



ZIMBABWE

NATIONAL POPULATION POLICY

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Preface

This document seeks to define the Government of Zimbabwe's policy on population as well as affirming the Government's commitment to the adoption and implementation of programmes and strategies aimed at the management of the population in a manner consistent with the desire for sustainable development. The ultimate goal of the national population policy is to achieve high standards of living of the people through influencing the population variables and development trends in a desirable direction which can contribute to the achievement of economic, social and other collective goals of the nation.

As part of the population policy formulation process, population policy sensitisation workshops were held in the provinces in order to capture aspirations and concerns of the people of Zimbabwe. Participants to these workshops included members of the civic society, Members of Parliament, Chiefs and other traditional leaders and Government Officials. Further research was conducted into areas which were considered priorities in terms of population policy formulation.

While measures, programmes and provisions will be put in place, within the policy frame-work, which are intended to alter the demographic patterns in a manner compatible with sustainable development, this policy will abide by the basic principle which recognises an individual's right to choose freely and responsibly the number, spacing and timing of children they want and to have the information to do so.

As this population policy evolved as a result of community

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participation through consultations at various levels in the country, it is anticipated that its implementation will ultimately be in the best interests of the population at large. Efforts should therefore be made to publicise the policy as widely as possible so that each individual in society will contribute much to the achievement of the goals and objectives as outlined in the national population policy.

As we continue to realise that the population factor is quite fundamental in our quest for sustainable development, all stake-holders are urged to collectively work together in order to make the goals and objectives of the document attainable.

May I take this opportunity to thank the United Nations Population Fund (UNFPA) for providing financial and technical assistance for the population policy formulation process.



The Honourable R.C. Hove, M.P.
Planning Commissioner,
National Economic Planning Commission.
OFFICE OF THE PRESIDENT AND CABINET.

Executive Summary

Chapter 1 of the population policy gives **the rationale** of having a comprehensive and explicit population policy for Zimbabwe amid arguments that due to Zimbabwe's huge resource endowment base and land mass, a population policy may not be necessary. The Government of Zimbabwe realises that the human component is fundamental to economic and social development hence the commitment to formulate an explicit and comprehensive national population policy that is aimed at improving the living standards of the population. The formulation of this policy and its ultimate implementation reinforces the Government of Zimbabwe's commitment to improving the standards of living of the population. The Government also recognises the need to strike a reasonable balance between economic growth and population dynamics in order to foster sustainable development. The population policy is being formulated at a time when a more holistic approach to development is being advocated for. Thus the multi-disciplinary nature of the policy will take into account pre-existing implicit sectoral efforts as well as other emerging aspects of population and related issues like HIV/AIDS/STI, gender and the environment. Through various implicit policies, the Government of Zimbabwe has managed to reduce both fertility and mortality levels since the early 80's. Despite these early successes in health and other sectors, statistics are beginning to show that living standards have begun to deteriorate as evidenced by, among other things, an increase in mortality rates from around 1988.

Chapter 2 of the population policy outlines the **Population Profile of Zimbabwe** as indicated by statistics from various sources. In 1992, the population of Zimbabwe was 10.4

million people and the average intercensal growth rate was 3.1 percent per annum between 1982 and 1992. New estimates show that the population had increased to 11.8 million by mid-August 1997 with an intercensal growth rate of 2.48 percent per annum (1997 ICDS). Sixty-eight percent of the population live in rural areas. The proportion of people residing in urban areas increased from 26% in 1982 to 31% percent in 1992 and 32% in 1997. Females constitute 52 percent of the population . This translates to a sex ratio of 92 males per 100 females. Forty-three percent of the population is aged below 15 years and 4 percent is aged above 65 years (1997 ICDS). Total fertility rate has declined from 5.96 children per woman in 1982 to 4.3 children for the 1992-1994 period. Fertility was still 4.3 children per woman in 1997. Adolescent fertility is a problem with 40% of adolescent girls already being mothers by the age of nineteen years. Contraceptive prevalence rate (for modern methods) for married women aged 15-44 years was 42% for 1994 although there is still an *unmet need* for contraception of 15 percent. Infant mortality declined from 83 deaths per 1000 live births in 1978 to 61 in 1988 and rose to 66 in 1990. By 1993, infant mortality rate had risen to 80 deaths per 1000 live births. Maternal mortality was 395 deaths per 100 000 live births in 1992. HIV/AIDS sero-prevalence rate is estimated to be around 20% among the adult population and reported AIDS cases continue to increase each year. Literacy rates for 1992 were 75 percent for females and 86% for males. For 1997, these rates had increased to 90 percent and 82 percent respectively.

The Implications of Zimbabwe's Population Growth and Structure are outlined in chapter 3 of the policy. The economy of Zimbabwe has experienced chronic problems of, among other things, high inflation, low level of investment

in productive sectors, falling real wages and high unemployment levels. The current structure of the population decreases the nation's ability to save as the nation spends a large proportion of its resources on providing social services like education and health. Despite the massive expansion in education facilities since independence in 1980, access to quality education is still a problem in some areas. Girls still have less access to education at higher levels and this disparity is invariably translated into areas of employment and decision making where women are largely marginalised. Government also realises that unless women are fully integrated into the mainstream of development, efforts to improve their lot will not be realised. The rate at which the environment is being depleted as shown by soil erosion, gully formation etc. is now a major concern. A reorganisation of settlements is being called for in order to set aside land for use by future generations while satisfying the needs of the current generations. As Zimbabwe is largely agrarian, the issue of food security at both national and household levels is of paramount importance. Maintaining food security is becoming difficult as continuous subdivision of the land as population increases reduces its productive capacity. The goal of *health for all by the year 2000* is becoming difficult to achieve as demand for services and manpower is ever increasing, a situation worsened by the high prevalence of HIV/AIDS/STI. Apart from the general economic downturn, the present high but declining rate of population growth also constrains the nation's ability to provide adequate health facilities and services.

Chapter 4 outlines the **Goals, Objectives and Targets** set in the population policy.

The ultimate goal of the national population policy is to achieve high standards of living of the population through

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influencing the population variables and development trends in a desirable direction which can contribute to the achievement of economic, social and other collective goals of the nation. The policy also outlines sector goals which collectively lead to the achievement of the overall objective. These include management of the economy aimed at high and sustainable growth and equitable distribution of benefits at the same time promoting a population growth that is sustainable. The policy has also specific goals pertaining to education, environment, employment, health, agriculture, poverty alleviation and legal reforms. Specific targets have been set to be achieved within the framework of the population policy.

Strategies to realise the goals and objectives of the population policy have also been outlined in chapter 5 of the policy

Chapter 6 outlines the **Institutional Arrangements** to be put in place for the implementation of the population policy. For effective implementation of the population policy, an institutional framework comprised of the National Population Council of Ministers (NPC) supported by a Population Forum of Senior Government Officials and representatives from non governmental organisations and the private sector will be constituted. The population forum is expected to deliberate on population issues as they arise and appropriately recommend to the NPC and in turn, NPC to Cabinet where appropriate decisions will be made. Strategies to mobilise resources for implementation of the policy as well as capacity building and training have been recommended.

Action plans will be developed which assign detailed responsibilities for implementing the population policy.

While this population policy outlines programs and provisions

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intended to alter demographic patterns in a manner compatible with development, individual rights to choose freely and responsibly the number, spacing and timing of children they want will be fully respected.

1. RATIONALE

- 1.1. The Government of Zimbabwe realises the indispensable contribution of human resource development to economic and social development. In this regard, the Government has taken the responsibility of committing itself to a multi-sectoral framework of programmes and provisions which aim at achieving high standards of living of the people. This will be done through influencing population variables and development trends in desirable directions which can contribute to the achievement of economic, social and other collective goals of the nation. In this framework, Government posits a definitive, comprehensive and explicit policy on population which encompasses all pre-existing implicit sectoral efforts which have so far contributed much to the reduction in fertility and improved health status of the population. While maintaining a people centred approach, the multi-disciplinary nature of the population policy will take into account other emerging aspects of population and related issues. Of particular importance is the new paradigm in population dynamics which has been brought about by the HIV/AIDS pandemic. The broader definition of development as adopted in the population policy means that issues other than macro-economic ones are also getting attention.

- 1.2. Zimbabwe's development plans since independence clearly indicate the Government's commitment to improving the standards of living of the people of Zimbabwe. The launch of the Economic Structural Adjustment Programme (ESAP) in 1991 as an integral

part of the Second Five Year National Development Plan was prompted by Government's concern at the inadequate performance of the economy during the first decade of independence. In addition, the Government has already begun the decentralisation of the planning process and devolution of power from Central to Local authorities. This signifies Government's continued commitment to a development thrust which responds to people's problems and represents their goals, objectives, priorities and aspirations. On the international level, Zimbabwe has already adopted resolutions deliberated on during the International Conference on Population and Development (ICPD 1994) which encourages national Governments to formulate and implement population policies, which are people centred and recognise individual rights and freedom. Although there are indications that the population's rate of natural increase is declining, the prevailing economic growth trends are such that they cannot sustain a youthful population such as that of Zimbabwe. While it is anticipated that further declines in population growth rate will be experienced because of the HIV/AIDS pandemic, it is still imperative that the living standards of the population be improved through proper management of the population. Zimbabwe's land mass of 390 757 square kilometres cannot be used as a measure of sustainability, given that over half of the population is settled in natural regions four and five which are characterised by poor soils and low rainfall.

- 1.3. Zimbabwe, through heavy investment in health, has managed to improve the health of its population since independence. Life expectancy at birth increased from

57 years in 1982 to 61 years in 1990; Infant Mortality Rate (IMR) decreased from 83 deaths per 1000 live births in 1978 to 66 deaths per 1000 live births in 1990. Child Mortality Rate (CMR) also decreased from 37 to 26 deaths per 1000 children aged 1-4 years for the same period (1992 Census.) Immunisation coverage for children aged 12-23 months was around 80% for all vaccines in 1994. Through various implicit policies and programmes, Zimbabwe has also managed to reduce its Total Fertility Rate (TFR) from 5.96 in 1982 to 4.30 children per woman in the 1992-94 period (ZDHS 1994). Despite these apparent successes, living conditions have continued to deteriorate.

- 1.4. Although there was a general declining trend in mortality between 1978 and 1990, statistics indicate that since 1988, there has been indications of mortality increase. Infant mortality increased from 61 deaths per 1000 live births in 1988 to 66 in 1990 and 80 in 1995 (1992 Census, 1997 ICDS). Data from ZDHS 1994 also indicate that both infant and child mortality are on the increase. Adult mortality rate has also risen as indicated by the increase in the number of reported deaths. Crude Death Rate for 1997 was estimated to be 12.2 deaths per 1000 population, an increase from 9.5 in 1992. The level of community-based maternal mortality which is in the range 300-400 deaths per 100 000 live births is considered to be too high. Major causes of maternal mortality are infection, haemorrhage, pregnancy induced hypertension and complications of abortion. The causes for the increase in mortality may be due to HIV/AIDS, droughts and deteriorating social conditions. As the development of a country is often measured in terms of its health indicators, it becomes

imperative that measures be put in place to lower morbidity and mortality at all ages.

- 1.5. HIV/AIDS have begun to have significant long term impacts on the population dynamics of the country and this trend will intensify as the estimated 20% of the adult population infected with HIV develop AIDS and die. A radical change in the age structure; increases in the dependency ratios and reductions in life expectancy are expected even in the next five to ten years. In fact, the apparent recent increases in infant and child mortality as well as maternal mortality may be attributable to this increase in the number of AIDS cases. Considerable pressure is already being exerted on the health services which are overwhelmed by the sheer number of cases. The profile of the age groups most severely affected shows that the productive age-groups are slowly being depleted resulting in a dramatic change in the population age structure. There is no doubt that the HIV/AIDS pandemic is already affecting the viability and productivity of companies. Many companies are experiencing a rise in production costs due to increased morbidity and absenteeism and decreased productivity due to loss of skilled and trained manpower. The number of orphans is expected to rise due to an increase in mortality of parents. This has the effect of transferring the burden of looking after these children on the community as well as the elderly. Psychologically, the disease has also left its toll on the surviving members of the family. It has also become increasingly clear that HIV/AIDS can no longer be viewed only as a health problem, hence the need for a multi-sectoral approach to deal with it. The seriousness of the threat HIV/AIDS poses to the well-being of the

nation calls for political commitment to provide the resources necessary to effectively combat this scourge.

- 1.6. The education system has expanded in an unprecedented manner since independence with the Government declaring education a human right for everyone. However, despite this impressive expansion, there are still areas where access to education is a problem. Zimbabwe's public investment in education was in relative terms the highest in the world in 1992 with 9.1% of GDP spent on education compared to a world average of 5.1% (HDR Smart Profiles, 1996). The youthful nature of the population (43% of the population below 15 years) implies that massive investment in the education sector has to continue if education for all is to remain an attainable goal. The demand for education facilities currently outstrips supply and at times the quality and content of education is compromised in the bid to provide education for all. There is also differential access to education by gender in favour of males which needs to be addressed. Moreover, the youthful nature of the population implies high dependency on other social services which could adversely affect savings at national level.
- 1.7. Zimbabwe's population density of 30 persons per square kilometre in 1997 cannot be said to be too high if the population were evenly distributed. As it stands, the pattern of spatial distribution gives rise to pockets of very high population density. The population residing in urban areas has risen rapidly over time, posing a serious threat to proper urban development, a case in point being the emergence of squatter settlements and an increasing number of children living on the streets

of the country's major urban centres. About seventy percent of the population of Zimbabwe live in rural areas and depend largely on agriculture for their livelihood. Poor access to inputs, resources and continuous subdivision of land has led to reduced yields, thereby jeopardising food security. This calls for reorganisation of settlements to meet the needs of present generations at the same time setting aside land for future generations while protecting the environment from further degradation resulting from uneven distribution of the population.

- 1.8. The Poverty Assessment Study Survey of 1995 shows that over 61 percent of households in Zimbabwe are living below the Total Consumption Poverty Line (TCPL), implying that these families can hardly afford basic commodities. The survey also reveals that 45% of the households are below the national Food Poverty Line (FPL). Given the magnitude of the problem, a multi-sectoral approach to alleviation of absolute poverty becomes a priority
- 1.9. Land degradation is prevalent in Zimbabwe. Recurrent droughts, increased use of agricultural chemicals, poor disposal of industrial waste, gold panning, stream bank cultivation, overstocking of both domestic and wild animals, have had adverse effects on the environment and natural resources. Relaxation of settlement enforcement mechanisms after 1980 accelerated the establishment of settlements in environmentally unsuitable sites like river/dam catchment areas, thereby resulting in aquatic disasters and heavy siltation of major rivers. Steps should therefore be taken in the context of a comprehensive population policy to ensure that

land use and conservation programmes are planned with the population factor in mind.

- 1.10. The marginalization of women from the mainstream of development has been cited as a cause for concern. Females constitute 52% of the population. Women are over-represented in agriculture and unpaid family work but are under-represented in spheres like education, employment and decision making. Very few women in rural areas have direct access to productive resources such as land and credit. There is evidence that after primary school, more males than females are attending school. This disparity continues into the job market and decision making sphere. The Government realises that unless women are fully integrated into the main stream of development, efforts to improve their standards of living can not be realised. To this effect a national gender policy is currently being concluded. As women play a major role in fertility management as well as development issues, it is imperative that their aspirations be given prominence within the policy framework.
- 1.11. The needs and aspirations of the youth aged 10-24 years as well as their problems have not been adequately addressed in many development plans yet they constitute 37% of the total population (1997 ICDS). Research has indicated that youth needs in the areas of employment, education, health and communication are yet to be addressed. Moreover, their reproductive decisions and choices have much bearing on the future of the country in terms of population growth and other related issues. There is, therefore, need for a concerted effort to address their health, education and other needs.

- 1.12. The elderly population, which is classified as that proportion of the population aged 60 years and above, constituted 6% of the population in 1997. As fertility continues to decline, this proportion is expected to increase substantially. This has implications on policy and planning as the elderly have needs in terms of health, nutrition and social security which are different from those of the general population, which the society and individual families have to meet in a continuously changing socio- economic environment.
- 1.13. Increasing concern is being registered regarding the situation of persons with disabilities in terms of access to education, health and employment. In 1997 the total number of persons with disabilities was estimated to be 218 421 persons (ICDS 1997). This segment of the population has been marginalised in the past hence the need to address their concerns through the population policy.
- 1.14. Legal statutes have often been passed in isolation from other sectoral policies. This has led in some instances, to contradictions within development policies. Co-ordination of such issues can be adequately covered in the context of a multi-sectoral population policy.
- 1.15. Information, Education and Communication (IEC) on population and related issues should be made an integral component in all national development initiatives. The IEC efforts should be put in place to transcend the traditional role of the communication media as a reactor to events. A multi-sectoral IEC strategy will create and increase awareness among the

general population on the virtues of the national population policy and hence solicit support for its implementation.

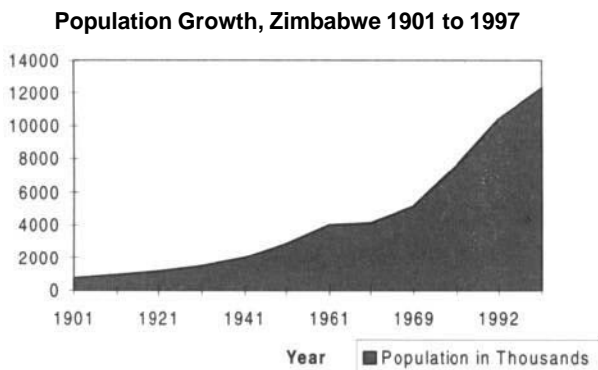
- 1.16. Although development policies in Zimbabwe have incorporated some elements of population and related facets, there has not been a coherent approach to development that embraced such issues as resource use and conservation, gender issues, HIV/AIDS and problems related to youth and adolescents. Given the Government's commitment to improving the standards of living of the population and the above socio-demographic scenario, it is quite evident that the comprehensive nature of the national population policy will enable various sectors to co-ordinate their activities in the quest for sustainable development.

2. POPULATION PROFILE

2.1 Population Size And Growth Rate.

2.1.1 According to the 1992 Population Census, the population of Zimbabwe was 10.4 million. Estimates from the Intercensal Demographic Survey indicate that the population had increased to 11.8 million by 1997. It is noted that since 1901, the total population of Zimbabwe increased more than ten times. The first doubling of the 1901 population occurred in 1931, after a period of 30 years. Since then, the doubling time has been in the region of 20 years. There are indications, however, that with the increase in HIV/AIDS pandemic, this doubling time may increase in future. The major factor for this rapid demographic transformation was the natural increase i.e. excess of births over deaths. Although the magnitude of the effect of HIV/AIDS related mortality on the growth rate is yet to be established, it is generally believed that the population of Zimbabwe will continue to grow, albeit at reduced levels.

Figure 2.1.1



2.2 Population Distribution, Density and Urban Growth

2.2.1. Statistics from the 1992 Census indicate that almost seventy percent of the population of Zimbabwe live in rural areas. Further reclassification of the population by land use sectors shows that about 51% of the population live in communal lands, 4% in resettlement areas, 2% in Small Scale Commercial Farming Areas (SSCF) and 11% in Large Scale Commercial Farming Areas (LSCF). About 28% reside in Urban Council areas while the remaining 5% reside elsewhere.¹

The proportion of persons residing in urban areas increased from 26% in 1982 to 31% in 1992 and 32% in 1997. The continued growth of urban areas is often associated with increased strain on the provision of housing and sanitation facilities. Zimbabwe's major urban centres are now characterised by an increasing presence of squatters and children living on the streets. The average household size as per 1992 census was 4.8 persons. Average household sizes varied by land use sectors from 5.81 persons in resettlement areas to 5.55 in SSCF, 5.31 in communal areas and 4.16 persons in LSCF areas. Women headed households constituted 41% in rural areas and 20% in urban areas. The average household size in Urban Council Areas was 4.08 persons.

2.2.2. The population density of Zimbabwe was found to be 30 persons per square kilometre in 1997, showing an increase from 19 persons per square kilometre in 1982 and 27 in 1992. Population density by land use is likely

¹ That is: Administrative Centres, Growth Points, Other Urban Areas and State Land.

to show higher concentrations of people in communal lands. There are provincial variations in density ranging from 9 to 50 persons per square kilometre² (ICDS 1997). The belt of high population density coincides with the agrarian and industrial tracts of the eastern and central parts of the country

2.3. Age and Sex Structure

- 2.3.1. In 1997, females constituted 52% of the population. The population aged 65 years and above was about 4 percent. Zimbabwe's population can be regarded as young with 43% of its population below 15 years (1997 ICDS). The youthfulness of the population has implications in terms of social services provision. Zimbabwe's population will continue to grow, even if fertility were to come down to replacement level, as a result of the large numbers of persons who will be entering the reproductive age group each year.

2.4 Marital Status

- 2.4.1. Data from the ZDHS (1994) show that marriage is virtually universal and occurs relatively early in Zimbabwe. About 90% of women aged 25-49 were already married by the time they turned 25 years. Polygamy is still prevalent in Zimbabwe with 18 percent of women who reported themselves as married being in such unions. The data show that for all levels of education, polygamy is increasing. The median age at first marriage has also changed from 18.9 years among women aged 40 - 49 years to 19.8 years among women aged 20 - 24 years. The data show that men, with a median age at first marriage of 25 years, enter

first marital union at a much later age than women. Only 11 percent of men aged 30-54 years were already married by age 20, compared to 62 percent of women aged 25-49 years (ZDHS 1994).

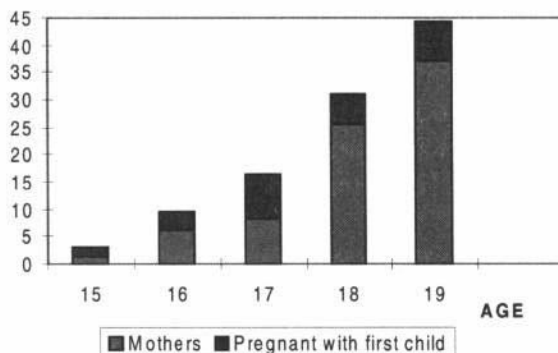
2.5 Fertility

2.5.1. The Total Fertility Rate has declined from 5.96 in 1982 to 4.30 children per woman in the 1992-1994 period. This decline was experienced for all provinces as well as across all socio-economic divisions. Provincial fertility levels in 1992 ranged from 6 children per woman in predominantly rural provinces to 3.5 children per woman in predominantly urban provinces. Fertility levels tended to decline with increasing level of education of the woman. In 1997, the TFR has remained at 4.3 children per woman (ZDHS 1994, 1992 Census, 1997 ICDS).

2.5.2. Adolescent (15-19 years) fertility has become an important issue on both health and social grounds. The median age at first birth remained around 20 years since 1988 (ICDS 1997). The low median age at first live birth means that women are exposed to the risk of childbearing for an additional 27-29 years following their first birth. Close to 40% of adolescents are already mothers by the time they are 19 years. However, the contribution of the age group 15-19 years to the decline in fertility has increased from 6.3% in 1988-92 period to 8.4% in the 1992-1997 period, implying a decline in adolescent fertility.

Figure 2.5.2

Percentage of Adolescent Women Who are Mothers or Pregnant with First Child, By Age, ZDHS 1994



2.6. Family Planning

2.6.1. Contraceptive prevalence rate (CPR) for married women aged 15-44 years is 42 percent for modern methods³ and 48 percent for all methods (ZDHS 1994). For modern methods, this was an increase from 26% in 1984 and 36 percent in 1988. The CPR comes down to 31 percent if all women aged 15-44 years are considered. Contraceptive prevalence rate for modern methods is highest among married women in the age group 25-29 years (53%) followed by those aged 20-24 years (47%). Contraceptive use is higher in urban areas and usage also increases with increasing level of education of the woman. The pill is the main method of contraception used with 80 percent of users relying on it. The current scenario calls for a more balanced method mix.

3 These are: Pill, Condom, Diaphragm, Foam/Jelly/Foaming Tablets, IUD, Injectables, Implant, Female Sterilisation, Male Sterilisation

- 2.6.2. Fifteen percent of married women in Zimbabwe have an *unmet need*⁴ for family planning. If all married women with art unmet need were to use a method, the contraceptive prevalence rate (for all methods) could be increased from 48 percent to 63 percent of all married women. The overall unmet need is highest for women aged below 25 and those over 34 years.
- 2.6.3. Data on the use of contraceptives by males indicate that men tend to depend on women for contraception. This is largely reflected by the high proportion (42%) of men who reported that their partners used the pill as their form of contraception. About six percent of married men were using condoms for contraception. This figure is higher for unmarried men (49.9%). About 4% of married men use traditional methods of family planning compared to 0.9% of unmarried men.

2.7. Morbidity and Mortality

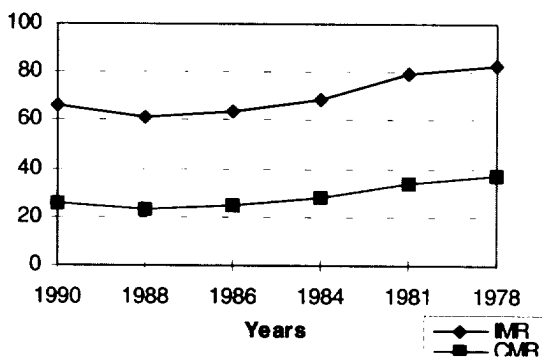
- 2.7.1. Infant Mortality decreased from 83 deaths per 1000 live births around 1978 to 66 deaths per 1000 live births in 1990. Trend analysis of mortality data indicate a gradual decline of both infant and child mortality since 1980. However, as from 1988, there are indications that mortality is on the increase with infant mortality increasing from 61 deaths per 1000 live births in 1988 to 66 in 1990 and 82 in 1995 (1997 ICDS). Child mortality also followed the same trend. Estimates from 1997 showed that rural areas experience higher rates of infant mortality than urban areas. Life expectancy has declined for males from 58 years in 1992 to 52.6

¹ Women who are currently married and who say either that they do not want any more children or that they want to wait two or more years before having another child, but are not using contraception, are considered to have an unmet need for family planning.

years in 1997 while for females, it declined from 62 years to 57.2 years respectively, From the 1992 Census, the maternal mortality rate was 395 deaths per 100 000 live births. This figure is considered high and calls for intervention.

Figure 2.7.1

Infant and Child Mortality Rates, 1978 to 1990. Zimbabwe 1992 Census



2.7.2. Institutional data show that the most common causes of illness and deaths among children are diseases of the respiratory system, diarrhoea, malnutrition, and malaria.

2.7.3. Zimbabwe is highly affected by the HIV/AIDS pandemic with around 20% of the adult population being HIV positive. The number of reported AIDS cases continues to increase every year. AIDS is more prevalent in the male population in general, with cases and mortality peaking in the 25-39 year age category. However, of concern also is the 15-19 year age group where up to 85% of cases are females (NACP 1997). Parallel to this increase in AIDS cases is the increase in cases of diseases such as tuberculosis which had been previously brought under control.

2.8. Gender issues

2.8.1. The demographic situation indicates that 52% of the population is female. The gender gap in enrolment ratios, although almost non-existent at primary school level, is quite evident at the secondary level and above. The University of Zimbabwe has introduced affirmative action in favour of female students in its enrolment policies. Since independence, the Government has taken steps to improve the status of women. The Government of Zimbabwe has since ratified the Convention of Elimination of all Forms of Discrimination Against Women (CEDAW). These efforts have since gathered momentum after the United Nations International Conference on Population and Development and the World Conference on Women held in 1994 and, 1995 respectively. These positive measures need to be strengthened further in order to adequately redress the situation and to benefit the majority of women, especially those in rural areas.

2.8.2. The gender imbalance in access to education invariably translates into gender inequity in other areas like employment and decision making at household level. There is also differential access to agricultural inputs including land resources with women being more disadvantaged. From the 1992 Population Census, 61% of the economically active population were men and 39% women. More men (76%) than women were paid employees. Seventy-four percent of the unpaid family workers were women. For those women in formal employment, the majority of them are in the agriculture sector. Statistics from 1997 ICDS show that

while equal numbers of males and females were economically active, more women than men are own *account workers*.

2.8.3. Marriage is almost universal in Zimbabwe. Most of these unions are governed by customary laws and traditions which are detrimental to the status of women. Thus the type of marriage has often a bearing on the status of women. Statistics from the 1997 ICDS show that 82% of marital unions in Zimbabwe are either traditional or customary law unions.

2.9. Education

2.9.1. Primary education is almost universal in Zimbabwe. The number of primary schools has increased from 3161 in 1980 to 4670 in 1997. Primary school enrolment for females increased from 588 233 in 1980 to 1231 473 in 1997. Enrolment figures for males for the same period increased from 647 761 to 1 259 888. Transition rates from grade seven to form one show that between 1990 and 1996, slightly more boys than girls proceeded to form one. However, for 1997, these transition rates were 75% for males and 78% for females. Statistics on secondary school enrolment for 1996 show that of the 750723 pupils enrolled, 46% percent were females (Ministry Of Education, 1997).

2.9.2. Adult literacy rate was 80% in 1992 showing an increase from 62% in 1982. Literacy rates for 1982 were 56% for women and 69% for men. These increased to 75% and 86% in 1992 for women and men respectively (1992 Census). A further increase was observed in 1997 with literacy rate of 82% for females and 90% for males. Enrolment in adult literacy programmes has been decreasing since 1990.

3. Implications Of Zimbabwe Of Zimbabwe's Population Growth And Structure:

The Government of Zimbabwe recognises the need to strike a reasonable balance between economic growth and population dynamics in order to foster sustainable development. Thus the sluggish growth in the economy and the youthful population and high dependency ratios resulting from past population growth trends and the impact of HIV/AIDS pose great challenges to the Government if sustainable development has to be fostered. The current disparities between population dynamics and economic growth are not only unsustainable but herald absolute poverty in the long run.

3.1 Population and the Economy

3.1.1. A review of the economy of Zimbabwe shows that between 1980 and 1996, the economic growth averaged 2.1% per annum. The population growth rate was estimated to be 3.1% per annum between 1982 and 1992 and 2.5% per annum between 1992-1997 (1997 ICDS). Although there are indications that the population growth rate might be declining, the population is likely to double in less than 30 years. Even if economic growth prospects were to improve, the rate of population growth is relatively too high to be sustainable. The economy has experienced chronic problems of high rates of inflation, high budget deficit, low level of investment in the productive sectors, falling real wages and high unemployment levels. This scenario is further worsened by the youthful nature of

the population. The current structure of the population decreases the national ability to save as the nation spends a large proportion of its budget on the provision of social services. The economic development of Zimbabwe will require an accelerated accumulation of capital and savings. Increased investments in the productive sectors of the economy will foster growth in output and employment.

3.2 Population and Education

3.2.1. Since Independence, the Government of Zimbabwe has declared education a human right, as it has been realised that education is an indispensable asset to individual and social development. Apart from the basic human rights point of view, education gives men and women new ideas and exposes them to new information. It increases their potential earning capacity as adults, as literate people tend to be more productive and are able to take on more complicated tasks. In the case of women, it increases their chances of working outside the home and increases their age at first marriage. Increasing education for women has also been linked to the reduction in fertility and lowering the morbidity and mortality of children.

3.2.2. A high proportion of children aged below the fifteen year threshold means rapid expansion of educational facilities in order to ensure that every child in the nation gets some education. More resources are needed in the sector, but the Government is unable to do so due to economic difficulties. This has led to an insufficient per capita grant in education. The pupil-teacher ratio has also increased. The expansion has led to an increase in enrolments, putting pressure on the limited facilities

hence the introduction of double-sessions (*hot sitting*) in some schools. Universal free primary education which ended in 1992 (at least in Urban areas) ensured almost universal enrolment and low levels of gender inequalities. However, there are marked gender differentials at secondary level with more girls than boys dropping out of school. Access to education at both primary and secondary levels is still problematic in some large scale commercial farming areas.

- 3.2.3. At household level, decisions on sending children to school are made, based on perceived micro-economic rationale that recognises *the boy's greater potential earning capacity than the girl's*. Apart from this perceived economic rationale, some parents tend to favour boys over girls as they perceive that boys are more intelligent than girls. Girls are also disadvantaged as they are expelled from schools when they fall pregnant and not allowed to go back to the same school, even after delivery. In remote rural areas, some children start school two years late on average, due to the long distance to schools. This will mean such children reach reproductive age at a lower grade than their counterparts in urban areas.

3.3 Population and Employment

- 3.3.1. The structure of our population is such that every year there are about 100 000 school leavers who have the potential to join the labour market. The formal sector has a limited capacity for generating sufficient jobs. The rate of unemployment in 1992 was 22%. The Poverty Assessment Study Survey of 1995 estimated an unemployment rate of 15%. Estimates from 1997 ICDS show that the unemployment rate had declined

to 7%. This apparent decline indicates that more and more people are joining the informal sector and because of poor economic performance, people are no longer looking for formal employment. The pattern of unemployment by age shows that the youth have the highest unemployment rates. Interestingly, a significantly greater proportion (80%) of the male economically inactive population were students compared to about 34% for females. Of concern also, is the number of children aged 10-14 who should be in school but instead, are currently employed. For 1997, this figure was 74 722 and 89% of these were employed in the agricultural sector (1997 ICDS).

3.4. Population and Agriculture

- 3.4.1. Zimbabwe's economy is largely agrarian. The agricultural sector provides food for the population, 60% of the raw materials used by agro-based companies, 25% of employment in the wage economy and generates 45% of foreign exchange earnings. The share of the agricultural sector varies between 10-22 percent of GDP depending on whether it has been a normal or poor rainfall season.
- 3.4.2. Zimbabwe's food situation is characterised by a disturbing paradox of recurrent food insecurity at household level in a country generally self-sufficient at national level. The focus on food security in Zimbabwe is now at the individual household level after having, to some degree, been successful in addressing the food availability equation at national level.
- 3.4.3. Household food security depends on the ability of each household to fulfil its food requirements in terms of

own production, remittances in cash or kind in terms of wages and other incomes as the means of acquiring food. While Zimbabwe is food secure in terms of national requirements, it is certainly still experiencing unacceptable levels of household level hunger as evidenced by the fact that 23 percent of children under the age of three are chronically malnourished and that 45 percent of all households in Zimbabwe fall below the national Food Poverty Line (ZDHS 1994, Poverty Assessment Study 1995).

3.4.4. In order to enhance food security there is need to increase agricultural production, distribution and storage of food. High population growth increases the pressure of numbers upon the nation's fertile land. The continuous subdivision of land as population increases, reduces its productive capacity. Attempts to minimise the effects of such constraints are hindered by a growing population whose immediate needs for land and food often take precedence over long term rational policies and strategies for sustainable land use.

3.4.5. Around 70-75 percent of the smallholder farming areas are located in agro-ecological regions three, four and five which are characterised by poor rainfall and poor soils. The desire to grow food crops, in particular maize, has meant that crop production is done in unsuitable areas resulting in low output. Most communal areas of Zimbabwe can be classified as experiencing land pressure if the relationship between population density, the cropping rate and livestock rate, in relation to carrying capacity, is considered.

3.4.6 Shortage of land in communal areas has forced people to cultivate steep slopes and other marginal land leading

to soil erosion. Initially, the introduction of resettlement programmes was meant to deal with the landless. However, the programme has, for the greater part, transferred from the communal areas problems like land degradation and deforestation. It is anticipated that the 1994 resettlement policy will adequately arrest further land degradation in resettlement areas.

3.5. Population and Environment

3.5.1. The rate at which the environment is being depleted as shown by soil erosion, gully formation, siltation of rivers, deforestation, water and air pollution is now a major concern. The basic factors that combine to determine the impact of society on environment are population size, growth rate, density, spatial distribution as well as human activities. The continued degradation of the environment as the large numbers of the population put pressure on resources undermines the nation's ability to ensure high living standards and sustainable development.

3.5.2. The industrial sector is responsible for the majority of pollutants from the energy sector and discharge of effluent in rivers and streams. Industrial and vehicle emissions are by far the biggest contributor to green house gases in Zimbabwe. Lack of strict control in terms of legislation, set out standards as well as lack of environmental auditing of industrial activities contribute seriously to pollution, especially in our urban and mining centres. It should also be noted that increased use of fertilisers in agriculture has become a major cause of pollution of rivers and dams.

3.6. Health and Nutrition

3.6.1. Figures from the 1992 Population Census show that Infant Mortality Rate (IMR) for 1990 was around 66 deaths per 1000 live births with Child Mortality Rate (CMR) being 26 deaths per 1000 children aged 1-4 years for the same period. For 1995, the corresponding figures for IMR and CMR were 80 and 36 respectively. The maternal mortality rate from the same census was 395 deaths per 100 000 live births. Immunisation coverage for children aged 12 to 23 months was around 80% for all vaccines (ZDHS 1994). Antenatal care coverage since 1988 has been over 90% with pregnant women relying mostly on nurses or midwives and doctors for service. However, this figure does not reflect on the quality or type of antenatal care received. Although, increasing maternal age and higher birth order are associated with lower levels of use of medically-trained personnel, the use of antenatal care services is strongly associated with mother's education. Compared to women giving birth in rural areas, those giving birth in urban areas are more likely to have received two doses of tetanus toxoid. At national level, 69% of births in the last 3 years were delivered in health facilities (ZDHS 1994). However, a child born in rural areas is four times more likely to have been delivered at home than an urban child. Higher birth orders are associated with delivery at home. Data from ZDHS 1994 show that the percent of children aged 3-35 months who are underweight (mainly due to acute malnutrition) increased from 13% in 1988 to 17% in 1994.

3.6.2. The goal to achieve *health for all by the year 2000* is becoming difficult to achieve as demand for services and human resources is ever increasing. Despite the

heavy investment in the health sector by the Government since Independence, the budget allocation for the sector in the 1990-95 period declined by 40% in real terms. Fee charging in health services may have contributed to reduced institutional delivery rates, *antenatal* care visits and immunisation coverage. Communication and transport in the health care delivery sector have always been problematic. The HIV/AIDS pandemic, at 20% prevalence for the adult population, puts a further strain on the provision of health services as facilities and staff are increasingly being required to attend to HIV/AIDS related illnesses, at the expense of other health related problems (NACP 1997). Staffing problems and shortages as can be deduced from the high doctor -patient ratio also hamper provision of health services.

3.7 Household and Housing Pressure

3.7.1. Zimbabwe's youthful age structure imposes a high dependency burden at household level in terms of the resources needed to take care of the large number of children. The child dependency ratio for 1997 was estimated to be 98. The average household size as per 1992 census was 4.8 persons. Average household sizes varied by land use sectors from 5.81 in resettlement areas to 5.55' in SSCF, 5.31 in communal areas and 4.16 persons in LSCF areas. The average household size in Urban Council Areas was 4.08 persons. Women headed households constituted 41% in rural areas and 20% in urban areas. About 11 000 households in 1992 were headed by children below 15 years of age. As HIV/AIDS related adult mortality increases this situation is likely to worsen and also result in increased child labour. At household level, HIV/AIDS leads to severe depletion of income and increased consumption costs.

3.7.2. Overcrowding within households and housing and/or affordability in urban areas are major problems. Rapid population growth often put pressure on urban areas to adequately provide housing resulting in the emergency of squatter settlements and increased presence of homeless people. This has ramifications on household pressure in terms of environment, sanitation and the economy. While there are standards for construction of homes in urban and resettlement areas, there are no such equivalent in the rural areas. Thus some people in rural areas may be living in substandard shelter which compromise their health status. Although there are some guidelines available at the Ministry of Health and Child Welfare on environment standards, the utilisation of these guidelines is questionable.

3.8 Information, Education and Communication (IEC)

3.8.1. Information, Education and Communication activities are now recognised as crucial components of the consultative development planning approach. In Zimbabwe, IEC activities are mainly sector specific and lack co-ordination and thus have limited impact. The need therefore to integrate IEC activities is critical if the goals and objectives of this policy are to be met.

4. Goals, Objectives And Targets

4.1 Goals

The ultimate goal of the national population policy is to achieve higher standards of living of the people through influencing population variables and development trends in desirable directions which can contribute to the achievement of economic, social and other collective goals of the nation.

4.2 Specific Goals

4.2.1. The Economy

- 4.2.1.1. Economic management aimed at a high and sustainable growth in the economy with a fair and equitable distribution of the ensuring benefits.
- 4.2.1.2. Attainment of a high standard of living of all Zimbabweans.

4.2.2. Demographic

- 4.2.2.1. Achievement of population growth, age and spatial distribution that are more favourable to sustainable socio-economic development.
- 4.2.2.2. Increased awareness and use of population and development issues in planning.

4.2.3. Education

- 4.2.3.1. Availability of skilled manpower.
- 4.2.3.2. Provision of quality education.
- 4.2.3.3. Achievement of gender equity at all educational levels.
- 4.2.3.4. Increased participation in education of disadvantaged groups.

4.2.4. Environment

- 4.2.4.1. Creation of enabling conditions for sustainable use of natural resources and growth in tourism.
- 4.2.4.2. Sustainable use of resources and their preservation for future generations.

4.2.5. Employment Creation and Poverty Alleviation

- 4.2.5.1. Employment creation.
- 4.2.5.2. Poverty alleviation

4.2.6. Youths /Adolescents

- 4.2.6.1. Development of a youth who is socially adjusted and economically empowered.
- 4.2.6.2. Promotion of adolescent health with particular emphasis on reproductive health.
- 4.2.6.3. Improved communication between parents and children.

4.2.7. Persons with Disabilities

- 4.2.7.1. Promotion of integration of persons with disabilities in development.

4.2.8. The Elderly

- 4.2.8.1. Promotion of health and welfare of the aged.

4.2.9. HIV/AIDS and STI's

- 4.2.9.1. Curbing the further spread of HIV/AIDS and other sexually transmitted infections.
- 4.2.9.2. Reduction of the impact of HIV/AIDS on individuals, families and communities.

4.2.10. Health and Nutrition

- 4.2.10.1. Reduction of morbidity and mortality levels for all age groups.
- 4.2.10.2. Maintenance of nutritional well being of all individuals in society

4.2.11. Reproductive Health

- 4.2.11.1. Provision of reproductive health services for all.
- 4.2.11.2. Promotion of male involvement in reproductive health decisions.

4.2.12. Gender Equity

- 4.2.12.1. Achievement of gender equity, and integration of disadvantaged groups into the main stream of development.

4.2.13. Domestic Violence and Child Abuse

- 4.2.13.1. Reduction of levels of domestic violence and child. abuse.

4.2.14. Agriculture and Land

- 4.2.14.1. Acceleration of land reform and reorganisation of settlement areas, taking into account population dynamics and conservation of natural resources.
- 4.2.14.2. Increase agricultural productivity to enhance food security.

4.2.15. Legal Reforms

- 4.2.15.1. Amendment or repealing of those laws and regulations that are contradictory to the goals of the population policy and other development policies.

4.2.16. Information, Education and Communication (IEC)

- 4.2.16.1. Adoption of a strong collaborative multi-sectoral and interdisciplinary approach to IEC dealing with all aspects of the population policy.

4.3 Objectives

The objectives of the population policy are to:

4.3.1. The Economy

- 4.3.1.1. Ensure a high rate of growth of the economy
- 4.3.1.2. Ensure a more equitable and fair distribution of the benefits derived from the economy

4.3.2. Demographic

- 4.3.2.1. Reduce the population growth rate to be in tandem with the pace of development.
- 4.3.2.2. Ensure that the human factor is central in all development plans at all levels of planning
- 4.3.2.3. Achieve a more even distribution of the population between rural and urban areas and within rural areas.

4.3.3. Education

- 4.3.3.1. Ensure the provision of facilities and curriculum for manpower development.
- 4.3.3.2. Achieve gender equity in education.
- 4.3.3.3. Provide education to disadvantaged groups and areas.

4.3.4. Environment

- 4.3.4.1. Increase awareness on sustainable development, conservation of natural resources and environmental management.
- 4.3.4.2. Ensure sound management of natural resources and the environment to promote sustainable use natural resources.

4.3.5. Employment and Poverty alleviation

- 4.3.5.1. Implement multisectoral programmes aimed at poverty reduction.
- 4.3.5.2. Promote employment creation.
- 4.3.5.3. Increase women's participation in gainful employment.

4.3.6. Youths /Adolescents

- 4.3.6.1. Promote youth participation in development activities.
- 4.3.6.2. Provide opportunities for the youth employment and initiatives.
- 4.3.6.3. Provide career guidance and counselling for the youth.
- 4.3.6.4. Promote policies that protect youth from any form of abuse.
- 4.3.6.5. Reduce incidence of abuse of drugs and alcohol among the youth.
- 4.3.6.6. Reduce prevalence of high risk sexual behaviour among the youth.
- 4.3.6.7. Strengthen parent-child communication.

4.3.7 Persons with Disabilities

- 4.3.7.1. Promote integration of people with disabilities in all aspects of national development.

4.3.8 The Elderly

- 4.3.8.1. Reduce poverty among the elderly.
- 4.3.8.2. Cater for the needs of the elderly in terms of health, employment, education and income security.
- 4.3.8.3. Strengthen the capacity of the elderly to look after orphans.

4.3.9. HIV/AIDS/STI

- 4.3.9.1. Promote attitudinal change and reinforce responsible sexual behaviour.
- 4.3.9.2. Provide adequate clinical management and social support for those affected and infected by HIV/AIDS/STI.
- 4.3.9.3. Reduce the spread of HIV/AIDS/STI.

4.3.10. Health and Nutrition

- 4.3.10.1. Improve the nutritional status of the population with particular emphasis on children.
- 4.3.10.2. Reduce levels of morbidity and mortality for all age groups.
- 4.3.10.3. Reduce the incidence of high risk births.

4.3.11. Reproductive Health

- 4.3.11.1. Encourage men's involvement and spousal communication in making family size decisions.
- 4.3.11.2. Facilitate an environment where reproductive health needs of women, men, the aged, people' with disabilities and adolescents are adequately addressed.
- 4.3.11.3. Reduce the *unmet need* for contraception.

4.3.12. Gender Equity

- 4.3.12.1. Advocate for gender equity and equality.
- 4.3.12.2. Promote programmes that ensure gender equity and equality in all areas.

4.3.13. Domestic Violence and Child Abuse

- 4.3.13.1. Reduce incidence of domestic violence.
- 4.3.13.2. Provide support services for victims of domestic violence and abuse.
- 4.3.13.3. Protect children from economic exploitation and sexual abuse.

4.3.14. Agriculture and Land

- 4.3.14.1. Strengthen programmes aimed at land reform and reorganisation of all settlements.
- 4.3.14.2. Increase agricultural food production and distribution to ensure food security at household level.
- 4.3.14.3. Encourage agricultural practices which are compatible with agro-ecological zones.
- 4.3.14.4. Lessen the impact of recurrent drought on the general population.

4.3.15. Legal Reforms

- 4.3.15.1. Ensure that those laws and regulations that are contradictory to effective implementation of the population policy and other development policies are either amended or repealed.
- 4.3.15.2. Encourage a review of those socio-cultural practices which may have a contradictory effect on the population policy.
- 4.3.15.3. Create an enabling environment that allows

disadvantaged groups to participate in all areas of life.

4.3.16. Information, Education and Communication (IEC) and Advocacy

- 4.3.16.1. Improve infrastructure in the communication sector.
- 4.3.16.2. Strengthen the skills base within the IEC sector.
- 4.3.16.3. Ensure total accessibility and coverage of the whole country by the communication sector.

4.4 Targets

The main targets of the policy are to¹ :

- 4.4.1. Increase the growth of the economy to at least 6% per annum in real terms from 1998 onwards.
- 4.4.2. Reduce the uneven distribution of wealth as measured by the *Gini - coefficient* from 0.72 in 1992 to below 0.5 by 2020.
- 4.4.3. Reduce fertility rate from 4.3 in 1997 to 3.5 children per woman by year 2002.
- 4.4.4. Reduce infant mortality rate from 61 deaths per 1000 live births in 1992 to below 50 by the year 2005 and to below 35 by 2015.
- 4.4.5. Increase the mean age at first marriage to 21 years for girls by year 2005,
- 4.4.6. Increase enrolment of girls at secondary and tertiary levels to 50 percent by year 2000.
- 4.4.7. Reduce the level of absolute poverty from 45% in 1995 to 20% by the year 2005.
- 4.4.8. Develop a youth policy by the year 2002.

- 4.4.9. Carry out a national disability survey by the year 2000.
- 4.4.10. Effect review/ amendment of legislation affecting persons with disabilities by the year 2000.
- 4.4.11. Reduce maternal mortality from 395 deaths per 100 000 live births in 1992 to below 200 by the year 2005.
- 4.4.12. Increase immunisation coverage for children aged 12 -23 months from 80% in 1994 to above 90% by year 2005 for all vaccines.
- 4.4.13. Increase percentage of births attended at health facility from 69% in 1994 to 80% in 2005.
- 4.4.14. Reduce the proportion of adolescents who are becoming mothers below the age of 20 from 40% in 1994 to a lower figure by the year 2002.
- 4.4.15. Reduce the proportion of high risk births by 50% by year 2005.
- 4.4.16. Increase contraceptive prevalence rate for modern methods from 42 percent to at least 52% by year 2002.
- 4.4.17. Increase resettlement land from 3.5 million hectares to 8.3 million hectares by the year 2002.
- 4.4.18. Amend and repeal those laws that are contradictory to the achievement of population goals and objectives.

5. Implementation Strategies

In order to realise the aforementioned goals and objectives, the following strategies are to be followed:

- 5.1. The Economy**
- 5.1.1. Create a conducive and attractive investment climate in order to encourage investment from both domestic and international sources.
 - 5.1.2. Reduce the budget deficit and allow market forces to operate freely as detailed in *Vision 2020, Three Year Rolling Plan 1998-2001 and ZIMPREST*
 - 5.1.3. Increase investment in order to foster a greater growth impetus in the economy
 - 5.1.4. Investigate and remove obstacles that prevent women from participating in the economy as entrepreneurs and having access to finance.
 - 5.1.5. Alleviate poverty
 - 5.1.6. Development planning to integrate population and gender variables at national, provincial and district levels for all sectors.
- 5.2. Education**
- 5.2.1. Develop a broad based and gender sensitive curriculum that meets the demands of the economy.
 - 5.2.2. Take affirmative action to provide disadvantaged groups with education.
 - 5.2.3. Incorporate population education curriculum at an early stage at all levels.

- 5.2.4. Promote more programmes aimed at improving the opportunities for girls in order to achieve gender equity in education.
- 5.2.5. Develop literature which is gender sensitive.
- 5.2.6. Provide for girls and women to continue with their education after they fall pregnant.
- 5.2.7. Make it mandatory that children stay in school up to *Ordinary level*.
- 5.2.8. Strengthen the delivery of education through distance education strategies.
- 5.2.9. Promote guidance and counselling in the education sector.
- 5.2.10. Make education more accessible and affordable to all with special emphasis on LSCF, border districts and street children.
- 5.2.12. Provide special facilities within schools to cater for educational needs of persons with disabilities.

5.3.

Environment

- 5.3.1. Enforce regulations that ensure proper use of natural resources.
- 5.3.2. Enhance community participation in the sustainable utilisation of natural resources.
- 5.3.3. Advocate for changes in the present land tenure system and intensify sound land use plans in order to curb environmental problems.
- 5.3.4. Develop a national water policy and promote proper management of water resources.
- 5.3.5. Enhance sound management of forests, veldts, wild life and protected areas.

- 5.3.6. Intensify awareness campaigns on management of agricultural chemicals, energy production and use, air pollution, noise pollution and working environment.
 - 5.3.7. Advocate for alternative sources of energy to reduce dependence on firewood for fuel.
 - 5.3.8. Make environmental impact assessment mandatory for any project before it is approved.
 - 5.3.9. Introduction of an integrated environmental and natural resources management.
 - 5.3.10. Educate the population on the need to conserve the environment and involve them in its management.
 - 5.3.11. Avoid over utilisation of resources and ensure that future generations also enjoy the benefits of the available natural resources.
- 5.4. Employment and Poverty Alleviation**
- 5.4.1. Introduce and/or strengthen career guidance.
 - 5.4.2. Create an enabling environment for micro-enterprise development.
 - 5.4.3. Ensure full participation of women in the labour force.
 - 5.4.4. Encourage labour intensive projects where appropriate.
 - 5.4.5. Create more opportunities for youth to be engaged in economically viable projects.
 - 5.4.6. Implement labour intensive projects which generate employment for the growing population.

- 5.5. Youths/adolescents**
- 5.5.1. Develop a comprehensive youth policy in consultation with the youth.
 - 5.5.2. Develop programmes (including training of health personnel) designed to address reproductive health problems of the youth, with their participation.
 - 5.5.3. Strengthen HIV/AIDS/STI management programmes targeting the youth.
 - 5.5.4. Strengthen reproductive health education in and out of school.
 - 5.5.5. Expand educational and vocational training facilities to adequately prepare the youth for a more productive economic and social life.
 - 5.5.6. Provide counselling services to minimise problems relating to alcohol and drug abuse and reproductive health issues.
 - 5.5.7. Provide employment opportunities and recreational facilities for the youth.
 - 5.5.8. Strengthen community based support programme for homeless street children and orphans.
 - 5.5.9. Advocate for establishment of parent education programmes related to youth problems and parent-child communication.
- 5.6. Persons with Disabilities**
- 5.6.1. Carry out a national disability survey and obtain a national profile of persons with disabilities.
 - 5.6.2. Put in place affirmative action for persons with disabilities.
 - 5.6.3. Make it mandatory that all public places and buildings be easily accessible to persons with disabilities.

- 5.6.4. Launch educational campaigns to increase awareness among the general public on the issues pertaining to persons with disabilities.
- 5.6.5. Integrate needs of persons with disabilities in all national plans and programmes.
- 5.6.6. Strengthen health programmes to address reproductive health needs and aspirations of persons with disabilities.
- 5.6.7. Establish new laws or amend/repeal old ones in order to realise the rights and aspirations of the persons with disabilities.

5.7. The Elderly

- 5.7.1. Introduce legislation on the care of the elderly.
- 5.7.2. Provide care for the elderly within the community.
- 5.7.3. Make health system more sensitive to the needs of the elderly
- 5.7.4. Provide those aged 60 years and above with some form of old age security.
- 5.7.5. Create awareness of all public assistance available for the elderly
- 5.7.6. Provide adequate resources for the elderly looking after orphans.
- 5.7.7. Identify ways and means through which the elderly could continue to make active contributions to the economic, social and cultural life of their families and communities.

5.8. HIV/AIDS/STI

- 5.8.1. Use effectively, the results of studies on the socio-economic impact of AIDS on the population.

- 5.8.2. Allocate adequate resources to deal with the added burden of HIV/AIDS on the health system.
 - 5.8.3. The National AIDS Co-ordination Programme (NACP) to be reflective of the multi-sectoral nature of the HIV/AIDS pandemic.
 - 5.8.4. Encourage community based support and care of orphans and people living with AIDS.
 - 5.8.5. Make testing for HIV and counselling services easily available and affordable.
 - 5.8.6. Promote behavioural change to reduce transmission rate of HIV/AIDS/STI.
 - 5.8.7. Strengthen the programmes to educate the population on HIV/AIDS/ST1 prevention.
 - 5.8.8. Political commitment and articulation for formulation of realistic programmes and policies aimed at HIV/AIDS prevention, control and care.
 - 5.8.9. Strengthen surveillance and evaluation system for HIV/AIDS/ST1 prevention and control
 - 5.8.10. Provide support for people living with AIDS.
- 5.9. Health and Nutrition**
- 5.9.1. Make health facilities more accessible and affordable for pregnant women in order to reduce maternal mortality.
 - 5.9.2. Launch educational campaigns to discourage high risk births.
 - 5.9.3. Encourage longer exclusive breast-feeding periods and longer births intervals.

- 5.9.4. Intensify existing programmes meant for child survival.
- 5.9.5. Encourage a multi-sectoral approach to health problems.
- 5.9.6. Introduce educational campaigns on the nutritional values of various food crops.
- 5.9.7. Intensify primary health care programmes.
- 5.9.8. Improve the efficiency of the health care referral system.
- 5.9.9. Reduce malnutrition among children.
- 5.9.10. Strengthen implementation of health programmes which target the reduction of morbidity and mortality.

5.10. Reproductive Health

- 5.10.1. The family planning programme to continue with ongoing efforts to increase contraceptive availability, accessibility, use and improve method mix.
- 5.10.2. Develop programmes to reduce the unmet need for contraception.
- 5.10.3. Intensify male motivation campaigns in order to increase men's participation in reproductive health.
- 5.10.4. Remove obstacles to make reproductive health services easily accessible and available to all those who are sexually active.
- 5.10.5. Integrate Sexually Transmitted Infections (STI) management and family planning services.
- 5.10.6. Health providers to be more sensitive to reproductive health requirements of various groups.

- 5.10.7. Educate and inform the population on the implications of their reproductive health decisions on the nation.

5.11. Gender Equity

- 5.11.1. Adopt a national gender policy by Government.
- 5.11.2. Create gender awareness in society, particularly among policy makers and opinion leaders.
- 5.11.3. Remove obstacles which militate against gender equity in all areas.
- 5.11.4. Continue various affirmative programmes until such a time when gender equity is achieved.
- 5.11.5. Repeal those laws and regulations which hinder the advancement of women.
- 5.11.6. Review sectoral policies and programmes in order to make them more gender sensitive.
- 5.11.7. Make gender consideration a requirement for all projects before approval.
- 5.11.8. Promote gender relevant research and collection of gender dis-aggregated data.
- 5.11.9. Review of customary practices that are retrogressive and which function as barriers to the integration of women into development.
- 5.11.10. Advocate for gender equity and equality.

5.12. Domestic Violence and Child Abuse

- 5.12.1. Instil self confidence in children, through guidance and counselling.
- 5.12.2. Intensify educational campaigns to

- discourage cultural practices that encourage child abuse.
 - 5.12.3. Provide support services to abused children.
 - 5.12.4. Introduce programmes which remedy gender bias in the law enforcement agencies.
 - 5.12.5. Educate society and condemn domestic violence on its detrimental implications.
 - 5.12.6. Emphasise the role of the family as a nurturing institution to eliminate domestic violence.
 - 5.12.7. Propagate that physical domestic violence is a criminal offence.
- 5.13. Agriculture and land**
- 5.13.1. Promote efficient and sustainable use of resources to generate higher output to ensure food security.
 - 5.13.2. Establish programmes that reduce the vulnerability of the population to uncertain and unpredictable weather patterns that seriously undermine agricultural production.
 - 5.13.3. Promote diversification of cropping and livestock farming.
 - 5.13.4. Increase irrigation facilities.
 - 5.13.5. Improve research, extension and farmer training linkages to enable the adoption of sustainable farming methods.
 - 5.13.6. Increase community participation in reviewing and implementing agricultural policies.

- 5.13.7. Implementation of the revised resettlement policy to be accompanied by monitoring structures to guard against carrying over, from the communal areas, problems associated with overcrowding.
- 5.13.8. Strengthen agricultural sector management and invest in storage, distribution and market development.

5.14 Legal Reforms

- 5.14.1. Review those customary laws which give limited rights to women and other disadvantaged groups.
- 5.14.2. Rationalise some legal statutes in order to avoid contradictions, inadequacies and inconsistencies as they affect the goals and objectives of the population policy
- 5.14.3. Review and amend the current law on rape to remove inadequacies.

5.15 Information, Education and Communication (IEC)

- 5.15.1. Ensure that comprehensive IEC activities are undertaken in order to incorporate the aspirations of the beneficiaries of development policies.
- 5.15.2. Integrate IEC activities in all development policies and programmes.
- 5.15.3. Improve accessibility of vital and relevant information on issues that have implications on population and sustainable development.
- 5.15.4. Facilitate linkages between and among sector stake-holders in the implementation

of development programmes through communication.

5.15.5. Accelerate policy reforms in the communication sector, especially broadcasting and thus ensure accessibility to multiple channels for information services to the population.

5.15.6. Provide access to information pertaining to legal matters.

6. Institutional Framework

6.1 Implementation Framework

6.1.1 To assist in the implementation of this policy, it is recommended that the National Population Council (NPC) formed in November 1994 and chaired by the Planning Commissioner be given the responsibility of implementing the population policy. The National Population Council of Ministers will be supported by a Population Forum consisting of senior officials from Government Ministries, representatives from Non-Governmental Organisations, and the private sector as represented by its respective organisations. This forum will be reporting to the National Population Council through the Planning Commission.

The National Population Council will include the following persons:

The Planning Commissioner (Chairman), National
Economic Planning Commission
Minister of Health and Child Welfare
Minister of Education, Sports and Culture
Minister of Higher Education and Technology
Minister of Local Government and National Housing
Minister of Information, Posts and
Telecommunications
Minister of Mines, Environment and Tourism
Minister of Agriculture and Lands
Minister of Rural Development and Water Resources
Minister of Public Service, Labour and Social Welfare
Minister of National Affairs, Employment Creation and
Co-operatives
Minister of Finance

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Minister of Justice, Legal and Parliamentary Affairs
Minister of Home Affairs.

6.1.2 The Population Forum will also be constituted by senior Government officials from the same ministries in the National Population Council and organisations like the following whose activities have a bearing on population and development:

University of Zimbabwe

National Council of Higher Education.

Zimbabwe Council of Churches (ZCC);

Prolife Association of Zimbabwe

Catholic Commission for Justice and Peace (CCJP);

National AIDS Co-ordination Programme (NACP);

Population Services of Zimbabwe

Zimbabwe National Family Planning Council
(ZNFPC)

Zimbabwe Human Rights Organisation
(ZIMRIGHTS;)

National Association of Non Governmental
Organisations (NANGO;)

Employment Confederation of Zimbabwe (EMCOZ;)

Zimbabwe Congress of Trade Unions (ZCTU;)

Zimbabwe National Chamber of Commerce (ZNCC;)

Confederation of Zimbabwe Industries (CZI;)

Commercial Farmers Union (CFU);

Zimbabwe Farmers Union (ZFU);

Donor Community;

Natural Resources Board

Zimbabwe Women's Resource Centre and
Network (ZWRCN);

Women's Action Group (WAG);

Msasa Project

Other NGOs not affiliated to NANGO

Local Authorities
Urban and Rural Council Associations
Political Parties

6.1.3 The Population Forum will be expected to deliberate on population issues as they arise and recommend appropriately to the National Population Council and ultimately the council to Cabinet where appropriate decisions will be reached.

6.1.4 At provincial level, the existing Local Government structures (Provincial Development Committee, District Development Committee) will be used to articulate population policy matters, with the National Economic Planning Commission responsible for the co-ordination of the activities.

6.2 Capacity Building, Training and Data Collection

There is need to assess short and long term training requirements of personnel for all the components of the population policy. To ensure that trained personnel are available for the implementation of the population policy, various strategies will be employed:

6.2.1. Short courses on population and development, including in-service training for civil servants, to be carried out by institutions.

6.2.2. Intensive training of population and related development personnel in the local and international educational institutions to promote national self sufficiency and execution of programmes.

6.2.3. Ensure that all the actors in the population policy have adequate material and

- financial resources.
- 6.2.4. Establish a comprehensive human resource policy for the retention of staff working on the population programme.
- 6.2.3. Training of communication media.
- 6.2.6. Ensure timely collection, processing and analysis of data, and dissemination of findings to policy makers, planners, researchers and the public at large.
- 6.2.7. Strengthen the capacity of all producers and users of statistics to collect, analyse and disseminate population and other relevant data.
- 6.2.8. Strengthen the vital registration system and establish data collection centres at district or lower levels.
- 6.2.9. Establishment of a data base to support all population activities.

6.3 Resource Mobilisation

The following strategies are going to be adopted in order to mobilise resources for population policy activities.

- 6.3.1. Review of current financing patterns and resource allocation with a view to preparing guidelines for resource mobilisation.
- 6.3.2. Inventory of available internal and external resources, including financial, technical and human.
- 6.3.3. Reduce overlap and improve co-ordination of resource utilisation.
- 6.3.4. Government should provide incentives to the private sector to encourage them to finance population programmes.
- 6.3.5. Further involvement of private sector in

population projects through education and marketing.

6.4 Monitoring and Evaluation

There is need to continuously monitor the socio-economic and demographic situation in the country *vis-a-vis* the population policy hence the adoption of the following strategies:

- 6.4.1. Continuous monitoring and evaluation of the implementation of the population policy and programmes.
- 6.4.2. Improve monitoring and efficiency of resource utilisation.
- 6.4.3. Provide feedback on monitoring reports and effective utilisation of valid evaluation results.

7. Glossary

1. **Child Mortality Rate (CMR)** is the number of deaths of children in the age group 1-4 years per 1000 children in the same age group.
2. **Contraceptive Prevalence Rate (CPR)** denotes the percent of women who are using a method of family planning. This is usually given for currently married women.
3. **Food Poverty Line (FPL)**- refers to the amount of income required to buy a basket of basic food commodities needed by an average person per annum. Those people who fall below the FPL are considered as very poor. **Total Consumption Poverty Line (TCPL)**-refers to the amount of income required to purchase a basket of food and non food commodities for example clothing, housing, education, transport etc. by an average person per annum. Those persons falling above the FPL but below the TCPL are considered poor. Those above the TCPL are considered as non poor.
4. **GDP**- Gross Domestic Product.
5. **Gini's coefficient**- an economic indicator which measures the distribution of wealth in society.
6. **HDR**- Human Resources Development Reports
7. **ICDS 1997**- Intercensal Demographic Survey 1997
8. **Infant Mortality Rate (IMR)** is defined as the number of children dying before their first birthday out of 1000 infants born alive.
9. **Life Expectancy at Birth** is the average number of years that a member of a cohort of births would be expected to live if the cohort were subjected to the mortality conditions expressed by a particular set of age

specific mortality rates.

10. **Maternal Mortality Rate** refers to the number of deaths occurring to women aged 15-49 and are caused by complications during the time of pregnancy, child birth as well as a result of complications occurring within forty-two days after delivery. The rate is expressed as the number of deaths per 100 000 live births.
11. **Total Fertility Rate (TFR)** refers to the average number of children that would be born per woman according to a given set of age specific fertility rates pertaining to a particular year or time interval if all women lived to the end of their child bearing years.
12. **Unmet Need for Contraception** : Women who are at risk of getting pregnant and who do not want to have any more children or want to wait for two or more years before having another child but are not using contraception are said to have an *unmet need* for contraception.
13. **ZDHS (1994)** Zimbabwe Demographic and Health Survey, 1994, Central Statistical Office
14. **STI** Sexually Transmitted Infection

Annex 1

Demographic Indicators

(Zimbabwe Fact Sheet: 1992 Population Census and 1997 ICDS)

Population Size	1992	1997
Total	10 412 548	11 789 274
Males	5 083 537	5 647 090
Females:	5 329 011	6 142 184
Sex Ratio (Males/1 00 females:	95	92

Urban/Rural Population

Population in Urban area:	3 187 720	3 826 580
Percent:	31	32
Population in Rural Areas	7 224 828	7 962 694
Percent:	69	68

Area and Density

Area (Sq.Km.):	390 757	
Density (Persons/Sq.Km.): 1992	27	30
1982	26	

Housing Conditions

Percent of households with Electricity:	28	35
with Safe Water:	77	83
with Toilet Facilities:	66	72

Source of energy

Percent of households using		
Wood for cooking	66	62

Fertility

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Crude Birth Rate (Births/1000 population)

Indirect methods:	43.5	
Direct methods:	34.5	34.7

Total Fertility Rate

(Average number of children/woman)

Indirect methods:	5.91	
Direct methods:	4.39	4.32

Age Composition (Percent)

Under 15 years:	45	43
15-64 Years:	51	53
65 + years:	3	5
The elderly 60 years plus	5	8

Mortality

Crude Death Rate (Deaths/1000 population)

Direct Methods:	9.49	12.2
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Infant Mortality Rate

(Infant deaths/1000 live births):

1990:	66	80 (1995)
1978:	83	

Child Mortality Rate

(Child deaths/1 000 children aged 1 - 4 years)

1990:	26	36 (1995)
1978:	37	

Expectation of Life at Birth

1990:	61	57 (1995)
1978:	57	

Maternal Mortality Rate

(Deaths from maternal causes)

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per 100 000 live births):	395	
Crude Rate of Natural Increase (The rate of natural growth per 1000 population):	25.5	2.25
Average Annual Intercensal Population Growth (percent)	3.14	248

Marital Status (population aged 15 years and above)

Percent never Married:	34	55
Percent Married:	56	42
Percent Divorced/Separated:	5	2
Percent Widowed:	5	1

Types of Marriages

Customary Law		12%
Civil Law		17%
Traditional		71%

Households

Number of Private Households:	2 163 289	2 510 410
Average Household Size:	4.8	4.7
Percent of Male-headed Households:	67	67

Education for population aged 5 + years

Percent never been to school:	17	12
Percent currently at school:	34	36
Percent left school:	49	50

Activity and Labour Force

Economically Active:	3 501 798	4 921 031
Percent Communal Farm Workers:	23	51
Percent Other Employed:	55	42

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Percent Unemployed:	22	7
Economically Inactive:	2 179 793	1 807 620
Percent Students:	33	51
Percent Homemakers:	51	37
Percent Retired/Sick/Too Old/Others	16	12

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Economic Indicators

EconomicIndicator	Year					
	1991	1992	1993	1994	1995	1996
Gross Domestic Product (GDP) Real Growth Rate	-5.3	-9.1	1.1	7.1	0	7.3
Total Formal Employment ('000s)	1244.0	1236.2	1240.3	1263.7	1233.7	1237.3
Gross Domestic Savings as % of GDP	13.6	11.1	20.9	21.8	20.3	25.0
Inflation Rate	23.3	42.1	27.6	22.4	22.6	21.4

