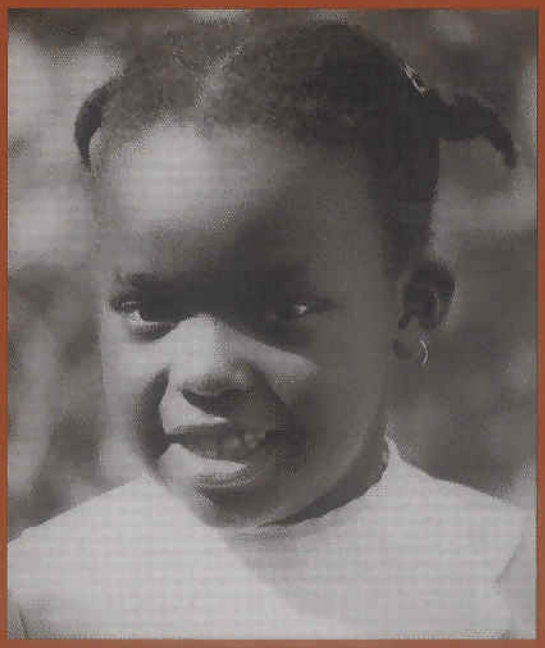
Zimbabwe

Demographic and Health Survey (ZDHS)
Key Findings Report



1999

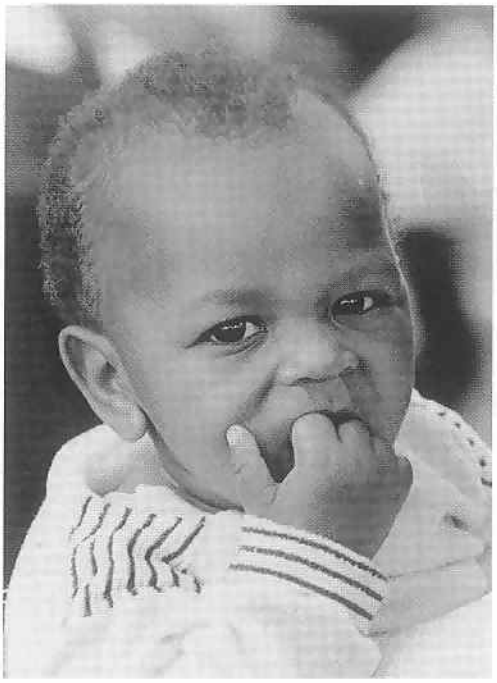
The 1999 Zimbabwe Demographic and Health Survey (ZDHS) was conducted by the Central Statistical Office (CSO) from August to November 1999. ORC Macro provided technical assistance and funding for the project through the Demographic and Health Surveys (*DHS+*) programme, a USAID-funded project that provides support and technical assistance in the implementation of population and health surveys in developing countries. Significantly expanded in content, the 1999 ZDHS is the third in a series of national-level surveys carried out in Zimbabwe in 1994 and 1988 and provides updated estimates of basic demographic and health indicators covered in the earlier surveys. The project received additional funding from UNICEF Zimbabwe. The 1999 ZDHS was conducted in all ten of the provinces of Zimbabwe. A total of 6,369 households, 5,907 women age 15-49 and 2,609 men age 15-54 were successfully interviewed in the survey.

For more information, contact:
Central Statistical Office
Kaguvi Building, Fourth and Central Avenues, 20th Floor
P.O. Box CY342, Causeway, Harare
Zimbabwe
Telephone: 706-681/8 and 703-971/7
Fax: 708-854
Email: census@cso.zarnet.ac.zw

Cover photo: UNICEF

1999 Zimbabwe Demographic and Health Survey

KEY FINDINGS



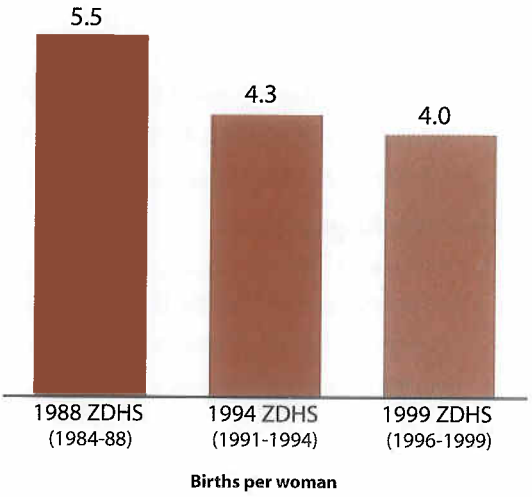
FERTILITY

The fertility indicators presented in the 1999 ZDHS are based on reports provided by women age 15-49 years regarding their reproductive histories. As in the previous ZDHS, each woman was asked to provide information on the total number of sons and daughters to whom she had given birth and who were living with her, the number living elsewhere, and the number who had died.

Levels and Trends

Findings from the 1999 Zimbabwe Demographic and Health Survey (ZDHS) show fertility levels in Zimbabwe continuing to decline. At the 1999 levels, a Zimbabwean woman will give birth to an average of 4.0 children during her reproductive years, 1.5 fewer children than recorded about a decade earlier.

Trend in fertility, 1988-1999



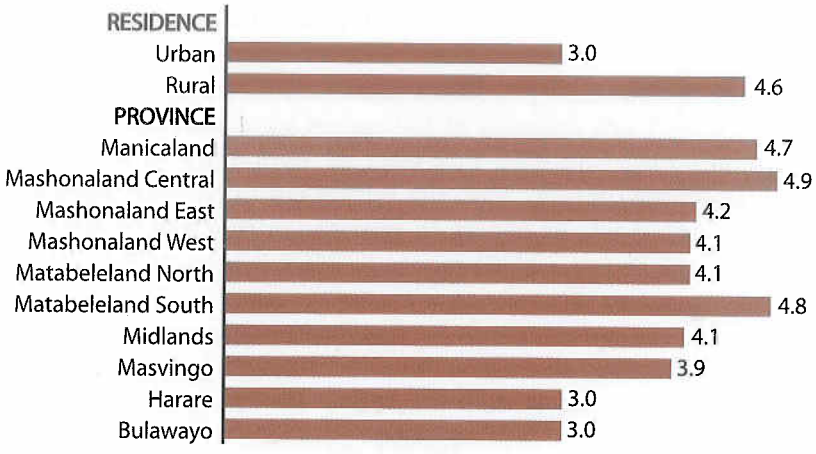
Fertility by Background Characteristics

In general, urban women have smaller families than rural women (3.0 and 4.6 children per woman, respectively). Specifically, fertility is lower among women in Harare and Bulawayo (about 3 children per woman) than in other provinces (4 or more children per woman). Education is inversely related to fertility: women with no formal education have more than 5 children on average, while women with higher than secondary education average fewer than 2 children each.

Factors Contributing to the Fertility Decline

One factor that contributed to the decline in fertility is the continuing increase in the age at which Zimbabwean women marry (18.9 years old in 1994 and 19.3 years old in 1999). Though age at first marriage is often used as a proxy for the onset of a woman's exposure to the risk of pregnancy, some women are sexually active before marriage. Hence, the age at which women initiate sexual intercourse marks the beginning of their exposure to reproductive risk more accurately. The median age at first sexual intercourse for women has risen slowly in recent years, from 18.0 years of age for women age 35-39 to 19.1 for women age 20-29. Men start having sexual intercourse at a later age than women. In general, men first have sex about 1 year later than women (median age at first intercourse is 19.7 years of age for men compared to 18.7 years of age for women).

How does fertility vary by residence?



Polygynous Unions

One in six currently married women in Zimbabwe reported being in a polygynous union. Older women and rural women are more likely to be in polygynous unions than other women. Polygyny varies across province: Bulawayo had the lowest level of polygynous unions (5 percent) while Mashonaland Central and Manicaland had the highest levels (31 percent and 25 percent, respectively). The level of polygynous unions increased between 1988 and 1994, but it decreased during the last 5 years (17 percent in 1988, 19 percent in 1994, and 16 percent in 1999).

FERTILITY REGULATION

Information on fertility preferences and steps taken to control fertility is of considerable importance to family planning programme planners as it allows an assessment of the need for contraception, whether for birth spacing or for birth limitation. Data on fertility preferences are also useful as an indicator of the direction that future fertility may take.

Levels and Trends

More than half of currently married women age 15 to 49 in Zimbabwe (54 percent) are using contraception, an increase of 6 percentage points since 1994.

Not only have more women adopted family planning in the past 5 years, they are also more likely to be using a modern contraceptive method (89 percent in 1994 compared to 94 percent of all users in 1999). Two methods stand out as being the most commonly used: the pill (36 percent) and injectables (8 percent). The increase in overall contraceptive prevalence during the past 5 years can be attributed largely to the sharp increase in the use of injectables from 3 percent in 1994.

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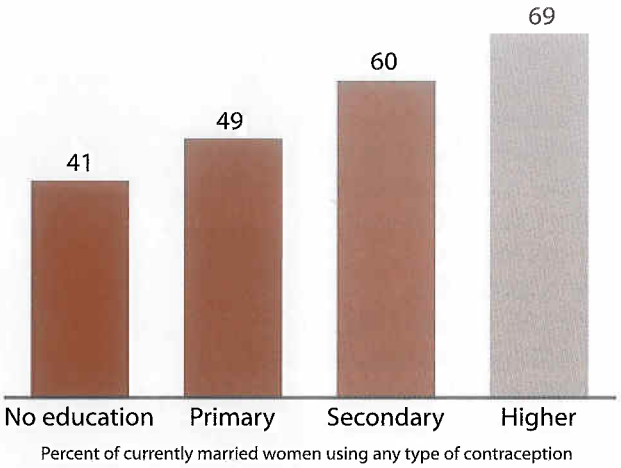
Family Planning Use by Background Characteristics

A woman's use of contraception varies by her age, place of residence, education and number of living children. Contraceptive use is higher among women age 25-39, urban women and better-educated women. Women frequently start using

How does contraceptive use vary by education level?



Percent of currently married women using any type of contraception

What is the fertility gap?

The Total Wanted Fertility Rate (TWFR) expresses the level of fertility that would theoretically result if all unwanted births were prevented. A comparison of the actual fertility rate with the wanted fertility rate indicates the potential demographic impact of eliminating unwanted births. This indicator is highly relevant for a country like Zimbabwe, which has an official policy to reduce the birth rate and thus the rate of population growth.

In 1999, the wanted fertility rate was an average of 3.4 children per woman, compared to the actual average of 4 children. In other words, Zimbabwean women are having more children than they actually want. Women with higher levels of education seem to be the most successful in achieving their fertility goals, with only a 0.2-child gap existing between desired and actual fertility.

How does use of family planning in Zimbabwe compare to that in other countries?

According to findings from the 1999 ZDHS and data available from other DHS surveys, Zimbabwe has the second-highest contraceptive prevalence rate (CPR) in sub-Saharan Africa.

South Africa 1998	56
Zimbabwe 1999	**54**
Kenya 1998	39
Zambia 1996	26
Ghana 1998	22
Burkina Faso 1999	12
Niger 1998	8
Guinea 1999	6

Percentage of currently married women age 15-49 currently using any method of contraception

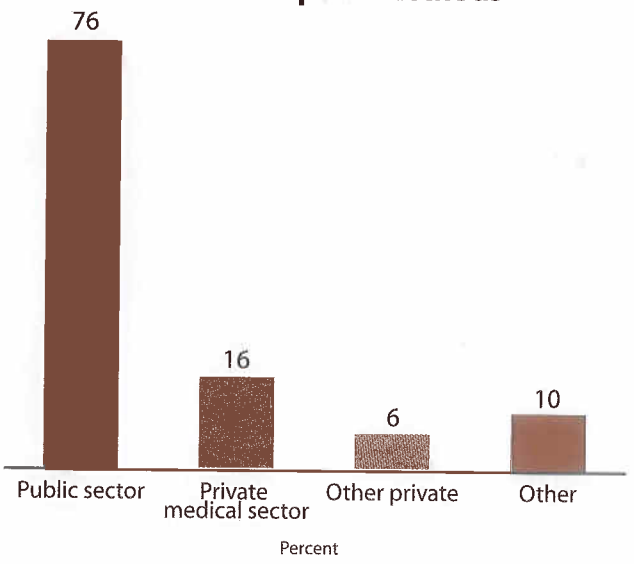
Looking at other countries around the world where DHS surveys have been conducted shows that Zimbabwe's CPR is comparable to that of Bangladesh 2000 (54 percent), Egypt 2000 (56 percent), Indonesia 1997 (57 percent), and Jordan 1997 (53 percent).

contraception as soon as they have their first child. Although only 8 percent of married women with no children use a contraceptive method, the proportion among women who have had at least one child is 58 percent or higher. Women in Harare and Bulawayo are more likely to use contraception than their counterparts elsewhere in the country (64 percent and 62 percent, respectively). On the other extreme, Manicaland and Matabeleland South show the lowest use (42 percent or lower).

Sources of Family Planning Services

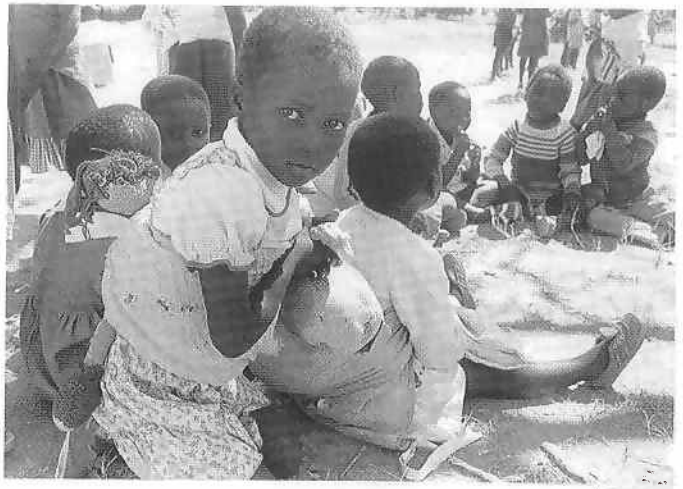
In Zimbabwe, the private medical sector is gaining importance in supplying users with contraceptive methods (12 percent in 1994, compared to 17 percent in 1999). The source of supply varies by method. More than half (56 percent) of pill users obtain their pills from a rural/municipal clinic or a rural health centre. The same health facilities supply 63 percent of women who use injectables. About a third of IUD users go to private doctors.

Source of supply for modern contraceptive methods



Unmet Need for Contraception

Currently married women who do not want any more children or want to wait 2 or more years before having another child, but are not using contraception, are considered to have an unmet need for family planning. In Zimbabwe, 13 percent of women have an unmet need for family planning: 7 percent for spacing and 6 percent for limiting births. There has been a slight improvement since 1994, when the level of unmet need was 15 percent.



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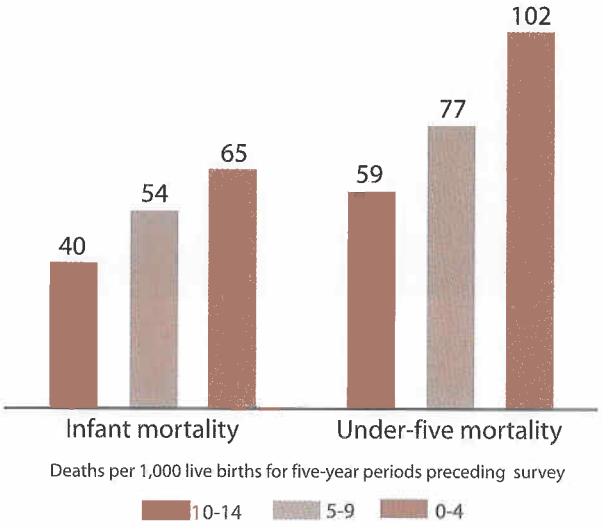
MORTALITY

Death rates, especially during childhood and those related to pregnancy and delivery, have long been used to evaluate a country's level of socioeconomic development and quality of life. In Zimbabwe, the recent increase in under-5 and adult mortality is particularly alarming.

Early Childhood Mortality

The 1999 ZDHS data show that 1 in 10 children born in the 5 years preceding the survey will not survive to reach the age of 5. This rate is higher than that recorded in the 1994 ZDHS (102 compared to 77 deaths per 1,000 live births). The worsening economic conditions and the direct and indirect impact of the AIDS epidemic on child health and survival may have led to the higher mortality rates in recent years.

Trends in infant and under-five mortality



Infant mortality varies significantly by mother's residence and education. Mortality risks are higher among rural children, children whose mothers have had no formal education, and children living in Mashonaland Central. Appropriate medical care during pregnancy and delivery plays an important role in children's survival. The probability of dying in infancy is almost three times higher for infants whose mothers received no antenatal care than for infants whose mothers received both antenatal care and assistance during delivery by medically trained personnel.

Although a child's socioeconomic condition does have an impact on his or her survival, the child's survival also depends upon health care and demographic characteristics. A child born within two years of an elder sibling has double the risk of dying in the first year of life compared to a child born 4 years or more after a prior birth (112 versus 54 deaths per 1,000 births). Mortality risks are also greater for children of birth order 7 or higher and for children born to mothers less than 20 years of age.

The 1999 ZDHS data show that there has been a sharp increase in the rates of adult mortality.

Adult Mortality

The 1999 ZDHS data show a sharp increase in the rates of adult mortality between the period of the late-1980s to the early-1990s and the period of the mid- to late-1990s. For both men and women in the age group 15-49, the increase was as much as two- to threefold (for women from 4 to 9 deaths per 1,000, for men 4 to 11). The largest changes among men occurred in the age group 30 and older; for women, the change took place at an earlier age (25 and older). This is consistent with the age pattern of HIV infection in Zimbabwe, i.e., younger women and older men.

Maternal Mortality

The maternal mortality ratio for the 1995-1999 period is estimated at 695 deaths per 100,000 live births. That rate is 2.5 times the rate estimated from the 1994 ZDHS (283 deaths per 100,000 live births). If data from the same survey are used to investigate the trend, to compare the period 5-9 years and 0-4 years preceding the survey, the change is about twofold. Regardless of which data are used in the comparison, the numbers suggest a rapid rate of increase in maternal mortality. However, among all female deaths, the proportion of maternal deaths has declined from about 14 percent in the 1994 ZDHS to 10 percent in the 1999 ZDHS. That drop suggests that deaths from non-maternal causes (such as HIV/AIDS-related deaths) rose faster than overall mortality.

Content of antenatal care

Besides knowing the number of antenatal visits and the timing of the mother's first antenatal visit, the content of antenatal care is important in judging its value. The 1999 ZDHS data indicate that only 4 in 10 women who received antenatal care were informed about signs of pregnancy complications. Women in urban areas were more likely to receive such information than women in rural areas (55 percent compared to 35 percent).

During antenatal care visits, 9 in 10 women had their blood pressure measured, 8 in 10 gave urine samples, 3 in 4 gave a blood sample, 8 in 10 received a tetanus toxoid (TT) injection, and 6 in 10 received iron tablets. Among women who received antenatal care, 23 percent were also given antimalarial drugs.

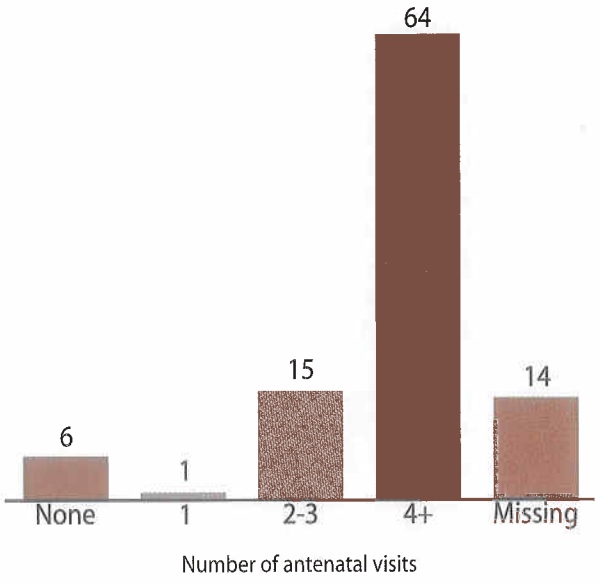
MATERNAL AND CHILD HEALTH

The majority of deaths due to maternal causes are avoidable if pregnant women receive adequate antenatal care during pregnancy, have their deliveries in hygienic conditions and with the assistance of trained medical practitioners, and receive appropriate and timely postpartum care. For children, vaccination against six serious but preventable diseases, along with early diagnosis and treatment of common childhood illnesses, can prevent a large proportion of deaths.

Antenatal Care

Data from the 1999 ZDHS indicate that during the 5 years preceding the survey, most mothers in Zimbabwe had received health care during pregnancy. For 9 in 10 of their most recent births, mothers received antenatal care from medical personnel (doctor, trained nurse or midwife). Antenatal care coverage in 1999 remained at the same level as in the 1994 ZDHS (94 percent).

Are mothers receiving adequate antenatal care?



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The 1999 survey shows that six in 10 pregnant women make four or more antenatal care visits. That proportion reflects a decline in the percentage from that recorded for the 1994 ZDHS (74 percent). The decline might be due to economic reasons, since most institutions had begun charging for antenatal services, or due to the fact that in 1999, the data refer to only the most recent birth in the previous 5 years (while in 1994 it was all births in the last 3 years).

Delivery Characteristics

Among births in the 5 years preceding the survey, 72 percent took place at a health facility and 23 percent took place at home. There were considerable differences among provinces in the place of delivery. Whereas 9 in 10 births in Harare and Bulawayo took place in a health facility, only 51 percent to 80 percent in the remaining provinces did. Home deliveries were most prevalent in Manicaland (44 percent).

In Zimbabwe, the majority of births (73 percent) were assisted by skilled personnel: a doctor delivered 12 percent and a trained nurse or midwife delivered 61 percent. The role of trained nurses and midwives in providing assistance at deliveries has become more prominent during the 5 years leading up to the recent survey (57 percent in 1994, compared with 61 percent in 1999).

Postnatal Care

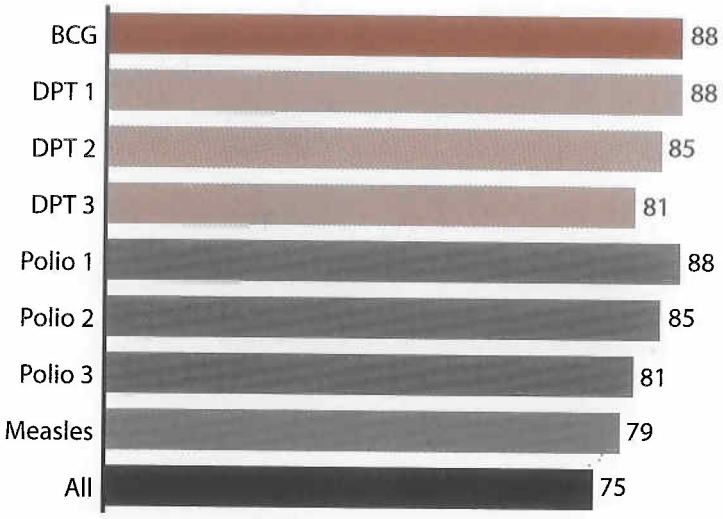
It is important that both the mother and the child receive postnatal care for treatment of complications arising from delivery. For more than half of all births occurring at home (56 percent), mothers did not receive a postnatal checkup. Among those who had received a postnatal checkup, only 14 percent were examined within 2 days of delivery. The low rate of postnatal care among women who delivered outside a health facility may be due to a lack of knowledge of the importance of these checkups.

For more than half of all births occurring at home (56 percent), mothers did not receive a postnatal checkup.

Immunisation of Children

A child is considered fully immunised when he or she has received one vaccination each against tuberculosis and measles, and three vaccinations each against diphtheria, pertussis, tetanus (DPT) and polio. Vaccines are

Percent of children 12-23 months who have received vaccination



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Perceived problems in accessing health care

Many factors can prevent women from getting medical advice or treatment for themselves. Some of the factors are real, others may be the women's perceptions and beliefs.

A lack of knowledge of where to go for service, a need to get permission, and a lack of female service providers were not perceived as a problem by the majority of women. However, rural women reported the lack of nearby facilities and having to find transport as constituting major problems (45 percent and 43 percent, respectively).

Getting the money for treatment is another obstacle in receiving health care for 26 percent of urban women and 39 percent of rural women. In addition, 1 in 7 women cited fear of verbal abuse by the health service provider.

most effective when given to children at the appropriate age. According to recommendations of the World Health Organisation (WHO), it is advisable for children to complete the vaccination schedule before reaching 12 months of age. The data from the 1999 ZDHS show that 67 percent of children were vaccinated by the time of their first birthday. The same level had been recorded in 1994.

Childhood Diseases: Prevalence and Treatment

One in 7 children under age 5 (14 percent) was reported to have had diarrhoea during the 2 weeks before the survey, and one-third of these children (32 percent) were taken to a health facility. Knowledge about oral rehydration therapy for treating diarrhoea is high among mothers of children under age 5 (97 percent); consequently, 80 percent of children with diarrhoea are given either a recommended homeade solution of sugar and salt or increased fluids.

B. Kanyama, Min. of Information

Sixteen percent of children under age 5 had a cough accompanied by rapid breathing during the 2 weeks prior to the survey. About half of those children were taken to a health facility for treatment. During the same period, 26 percent of children had a fever. These figures show that the prevalence of cough and fever is slightly lower than what was recorded in 1994.

NUTRITION

Malnutrition among women can be an underlying factor in maternity-related complications and infant deaths. Malnourished mothers are more likely to have malnourished children. Inadequate nutrition can compromise a child's physical and mental development.

Infant Feeding Practices

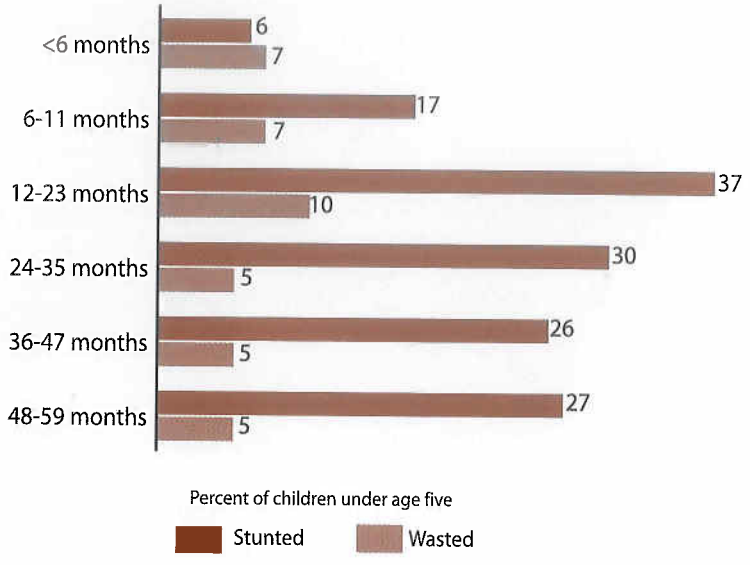
Breastfeeding is nearly universal in Zimbabwe with 98 percent of children breastfed at some time. Breastfeeding typically lasts for almost 20 months, about a month longer than was reported in 1994. Because of the advantages of breastfeeding for both the child and the mother, mothers are generally advised not to supplement breastfeeding with other foods and liquids until a baby reaches 4 months of age. The duration of exclusive breastfeeding was relatively short (1.3 months). Children whose mothers are living in rural areas, living in Matabeleland North, or had no education are likely to be breastfed longer than other children.

Duration of exclusive breastfeeding remains relatively short (1.3 months).

Nutritional Status of Children

Three standard indices of physical growth that describe the nutritional status of children, height-for-age, weight-for-height and weight-for-age, are available from the survey. Each of the indices gives different information about growth and body composition that can be used to assess nutritional status (see sidebar).

What percent of children are stunted or wasted?



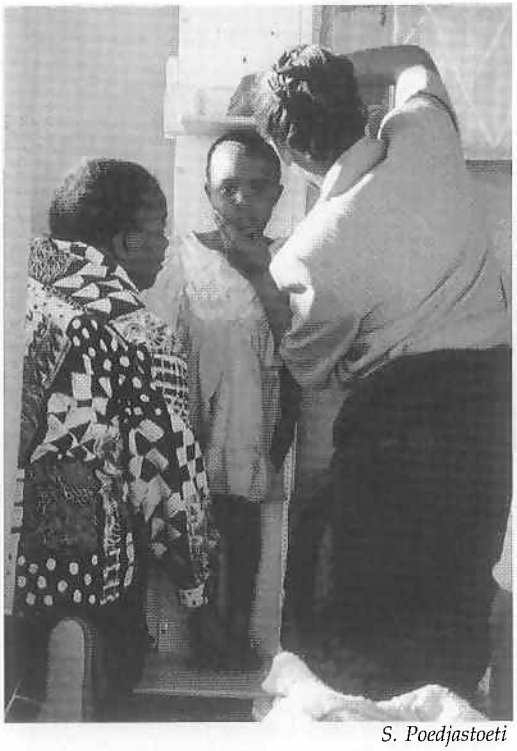
What are the standard indices of physical growth?

Height-for-age is a measure of linear growth. A child who falls below minus-two standard deviations (-2 SD) from the median of the NCHS reference population in terms of height-for-age is considered *stunted*, or short for his/her age, a condition reflecting the cumulative effect of chronic malnutrition.

Weight-for-height describes current nutritional status. A child who falls below minus-two standard deviations (-2 SD) from the reference mean for weight-for-height is considered *wasted, or* too thin for his/her height, a condition reflecting acute or recent nutritional deficit. Severe wasting is closely linked to mortality risk.

Weight-for-age is a composite index of weight-for-height and height-for-age. A child can be underweight for his age because he is stunted, because he is wasted, or because he is stunted and wasted. Weight-for-age is a good overall indicator of a population's nutritional health.

In the 1999 ZDHS, all children born since January 1994 were measured. The following data refer to those children whose mothers were successfully interviewed. More than one-fourth (27 percent) of children under 5 years old were classified as stunted; almost 10 percent of the children are severely stunted. Children born after a short birth interval (less than 24 months) are much more likely to be stunted than children born after longer birth intervals. About 6 percent of children younger than 5 years old in 1999 were wasted; 2 percent of children were severely wasted. Wasting was found to be most common in children between 12 and 23 months of age, indicating that food supplementation during the weaning period may be inadequate. Overall, 13 percent of children under age 5 in Zimbabwe in 1999 were underweight, which may reflect stunting, wasting, or both.



S. Poedjastoeti

Nutritional Status of Women

Height and weight measurements of all women age 15-49 were taken as part of the survey. In this report, two measures have been used to assess the nutritional status of women: their height and their body mass index (BMI), an indicator combining height and weight data. A woman's height is associated with her past socioeconomic status and with her nutrition during childhood and adolescence. Maternal height can be used to predict the risk of difficult delivery, since small stature is often associated with small pelvis size. The risk of having a low-birthweight baby also seems to be higher for short women. The optimal cutoff point, below which a woman can be identified as at risk, is in the range of 140 to 150 centimetres. The mean height of women measured in the ZDHS was 159.6 cm. Less than 2 percent of women were less than 145 cm tall. Women under 20 years of age and women with no education are more likely to be less than 145 cm tall than older women and women with some education. There is little variation by province in women's height.

Various indices of body mass are used to assess thinness and obesity. The most commonly used, BMI, is defined as weight in kilograms divided by squared height in metres. A cutoff point of 18.5 has been recommended for defining energy deficiency among non-pregnant women. The mean BMI among the weighed and measured women[1] was 23.4, with 5 percent having a BMI below 18.5, reflecting a nutritional deficit.

[1] *Pregnant women were excluded from the BMI analyses because precise data on gestational age, necessary for adjustments, were not available.*

S. Poedjastoeti

AIDS Awareness

According to United Nations AIDS and World Health Organization estimates, one in 4 Zimbabwean adults age 15-49 are currently infected with HIV, the virus that causes AIDS. The future course of Zimbabwe's AIDS epidemic depends on a number of important variables including the level of AIDS-related knowledge among the general public, risk-behaviour modification, access to high-quality services for sexually transmitted diseases, and provision of HIV-testing and counseling.

Knowledge of HIV/AIDS

Although knowledge of HIV and AIDS is nearly universal in Zimbabwe, the 1999 ZDHS reports that 17 percent of women and 7 percent of men could not cite a single means of avoiding infection. Level of education is very closely linked to level of AIDS prevention knowledge. Whereas about 45 percent of women without any formal education did not mention a way to avoid HIV/AIDS, less than 1 percent of those with more than secondary school education did not mention a way. Rural residents, especially women, were far less knowledgeable than their urban counterparts.

17 percent of women and 7 percent of men could not cite a single means to avoid HIV infection.

The most widely cited means of avoiding HIV/AIDS were using condoms (76 percent for men, 66 percent for women) and limiting sexual activity to one or fewer partners (69 percent for men, 63 percent for women). Sexual abstinence was mentioned by 30 percent of men and 17 percent of women.

When asked whether a "healthy-looking person can have the AIDS virus", 76 percent of women and 85 percent of men gave the correct response. Nine in 10 women and men knew that the AIDS virus can be transmitted from mother to child. When asked the question "Do you personally know someone who has the AIDS virus or who has died from AIDS?", 60 percent of women and 64 percent of men in the 1999 ZDHS responded that they knew someone who had the AIDS virus or who had died from AIDS. The fact that the figures from 1999 are higher than those from 1994 (49 percent of both women and men) reflects the spread of the AIDS tragedy across Zimbabwe's social landscape.

Sexual Behaviour

Given the evidence that the vast majority of HIV infections in Zimbabwe are contracted through heterosexual contact, information on sexual behaviour is important in designing and monitoring intervention programmes to control the spread of the disease.

Men reported having more sexual partners and more extramarital relations than women. Whereas only 1 percent of currently married women reported having had extramarital sexual activity in the 12 months before the survey, 16 percent of married men had had sex with women other than their spouse. In the 1999 ZDHS, 7 percent of men age 15-54 reported

Drinking habits and sexual activity

The 1999 ZDHS collected information on the respondents' drinking habits (including getting "drunk") during the prior 30 days, information that can be analysed together with patterns of sexual activity. Drinking alcoholic beverages is associated with higher rates of both extramarital sexual activity and multiple partnering among unmarried individuals.

Thirty-six percent of married men and 15 percent of unmarried men reported having been drunk at least once during the prior 30 days.

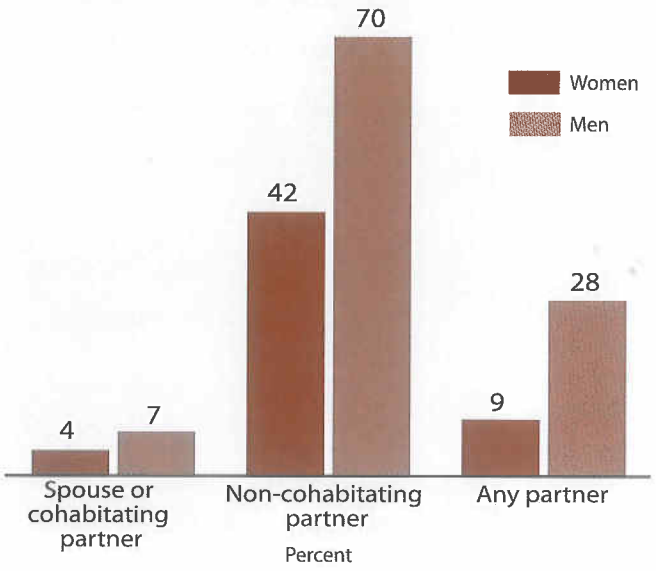
Eleven percent of married men who said they did not drink reported having engaged in extramarital sexual activity, compared to 24 percent of men who had gotten drunk more than once during the 30 days prior to the survey. Among unmarried men, 5 percent of those who said they did not drink had had two or more partners during the prior 12 months, compared to 33 percent of those who had been drunk more than once during the prior 30 days.

having "paid for sex" in the prior 12 months. Unmarried men were nearly twice as likely to have paid for sex during the previous year than married men.

Testing for the HIV/AIDS Virus

Women were more likely to have been tested for HIV than men (12 percent compared to 9 percent). Higher levels of HIV/AIDS testing were reported by women and men in urban areas, respondents with more education, and respondents who were in the peak childbearing years (women age 20-39 and men age 25-49).

Use of condoms during last sexual intercourse



The overall demand for HIV/AIDS testing includes those who have not yet been tested but would like to be (i.e., unmet demand) and those who have already been tested (i.e., "met" demand). Seven in 10 women and 66 percent of men expressed a desire to be tested. For women, 12 percent had already had the test, which means that only 17 percent of the demand had been satisfied. The corresponding figure for men is lower (14 percent). Two in three respondents (63 percent of women and 67 percent of men) who reported not yet having been tested for the AIDS virus but wishing to be tested were not aware of a place where they could be tested.

Knowledge of Sources for Condoms

Because of the important role that the condom plays in combating the transmission of HIV, respondents were asked where condoms could be obtained. More than one-quarter of women and one-sixth of men could not cite a place where they could obtain a condom. Knowledge of a source for condoms varied widely. Less-educated men and women, and those living in rural areas (particularly in the provinces of Manicaland, Masvingo, and Matabeleland North) were less likely to know where to go to obtain a condom. When asked where a person would go for condoms, 50 percent of women and 35 percent of men responded that they could go to a public facility.

Population Services International (PSI)

Use of Condoms

Men are about three times more likely than women to have used a condom during the most recent sex. Condom use at last sex with any partner was reported by 9 percent of women and 28 percent of men.

Both men and women used condoms much less with cohabiting partners (mostly spouses) than with non-cohabiting partners (see graph). Among men who had paid for sex in the 12 months preceding the survey, 82 percent used a condom during the last paid sex. It is clear that both women and men understand that sex outside of stable relationships entails greater risk.

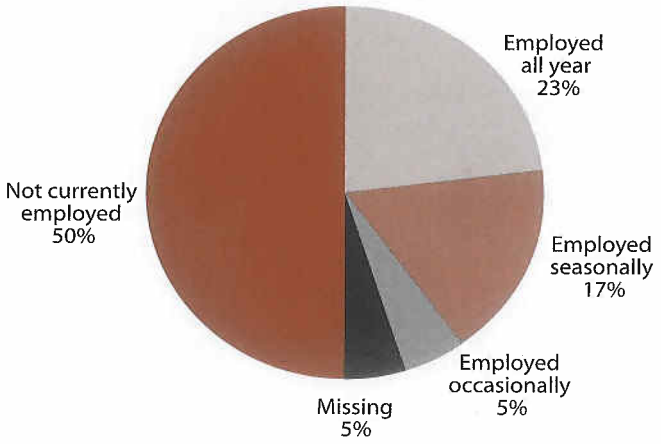
WOMEN'S STATUS

In the 1999 ZDHS, information was collected on the background characteristics of the women interviewed, including their education and employment status, household decision-making power, and opinions on domestic violence. Such information is useful in understanding the factors that affect reproductive and health-seeking behaviour, as they provide a context for the interpretation of the demographic and health indices.

Education

The level of education in Zimbabwe is high, and most people have had formal education. The improvement in levels of education reflects the significant expansion, and consequent improved accessibility, of the educational system after independence in 1980. Overall, males are more educated than their female counterparts. The proportion of women who had never been to school was more than two times greater than that of males (7 percent and 3 percent, respectively).

What percent of women are employed?



Women's Employment and Earnings

The 1999 ZDHS data show 45 percent of women are currently employed. Twenty-three percent were employed throughout the year, 17 percent were employed seasonally and 5 percent were employed occasionally. Most working women had non-agricultural jobs (61 percent). As was expected, employment in non-agricultural occupations was relatively more common among women who lived in urban areas and women who had had some formal education. Among employed women, more than half were self-employed; 86 percent of working women earn cash while 14 percent are either unpaid or paid in-kind only.

Women's Empowerment

Information on who decided how to use the cash earned by employed women can be used as a measure of the status of women. Among women who receive cash earnings, 63 percent decide for themselves how to spend their money, whereas 24 percent decide jointly with their husband/partner. Only 8 percent of women who earned cash reported that their husband/partner decided how their earnings would be spent. Marital status has a strong influence on whether a woman has a say in the use of the money she earns. Unmarried women are more likely to have control over the spending of the cash they earn than married women. Women who contribute at least half of household expenditures are more likely to have control over the use of their income than women who contribute less than half.

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Another indicator of women's status is their ability to undertake specific household decisions. Married or separated women are most likely to make their own decisions in seeking health care, making daily household purchases, and choosing the type of food to be cooked each day. However, they are more likely to decide jointly with their husbands when purchasing large household

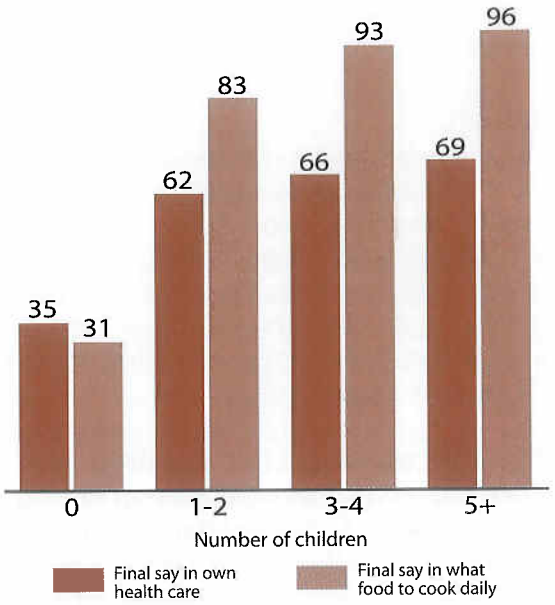
Can women refuse sexual relations?

Women's ability to refuse sex shows their power to bargain over sexual behaviour, which in turn affects their chances of becoming pregnant and getting infected with sexually transmitted infections (STIs). In the ZDHS, respondents were asked whether they thought that a wife was justified in refusing to have sex with her husband or partner for specified reasons. The reasons listed in the survey: tiredness or not in mood, recently gave birth, knows that her husband has sexual relations with other women, and knows that her husband has an STI.

In general, older women, urban women, better educated women, and women earning cash were more likely to agree to any reason for refusing sex. Women who had never been married were more likely (40 percent) to agree with all of the specified reasons for refusing sex, compared to women who were married or in union (33 percent) or women who were divorced, separated, or widowed (35 percent).

goods and when visiting family or relatives. It is interesting to note that single women are less likely to make any of the specified decisions, which suggests that single women are more dependent on other people than married women are.

Does a woman's final say in household decisions increase with the number of children she has?



Having children seems to increase women's level of decision-making. As a woman's number of children increases, so does her decision-making ability. As expected, women who were currently employed and earning cash were more likely to make decisions than unemployed women or employed women not earning cash.

In the ZDHS, respondents were asked whether they thought a husband was justified in beating his wife for specified reasons. These reasons are: wife burning the food, arguing with husband, going out without telling husband, neglecting the children, and refusing sexual relations. The proportion of women agreeing with at least one specified reason justifying wife beating declines with increasing age, education and duration of marriage. Women married for less than 5 years are more likely to agree with one of the specific reasons than other women. As expected, financially independent women are less likely to agree to justifications for wife beating.

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SUMMARY AND CONCLUSIONS

Achievements

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- Fertility levels in Zimbabwe continue to decline. In 1997-1999, women on average had 4.0 children, 1.5 fewer children than in 1984-1988. Urban women and better-educated women tended to have smaller families than other women.

- Women in Zimbabwe have become more successful in controlling their fertility. In 1994, the gap between wanted and actual fertility was 0.8 children. By 1999, the figure had declined to 0.6 children.

- Contraceptive prevalence among currently married women increased from 48 percent in 1994 to 54 percent in 1999. Not only was the level of contraceptive use in 1999 higher, but larger proportions of women had started using modern methods (89 percent in 1994 compared to 94 percent in 1999).

- There was a slight decline in the level of unmet need for family planning services; 15 percent in 1994 to 13 percent in 1999.

Challenges

- Although antenatal care coverage remained at a level close to that of 1994, in 1999 women were less likely to see a doctor and more likely to see a midwife or a nurse. The role of a midwife or nurse during delivery had also become more important. Women had become less likely to make the recommended four or more antenatal care visits (75 percent in 1994 compared to 64 percent in 1999).

- According to WHO recommendations, all children should complete the prescribed vaccination schedule before their first birthday. Only two-thirds of children receive all the vaccinations before their first birthday, the same level as in 1994 (67 percent).

- Overall breastfeeding duration in 1999 was 19.6 months, about 1 month longer than the duration recorded in 1994. However, the duration of exclusive breastfeeding remains relatively short (1.3 months).

- Mortality rates have been on the increase. One in 10 children will not survive to age 5. The 1994 ZDHS data had shown a lower level of 77 deaths per 1,000 live births.

- Rates of adult mortality for both men and women have also been increasing. For the period between the late 1980s and the early 1990s and mid-to late-1990s, the increase ranged as high as from 4 to 9 deaths per 1,000 women and from 4 to 11 deaths per 1,000 men.

- The 1999 ZDHS data indicated a rapid increase in maternal mortality. The decline in the proportion of maternal deaths among all female deaths suggests that deaths from non-maternal causes (such as HIV/AIDS-related) increased faster than overall mortality.

- Although most women and men in the survey knew of AIDS and the virus that causes AIDS, 17 percent of women and 7 percent of men could not cite a single means of avoiding infection. Twelve percent of women and 9 percent of men had been tested for AIDS and the desire to be tested for AIDS was high (59 percent of women; 57 percent of men). However, the majority of those who reported that they had not yet been but wanted to be tested for the AIDS virus did not know where they could be tested.

KEY INDICATORS FACT SHEET

1997 POPULATION DATA[1]

Total population (millions)	11.789
Sex ratio (males per 100 females)	92
Annual intercensal population growth (percent)	2.25
Crude birth rate (per 1,000 population)	34.7
Crude death rate (per 1,000 population)	12.2
Life expectancy at birth (years)	
for males	52.6
for females	57.2

ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1999

Sample Population	
Women age 15-49	5,907
Men age 15-54	2,609

Background Characteristics of Women

Percent urban	38.6
Percent with no education	6.7
Percent attended secondary school or higher	53.0

Fertility

Total fertility rate[2]	4.0
Mean number of children ever born to women age 40-49	5.9

Use of Family Planning

Percent of currently married women currently using:	
Any method	53.5
Any modern method	50.4
Traditional methods	3.2

Mortality

Infant mortality rate[3]	65.0
Under-five mortality rate[3]	102.1
Maternal mortality ratio[4]	695

Health

Percent of births[5] to mothers who:	
Received antenatal care from medical provider	93.1
Received tetanus toxoid injections[6]	78.9
Percent of births[5] to mothers who were assisted at delivery by:	
medical provider	72.5
non-medical provider	23.9
no one	3.2
Percent of children 0-3 months who are breastfeeding	99.6
Percent of children 0-3 months who are exclusively breastfeeding	38.9
Percent of children 12-23 months who received[7]	
BCG	88.1
DPT (three doses)	80.9
Polio (three doses)	80.7
Measles	79.1
All vaccinations	74.8
Percent of children under 5 years who in the 2 weeks preceding the survey:	
had diarrhoea	13.9
had a cough accompanied by short, rapid breathing	15.8
Percent of children under 5 years who:	
are chronically malnourished (stunted)[8]	26.5
are acutely malnourished (wasted)[8]	6.4

[1] Based on 1997 Inter-censal Demographic Survey (Central Statistical Office. 1998. 1997 Intercensal Demographic Survey Report. CSO, Harare)

[2] Based on births to women 15-49 years during the period 0-2 years preceding the survey

[3] Rates for the period 0-4 years preceding the survey (roughly 1995-1999); expressed as deaths per 1,000 live births

[4] Ratio for the 7-year period preceding the survey; expressed as maternal deaths per 100,000 live births

[5] Figure includes births in the period 1-59 months preceding the survey

[6] Refers to injections received during pregnancy

[7] Based on information from vaccination cards and mothers' reports

[8] Stunting assessed by height-for-age, wasting assessed by weight-for-height; the percent malnourished are those below -2 SD from the median of the international reference population, as defined by the U.S. National Centre for Health Statistics, and recommended by the World Health Organisation