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Review Article

Revitalizing Primary Health Care for Maternal and Child Healthcare En-route to Attaining Universal Health Coverage, and the SDGs in Zimbabwe by 2030

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Abstract

The state of health is linked to the national socio-economic conditions and development paradigms. Zimbabwe has undergone a protracted and complex social, economic and political strife that has over the past two decades, negatively impacted on key national systems and institutions including health, education, social welfare and economic development. This situation severely challenged the health system, putting vulnerable populations, especially women and children at high risk of ill health and premature demise from unattended disease and health conditions. The health sector was already facing deep structural and operational challenges, even before COVID-19, and the pandemic worsened and further exposed the system wide demise.

Keywords: COVID-19; Maternal Mortality Rate (MMR)

Introduction

The sector has suffered from years of gross underfunding and investments, with public health spending accounting for a relatively small proportion of total government spending, the health sector allocation standing at 10.6% in 2022 down from 13.0% in 2021 [1]. The inadequate public financing of health has resulted in a poorly run, poorly performing health system with an overreliance on out-of-pocket and external financing. This has evidently been highly unsustainable and inconsistent with achieving universal access to health, among other targets to be achieved by the country by 2030. Zimbabwe has therefore failed to adequately serve the major users of the health delivery system, the mothers and children under five, and today faces a critical challenge in ensuring the safety and well-being of mothers during and in the aftermath of childbirth. The stark reality is a high maternal mortality rate (MMR) of 363 deaths per 100,000 live births, according to a 2022 report by UNFPA Zimbabwe and confirmed by the national census of 2022 [2]. This figure stands in stark contrast to the global target of 70 per 100,000 live births set by the Sustainable Development Goals (SDGs), highlighting a significant gap that needs to be addressed urgently.

Several factors have contributed to this disparity in maternal healthcare outcomes. A major concern is the under-resourced public healthcare system. Reports by Amnesty International, reveal underfunding and understaffing of government hospitals. This translates to a lack of skilled healthcare providers readily available during childbirth, a critical time when access to qualified medical professionals can make the difference between life and death.

Zimbabwe has been a signatory international policies and declarations on health and its determinants, including the Alma Ata, (1978) [3] Ouagadougou, (2008), Astana, (2018) [4] declarations on primary health care, (PHC), the Millennium Development Goals (MDGs, 2000 – 2015) [5], the Sustainable Development Goals (SDGs, 2015-2030), WHO Global and African Regional, (WHO Afro) pronouncements on health; the Continental Agenda 2063, the Abuja Declaration of 2000 [6], the UNICEF regional agenda on maternal and child health among other commitments to improve the health of women and children.

Nationally, a number of frameworks and policy pronouncements have been developed to support the health, social and general wellbeing of women and children; the National Constitution (2013) [7], the National Development Strategy, (NDS 1, 2021-25) [8], and the National Health Strategy, (NHS, 2021-25) [9], of the Ministry of Health and Child Care, (MOHCC). Furthermore, the World Health Organization, (WHO) through its Country Cooperative Strategies [10], UNICEF, UNFPA, the World Bank, Global Fund, Gavi and other partners also provide various levels of support to the MOHCC and related sectors for improving maternal, child and general health care.

The National Health Strategy (MOHCC, 2021-2025) prioritizes 10 strategic areas – (i) access to medications and commodities, (ii) improved water and sanitation, (iii) improved health infrastructure and equipment, (iv) improved governance, (v) improved health sector personnel performance, (vi) improved domestic funding, (vii) reduced morbidity and mortality, (viii) improved reproductive, maternal and child health care and nutrition, (ix) improved public health surveillance and disaster response and preparedness, (x) and improved hospital care. Despite being directed to the whole health delivery system, all ten impact on women and children as they are the major users of health services.

Meanwhile the country having previously achieved many public health successes in areas that were once deemed controversial and challenging during the colonial era, has once again set itself to regain the glory of yesteryear by setting very ambitious 2030 goals for its development, including that of becoming "an upper middle income economy by 2030". In our view, these targets can be realized, provided the right decisions, the right actions and a roadmap is urgently defined, implemented and monitored, truly ensuring that the current mantra of "leaving no one behind" is fulfilled.

Given the nation's resilience and previous successes, the structuring of the public health delivery sector and solid infrastructure among other important foundational aspects, we see the possibility of turning the health and social sector situation around through investing in a strategic review of both the "hardware" and "software" aspects of the system using a revitalized primary health care, (PHC4UHC, CWGH, PHCPI, 2022) [11], approach with a special focus on the health and wellbeing of women and children.

The public health system, which provides up to 70% of the health care services in the country, comprises the central and local government arms, the church or faith based institutions, the uniformed health services, while the private sector comprises the non-governmental organizations and the private for-profit sectors. The public health care service has a clinic as the first point of contact with the rural or urban communities, with 14 to 50 clinics referring to a district hospital and 7 to 9 districts referring to a provincial hospital. There are 8 such rural provincial hospitals and three urban provinces, which are a new formation and yet to construct and operate their provincial hospitals, while six central hospitals are at the apex of the national health delivery system. The urban local authorities also provide health services through their hospitals, polyclinics and clinics, while rural local authorities mostly provide health services through rural hospitals and clinics, and the faith based organizations offer clinic, district and sometimes specialized hospital services. This whole system renders general and various levels of maternal, child, sexual and reproductive health services.

The majority of health services have been provided free of charge, especially when the referral chain was followed in accordance with the government's free healthcare policy for selected vulnerable groups which include pregnant women, children, the elderly, and other indigent groups. Additionally, as per agreement with some donors and vertical programmes such as the tuberculosis, HIV and AIDS, national immunization programme, more patients were getting free treatments and diagnostics. This meant that even patients preferring to be seen in the private sector would have to attend public health services to access the free TB, HIV, family planning or other services. With the current demise in health services provision and the impending donor withdrawal, most patients are just getting exempted for the consultation fee, some diagnostics and treatments, but must pay for diagnostic tests and buy their medication due to non-availability at local levels in both rural and urban public health facilities. This necessitates further travel to access private pharmacies and laboratories at the districts or towns, thus impacting negatively on the access and placing hardship on those with limited or no means to travel further, (CWGH, PHCPI, 2022). This points to a need to address all identified barriers of access and utilization of health services, including geographic disparities, that is now evident in the high levels of morbidity and mortality. UNICEF reports [12], highlight the uneven distribution

of maternal and child healthcare services across the country, with financial constraints adding another layer of complexity. Various reports point to this economic barrier as a factor that forces some women, particularly those living in poverty, to make agonizing choices, potentially jeopardizing their own health and the well-being of their unborn and newborn children.

There is a critical shortage of healthcare staff with the number, quality and capability of health care workers as a ratio of the population being critically low. The depleted health personnel are also highly demotivated owing to dwindling real incomes, under-equipped, undersupplied health institutions and poor working conditions. According to the World Health Organization (WHO) database, as at 2014 Zimbabwe had a minimum density threshold of 22.8 health professionals per 10,000 people to provide the most basic health coverage, and a skilled health professionals' density (per 10,000 population) of 12.44. Emergency medical services in Zimbabwe also remain relatively under-developed and under-resourced. The majority of the country's 62 districts just have two or less ambulances, serving the 20-50 clinics per district, thereby leaving the burden of transporting the sick to the communities, who have to contend with unreliable, unsuitable and unsustainable alternative transport and bad roads.

Most rural health facilities have a trained staff compliment of 2-3 nurses. This is grossly inadequate as the catchment area of the clinics has increased from natural population growth as well as with population movements such as the land reform program, and other internal movements. There has been no corresponding increase in health facilities, thus negatively affecting access and quality of health service delivery. District hospitals also lack adequate numbers and skills mix of the required health personnel to support the disease burden and the catchment clinics that refer patients to them. According to the 2022 National Budget Estimates book, only 25% of the provincial hospitals were providing selected major surgeries, while there are few provincial hospitals offering selected specialist services. Only 20% of the hospitals were providing chemistry and hematology analysis services, and only 10% of the health facilities are providing at least 80% of tracer medicines above minimal levels.

This fragility of the health delivery system calls for urgent actions to cover gaps observed, especially those that favor improvements in maternal and child health outcomes. There has not been due consideration of the broader context of the definition of health, which states that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1948) [13]. This despite the fact that the country is a member state of the WHO since independence in 1980, when it adopted the concept and philosophy of primary health care just two years after the Alma Ata Declaration, (WHO, UNICEF, 1978) [3], and successfully applied PHC with notable improvements in the health delivery system during the first two decades post-independence. The enjoyment of the highest attainable standard of health as one of fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition is well articulated in the national Constitution, (2013) as well as in the strategic plans of the Ministry of Health, but implementation has been lagging behind.

There is therefore a dire need for ensuring equitable access to health care, the need to consider the social determinants of health, (SDH, WHO, 2008, 2012) [14], and the need for more emphasis on surveillance, prevention, and effective response to public health threats, including the Covid-19 pandemic which have continued to weaken health system resilience, denying health services to the public, especially women and children. Furthermore, a number of major determinants of maternal and child health require urgent attention;

Child Sexual Abuse: Child marriage and teenage pregnancy

The challenge of maternal healthcare in Zimbabwe cannot be fully understood without acknowledging the interwoven issues of child marriage and teenage pregnancy. These practices expose young girls to significant health risks. Their bodies are simply not yet fully developed to safely carry a pregnancy to term, leading to a heightened risk of complications such as obstructed labour, pre-eclampsia, and fistula (UNFPA, UNICEF, Zimbabwe), [15]. Beyond the physical dangers, young mothers often lack the knowledge and support systems necessary to navigate pregnancy and childbirth effectively. Social stigma can further isolate them, hindering access to vital healthcare and other social services. The pressure to hide their situation or the fear of being ostracized can prevent them from seeking the medical attention they desperately need.

Education, a crucial tool for empowerment, is often sacrificed in the face of early marriage and childbearing. This disrupts their schooling and limits their future opportunities, perpetuating a cy-

cle of poverty and vulnerability for both mothers and children. This therefore calls for the promotion of a multi-sectoral approach with regards to health, the social and economic determinants of health, including gender equity and women's empowerment, recognizing health as represented in the 13 targets under SDG 3, and in 35 additional health-related targets under other SDGs (WHO 2016). In Zimbabwe child marriages happen within and are condoned by certain churches, traditional and other groups in sharp contrast to their founding and guiding principles which must protect children, and despite glaring high maternal complications, deaths, HIV, cancers, transgenerational sex, and this requires urgent attention to reverse the observed adverse health outcomes.

Impact of high maternal and child mortality rates

Hundreds of mothers tragically lose their lives every year due to complications during pregnancy and childbirth. This leaves families devastated and children without their primary caregivers. Global trends according to the World Health Organization (WHO) and UNFPA, reveal that complications during pregnancy and childbirth are a leading cause of death for women aged 15-49 globally. In addition, UNICEF consistently demonstrates a strong link between high Maternal Mortality Rate (MMR) and increased infant and child mortality rates.

Increased child mortality

High MMR often coincides with increased infant and child mortality rates. When mothers die during childbirth, new-borns are more likely to die in their first weeks or months due to a lack of proper care and breastfeeding.

Orphaned children

The loss of a mother due to childbirth complications results in a significant number of orphaned children. This can have long-lasting social, emotional, and economic consequences for these children.

Intergenerational impact

The loss of a mother can have a ripple effect across generations. Orphans may face challenges in accessing education, healthcare, and economic opportunities, perpetuating a cycle of poverty and vulnerability. Beyond the tragic loss of life, the high MMR also places a significant strain on healthcare systems, communities, and the nation**.** The cost of treating complications arising from childbirth diverts resources away from other essential health services. Additionally, the emotional toll on families and communities can be immense.

In conclusion, the high maternal mortality rate in Zimbabwe has a devastating impact on mothers, children, families, communities, and the nation at large. Addressing this critical issue requires a multi-pronged approach that tackles the underlying causes, such as under-resourced healthcare systems, geographic disparities, social, gender, and financial barriers. By improving access to skilled care, empowering women with knowledge, and promoting healthy pregnancy practices, we can significantly reduce maternal mortality and ensure a healthier future for mothers and children in Zimbabwe**.** Healthy mothers equals healthy families, healthy communities, and a healthy nation.

A Nation in Crisis; Halting and reversing the maternal and child deaths explosion

In this article we shine a light on some of the interventions attempting to correct this adverse situation of unprecedented maternal and child loss in the country.

Data and evidence basis for interventions

The country has since its Independence in 1980, regularly collected very sound data on both population and health parameters. We strongly recommend the full scrutiny and utilization of these data to inform sound policy, management, and implementation actions to halt the current wave of preventable morbidity and mortality. The Zimbabwe Population Census series, (ZIMSTAT; 1982, 1992, 2002, 2012, 2022) [16], the intercensal demographic surveys, (ICDS), the Zimbabwe Demographic and Health Survey series, (1985, …2005/6, 2010/11, 2015, 2020) [17], and the Multiple Indicator Cluster, (MICS, UNICEF) [18], series all have population representative data on maternal, child and other critical health and health determinants data. Additionally, there have been specific surveys such as the maternal and perinatal mortality survey of 2009, [19] the service readiness and availability surveys among other evidence gathering strategies, but these have not translated into much change to the high maternal and child mortality rates the country continues to experience.

Furthermore, Zimbabwe is a signatory to a number of sub-regional, regional, continental and global pronouncements on maternal and child health, but continues to lag behind fulfilling even the basics of its commitments towards women and children. The safe motherhood initiative of 1987 which aimed to reduce MMR by 50% by 2000, the 1994 ICPD and programme of action which added sexual and reproductive health and rights to the primary healthcare agenda, the millennium development goals, (MDGs) whose objective was to reduce MMR by 75% by 2015, and the sustainable development goals whose 17 goals all have health related targets. In 2018 and 40 years after the PHC declaration, the Astana Declaration acknowledged the centrality of sexual and reproductive health in PHC.

As 2030 approaches, there is need to revisit, evaluate progress and reasons for lack of it on all these commitments including the continental and regional declarations and pronouncements including the Maputo plan of action, a framework focused on improving sexual and reproductive health and rights in Africa of 2006, which has been updated to 2016-2030; and, the campaign on accelerated reduction of maternal mortality in Africa, (CARMMA), launched by the African Union in 2009, in response to the high levels of maternal mortality.

As the Community Working Group on Health, (CWGH) we have since our formation in 1998 supported health as a right and advocated for the primary healthcare, (PHC) approach towards universal access to health in the country. In 2013, we successfully advocated for the inclusion of health as a right in the Constitution, as the previous one only had life as a right. Over the years, we have continued to advocate for specific health rights, including adequate health financing for the public health sector, improved health governance, adequate health budget and efficient utilization. On maternal and child care we currently chair and convene the Global Financing Facility – Civil Society Platform on maternal reproductive, adolescent, child health and nutrition, (GFF-CSO, RMNCASRHN+). This includes coordinating the NGO response on the maternal and child health crisis, while also participating on the Ministry of Health's maternal and perinatal deaths surveillance and response committee, (MPDSR), which convenes regularly at all levels of the health delivery system to discuss maternal, perinatal and child deaths on a case by case basis, focusing on identifying, investigating and reviewing all reported deaths to inform strategies for improving care.

In our considered opinion and based on our decades-long relationship with the government of Zimbabwe, other governments, the UN family, and health players working in the country, and based on our unique positioning as the lead advocate for primary health care revitalization, we urge the following:

- Delving into the population level data (Censuses, ZDHS, MICs) and the national HMIS data for determination of the extent of the maternal and child health crisis, for evidence on what has worked and what hasn't, and therefore a better plan for 2030 targets.

- Making a commitment and bold steps towards revitalization of the primary health care approach to health service provision (CWGH, PHCPI, 2022) in collaboration with the government and all health actors.

- Conducting a quick audit of donor funding within the health delivery system with respect to national obligations and private sector share of the health delivery system to redefine the health financing trajectory in the aftermath of the unexpected United States Government's withdrawal of USAID, CDC, and other related support to Zimbabwe.
- Support the development of an implementation strategy and road map for the recently adopted national health financing dialogue (CWGH, GFATM, 2023 Communique, Nov 2024 National Dialogue)
- Assist the government and key health players to adopt strategies that reduce overreliance on external support as this has not only been challenged by the earlier announcements by major funders of a transitioning out by 2030, but now assumes urgent proportions due to the abrupt aid cut by the United States Government. This calls for the nation to not only fulfill its health and social obligations but to address the ongoing multiple health crises, especially that of high maternal and child mortality.

Several factors associated with high MMR in Zimbabwe also contribute to child mortality and require urgent actioning:

- **Limited Access to Skilled Care:** The lack of skilled healthcare providers during childbirth can lead to complications that not only endanger the mother but also affect the new-born's health.
- **Pre-partum and intra-partum care:** This continues to fall short of the requisite technical capacities due to huge staff

turnovers, inadequate skills, limited medicines and supplies.

- **Postpartum Complications:** Mothers who experience complications during childbirth continue to face challenges providing adequate care for their new-borns, increasing the risk of illness and death in the first weeks or months.
- **Poverty and Lack of Resources**: Women living in poverty, who are more likely to face limited access to healthcare, are also less likely to have access to proper nutrition, sanitation, and hygiene, all of which are crucial for child survival.

We conclude that Zimbabwe currently has a considerably high maternal and child health morbidity and mortality burden, but may have what it takes to halt, reverse, and reclaim progress towards the fast-approaching 2030 targets, provided the right decisions and actions are urgently implemented. These include, but are not limited to what we have listed above, and in addition, urging the following.

- Central government to reclaim its stewardship role on the country's health mandate:
    - Improve its own public health service delivery
        - Address all the glaring health systems strengthening challenges in accordance with the WHO six building blocks
        - Derive learning and best practices from the vertical programming and input this into a comprehensive transitioning to integrated programming while ensuring all key health players in the country are schooled on PHC for the attainment of universal health care.
        - Call to order the local health authorities, church based health, uniformed forces health, governments and NGO health in a strategic health systems strengthening re-engineering of the public health delivery system
- Hold the Ministry of Finance to their mandate of financing, timely disbursements to health. Scrutinize the current adequacy of the Abuja target – 15% in 2000, realising that originally, it was earmarked for a mere 60% coverage towards ATM, maternal and selected child health conditions, and therefore becomes grossly inadequate in view of universal health coverage, (UHC which means 100% coverage of all health conditions);
    - Calculate the deficit and how best the gap can be closed by 2030
    - Articulate the road map agreed at the national health financing dialogue, on implementing PHC, and assign implementation and financing roles to each entity
    - Articulate the government's plan for both the transitioning out and the sudden aid cut by USA, and out of major funders by 2030.
    - Develop the full health financing road map to 2030 and the targets to be met
- Convene other ministries holding the key social determinants of health in accordance with the national Constitution, (2013) [7], the public health Act in line with health in all policies, the social determinants of health, (SDH, WHO, 2008, 2012), the national coordination framework and the primary health care for universal health coverage, (PHC4UHC, CWGH, PHCPI, 2022) approach.
- As civil society and on our GFF-CSO platform, we will mobilize resources to address the knowledge gap, improve technical competence of all networking members, governance, accountability, and continue our engagements to hold the government to account on its health mandate.
- We will also extend collaboration to academia and research, identify and work with teams to capacitate them on reporting and tracking maternal and child health, PHC, and universal access to health and the SDGs. We will explore the use of evidence, and technology to support the improvement of health service delivery, staff motivation, and support the monitoring and track health outcomes towards 2030 targets.
- In line with PHC, the CWGH will continue to work smarter with all communities, churches, political, traditional, and cultural leaders, and the national parliament to improve the local and institutional environment for mothers and children.

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Conflicts of Interest

The authors declare no conflicts of interest.

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