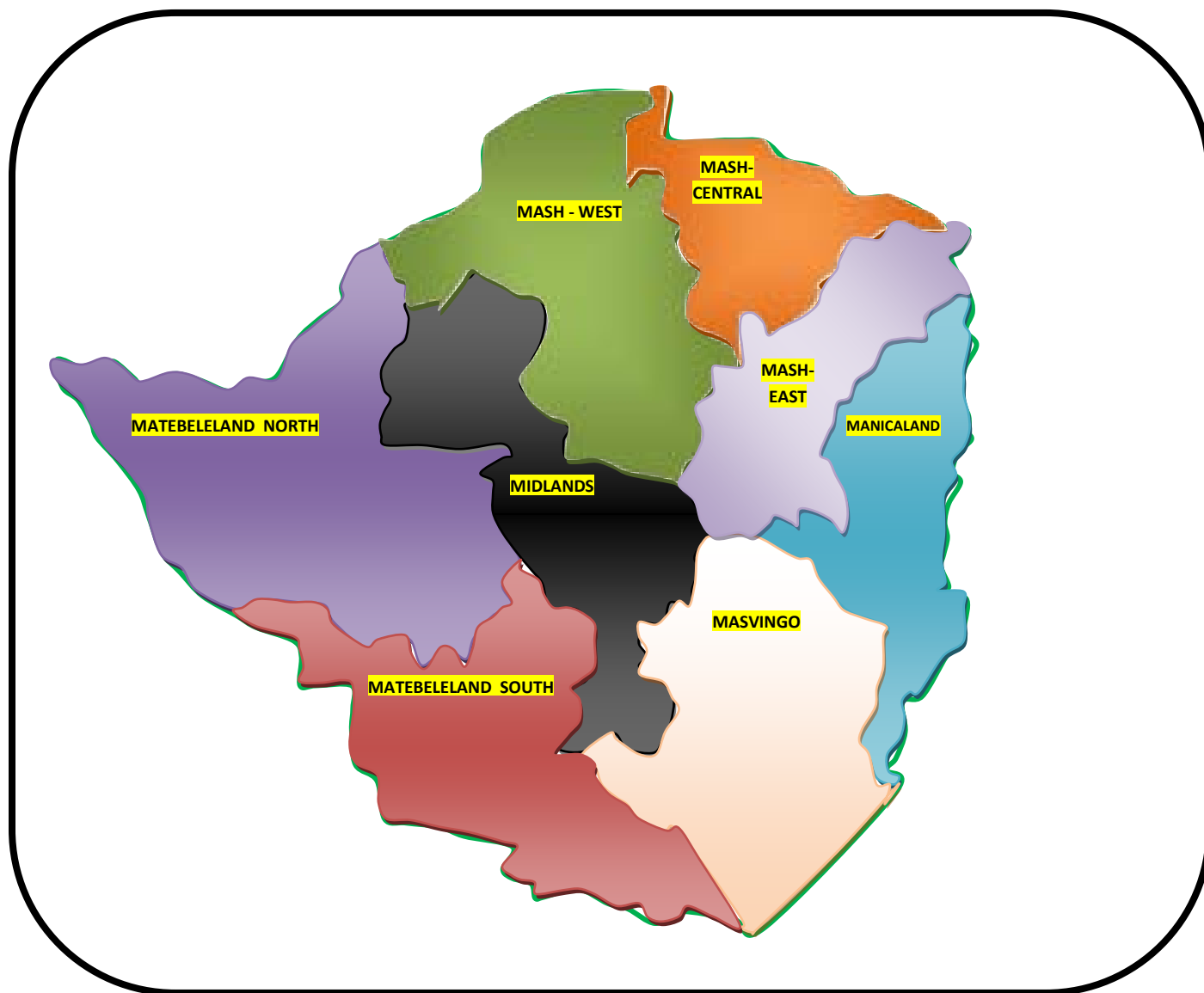


ZIMBABWE POPULATION STABILISATION REPORT



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(August 2011)

INTRODUCTION & BACKGROUND

Geography of Zimbabwe

Zimbabwe is a land locked country in Southern Africa with a total land area of 390 757 square kilometres. It is surrounded by Zambia on its northern border, South Africa on the south, Mozambique on the east and Botswana on the West. The country is made up of 10 Administrative Provinces (8 rural provinces - Mashonaland Central, Mashonaland East, Mashonaland West, Midlands, Manicaland, Masvingo, Matebeleland North and Matebeleland South; and 2 metropolitan provinces - Harare and Bulawayo. The rural provinces are made up of Districts, with a total of 62 rural districts in the country.

Policies on Population & Development in Zimbabwe

Post the 1994 Cairo conference, Zimbabwe developed an enabling environment by developing strategies, guidelines and policies in order to meet the expectations of the ICPD Plan of Action. The Population Policy was developed in 1998. It is the primary document guiding the population agenda in Zimbabwe. The Policy was developed in order to address the socio-economic and environmental challenges related to population issues, in a holistic way. In addition there are many policy documents and statutory instruments supporting the population agenda in Zimbabwe. These include among others; National Reproductive Health Policy 2003 (including RH and FP Service Delivery Guidelines), National Gender Policy 2003, National HIV/AIDS Policy 1999 and 2002 (including STI & HIV/AIDS Strategic Plans), National Health Strategy 2010-2015, Zimbabwe Maternal and Neonatal Health Road Map, Educational Policy (life skills), National Youth Policy, Zimbabwe National Family Planning Council Act 1984, Child Survival Strategy, Poverty Reduction Strategies, Economic Development Plans (Medium Term Plan 2011-2015, being the latest).

ICPD and MDGs Context

Zimbabwe is one of the countries that took part in the negotiations that culminated in the adoption of a 20 year Programme of Action (PoA) at the International Conference on Population and Development (ICPD) in Cairo, Egypt in 1994. The main objective of the PoA is to raise the quality of life of human beings and to promote human development in the next 20 years from 1994. This is through focusing on achievement of sustained economic growth, eradication of poverty, increasing access to education, especially for girls, promoting gender equity and equality, and provision of universal access to comprehensive reproductive health services including family planning, and HIV prevention, mitigation and support. In 2004 the Ministry of Finance and Economic Development with support from UNFPA commissioned the ICPD +10 report. The report was a review of the implementation of the ICPD PoA put together by the National ICPD Steering Committee, through the contribution of various government departments, NGOs and Civil Society.

The government of Zimbabwe is proud to be one of the successful implementers of the Millennium Declaration adopted by the Heads of State and Government at the 55th Session of the United Nations General Assembly in September 2000. The government

then developed national targets to serve as benchmarks for all development policies and interventions. The identified 3 Goals on; Poverty; Empowerment of Women; and HIV/AIDS as main priorities which would underlie the achievement of MDGs in Zimbabwe, due to their strong linkages. With the support of UNDP, the government produced an MDG progress report in 2004, providing an analytical summary of the development progress, challenges priority areas for intervention and the expected cost in meeting the national targets.

SITUATIONAL ANALYSIS

Population & Development in Zimbabwe

Population Policy

With the support of UNFPA, Zimbabwe developed a comprehensive Population Policy in 1998 under the auspices of the then National Economic Planning Commission (NEPC). The overall aim of the policy is to achieve higher standards of living for the people through influencing population variables and development trends in order to achieve economic and social goals of the nation. However in 2002 the NEPC was merged with the Ministry of Finance, Economic Planning and Development. The resulted in population matters being marginalized by more pressing issues. Toward end of 2004, the population agenda regained its momentum as the ICPD+10 became a global issue, with all countries required to report on progress on the ICPD 1994 PoA. This led to the Ministry of Finance, Economic Planning and Development to actively participate in population issues locally, regionally an internationally.

Population Evolution (Distribution, Growth Rates and Traits)

Population Size and Growth Rate

The total population was estimated at 12.1 million people (6.2 million females and 5, 9 million males) (Projected figures, CSO 2008). The population of Zimbabwe has grown more than tenfold from 713 000 in 1901. The first doubling of the 1901 population occurred in 1931 (within 30 years). Thereafter the doubling time has been around 20 years. A steep increase in population was observed between 1969 an 1992. This was largely due to the attainment of independence, which saw an influx of people into the country. The 1997 Inter-censal Demographic Survey (ICDS) reported a population of 11, 8 million, which was slightly higher than the 2002 Census. This decline in population between 1997 and 2002 could be partly explained by exodus of people from the country to seek greener pastures due to prevailing economic hardships.

Population growth rate has increased since 1901, from 2, 4% per annum between 1901 and 1911, stabilizing at 3, 5% between 1951 and 1961. The 2002 Census indicate that the average population growth rate was 1, 1% per annum between 1992 (10, 4 million) and 2002 (11, 6 million). The decline in population growth rate between 1992 and 2002 to 1, 1% is due to many factors including HIV/AIDS related mortality, success of the family planning programme, improvements in female education, decline in fertility, and migration of people out of the country.

Table 1 - Population in Millions 1901 - 2002

1901	1911	1921	1931	1941	1951	1961	1969	1982	1992	2002
0,713	1,0	1,2	1,6	2,1	3,6	4,1	5,7	7,8	11,1	11,7

Age and Sex Structure

The sex composition of the population indicates that there are more females than men, 52% and 48% respectively. The 2002 census indicates that the population of Zimbabwe is relatively young with 40, 1% aged below 15 years and 4% aged above 65 years. This is largely due to relatively high fertility and increased mortality in adult population aged 15-49 years due to HIV/AIDS. The youthful population implies future population growth as the young enter into the reproductive age group. The age group 15-64 constituted about 53% of the population between 1982 and 2002 and is critical for economic development and providing for the children and elderly.

Population Distribution and Density

The 2002 Census showed that the population density is 29 persons per square kilometer, indicating a rise from 27 persons per square kilometer in 1992. The population density has more than doubled since 1969 from 13 persons per square kilometer. More people in Zimbabwe reside in rural areas 65% (2002 Census). The proportion of people residing in urban areas has increased since independence from 26% in 1982 to 35% in 2002, with the Capital City (Harare province) the most populous with 16% of the country's population. This continued growth in urban population is associated with strain in provision of basic social amenities (infrastructure, housing, transport, health, education, water and sanitation). The rural to urban migration is mainly by young people, especially men, as they seek better economic opportunities in towns and cities. As a result there are more women than men in Zimbabwe rural areas. In an effort to regulate and minimize rural to urban migration, government established Growth Points in rural areas to create employment.

Fertility

The crude birth rate (CBR) in 2002 was estimated at 30 births per 1000 population. The CBR has been declining from 48 births per 1000 population in 1969, 39, 5 in 1982 and 34, 5 in 1992. Age specific fertility rate (ASFR) from the 2006 DHS indicates that child bearing peaks at ages 20-24 years and then drops sharply after 30-34 years.

Table 2 - Age Specific Fertility Rates 2006

Age	15-19	20-24	25-29	30-34	35-39	40-44	44-49
Rural	120	248	198	164	111	59	17
Urban	70	147	130	112	51	6	0

There has been a decline in fertility across all age groups since 1988. The biggest decline in fertility was observed among young women between age groups 25 to 34 years.

The total fertility rate (TFR) was 3, 8 in 2006, with rural women more likely to have more children (4, 6%) compared to urban women (2, 6 children). Women with no education have the highest fertility (6, 1 children per woman). Women in the lowest wealth quintile have higher fertility (5, 5 children) compared to 2, 3 children in women from the highest wealth quintile. Men generally prefer slightly larger families than women

Table 3 - Total Fertility Trends 1988 – 2006

1988	1894	1999	2006
5,5	4,3	4,0	3,8

The median age at first live birth is higher in urban areas (20, 7 years) than in rural areas (19, 6 years). The median age at first live birth is also related to education and economic status, with better educated and wealthier women having a higher age at first live birth and prefers fewer children.

Mortality

This general decline in mortality in the early years after independence can be attributed to massive investment in Primary Health Care (PHC) resulting in increased access to health care services throughout the country. This led to decline in maternal and child mortality. However with the advent of economic structural adjustment programme and reforms there was removal of consumer subsidies and reduction in government spending. This reversed the social gains of the first decade after independence. This scenario was worsened by the emergence of the HIV/AIDS epidemic. Mortality in the country has been increasing since the early 1990s, with higher mortality rates among men than females. This is true in all the other measures of mortality including infant and child mortality. The average life expectancy decreased from 58 to 53 years (males) and from 62 to 57 years, from 1992 to 1997. The life expectancy has further declined to 45 years in 2002.

Migration

Historically prior to independence, movement of black people was restricted in Zimbabwe. This resulted in selective migration of young men from rural areas to urban areas leaving the women, children and the elderly behind. After independence the restrictions were removed resulting in influx of people into urban areas. Rural to urban migration is the dominant type in Zimbabwe (78%). This is mainly due to limited economic opportunities and poor living conditions in rural areas. The 2002 land reform programme also resulted in some people moving from urban areas to the commercial farming areas. To reduce the rural to urban migration in Zimbabwe the government set up Growth Points and Vocational Training Centres to create employment. In addition the Rural Electrification Programme and the 'Give a Dam Project', were launched to provide reliable energy and water sources in the rural areas.

A large proportion of the population has migrated to neighbouring countries and abroad due to economic hardships. This has resulted in acute shortage of professional and skilled personnel particularly in health and education sectors. It is estimated that around 2 million Zimbabweans are in the diaspora, with largest percentage in South Africa.

The Elderly

Data on the elderly is very limited in Zimbabwe. The 2002 Census indicate that 5,6% of the population are over 65 years (2,5% males and 2,8% females. The HIV/AIDS epidemic is a major challenge, with the elderly now left to take care of a large number of orphans. In addition, the old are faced with a serious problem of food security, since they require special diet and are not able to work to provide for themselves and the orphans in their care. The Social Dimensions Fund provides social welfare support to old people but resources are not adequate. HelpAge Zimbabwe has several projects to support the elderly.

Persons with Disabilities

The Poverty Assessment Study (PASS) of 2003 showed that 3% of the population is living with disabilities. Rural areas were reported to have a slightly higher prevalence of persons with disability (3,3%) than urban areas (2,3%). Of all people with disability, only 10% had received assistance. In 2006, 0,7% of primary school pupils were disabled.

Economic Development & Poverty Reduction

At independence in 1980, Zimbabwe inherited a dual economy characterized by a relatively well developed modern sector and a largely poor informal sector. Employment levels were about 80% of the labour force. The manufacturing sector and agriculture have been the major drivers of the economy since 1980, contributing 20% and 16% of Gross Domestic Product (GDP) respectively. In the decade after independence a number of initiatives were developed which led to expansion of education, health and rural infrastructure¹. The real Gross Domestic Product averaged 3-4% per annum between 1988 and 1998.

However between 1991-1995 the GDP was now averaging only 1,5% with an annual inflation of 23% compare to single digit inflation in the 1980s. This was mainly a result of persistent droughts and the Economic Structural Adjustment Programme (ESAP) of

1991. From 1997 the GDP registered negative growth up to 2008. Between 1999 and 2003 Zimbabwe witnessed a dramatic decline in the flows of Official Development Assistance (ODA) and Foreign Direct Investment (FDI). During this period the economy was faced with a number of challenges which include among others

- Severe macro-economic instability, characterized by hyper-inflation and high unemployment of over 80%
- Low national savings as a percentage of GDP
- Low international investment
- Severe shortage of basic utilities including, electricity, fuel and water as well as basic commodities and drugs.
- Real Gross Domestic Product declined by over 50%
- Massive decline in agricultural production
- Manufacturing and service sectors were hampered by foreign currency shortages, loss of skilled labour and unreliable energy and water supplies
- Price controls and an over-valued exchange rate regime
- Low capacity utilisation
- Negative trends in mining and tourism sector

Table 4 - GDP Growth Rate 1990 - 2007

1990	1995	1996	1997	1998	1999	2000	2002	2003	2005	2007
7,0	0,2	10	1,6	0,1	-4,0	-8,2	-14,0	-13,9	-4,0	-4,3

Current trends indicate that poverty is on the increase in both rural and urban areas. Poverty is more common in female-headed households at 78% than in male-headed households at 58%. The Poverty Assessment Survey of 1995 indicated that 57% of the population lived below the Food Poverty line (FPL), rising to 69% in 2002. This led to the country adopting the Poverty Alleviation Action Plan (PAAP) in 1995, with targeted social expenditure and decentralized decision making for greater involvement of poor people. However the withdrawal of support by World Bank and IMF resulted in failure to fully implement the PAAP. The 2003 Poverty Assessment Study (PAS) indicated that the total consumption poverty increased from 42% in 1995 to 63% in 2003. This is a 51% increase in poverty incidence. During the same period food poverty increased from 20% to 48%. As a result more people moved into the very poor category instead of out of poverty. The poverty incidence was worse in rural areas (63%) compared to urban areas (53%), but poverty increased more rapidly in urban areas than in rural areas. Thus households in urban areas are most affected by the deteriorating macro-economic environment, especially unemployment. The Human Poverty Index (HPI) increased from 23,9% in 1995 to 33,1% in 2003.

The formal sector employment growth has declined from 2,7% before 1990 to (-1,7) by 2002, mainly due to massive retrenchments under ESAP and closure of companies due to macro-economic instability. Currently unemployment is estimated around 80%. This

has led to informalisation of the economy, and therefore a need to support small to medium enterprises in order to create employment and wealth. The government established the Ministry of Small to Medium Enterprises (SMEs) in 2001, to support upcoming entrepreneurs at grassroots with resources and setting up income generation projects. In 2003 the government launched the National Economic Revival Programme (NERP) to address the effects of ESAP and address the prevailing socio-economic challenges.

With the formation of the inclusive government in 2008, Zimbabwe launched the Short Term Economic Revival Plan (STERP). This led to stabilization of the economy and reduction of inflation. Benefits of STERP in the social sector included; re-opening of schools and hospitals; increased drug availability among others. Support to the health sector has been emphasized in the Short Term Emergency Plan (STERP) and the Mid-Term Plan of 2010-2015. The Inclusive Government has indicated its commitment to reaching the Abuja target of 15% of total government expenditures going towards the health sector.

In 2011 the government launched the Medium Term Plan (MTP) 2011-2015 with the theme, "Towards Sustainable Inclusive Growth, Human Centred Development, Transformation and Poverty Reduction". The MTP is the premier economic and social policy document of Zimbabwe. One of the focus areas of the MTP is improving social indicators including education, health, and population issues as they are fundamental for sustainable development of Zimbabwe¹.

Education

The literacy rate in Zimbabwe is at 97%, the second highest in Africa after Mauritius. Adult literacy rate has been increasing from 62% in 1982, 80% in 1992 and 97% in 2002. This was a result of the Adult Literacy Campaign launched soon after independence to enable those disadvantaged during the colonial era to get education. Literacy rates are higher in men than women in all age groups.

The post-independence era witnessed the massive expansion in the educational system especially basic education, with almost universal primary education for all. However women are still generally disadvantaged compared to men in terms of access to education. Net enrolment for primary education increased from 81,9%% in 1994, to 92% in 2003 then 97% in 2006, with the country almost achieving universal primary education. However it should be noted that net enrolment does not translate to effective access, as actual attendance is lower than enrolment due to absenteeism, poverty, illness and hunger, given the current economic challenges and the HIV/AIDS epidemic. This is compounded by lack of adequate teachers in schools. The gender gap in primary schools has generally been closing since independence. Secondary school enrolment ratios are lower than those at primary school, with an evident gender gap. Primary school completion rates have declined from 73,2% in 1995 to 67,6% by 2004. The secondary school completion rates are generally higher, with an overall peak of 87,6% in 2006. Females have lower completion rates than males in secondary school, 83% and 92% respectively. There is a higher drop-out rate among girls compared to boys from primary to secondary school, with fewer girls than boys proceeding to

secondary school from primary school. At tertiary education level female enrolment is generally about 30%, with exception of teacher training colleges and nursing colleges where female enrolment has been over 50%. The drop in the number of teaching staff has had an impact on the pupil to teacher ratio and ultimately the quality of education.

Policies and programmes have been put in place by government to promote universal quality education for children in Zimbabwe. These include the National Strategic Plan for Education and Vulnerable Children of 2006, the Girl Child Education Policy and Early Childhood Development (ECD). Social Safety Nets in Education, including Basic Education Assistance Module (BEAM) of 2001 were established to provide education assistance to orphans and vulnerable children. Introduction of School Development Committees/Associations was meant to involve parents in the running of schools and to improve standards.

Population and Environment

Agriculture and Land Reform Programme

Agriculture is the mainstay of the Zimbabwe economy contributing almost 20% of GDP. In addition, agriculture is interlinked to other key sectors of the economy especially the manufacturing and processing industries. The agricultural sector declined by an average of 2,4% between 2000 and 2007, mainly due to combination of poor rainfall and inadequate inputs. This has resulted in shortage of basic foodstuffs leading to poor food security and malnutrition in the country.

Increasing agricultural production depends on ensuring more land is under irrigation. Currently the country has a total of 174 000 hectares under irrigation, with 139 000 hectares in the former large scale commercial agricultural sector. The total irrigation potential for Zimbabwe is estimated at 240 000 hectares, which is targeted by 2015.

Before and immediately after independence there was imbalance in the ownership of land in Zimbabwe, with 6 000 white commercial farmers owning 15,5 million hectares, whilst the black majority communal farmers had 16,4 million hectares of land. To ensure equity and sustainable growth, the government embarked on a land reform programme in 1983. However this initial initiative was slow with very few people allocated land. In 2002 the government then launched the Fast Track Land Reform Programme which led to over 135 000 families being beneficiaries of land, with a total of 6,4 million hectares allocated. Long term leases were given for tenure security to indigenous commercial farmers. To support the new farmers and to increase productivity the government provided input schemes and equipment for mechanization through the national budget.

Environment

The total land area covered by forest has been falling significantly, signifying massive deforestation of around 140 000 hectares per year (MDG Report 2007). The total land area covered by forest decreased from 58% in 1990 to 45% by 2003. This deterioration of forests is mainly due to economic hardships and high population density in some communal areas. Poor forest management, increasing use of firewood in urban areas and opening up of land for agriculture being the major causes of deforestation. Use of

firewood is increasing due to electricity shortages and the lack of alternative fuels such as coal and paraffin. The country introduced a programme of afforestation but this is not able to keep pace with rate of deforestation. Over the years it is estimated that 17 million trees have been planted in the country.

The Environment Management Act 2002, the National Environmental Policy, and the Environmental Strategic Plan of 2003 provide a comprehensive framework for mainstreaming environmental issues into national policies and programmes to ensure sustainable land use and protection of the environment. Other institutions mandated to manage the environment include the Parks and Wild Life Management Authority, Zimbabwe National Water Authority, Forestry Commission and the Rural Electrification Agency

Energy Sources

In Zimbabwe the main sources of energy include wood, electricity, petroleum fuels and coal. The 2006 DHS indicates that 37% of households in the country have electricity supply (91% in urban areas and 9% in rural areas). The most commonly used fuel for cooking is firewood (66%), followed by electricity (33%). The use of wood fuel as an energy source is not sustainable as the rate of use exceeds natural annual yield. There is generally shortage of electricity in the country and the shortfall in generation capacity is met by importing power from neighbouring countries (Mozambique, Zambia, Congo and South Africa). In addition Zimbabwe imports all of its petroleum and this constitute large foreign currency expenditure annually.

Water and Sanitation

The majority of households (78%) have access to safe water, with urban areas having 99% of the households accessing safe water compared to 67% in rural areas. In recent years households in urban areas have been experiencing erratic water supplies, compromising access to safe water. The shortage of water in urban areas is primarily due to inadequate infrastructure; old equipment; shortage of water treatment chemicals; power cuts at water treatment plants; and the rapid expansion of residential areas. This has led to outbreaks of diseases like cholera in some cities and towns in last few years. In rural areas siltation of rivers due to deforestation and poor agricultural activities has significant reduction of water sources. Through the drilling of boreholes and construction of deep wells the access of safe water in rural areas increased from independence to about 75% in 1999. However this has decreased to about 67% in 2003 due to inadequate investments and poor maintenance of water infrastructure.

In 2006, 40,1% of the population had access to improved sanitation facilities. The proportion of households with access to improved sanitation is higher in urban areas (58,5%) compared to rural areas (30,5%). There has been a general decline of access to improved sanitation in both urban and rural areas between 1999 and 2006.

Housing

The demand for housing has been growing since independence, outstripping the capacity of government and Local Authorities to provide adequate and affordable

accommodation. The annual target of 250 000 housing units per year has not been achieved. In rural areas the challenge is to improve the quality of housing. This led to the government setting up the Ministry of Rural Housing and Social Amenities to embark on a Rural Housing Programme.

Health and Development

The Zimbabwean health system has been in decline for more than a decade and the result is a systematic decrease in coverage of most basic services and a rising maternal and child mortality rate. This is most noticeable in key areas of maternal and child health, such as the Expanded Programme on Immunization and obstetric care for pregnant women, once high-performing core elements of Zimbabwe's Primary Health Care System. The disparities between urban and rural access to health care continue to grow. An ambitious National Health Strategy is now in place that covers the period 2009-2013. The Health Sector Investment Case, 2010-2012, outlines the key package of health services, the key health system bottlenecks to be overcome, the desired coverage targets, the incremental costs and the expected achievements in relation to the health MDGs.

The investment case validates the historical focus of the Ministry of Health and Child Welfare on Primary Health Care, with a strong focus on community-based approaches, complemented by robust referral systems and facilities. Under the most ambitious scenario in the investment case, an additional investment of 700 million USD over 3 years or around 19 USD per capita is required to achieve a reduction in under-5 and maternal mortality of 38% and 17% respectively. The Ministry is currently undertaking a mapping exercise to determine the current resources available, mostly through the support of bilateral and multilateral partners, in order to determine the precise financing gap. Concerted efforts will then need to be made in order to expand the fiscal space available for the health sector through internal and external sources.

Further efforts will now be made to ensure that both government resources and external aid are focused on the national health packages and priorities outlined in the investment case. While it is clear that more aid is required, it is also clear that there are risks of fragmentation of the assistance for the health sector, unless the health system is supported more broadly to deliver on the health MDGs in Zimbabwe.

Reproductive Health and Maternal Health

Maternal mortality remains a cause for concern, as most maternal deaths are preventable through increased access to antenatal, delivery and post natal care. The 2005/06 Zimbabwe Demography and Health Survey showed that maternal mortality ratio has been rising from 283 per 100,000 live births in 1994 to 578 and 555 per 100,000 live births in 1999 and 2005/6 respectively. This sharp rise in maternal mortality is largely explained by the rapid spread of the HIV and AIDS epidemic. The Maternal & Perinatal Mortality Study of 2007 shows that the maternal mortality has risen further to 725 per 100 000 live birth, with HIV&AIDS related deaths accounting for 25.5% of all maternal deaths.

Table 5 - Maternal Mortality Trends 1994 – 2007

1994	1999	2006	2007
283	578	555	725

The 2004 Maternal and Neonatal Health Services Assessment found out that maternal deaths were due to three delays. The first delay was identified as the time lost in recognizing the seriousness of the situation and deciding whether or not to seek medical attention. The second delay was the time needed for reaching a health facility or a trained service provider, once a decision was taken to seek care. The third delay is that of receiving expeditious and effective care, once the challenge of referral was overcome.

Appropriate care during prenatal pregnancy, delivery and postnatal care, are important for the health of both the mother and the baby. There has been an increase in women attending at least one antenatal care visit from 81% in 1999 to 94% in 2006 (ZDHS) and 93% in 2009 (Multiple Indicator Monitoring Survey - MIMS). Coverage of antenatal care is slightly higher in urban areas than in rural areas. Skilled attendance at delivery, declined from 73% in 1999 to 69% in 2006 (ZDHS), and then fell to 60% in 2009 (MIMS). Institutional deliveries declined from 72% to 68% over the same period (ZDHS 1999, 2006), and subsequently to 61% in 2009 (MIMS).

Perhaps the most important intervention to reduce maternal and neonatal morbidity and mortality is to develop and sustain a strong national Family Planning programme, designed to prevent unwanted pregnancies, and to encourage child spacing

Family Planning

The Contraceptive Prevalence Rate or the percentage of currently married women, using a family planning method in Zimbabwe, has increased steadily from 35% in 1984 to 60% in 2006; the CPR was reported as 65% in 2009 (MIMS 2009). This is now one of the highest rates in Sub-Saharan Africa. This is in sharp contrast to the knowledge level of modern methods of family planning, which is almost universal at 99%. This may imply that knowledge levels of family planning are not necessarily translating to actual use of contraception. The Total Fertility Rate has declined from 5.5 in 1988 through 3.8 in 2006 (ZDHS, 2005-6) to 3.7% (MIMS 2009).

According to the ZDHS 2005/6, the unmet need of family planning stands at 13%, which signifies an increase of 2% from the previous ZDHS. This presents an anomaly as generally, the rise of CPR should conversely signify the decrease in the unmet need. The family planning method most commonly used is the pill (43%), followed by injectables at 10%. These commonly used methods in Zimbabwe do not protect against the transmission of STIs including HIV/AIDS. The Behavioural Change Strategy also outlines that condom use in regular and marriage relationships remains

low (about 1%), despite the fact that being in long term relationships is not necessarily a protective factor against STIs and HIV/AIDS.

After independence, the ZNFPC made significant strides in ensuring a wide coverage in FP service provision. However, these gains have been seriously negatively affected in the recent past mainly by macro-economic challenges affecting the nation. The declining number of Community Based Distributors (CBDs), due to natural attrition or retirement has drastically reduced the coverage of family planning services at community level.

Service delivery, through the clinics has been affected by shortage of fully qualified staff and this has affected the provision of comprehensive and quality services, particularly long-term and permanent family planning methods.

Children and Child Health

The child mortality rate reflects the level and burden of poverty and is consequently a sensitive indicator of socio-economic development. The under five mortality rate (<5MR) has been rising from 77 per 1 000 live births in 1994 to 102 per 1 000 live births in 1999 (ZDHS). The rate then decreased to 97 per 1 000 live births in 2009 (MIMS). The infant mortality (IMR) also followed the same trend and is currently at 67 per 1 000 live births (MIMS 2009). The rise in mortality between 1994 and 1999 was mainly attributed to the direct and indirect impact of the HIV and AIDS epidemic, declining coverage of immunisation against childhood illness, malnutrition and the concomitant rise in poverty levels. The proportion of children 12-23 months fully immunized has dropped from 67% in 1997 to 49% in 2009 (MIMS).

According to a recent Child Health Situation Analysis Study (2006), the recent decline in child mortality rates could be linked to the overall decrease in HIV incidence and prevalence and greater access to opportunistic infection treatment for children using cotrimoxazole. The Integrated Management of Childhood Illnesses (IMCI) is a broad strategy which was adopted by the Ministry of Health and Child Welfare in 1999 in order to address child health problems and ensuring maximum development of the child. The overall objective of the strategy is to contribute towards the reduction of child morbidity and mortality.

The Ministry of Health & Child Welfare reports indicated that under-nourishment in children below 5 years rose from 13% in 1999 to 20% in 2002. The 2002 National Nutritional Assessment Study estimated that 11% of the children in urban areas and 26,5% of the children in rural areas were malnourished. The Poverty Assessment Survey of 1995 showed that 61% of children under-five years were taking 3 meals a day, leaving a big proportion under risk of malnutrition.

A number of programmes to improve the status of child health have been put in place in Zimbabwe. These include; Child Supplementary Feeding Programme; Vitamin A Supplementary programme, Expanded Programme of Immunisation (EPI); PMTCT Programme; Village Health Worker programme. In addition there is a Zimbabwe Children Act that protects children from abuse, and neglect. Zimbabwe is a signatory to

the UN Convention on the Rights of the Child and is a State Party to the African Charter on the Rights of the Child.

Adolescents and Youths

The ICPD (1994 Cairo), embraced the new broader concept of RH and Rights that include ASRH. Prior to the ICPD, Zimbabwe health programmes were mainly targeting the needs of women of child bearing age and children under-5 years. Adolescents were being left out on the assumption that they were the healthiest segment of the population. Since then the MOH&CW has remained committed to the improvement of the reproductive status of young people (10-24yrs), who constitute 36,4% of the population (Census 2002). Young people in Zimbabwe face considerable challenges as they grow up which threaten their individual and collective survival, yet they are the future generation. However, there has only been limited coverage of services in a few districts in the country. Sexual and reproductive issues affecting the youth include, HIV/AIDS epidemic exposing young women to extraordinary high rates of new infections, high level of teenage pregnancies and limited access to sexual and reproductive health rights. Of particular concern is the vulnerability of young women to maternal mortality, due to gender inequality, low access to education, early marriage, adolescent pregnancy and low access to sexual and reproductive health services.

Over the past decade Zimbabwe has developed a number of policies and strategies to facilitate ASRH service provision. These include the National RH Policy, National RH Service Guidelines, the Zimbabwe National HIV/AIDS Strategic Plan (2006-2010) and the Zimbabwe Maternal and Neonatal Road Map (2007-2015). A number of ASRH programmes have therefore been developed within this context by the Ministry of Health & Child Welfare, Zimbabwe National Family Planning Council, National AIDS Council, other ministries (Youth & Gender, Education), and several NGOs. The ASRH Strategy (2010 – 2015) reaffirms this commitment through refocusing and realigning its priorities with regard to sexual and reproductive health for young people for the period, in line with the MDGs.

The MOHCW has the primary responsibility for providing and coordinating the provision of ASRH services in Zimbabwe in collaboration with ZNFPC and NAC. It works closely with the ZNFPC, especially in provision of FP, IEC and Youth Centres services. The components of the ASRH programme in Zimbabwe include; training of service providers and Peer Educators; establishment of Youth Centres and Youth Friendly Corners; procurement of commodities (contraceptives, STI drugs, HIV test kits and condoms); production and distribution of IEC materials and BCC. To ensure a holistic and comprehensive programme the MOHCW uses a multi-sectoral approach by engaging other government departments, ministries, and NGOs. However the information dissemination and programme coverage is not adequate. Through the ASRH Strategy 2011-2015 the MOHCW has ensured a standard package for comprehensive services for young people. Service provided for young people include FP, MCH, STI, HIV, Post Abortion Care, Emergency Contraception but these are not universally available in all areas in the country. In addition the accessibility and utilization of services by young people is limited due to restrictive operating hours, transport costs and lack of privacy.

UN agencies have been supporting national efforts to improve sexual and reproductive health education and services for young people in Zimbabwe. Areas of support by the UN family include; sexual and reproductive rights, sexual and reproductive health research, promotion and scaling up evidence based interventions, multi-sectoral approach in young people interventions, and the provision of norms and standards in programming for young people.

The Ministries of Education Sport & Culture; and Higher & Tertiary Education espouses and promotes abstinence and it endeavours to provide life skills, HIV/AIDS information, SRH information, BCC to in-school young people. The education ministries provide gender sensitive learning and teaching materials for the empowerment of both girls and boys.

The Ministry of Youth Development, Indigenisation and Empowerment has the primary responsibility for overall youth development and empowerment issues to ensure poverty reduction and better economic prospects. This is through skills development and entrepreneurship programmes. Through vocational training centres (a total 42 in the country) the ministry offers a range of trainings to empower young people with skills to be self sustainable and start their own businesses and projects in areas like horticulture, agriculture, catering, metal work, carpentry etc. To support young people establish their businesses the government set up a Youth Development Fund in 2006. In addition there is a Zimbabwe Youth Council to ensure efficient and effective youth participation in the social and economic development of the country.

About 8% and 18% of single female and male adolescents (15-19 years) respectively had had sex in the last 12 months preceding the 2006 DHS. In those aged between 20-24, 27% of females and 46% of the males had had sex in the year preceding the 2006 DHS. The majority of (75%) of the female adolescents who had had sex indicated that their first encounter was wanted. However the younger the age, the more likely they were to have been forced into sexual intercourse, and mostly by people they knew (partner or boyfriend).

Age at first sex was reported to be below 15 years by 4,9% and 5,2% of females and males respectively by those aged 15-19 years during the 2006 DHS. The median age at first sexual intercourse was about 19 years for both females and males in the 20-24 year age group. Young females in rural areas were noted to have experience sexual intercourse earlier than their urban counterparts, for example 23% of urban female adolescence (15-19 years) had experienced sex compared to 35% in rural areas.

About 24% and 97% of sexually active female and male adolescents (15-19 years), respectively and about 13% and 70% of sexually active female and male young people (20-24), respectively had had high-risk sexual intercourse, in the past 12 months before the 2006 DHS. However, 43% and 68% of sexually active female and male young people who had had high risk sexual intercourse, in the year preceding the DHS had used a condom. The 2007 DHS also showed that 5% of adolescent girls (15-19) who had higher risk sex had had intercourse with a man 10 or more years older than themselves. About 3,3% of young men 15-24 years had paid for sex in the year before the 2006 DHS.

About 6% of the 15-19 year old adolescents and 9% of those aged 20-24 were pregnant at the time of the DHS in 2006, (majority of these were in rural areas), whilst 72% of the female young people (15-24) who had begun child bearing were aged 15-19 when they first gave birth. About 4% of female young people who were interviewed in the DHS reported ever had a terminated pregnancy, with a higher proportion in rural areas. About 43% of female young people managed to attend ANC and the majority of young women had delivered within a health facility (94% in urban areas and 66% in rural areas. Over 95% of young people knew a modern method of contraception, 34% and 40% of male and female young people, respectively had ever used a modern contraceptive method.

The HIV prevalence for young people (15-19 years) in 2006, was 6,2% in females and 3,1% in males; and for the age group 20-24 years the HIV prevalence was, 16,3% in females and 5,8% in males. Urban young people were slightly more likely to be infected with HIV. The level of education has an inverse relationship with HIV prevalence. Use of condoms in unmarried sexually active young women is lower compared to their male counterparts (40% and 67% respectively). This is despite that 66% of young people knew at least one source of condoms.

HIV and AIDS

Zimbabwe is experiencing one of the worst HIV epidemics in Southern Africa, which threatens the socio- economic fibre of the country, and places a tremendous strain on the capacity of the health sector to respond to the health needs of the population. Zimbabwe responded to the epidemic by setting up the National AIDS Council to coordinate the national response and declaring HIV/AIDS a national emergency. To raise resources to scale up interventions to control HIV/AIDS the government established the AIDS Trust Fund or AIDS levy (3% of taxable income) in 1999.

The National HIV/AIDS Policy and the Zimbabwe National HIV and AIDS Strategic Plan (2006-2010) (ZNASP) the Health Sector HIV Prevention Strategic Framework were developed to guide the national response towards HIV. According to National HIV and AIDS Estimates of 2007, HIV prevalence in Zimbabwe peaked at 29.3% around 1997, before gradually declining to 26.5% in 2001, 23.2% in 2003, 19.4% in 2005 and 15.6% in 2007. Although the country has reported a decline, HIV prevalence still remains high. The declining HIV prevalence was first observed in the late 1990's and was supported by data from Antenatal Clinic surveillance (ANC) 2002, HIV and AIDS estimates from modeling and the population based survey, Demography and Health Survey of 2005/06. With increase in availability of antiretroviral therapy (ART), it is expected that prevalence will stabilize and then begin to increase once again as a reflection of survival on ART. The estimated number of adults and children living with HIV and AIDS is 1,189,279 (1,078,758 – 1,312,981) in 2009 - (2009 HIV Estimates – April 2010). The HIV prevalence among pregnant women 15-49 years has declined from 17.7 % in 2006 to 16.1% in 2009 ($p < 0.001$). A similar trend was observed in the 15-24 age group where HIV declined from 12.5% in 2006 to 11.6% in 2009 ($p < 0.001$). High HIV infection rates were observed among women 30-34 (24.9%) and 35-39 (24.6%) years of age - (2009 ANC Surveillance Report).

The DHS of 2006 reported an HIV prevalence rate of 18,1% among adults 15-49 years, with HIV prevalence being higher in women (21,1%) compared to men (14,5%). Of the estimated 1,1 million people living with HIV, 60% are women. Women are more vulnerable to HIV infection than men due to several factors including, physiological, socio-cultural and gender inequality.

Table 6 - HIV Prevalence 2001 - 2009

	2001	2002	2003	2004	2006	2007	2009
Adult Prevalence	26,5		23,1		18,1	15,6	14,3
ANC Prevalence		25,7		21,3	17,7		16,1

The ZNASP and the Health Sector HIV Prevention Strategic Framework have both identified HIV Testing and Counseling (HTC) as an important component of the national response. Given the importance of HTC as a gateway to HIV and AIDS prevention, treatment and care interventions, the MOHCW has developed this strategic plan to guide the scale-up of HTC towards universal access by 2010. The goals described in the national HTC strategic plan 2007- 2011 aim to reach universal access to HTC by 2010 with 85% of the Zimbabwean population, children and adults, knowing their HIV status and to increase the coverage of HIV testing and counseling services enabling access within a 10 km radius in all districts by 2010. Awareness and demand creation for HTC through a comprehensive integrated communication strategy, which should inform about client initiated testing and counselling (CITC) as well as provider initiated testing and counselling (PITC) are important to ensure uptake of the services provided among the different target groups. The strategy also emphasises on further expansion of CITC services in rural areas and to most at risk populations through expansion of mobile services and community and home based counselling and testing. There is need to strengthen the integration of PITC at all levels of health care in the private and public sector.

PMTCT is a key strategy in Zimbabwe's National HIV/AIDS strategy, and has been given prominence in Zimbabwe's National Health Strategy, being recognized as a tool to improve maternal health, reducing maternal morbidity and mortality towards attainment of MDG 5, as well as significantly reducing new paediatric HIV/AIDS cases. Zimbabwe has recently launched the campaign to Accelerate Reduction in Maternal Morbidity and Mortality (CARMMA), at which the contribution of HIV/AIDS to maternal and child morbidity and mortality was highlighted. The rights of women to focused ANC, together with access to a skilled birth attendant is an area of emphasis for the CARMMA, as well as strengthening comprehensive PMTCT that takes into account the sexual and reproductive health needs of all women, including those that are HIV positive; using a human rights based approach. The current challenges in the PMTCT programme include a low percentage of women counseled for HIV (66%), and those tested for HIV during ANC visit for the last pregnancy (58%) - (MIMS 2009).

Zimbabwe has adopted the United Nations “4 pronged” approach towards the prevention of mother-to-child transmission of HIV i.e. 1) Primary prevention of HIV infection in women and girls; 2) Prevention of unintended pregnancy in women living with HIV; 3) Prevention of vertical transmission in pregnant women living with HIV and 4) provision of comprehensive care, treatment and support to women with HIV and their families. It can be understood that these four prongs together encompass many aspects of an entire HIV response. The extremely cross-cutting nature of PMTCT services means strategic actions related to all four prongs are also found in many other strategy documents including HIV Testing and Counseling, Antiretroviral Treatment, the National Behaviour Change Strategy, Maternal & Neonatal Health Roadmap and the Child Survival Strategy.

In addition to the HTC and PMTC components of the HIV programme the country is also increasing access to ART, care and support to HIV+ people. The goal of scaling-up ART is to reduce morbidity and mortality due to HIV and AIDS, and to improve the quality of life of people living with HIV and AIDS in Zimbabwe in the context of comprehensive care. However the coverage of treatment and care services remains low relative to the burden of HIV/AIDS, with only 54% and 57% coverage of ART for adults and children respectively. To achieve better coverage, the country adopted strategies including, expanding the provision of ART services in all sectors through decentralization with special attention to pregnant mothers ; development of human capacity, through OI/ART training and mentorship, to provide ART; ensuring availability of quality AIDS medicines, diagnostics and supplies; strengthening community involvement in the provision of ART through Community Empowerment and Mobilisation for Improved Access to Care, Support and Treatment (CMEIAST); strengthening of systems for ART programme monitoring, including patient tracking, HIV drug resistance surveillance, evaluation and research; resource mobilization for increasing access to ART; strengthening ART programme management, coordination and supervision; strengthening public-private partnership; strengthening TB/HIV collaborative activities and advocacy for a supportive environment (including policies and legislation) to ensure a sustained environment for scaling up ART; and community and home based care.

Gender Equality, Equity and Women Empowerment

Women constitute over 50% of the population and produce 80% of the agricultural output in Zimbabwe. The National Gender Policy was adopted in 2003 in order to address the gender disparities existing in the country. In addition there is also the Public Sector Gender Policy 2004, the Sexual Offences Act, Domestic Violence Act 2007, Women Parliamentary Caucus, and the University Affirmative Action Policy to increase women enrolment. Zimbabwe is a signatory to several regional and international conventions, protocols and declaration that promote gender equality and human rights. These include the Convention on Elimination of all Forms of Discriminations against Women (CEDAW) 1991, the Beijing Platform of 2005, and the SADC Declaration on Gender and Development. The country is also committed the attainment of Millennium Development Goals on “Universal Access to Primary Education” and “Promote gender

Equality and Empower Women". This has resulted in an improvement in the collection, dissemination and utilization of gender-disaggregated data in many sectors.

The marginalization of women regarding inheritance and property sharing at divorce or death of the spouse is a common problem in the country, with women denied the right to inherit or share property equitably. The death of the man frequently results in complicated inheritance issues, which can lead to the impoverishment of women and girls, if customary inheritance practices are followed as these continue to favour male heirs over women and girls. As long as these cultural practices continue to be practiced they will act as barriers to universal access as they predispose women and girls due to HIV.

The gender imbalances that exist in access to education which translates to gender inequity areas of employment, health status, poverty and decision making. Women are more likely to be found in the informal sector economy which in most cases is non-value producing activities. Women in the informal sector are poor due to the fact that their work is poorly recognized and poorly paid. The informal sector receives very little national resources, as most national policies support the formal sector. The percentage of women in the informal sector increased from 64% in 1984 to 75% in 2000. There are gender disparities in access to land, with very few women (15%) having benefited from the land reform programme, compared to the government target of 20%.

The proportion of women in decision making positions is very low. In 2008 elections, only 29 (26%) women were elected into parliament, below the SADC quota of 30% women representation in top positions. This was however a significant increase compared to 16% representation in the previous parliament of 2005-2008, and at independence when women constituted only 9% of the legislature. At ministerial level there were only 4 women out of 32 Ministers (13%) in 2005. A decline from 14% in 2000 and 19% in 1998. The 2006 Human Development report noted that out of 10 Governors in 2005, 2 were women. The proportion of women councilors in Local Authorities increased from 2,7% in 1998, 4,3% in 2003 and 18,6% in 2006, but is way below the SADC benchmark of 30%.

Zimbabwe is a patriarchal society, largely characterized by male dominance thereby exposing females to reproductive health problems more than their male counterparts. Gender inequality and widespread negative cultural practices such as polygamy, wife inheritance, multiple and concurrent sexual relationships and cross-generational sex are some of the factors which fuel Zimbabwe's HIV epidemic, particularly among women and girls. Stigma and discrimination associated with HIV and AIDS are also preventing many from knowing their sero-status. The inability of many to talk about HIV status or sexual relations also creates barriers to behavior change. The practice of polygamy is discriminatory against women as it allows men to enter into multiple relationships which impose various pressures on family resources.

Gender-based violence is a key factor in women's vulnerability to HIV as forced sex does not allow negotiation for condom use. The risk of HIV transmission is greater when

sex is forced and therefore the need to address the inter-linkages between sexual violence and HIV and AIDS in national programming. Sexual violence crimes are under-reported as they evoke shame and blame, social stigma, and often rejection by the survivor's family and community. Statistics¹ on rape survivors provided by the Adult Rape Clinic provide telling evidence of the linkages between gender based violence and HIV. Most rape survivors are presenting late due to lack of knowledge of services available for survivors, the complexities of accessing services and in instances cases being dealt with at family level. The statistics revealed (35.5%) survivors were raped by strangers while (64.5%) were raped by persons known to them. These include boyfriends, religious sect leaders and relatives. There is need to increase public awareness on the consequences of not presenting to the clinic within 72 hours of rape both on the part of the public and the police.

Emerging Issues on Population and Development

Despite economic challenges faced in the past decade, Zimbabwe has made some notable achievements:-

- HIV/AIDS prevalence declined from 29% to 14% over the last two decades, becoming the first country in Southern Africa (and Second in Africa) to achieve that feat. This has been due to multi-sectoral collaboration and government commitment. The challenge now is to sustain the trend and maintain behavior change.
- Great strides have been made in the family planning area with a rising CPR which has surpassed the target of 52% by 2002, set by the National Population Policy. The current CPR of 60% is one of the best in Sub-Saharan Africa.
- A decline in fertility has been realized. The TFR of 3,8 in 2006, was close to the Population Policy target of 3,5 by 2002.
- There has been an improvement in the collection, dissemination and utilization of gender-disaggregated data in all sectors.
- High literacy rate have been achieved due to high enrolment into primary school education and the Adult Education Programme.

However challenges still exist and these include:-

- Population growth exceeded the economic growth over the last 2 decades due to declining GDP. Negative GDP growth was been registered between 2000 and 2008, whilst the population growth rate was 1,1% in the same period
- The eradication of poverty still remains a major obstacle as poverty levels have been rising over the past 10 years. The standard of living has been falling over the last decade. The target of the Population Policy was to reduce poverty from 45% in 1995 to 20% by 2005. Poverty levels have been increasing due to poor economic performance, low productivity in agriculture, declining industrial activity, and the impact of HIV/AIDS

- To reduce rural to urban migration government set up Growth Points, started the Rural Electrification programme, and built community dams to create employment opportunities and income generation activities.
- There is limited application of gender analysis in formulation of policies and strategies at all levels. In addition the involvement and participation of women in decision making is limited, mainly due to existing socio-cultural attitudes, beliefs, practices and norms.
- Zimbabwe Constitution, the country has a dual legal system allowing Customary Law to co-exist with General Law. Thus section 23 of the constitution allows discrimination against women in application of Customary Law in matters relating to adoption, marriage, divorce, inheritance of property etc.
- The socio-economic challenges continue to hinder the attainment of universal education for children, due to non-attendance and children dropping out of school. The quality of education has also been declining due to inadequate staff and learning materials
- The HIV/AIDS epidemic still remains a big concern despite declining prevalence. Zimbabwe still remains one of the high burden HIV/AIDS countries in the world. The disease has resulted in high morbidity and mortality in adults and children, stigma still a major issue. Inadequate resources have resulted in many people failing to access treatment and care for HIV/AIDS.
- High maternal mortality due to lack of skilled manpower, poor transport and communication systems, poor community awareness, inadequate equipment and drugs. This is compounded by declining skilled attendance at delivery and high number of adolescent pregnancies.
- The unmet need for family planning is relatively high (13%), and is coupled with the low uptake of long acting and permanent family planning methods.
- Poor method mix for family planning methods and a high unmet need of family planning remain an obstacle to better quality of service
- The target of the Population Policy was to have immunisation coverage in children of all vaccines of over 90% by 2005. However the coverage of immunization had dropped to a 53% by 2006. In addition levels of malnutrition have increased among children under-5 years.
- Children health and welfare is greatly compromised due to poor food security, poverty and hunger, HIV/AIDS, poor access to safe water and sanitation and low levels of immunization.
- Due to deaths of adults in the productive age groups there is an increasing number of orphans which are now under the care of the elderly (especially grandparents)
- The proportion of people residing in urban areas has increased from 31% in 1992 to 35% in 2002. This has resulted in urban areas failing to cope with the provision of basic services and amenities including housing, health, and water and sanitation. The current infrastructure cannot sustain increasing population.
- Young people, especially women facing serious challenges in accessing reproductive health services exposing them to unintended pregnancies, unsafe

abortion, HIV/AIDS and physical/emotional abuse. The economic challenges and poverty has worsened the plight of young people threatening their livelihoods.

- The Population Policy of 1998 is outdated and need to be reviewed in line with current trends in population and development.
- The exodus of Zimbabweans to other countries has created new kinds of families in which a single parent is left alone looking after the children, or both parents go abroad leaving many child-headed families.
- There is limited data on elderly people and the disabled making programming for this vulnerable groups difficult
- Provision of safe water and sanitation remains a challenge in both urban and rural areas.
- Implementation of the provisions of the Environment Management Act is key to ensure sustainable development, but this has not been done to the full extent. There is need for a comprehensive energy policy to address current energy problems, with focus on alternative sources and renewable energy. There is need to strengthen the re-forestation programme, land reclamation and natural conservation programmes for environmental sustainability.
- Provision of decent accommodation in urban areas and improving quality of houses in rural areas is a priority.

Conclusion and Way Forward

The key challenge to the implementation of the Population Policy is putting in place an appropriate and effective coordinating and monitoring institutional framework.

The following strategies are critical to further strengthen the population and development agenda in Zimbabwe:-

1. Macroeconomic Stability
 - Maintaining the economic recovery momentum and consolidate gains of the inclusive government
 - Resource mobilization internal and external to support the Population and Development Agenda.
 - Reviewing the Population Policy of 1998
2. Improving Access to Comprehensive RH Services (including FP)
 - Provision of services to marginalised populations (including new settlements)
 - Increasing coverage of ASRH services
3. HIV/AIDS
 - Reducing incidence and prevalence of HIV/AIDS
 - Providing care and support for people living with HIV/AIDS
 - Scaling up PMTCT programme to eliminate parent to child transmission of HIV/AIDS
4. LEGAL
 - Constitution amendments to promote gender equality

5. SOCIO-CULTURAL

- Addressing negative socio-cultural beliefs and practices

6. Monitoring and Evaluation

- Mechanism for timely and accurate data for monitoring implementation of ICPD-Plan of Action and MDGs

Table 7 - Key Development Indicators Table

INDICATOR	1990	1995	2000	2002	2003	2005	2009	MDG TARGET 2015
Real GDP Growth	7,0	0,2	-8,2	-14,5	-13,9		6,3	5
Population Growth Rate	2,5		2,5	1,1	0,3			
Population Below the Food Poverty Line (%)		57		69				35
Population Below the Total Consumption Poverty Line (%)		74		80				40
Human Poverty Index (%)			36					18
Net Enrolment Ratio, Primary Education (%)		82		93				100
Completion Rates – Primary Education (%)	83	75	75					100
Literacy Rates, 15-24 yrs (%)	95	98						100
HIV Prevalence (15-49 yrs)			28			18,1	13,7	16

Crude Death Rate			17,2				20	
Maternal Mortality Ratio		283	578			555	725 (MNMS)	174
Skilled Attendance at Delivery (%)			72,5			68	60 (MIMS)	100
Under 5 Mortality Rate			102			82	86 (MIMS)	34
Infant Mortality Rate			65			60	60 (MIMS)	22
Stunting in Children under 5 year (%)			27			29	35	7
Children 12-23 Months Fully Immunised		74	67			53	49 (MIMS)	90
Life Expectancy			45			43	43	
University Enrolment, Women (%)		30	32					50
Women in Senior Government Position (%)	22		30					50
Unemployment Rate (%)			50				80	10
Safe Water Access, Rural Areas (%)		73	75					100
Safe Sanitation Access, Rural Areas (%)	48	56	58					100

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