal, Newborn and Child Health (RMNCH) Scorecard
11. Commissioned the following studies whose results/ findings are currently being used to inform implementation of various low cost and high impact Sexual and Reproductive Health Interventions:

    - National Integrated Health Facility Assessment – 2010
    - National Service Availability and Readiness Assessment – 2014
    - National Adolescent Fertility Study – 2016

The above strategies show that the problem with Zimbabwe's health systems in terms of maternal health does not lie within policy frameworks but with implementation. It is important to address the gaps in the system so as to increase the rate of reduction of the Maternal Mortality Rate.

GAPS IN THE HEALTHCARE SYSTEM

The healthcare system in Zimbabwe has a lot of gaps which are even highlighted in the National Maternal and Neonatal Health Strategy for 2017 to 2021, which if addressed, the SDG target of 70 deaths per 100 000 live births will be achieved in the next few decades. These gaps include:

i. **Lack of financial protection for low income groups to access healthcare:** Government introduced user fee exemptions in public facilities for selected services, including for pregnant and lactating women, children under the age of 5 years and elderly persons above 70 years of age (Ministry of Health and Child Care Zimbabwe, 2017). However, there are hidden costs (Out-of-pocket (OOP) payments) that one will incur to access these services and a few institutions will offer free medication after consultations. Some of the facilities continue to charge user-fees for maternal services and they are not penalized although it is against government policy. Moreover, maternal services are free for just primary care but anything beyond that one will have to pay to get the service. In the Zimbabwe Demographic and Health Survey 2015 women were asked about the challenges they faced in accessing health care in terms of getting permission to go to the doctor, getting money for advice or treatment, distance to a health facility and not wanting to go alone. The most reported

problems were obtaining money to pay for treatment (43%), and distance to the health facility (33%) (Zimbabwe National Statistics Agency and ICF International, 2016).

ii. **Over reliance on donor funding**: most hospitals/ health institutions in Zimbabwe rely on donor funding in order to run as government financing is not adequate which hinders the service provision from being sustainable. Due to this funding crisis, the country still has a few very good public hospitals and **underequipped clinics** that are not enough to provide services to poor rural communities.

iii. **Shortage of staff**: the health sector has been understaffed leaving a lot of gaps, decreasing the quality of services and increasing the levels of human errors when it comes to maternal care. The majority of nurses and midwives in Zimbabwe are notorious for being temperamental, which usually comes as a result of heavy workloads and low pay showing low levels of motivation for the staff in the sector. Moreover, according to the study done by the Ministry of Health and Child Care, most nurses lack in competence for emergency obstetric and neonatal care, which results in a critical skills gap in the delivery of quality Maternal, Newborn and Child Health (MNCH) services. The ZDHS 2015 study revealed that all the maternal deaths that were reviewed in the study were institutional and avoidable, were due to the 3rd delay, and that most were due health worker error (Zimbabwe National Statistics Agency and ICF International, 2016).

iv. **Underutilization of existing structures of the village health workers (VHWs**): Village health workers are volunteers who are selected by the village elders and are in charge of a 100 households in each village. They play a critical role in the primary health care system in Zimbabwe and receive a short term training, a bicycle and a $14 incentive per month from the government. However, they are not permitted to provide some important interventions such as the life-saving antibiotics for acute respiratory infections (ARI) amongst other things (Ministry of Health and Child Care Zimbabwe, 2017). Their trainings are not extensive enough to provide more dynamic health services. The databases for VHWs are inconsistent mainly due to the fact that it is voluntary and this poses challenges to the provision of support and follow up

v. **Religious beliefs and cultural norms**: a lot of the women who do not go to health facilities for safe delivery , do not do so due to religious beliefs and/or cultural norms. There are still a lot of misconceptions about seeking professional medical services in some religious sects especially the apostolic sect where it is unreligious to do so. The churches are usually notorious for letting their women give birth in shrines and when complications arise they try to pray it away which usually results in either the mother or child or both lose their lives or survive and have to live with some health complications.

KEY ASKS TO GOVERNMENT

With all this in minds we recommend that government should carry out its National Maternal and Neonatal Health Strategy (Ministry of Health and Child Care Zimbabwe, 2017) by :

1. Implementing existing policies and guidelines so as to provide free, quality maternal health services which includes the provision of the full package of emergency obstetric care, management of pre-eclampsia and eclampsia, haemorrhage and sepsis, which are the major causes of maternal morbidity and mortality, as well as the management of HIV and AIDS as an indirect cause of maternal mortality;
2. Holding health workers accountable for any mal-practice, and the scaling up of mentorship in order to enhance and reinforce health worker skills in dealing with obstetric emergencies.
3. Scaling up funding and finding other sustainable means to finance the health sector, so as to make healthcare more affordable especially to those in poor resource communities
4. Building more hospitals and clinics that provide integrated services
5. Availing well-equipped ambulances, re-orient health workers on life-saving skills to support patients during referral, and re-orienting the provincial MDSR committees so as to standardize the conduct of maternal deaths audits and on the classification of causes of deaths
6. Providing all the necessary facilities in order for caesarean section to be performed on the pregnant women who need it. This includes infrastructure, equipment, medicines and other supplies, a reliable power source and water supply, as well as the human resources. The latter include the doctors and anaesthetists with the right skills, confidence and attitude, as

well as the other theatre staff to complete the full team.

7. Utilising and scaling up the work done by village health workers in order to provide primary health care services as well as increasing their incentives

8. Prioritising the SRH of women by providing quality maternal services especially in emergency context such as the Covid-19 pandemic

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