ZIMBABWE

SYNTHESIS REPORT

2026

Analysis of Reproductive, Maternal, Newborn, Child and Adolescent Health Indicators for 2020-2025

Countdown to 2030 in partnership with Zimbabwe's Ministry of Health, Global Financing Facility, WHO, WAHO & UNICEF

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KEY FINDINGS

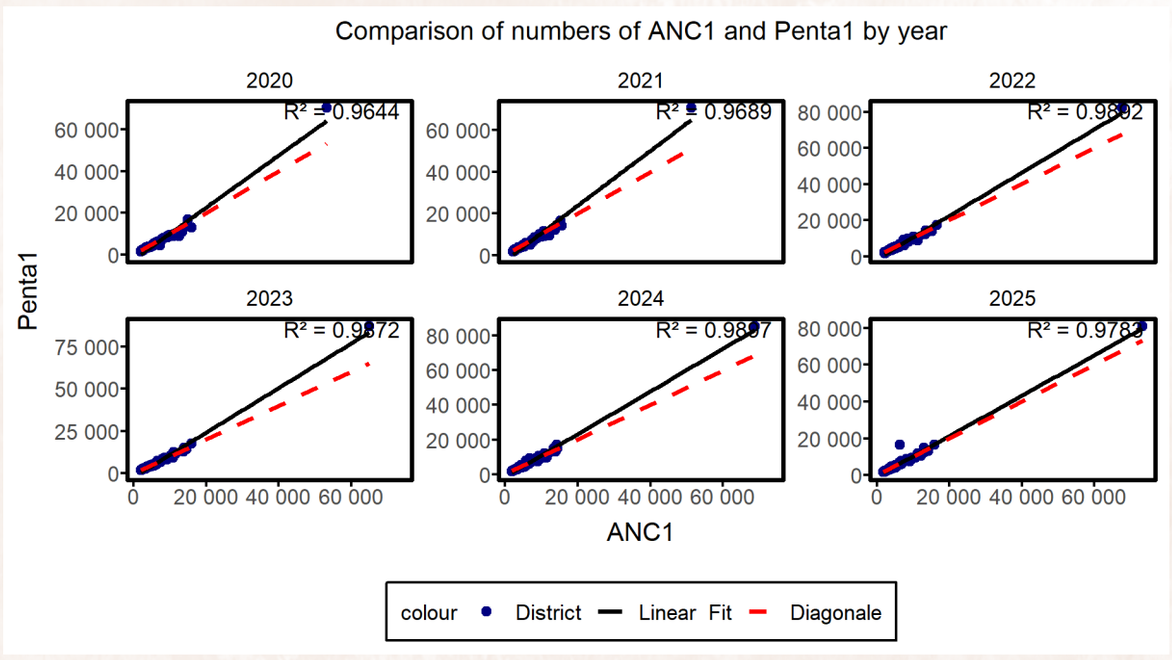
1. Health facility data quality assessment: numerators and denominators

	Data Quality Metrics	2020	2021	2022	2023	2024	2025
1. Completeness of monthly facility reporting (mean of ANC, delivery, immunization)							
1a	% of expected monthly facility reports (national)	92	91	93	94	96	98
1b	% of districts with completeness of facility reporting >= 90	68	66	75	77	87	96
1c	% of districts with no missing values for the 4 forms	100	100	99	100	100	100
2. Extreme outliers (mean of ANC, delivery, immunization)							
2a	% of monthly values that are not extreme outliers (national)	99	100	100	100	97	96
2b	% of districts with no extreme outliers in the year	87	89	89	90	85	86
3. Consistency of annual reporting							
3a	Ratio anc1/penta1	1.15	1.10	1.07	1.05	1.02	1.05
3b	Ratio penta1/penta3	1.08	1.07	1.04	1.03	1.00	1.02
3c	% district with anc1/penta1 in expected ranged	95	87	66	76	63	73
3d	% district with penta1/penta3 in expected ranged	97	89	81	74	56	63
4	**Annual data quality score**	**91**	**89**	**86**	**87**	**83**	**87**

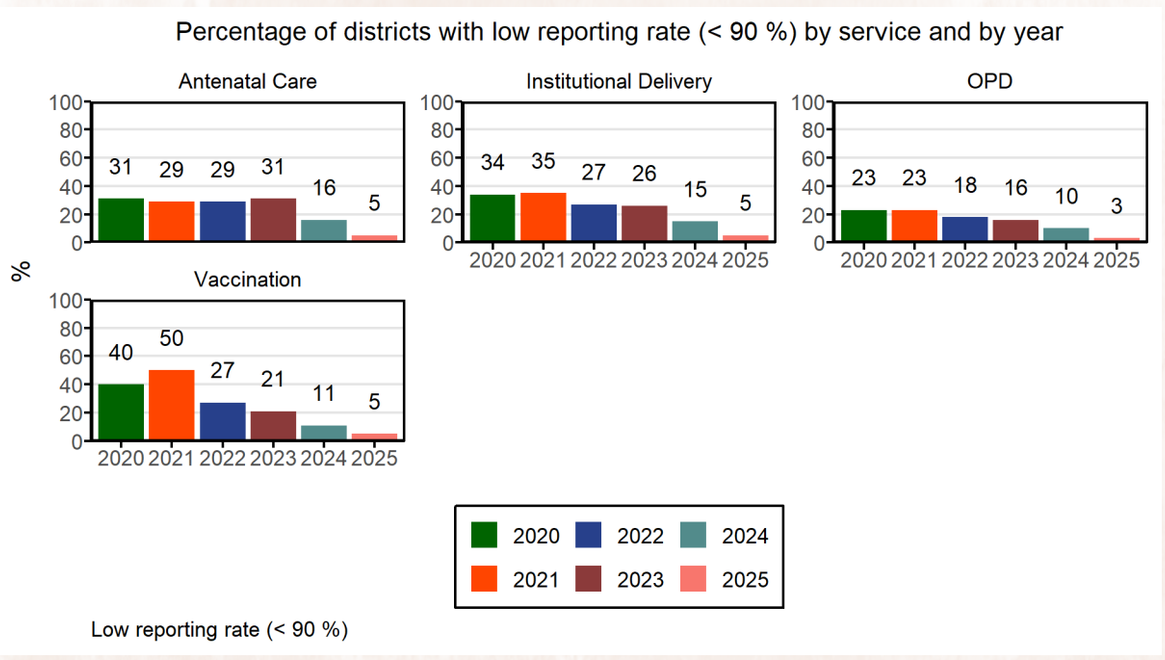
Interpretation

- Overall, data quality in Zimbabwe showed mixed trends between 2020 and 2025, with improvements in reporting completeness offset by declines in consistency and internal validity measures, and persistent weaknesses in metropolitan provinces.
- The overall data quality score experienced a slight but consistent decline, dropping from 91% in 2020 to 87% in 2025.
- Reporting completeness showed a positive trend, with the proportion of districts achieving above 90% completeness gradually rising from 68% in 2020 to 96% in 2025.
- The notably low performance in consistency of annual reporting observed in 2024 is attributed to the introduction of new reporting tools.
- The percentage of districts with Penta1/Penta3 ratios within the expected range declined progressively, falling from 97% in 2020 to 63% in 2025.
- Harare and Bulawayo provinces continue to record persistently low data quality scores, consistently averaging below 70%.
- A k-factor of 0.25 was applied uniformly across all services as an adjustment, based on the estimation that non-reporting facilities contributed approximately 25% of the service volumes recorded by reporting facilities.
- Continued monitoring of the ANC1 to Penta1 ratio is necessary to ensure it remains at or above 1.0, particularly given that high perinatal mortality may be affecting this indicator

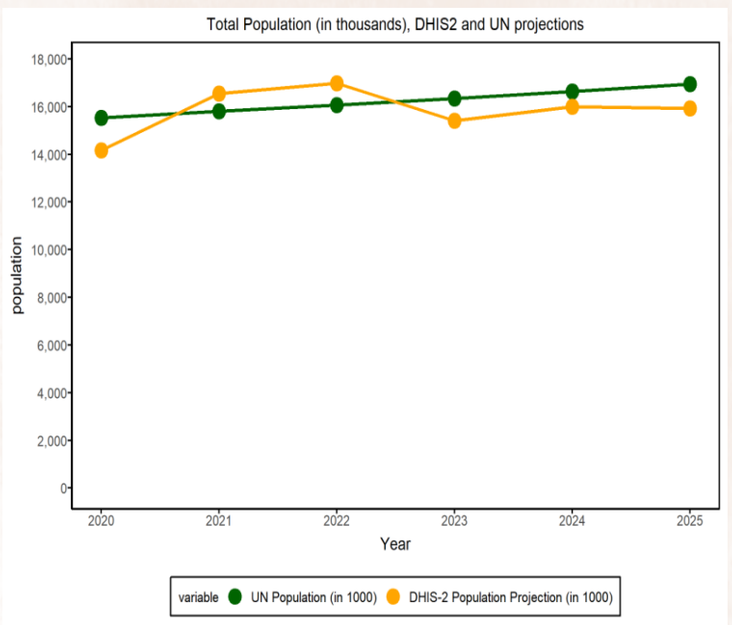
The figure below shows ratios that are generally within the expected range over the years though 2025 shows one district outside the range.

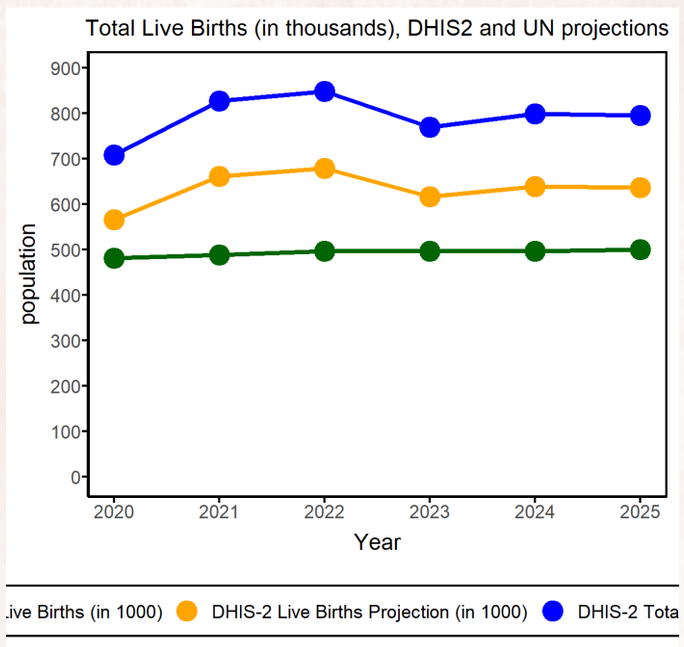


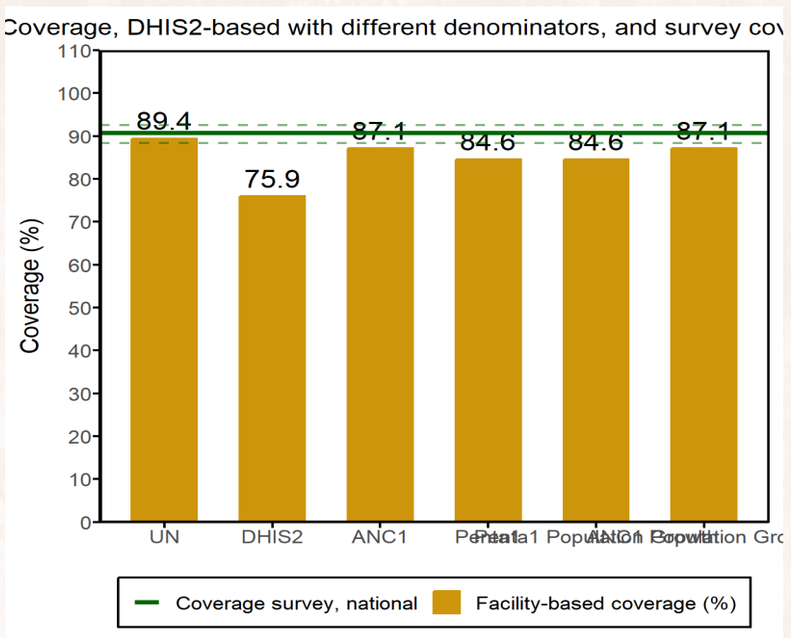
Reporting rates have progressively improved across services, with declines in the percentage of districts reporting below 90%. Higher reporting completeness increases confidence that the data are representative of service delivery patterns and reduces the risk of bias due to missing reports.



DENOMINATOR SELECTION







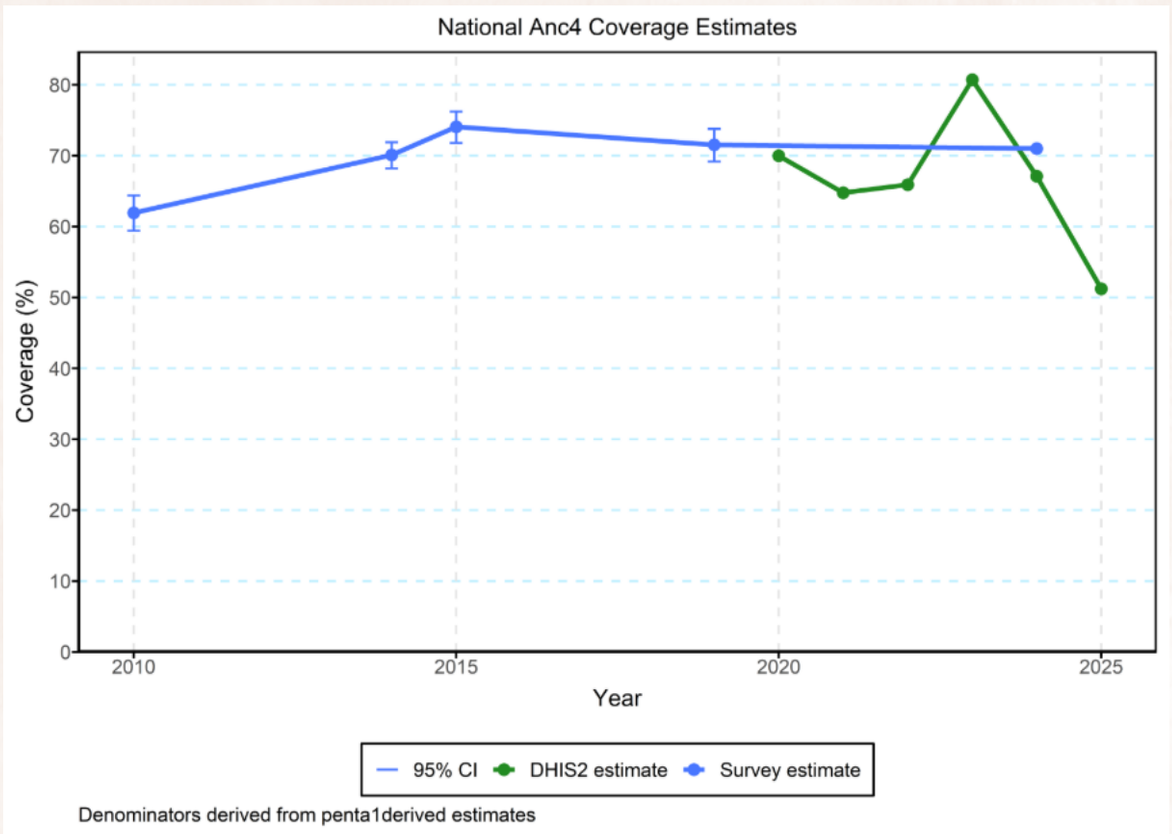
Interpretations

- A review of three potential denominators, DHIS2 total population, UN population projections, and live births projections, identified DHIS2 total population as the most appropriate basis for coverage calculations, given its superior consistency across the review period. The remaining options were found to be unreliable: DHIS2 live births consistently exceeded UN estimates, which would lead to an understatement of coverage, while the DHIS2 Under-1 population projection showed marked inconsistencies against UN figures, particularly in 2023

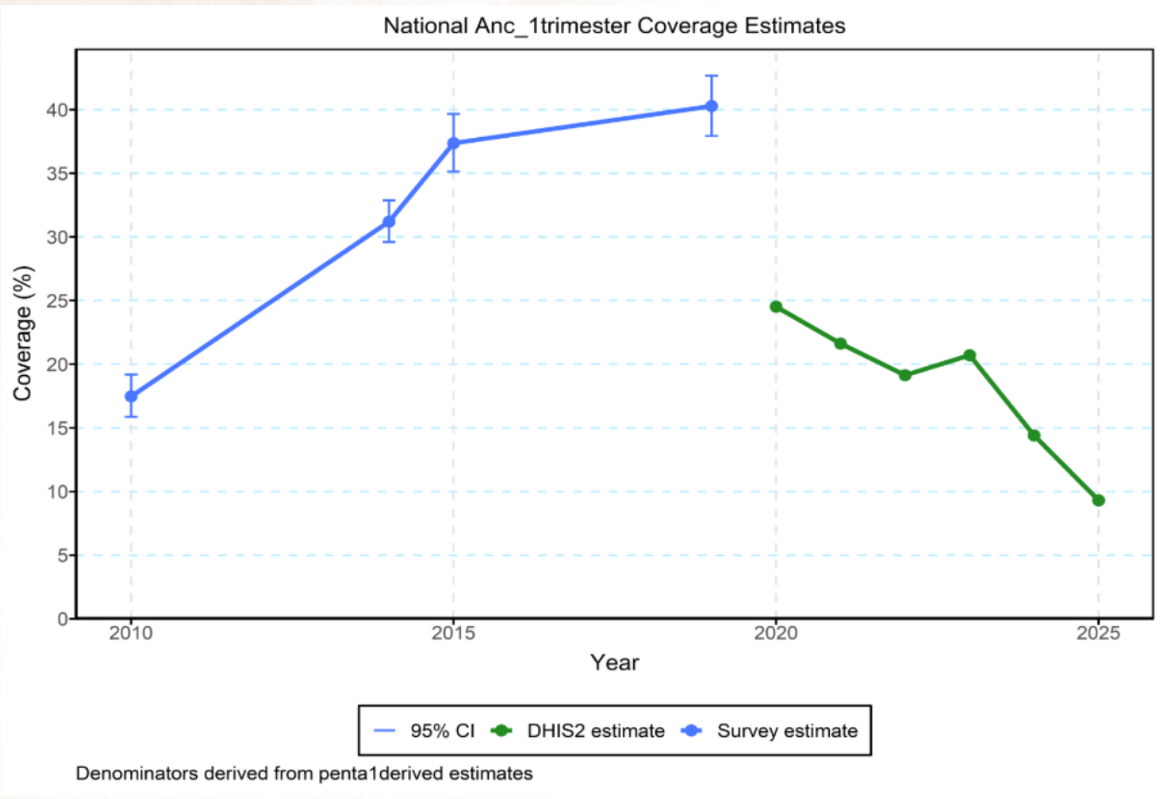
2. National coverage trends: facility data and surveys

Antenatal care: ANC4, ANC early visit, first trimester of pregnancy

ANC 4



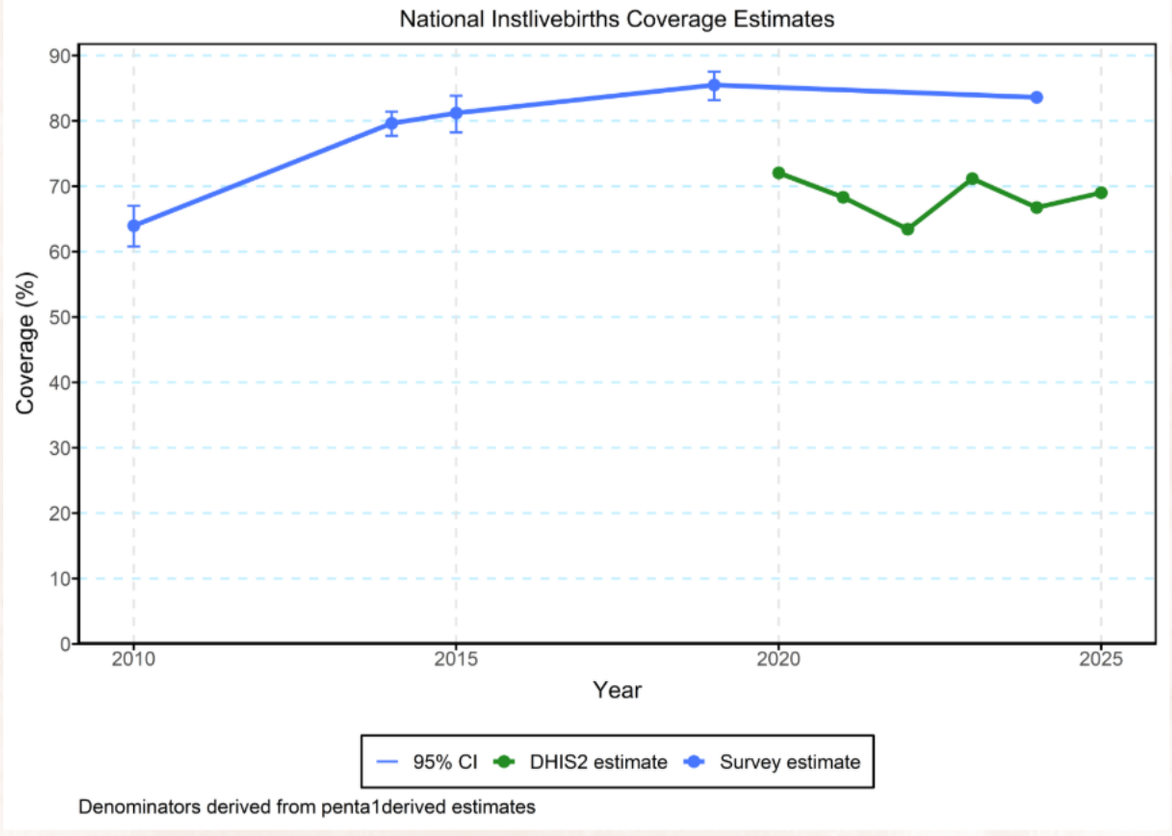
ANC early visit



Interpretations

ANC4 coverage remains broadly consistent with survey estimates, although trend interpretation is complicated by methodological changes in 2024. From a gender perspective, low early ANC coverage (definition timeline down from 16 weeks to 12 weeks) suggests persistent barriers to timely care-seeking and access for women and adolescent girls. The health system should focus on addressing such persistent barriers to early booking.

Institutional delivery



Interpretations

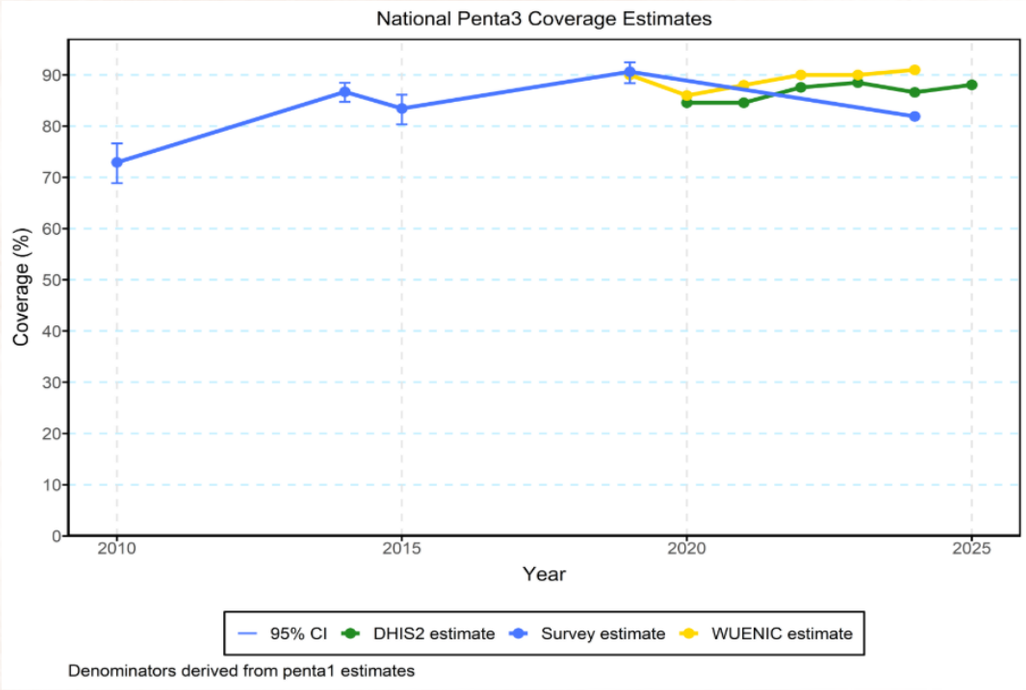
The sustained high coverage in institutional delivery suggests important progress in enabling women and adolescent girls to access skilled care during childbirth.

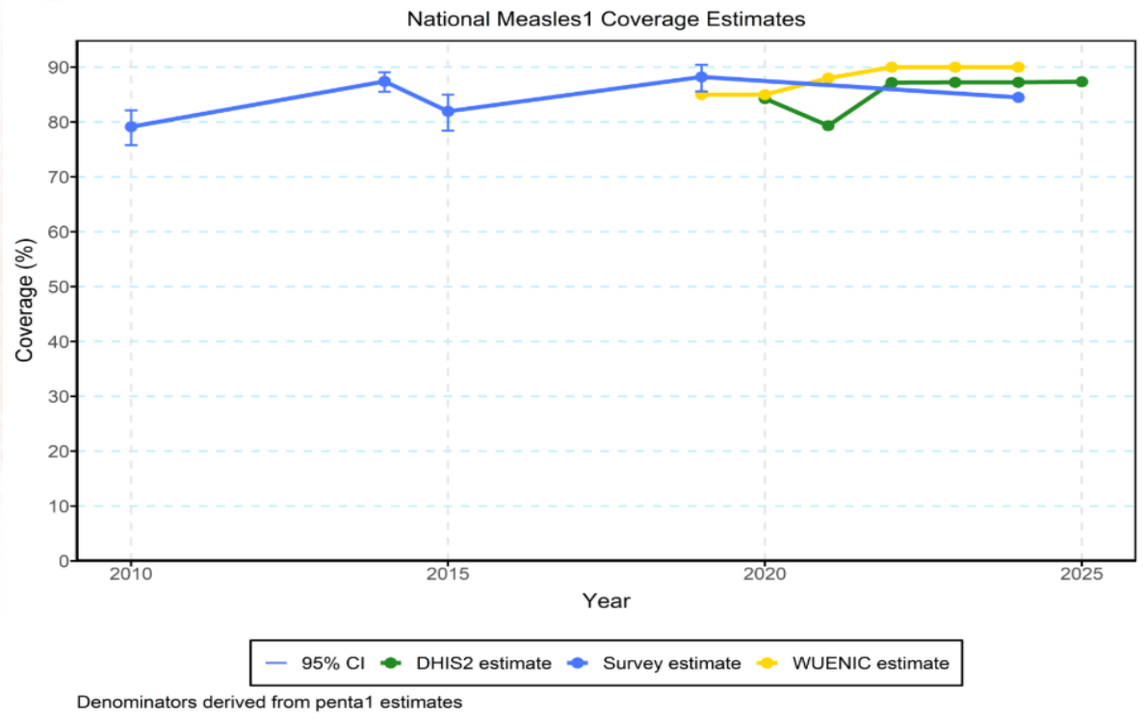
The remaining coverage gap warrants further assessment of demand- and supply-side barriers affecting access to facility-based delivery.

Survey estimates increased from approximately 64% in 2010 to 85% in 2019, indicating substantial improvements in access to facility-based childbirth services.

The steady increase across multiple survey rounds suggests that the trend is both plausible and robust.

Immunization: Penta 3, Measles 1





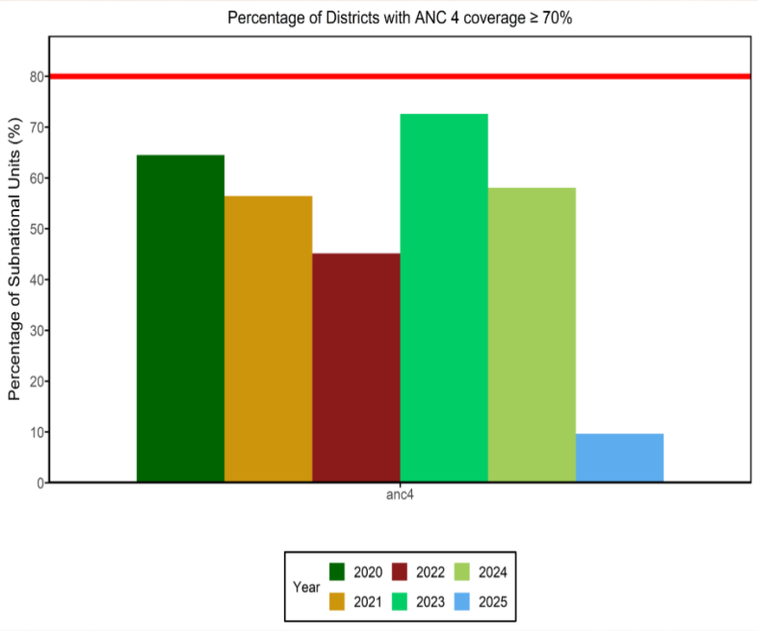
Interpretations

Penta3 and Measles1 coverage trends between 2020 and 2025 reveal a system that has demonstrated recovery from COVID-19 disruptions but continues to fall short of the thresholds needed for sustained population immunity, with persistent equity gaps requiring targeted attention.

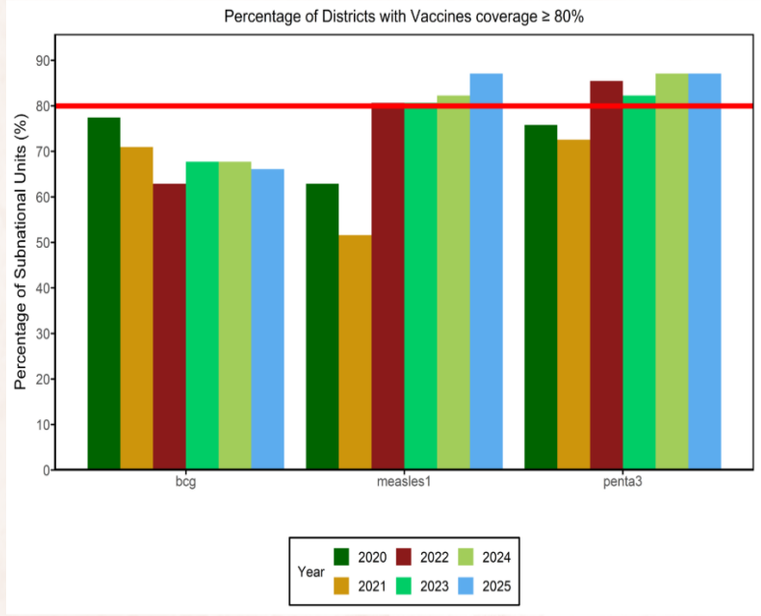
- Coverage trends for both antigens show plausible and internally consistent patterns, reflecting a coherent picture of immunization service performance over the period.
- Both antigens experienced a marked decline in 2021, likely driven by COVID-19 related service disruptions, followed by a gradual recovery through 2023 and modest reductions thereafter.
- While survey and WUENIC estimates consistently place national coverage within the 85–91% range, routine data remain 10–20 percentage points lower, plateauing at 72–77%.
- Although the recovery observed post-2021 demonstrates the restoration of immunization services, coverage has yet to reach the 90% threshold required to sustain population immunity for DTP3 and 95% threshold for measles 1.
- From a gender and equity perspective, sustaining coverage gains requires deliberate attention to the access barriers faced by caregivers, particularly women, who typically bear primary responsibility for child health, including time constraints and transport costs.

Percent of districts achieving high coverage targets

ANC 4



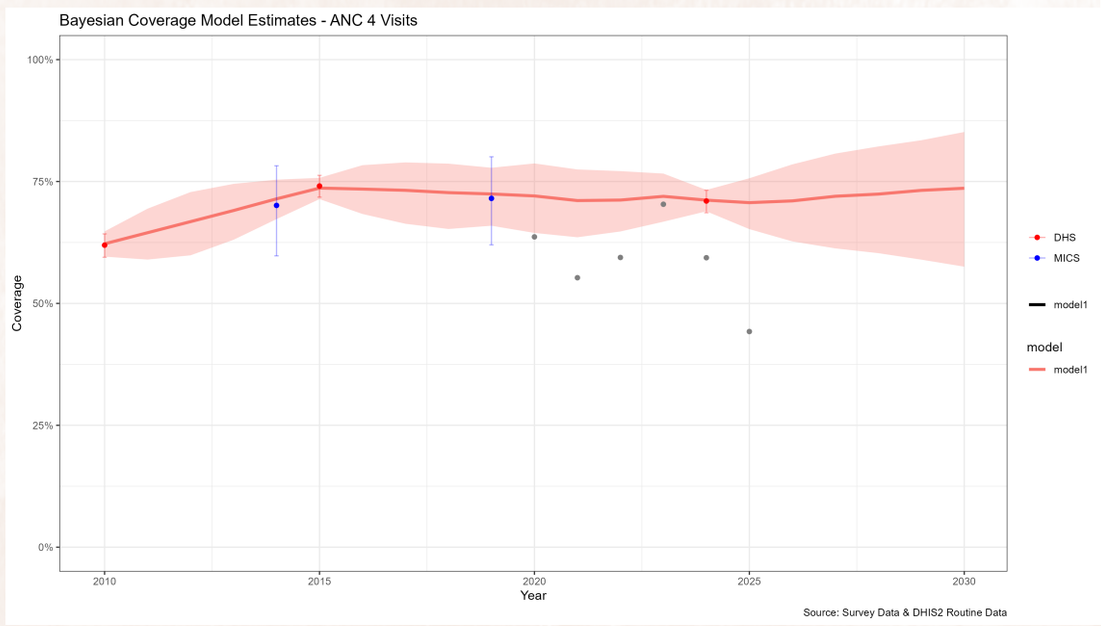
Vaccination

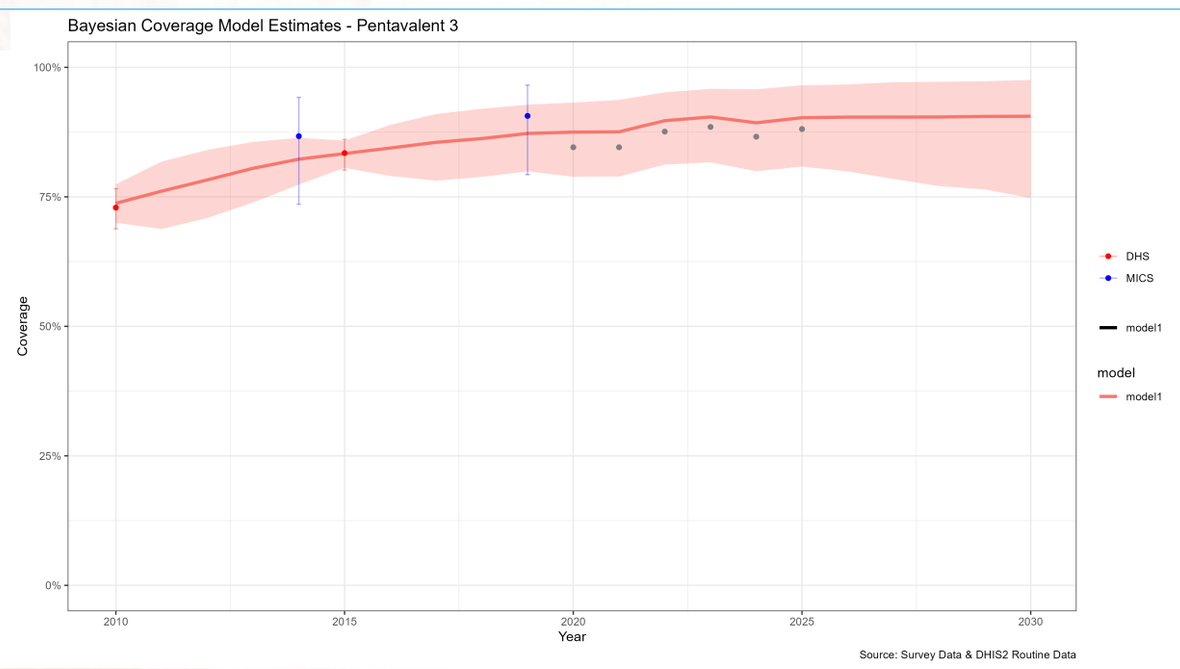


Interpretations

- No district achieved the EWENE target of at least 80% reaching 70% ANC4 coverage in any year, reflecting persistent subnational disparities driven by barriers to completing recommended contacts and service quality concerns. This decline was likely compounded in 2025 by changes in data collection tools, which are probably the major contributor to the marked drop in coverage from above 60% to 10%.
- Immunization coverage tells a mixed story: BCG remained below the 80% district threshold, while measles 1 and Penta 3 showed improvement between 2020 and 2025.
- Targeted outreach to low-performing districts remains essential to address the geographic and gender-related barriers driving these gaps; however, the underlying causes of poor performance warrant further investigation

Bayesian analysis





The Bayesian estimates for ANC4 are broadly consistent with both survey and routine data, suggesting that the two data sources tell a similar story regarding long-term coverage levels and trends (2010–2020). Similar observations were made for Penta3.

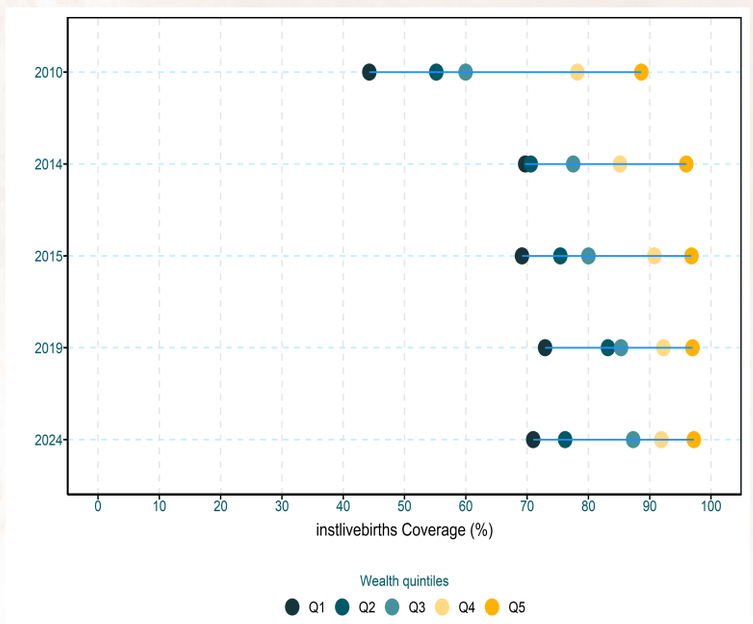
The model indicates that routine data provide useful information on changes over time, while surveys remain important for anchoring coverage levels. The 2025 decline should be interpreted with caution given the documented reporting changes introduced during that period.

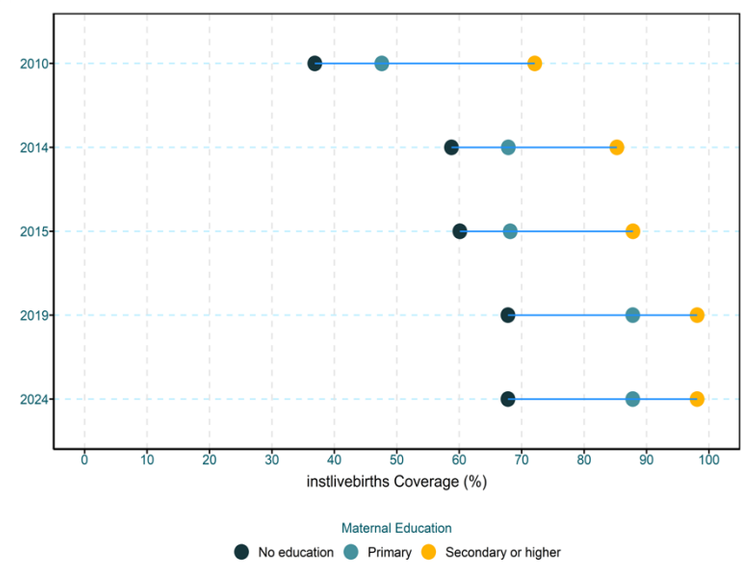
Harare's urban reporting gaps and Masvingo's maternal–child disconnect reveal that high ANC4 coverage does not automatically translate into strong Penta3 uptake.

3. Equity

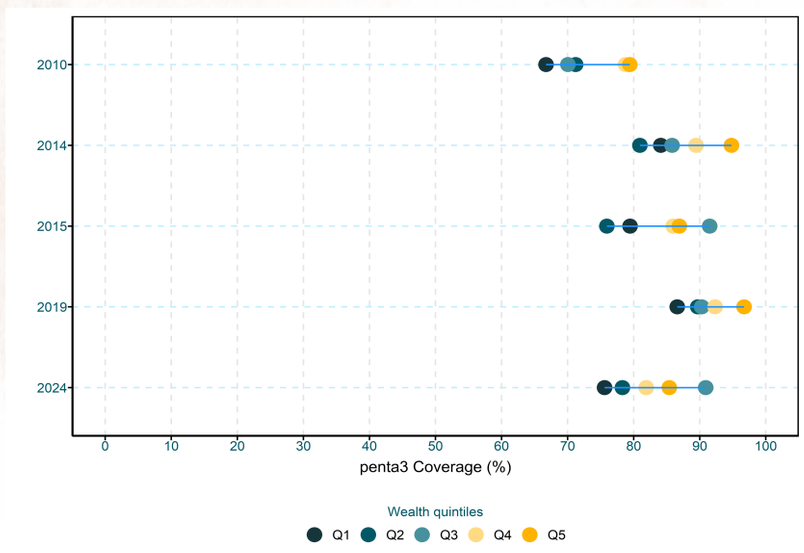
Equity by wealth, education, rural-urban residence (from surveys)

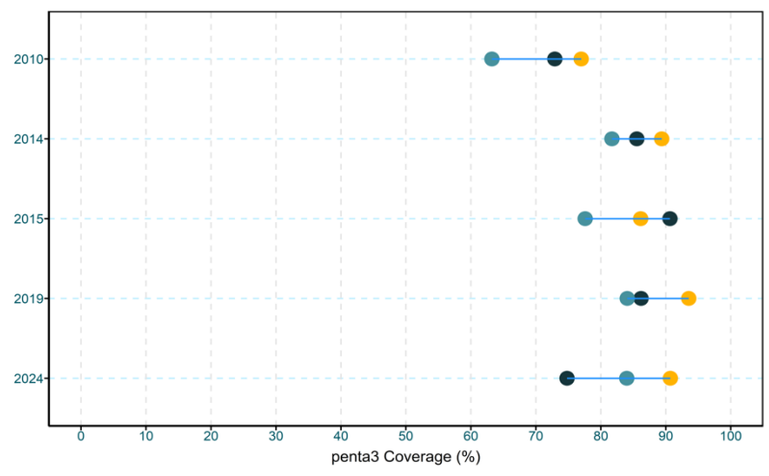
Institutional Deliveries





Pentavalent 3rd Dose





Interpretations

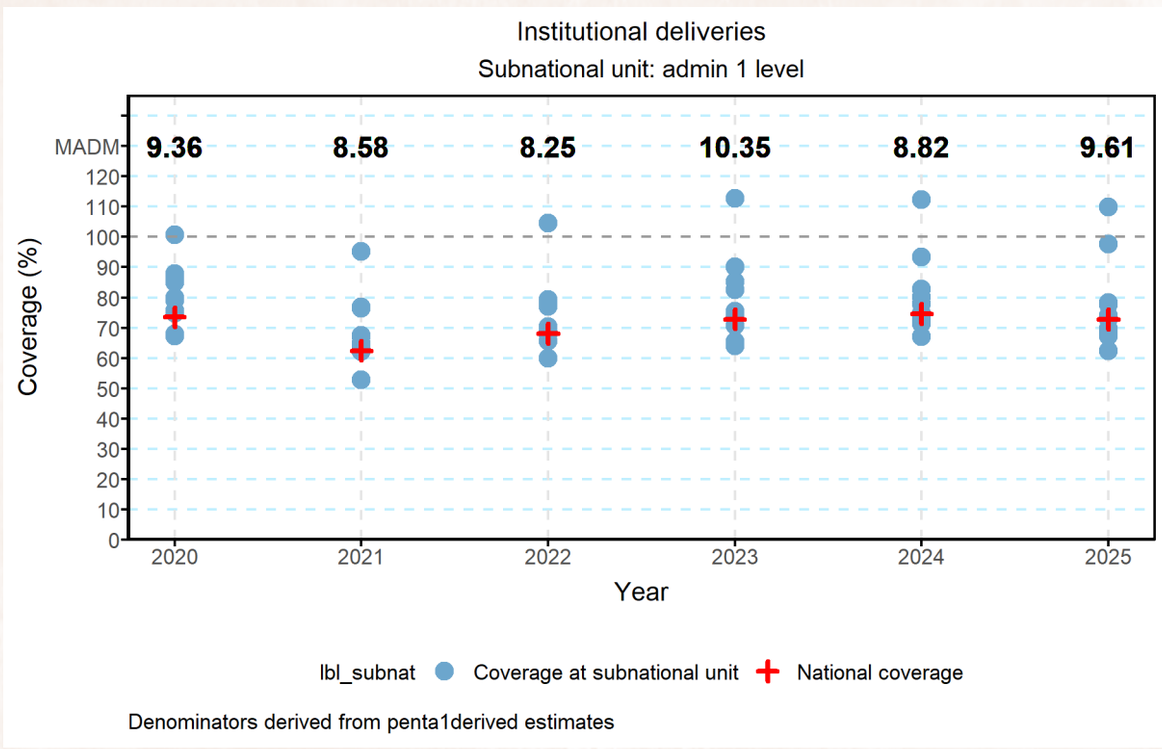
Institutional coverage among the poorest women increased substantially between 2010 and 2024 while coverage among the richest quintile has remained close to universal. The gap between the poorest and richest quintiles narrowed considerably, although disadvantaged women still have lower coverage compared to their wealthier and more educated peers. Remaining disparities may reflect barriers to care including poverty, transport constraints, and unequal access to information and services.

Deliveries in health facilities increased across all maternal education groups, and educational inequalities appear to have narrowed since 2010. Women with higher educational attainment consistently show higher coverage than women with little or no education.

For Penta3, equity gaps are smaller than for institutional delivery but persist most years among poorer and less educated households the disparities in Penta3 coverage by maternal education suggest that education attainment remains an important determinant of access to maternal health services, underscoring the importance of investing in girls' education, health literacy, and women's empowerment to increase utilization of reproductive, maternal, newborn, and child health services. The improvement in coverage levels for children of non-educated mothers in 2015 reflects the importance of program activities targeted at disadvantaged population groups. Furthermore, health services need to ensure that communication materials, counselling approaches, and service delivery models are accessible and responsive to women with all educational backgrounds, to help close these disparities.

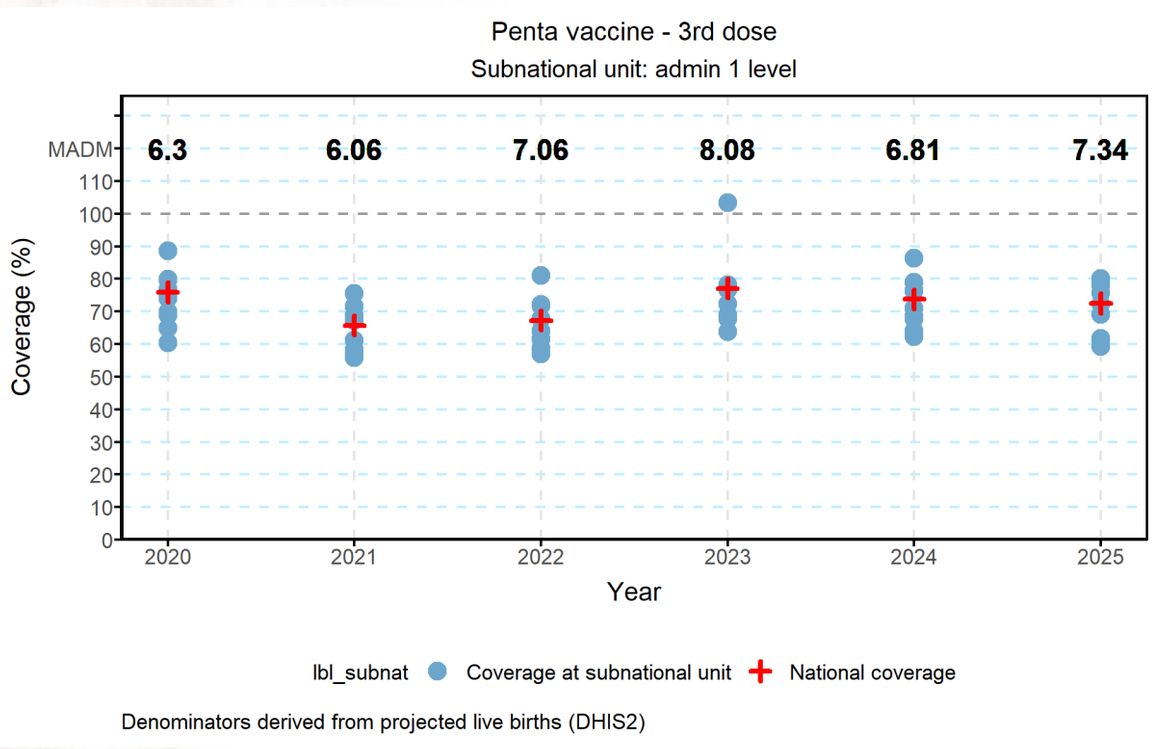
Geographical inequalities: Health facility data

Institutional Deliveries

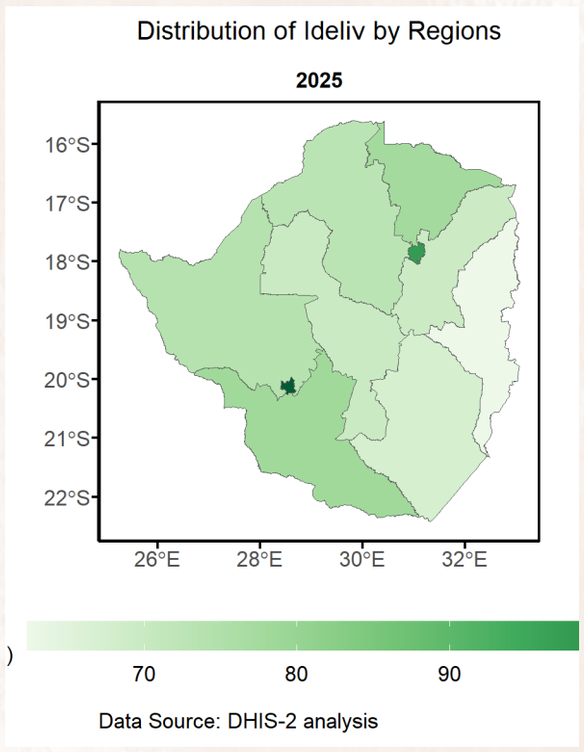


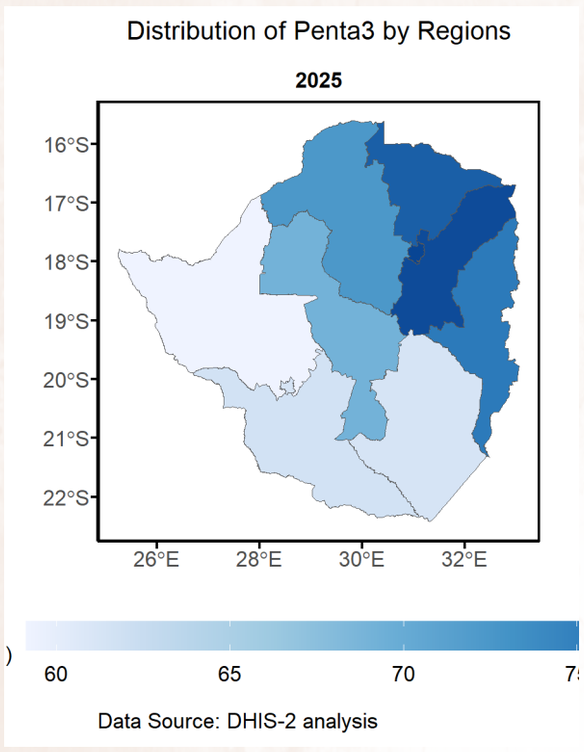
Denominators derived from penta1derived estimates

Pentavalent 3rd Dose



Denominators derived from projected live births (DHIS2)





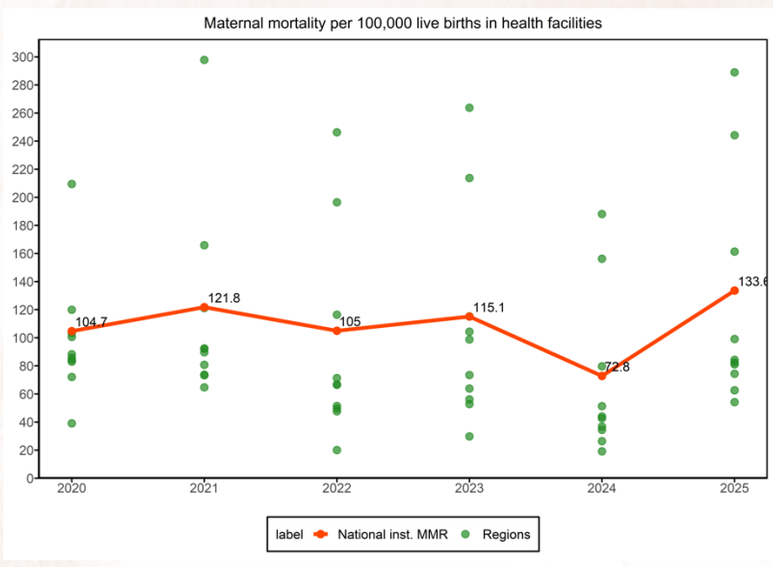
Interpretations

- Institutional delivery coverage remains relatively stable at national level, but significant geographic disparities persist across provinces. This indicates that location remains an important determinant of women's access to skilled childbirth services, reflecting differences in transport, service accessibility and availability, and other barriers to care. Matabeleland South, which does not charge for maternal services, has correspondingly good institutional delivery coverage, while Manicaland with high institutional charges, has the lowest coverage
- Penta 3 immunization coverage remains sub-optimal (below the recommended ≥90% national target for routine immunization), with persistent inequities across provinces.
- Disparities by wealth quintile are not pronounced as the gap between the richest and poorest quintiles is small.
- Remaining gaps may reflect barriers faced by women caregivers in accessing routine child health services, particularly in underserved areas where distance constraints affect uptake
- National performance for Penta3 has been fairly stable (between 65–70%) over the six-year period. Coverage above 100% (mostly in the two metropolitan provinces) generally reflects denominator or population movement issues.

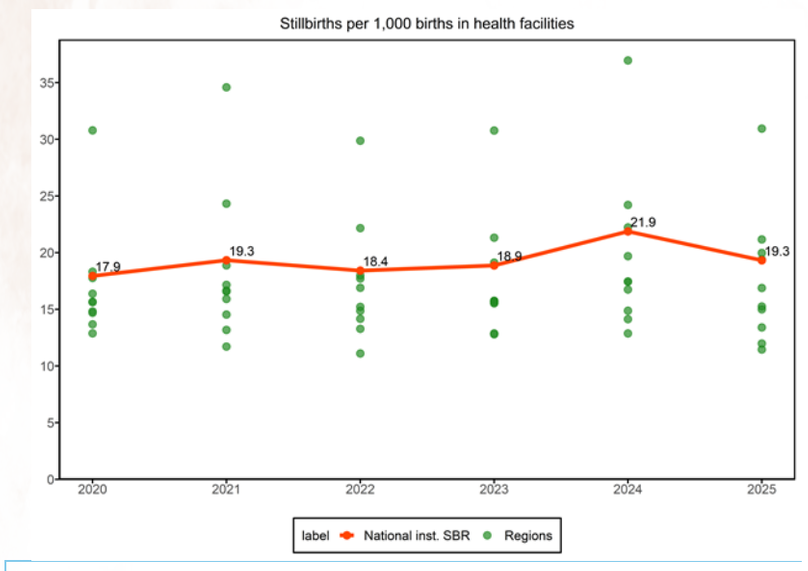
4. Institutional mortality

Institutional Mortality trends (iMMR, iSBR, iNMR)

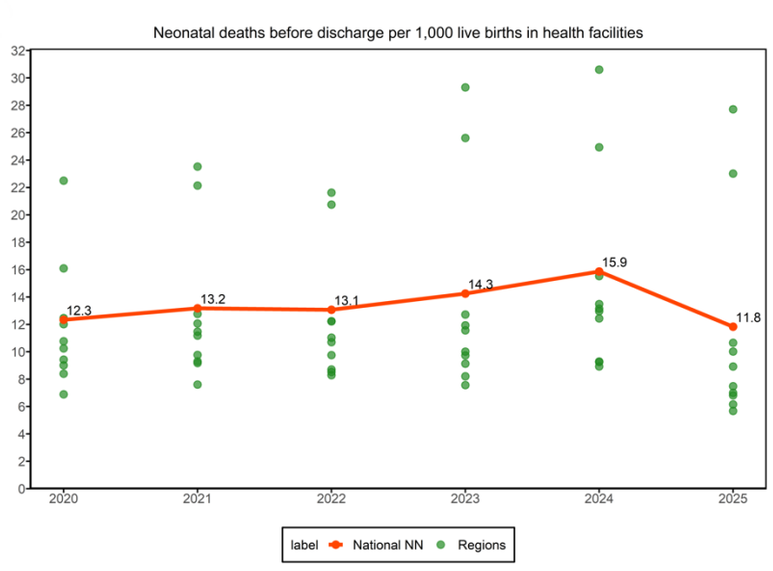
iMMR



iSBR

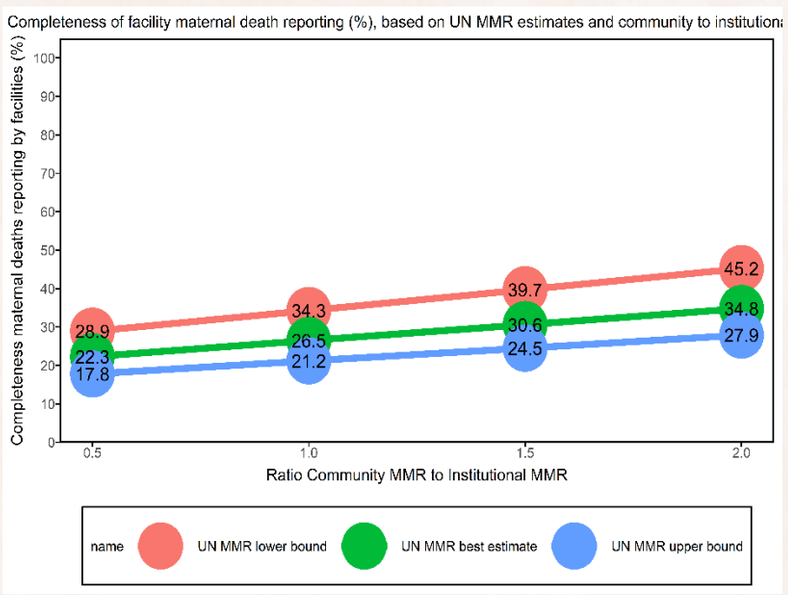


iNMR



Interpretations

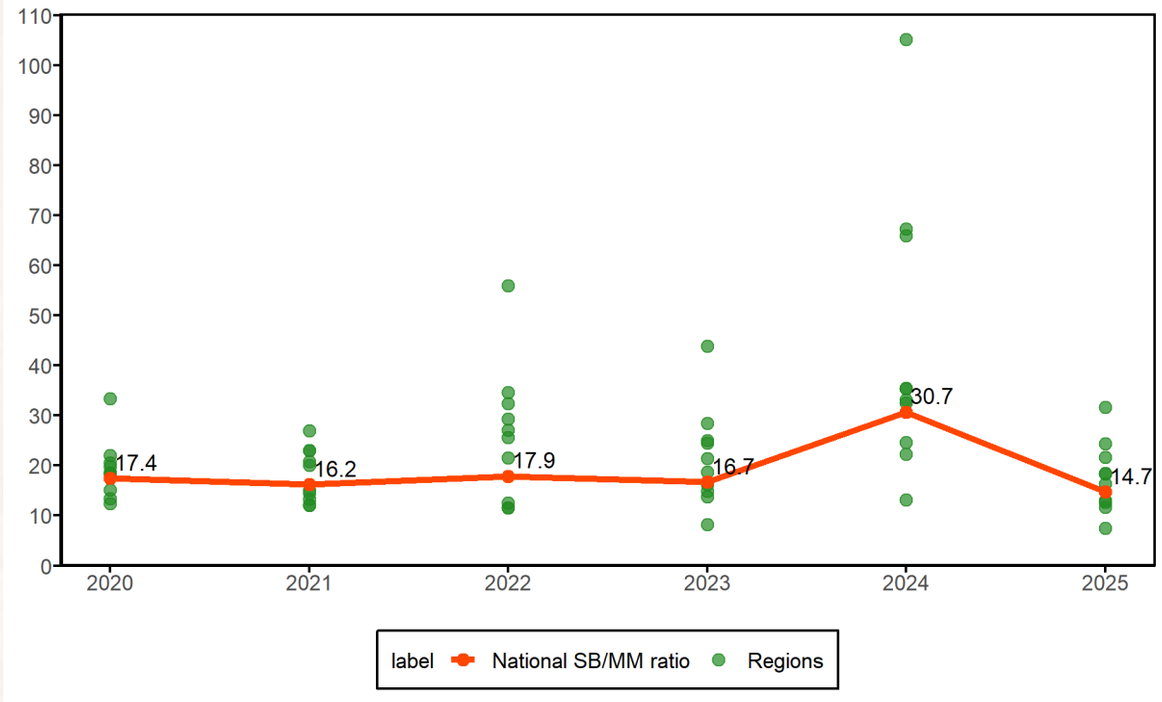
- Maternal mortality remains a persistent concern, with the institutional Maternal Mortality Ratio (iMMR) showing an overall upward trend over the past five years.
- Wide regional variation suggests inequities in the quality, readiness, and timeliness of maternal health services as well as variations in social determinants. These findings suggest that increasing service utilization alone is insufficient; women may continue to face supply and demand side barriers to receiving timely, high-quality care during pregnancy, childbirth, and the postnatal period.
- Stillbirth rates have followed a gradual upward trajectory over the review period, signalling an area of growing concern for neonatal health outcomes.
- The persistence of poor outcomes highlights the need to focus on quality, affordability, and equity of care, particularly in high-burden regions.



- Maternal deaths in Zimbabwe are largely well reported, but the underlying causes point to gaps in intrapartum care rather than surveillance. Poor intrapartum care and hypertensive disorders in pregnancy remain leading contributors to maternal mortality, underscoring the need to strengthen quality of care at the point of service delivery rather than focusing solely on data completeness
- Facility-level stillbirth reporting demonstrates near-complete data capture, yet significant gaps persist at the community level that temper an otherwise encouraging picture. From a gender lens, incomplete reporting can mask where women face the greatest risks during pregnancy and childbirth, limiting the visibility of inequities and weakening accountability for improving maternal health
- Strengthening maternal death surveillance and surveillance of stillbirths is critical to ensure that preventable deaths among women are visible, measured, and addressed and that equity in newborn health is improved.

Data quality metrics

Ratio stillbirth to maternal deaths in the health facility data at national level



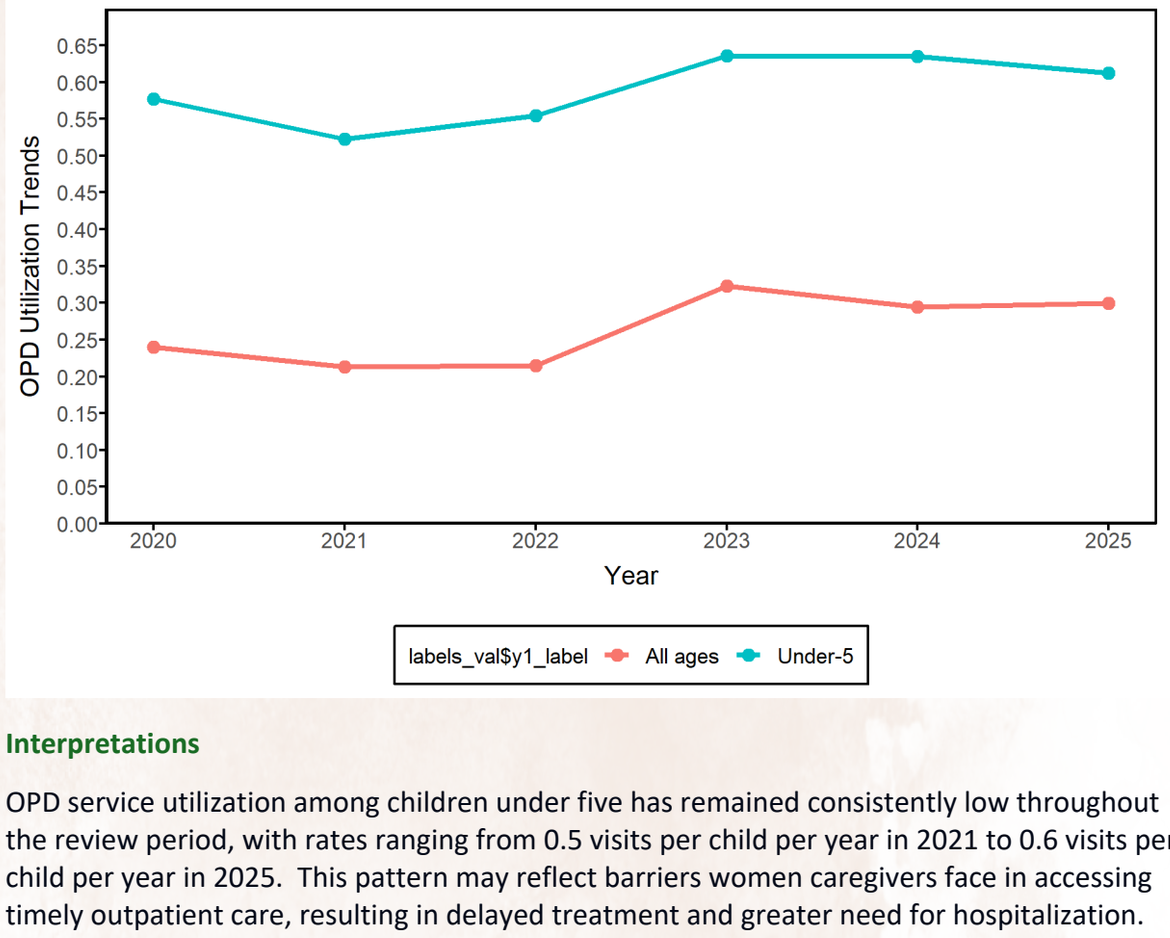
Interpretations

- **The stillbirth-to-maternal death ratio fluctuates over time and varies across regions, suggesting differences in maternal and newborn outcomes and/or reporting practices, excluding 2024, 2025 recorded the lowest ratio**
- **The ratio of stillbirths to maternal deaths in health facilities reveals a longstanding imbalance in prioritization between maternal and perinatal outcomes.**
- The ratio highlights the need to view maternal and newborn health as interconnected outcomes that reflect the quality of care women receive during pregnancy, childbirth, and the immediate postnatal period.
- Strengthening maternal death and stillbirth reporting is critical to ensure inequities affecting women and newborns are visible and addressed.

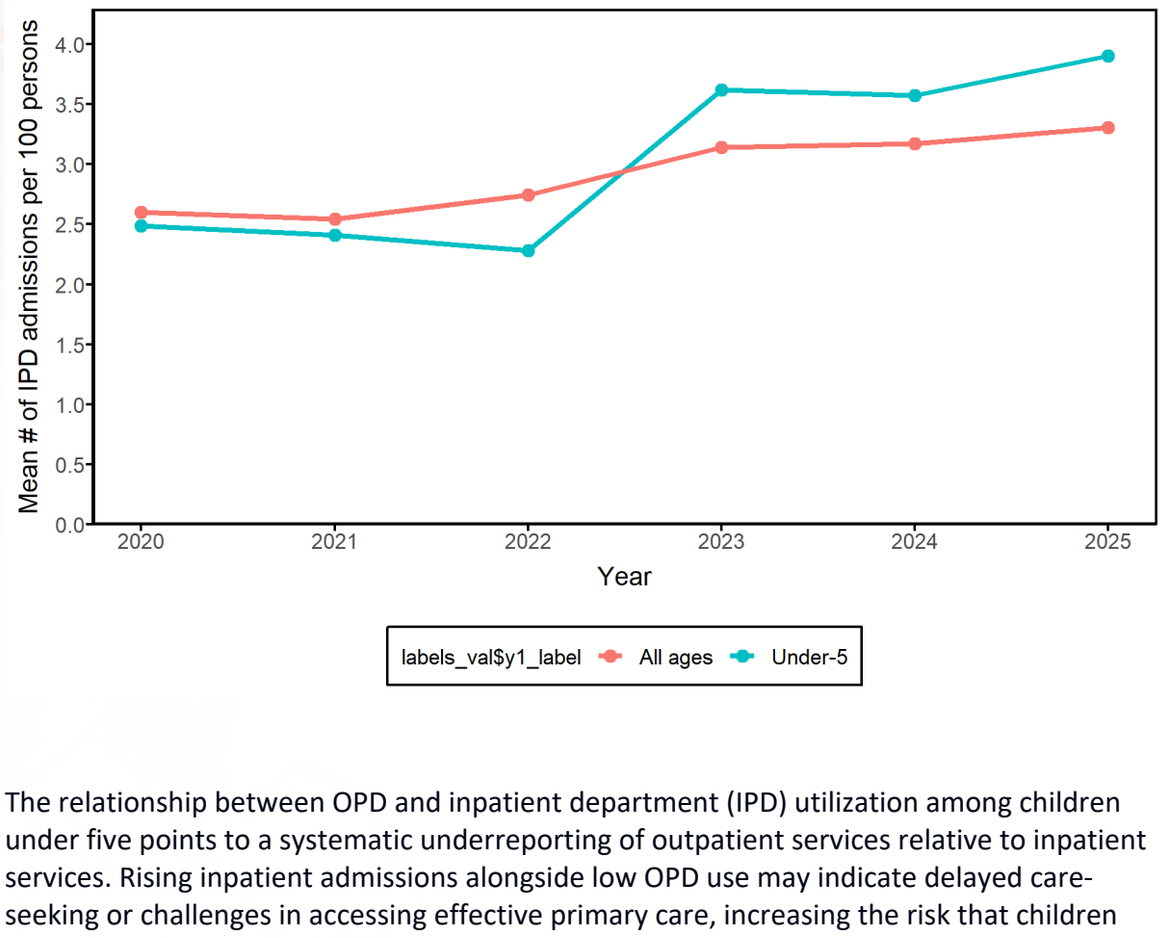
5. Curative health service utilization for sick children

Outpatient and inpatient service utilization

OPD per person per year



IPD admissions

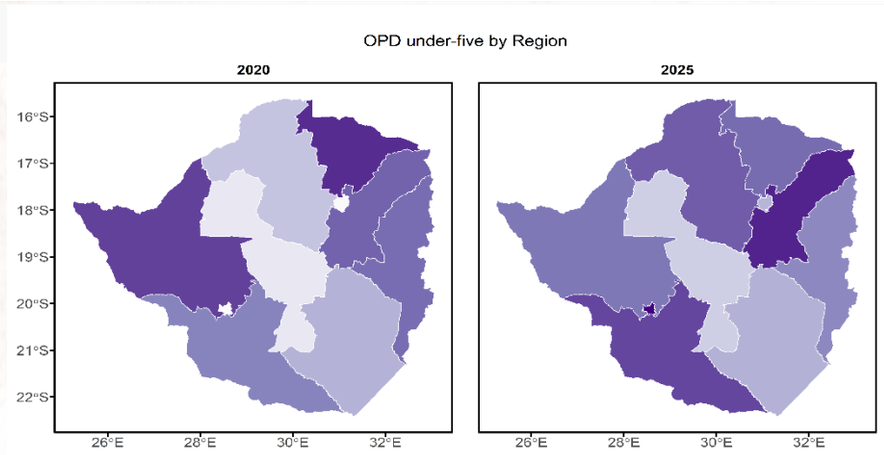


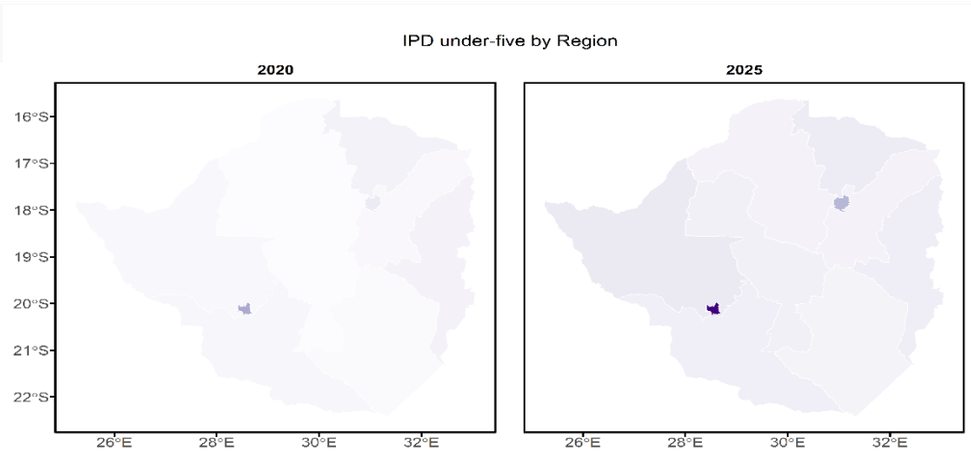
Interpretations

OPD service utilization among children under five has remained consistently low throughout the review period, with rates ranging from 0.5 visits per child per year in 2021 to 0.6 visits per child per year in 2025. This pattern may reflect barriers women caregivers face in accessing timely outpatient care, resulting in delayed treatment and greater need for hospitalization. The findings highlight the importance of strengthening access to primary child health services and reducing care seeking barriers.

The relationship between OPD and inpatient department (IPD) utilization among children under five points to a systematic underreporting of outpatient services relative to inpatient services. Rising inpatient admissions alongside low OPD use may indicate delayed care-seeking or challenges in accessing effective primary care, increasing the risk that children present with more severe illness. However, improved inpatient reporting may also be driving this upward trend.

Regional/provincial service utilization



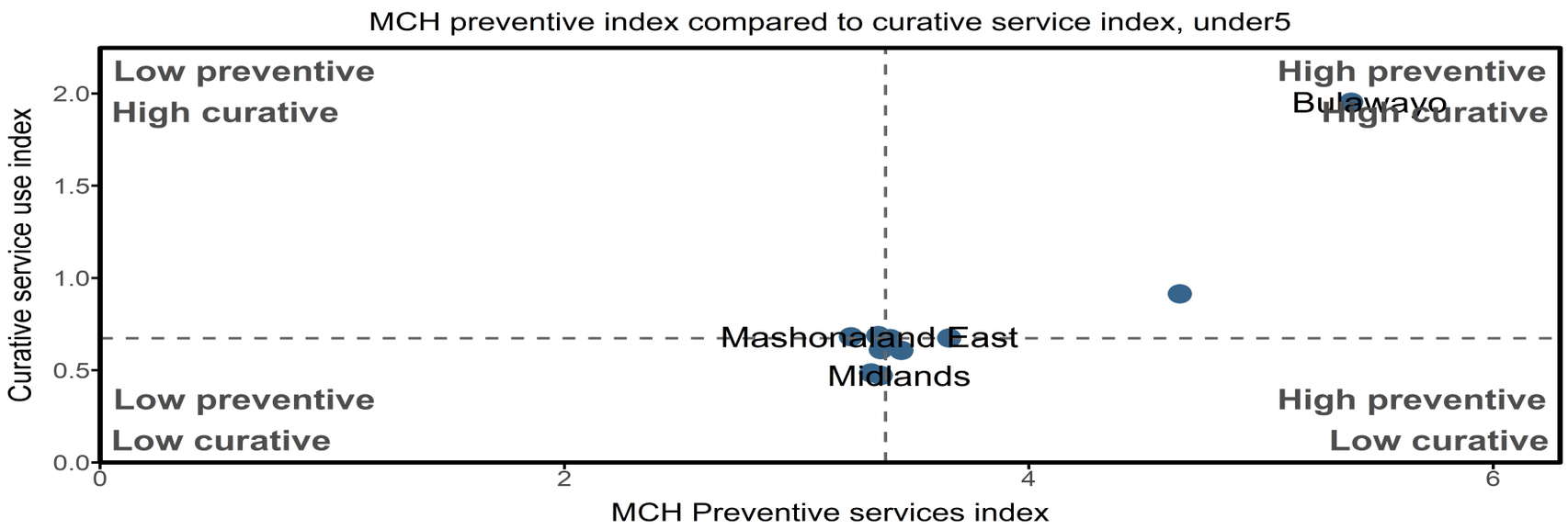


Interpretations

Regional variation in OPD utilization appears to be closing over time, although unequal access to primary child health services across provinces persists. Regions with lower utilization may face barriers in care seeking, service availability, staffing, readiness, and quality. Reporting completeness for outpatient department (OPD) service utilization data is generally high across the review period, reflecting improvements in health information system performance over time.

Inpatient department (IPD) admission rates among children under five have remained within the acceptable range of 1 to 15 admissions per 1,000 persons per year throughout the 2020 to 2025 review period, though notable fluctuations point to the influence of broader contextual factors on service utilization

MCH Preventive vs Curative Index

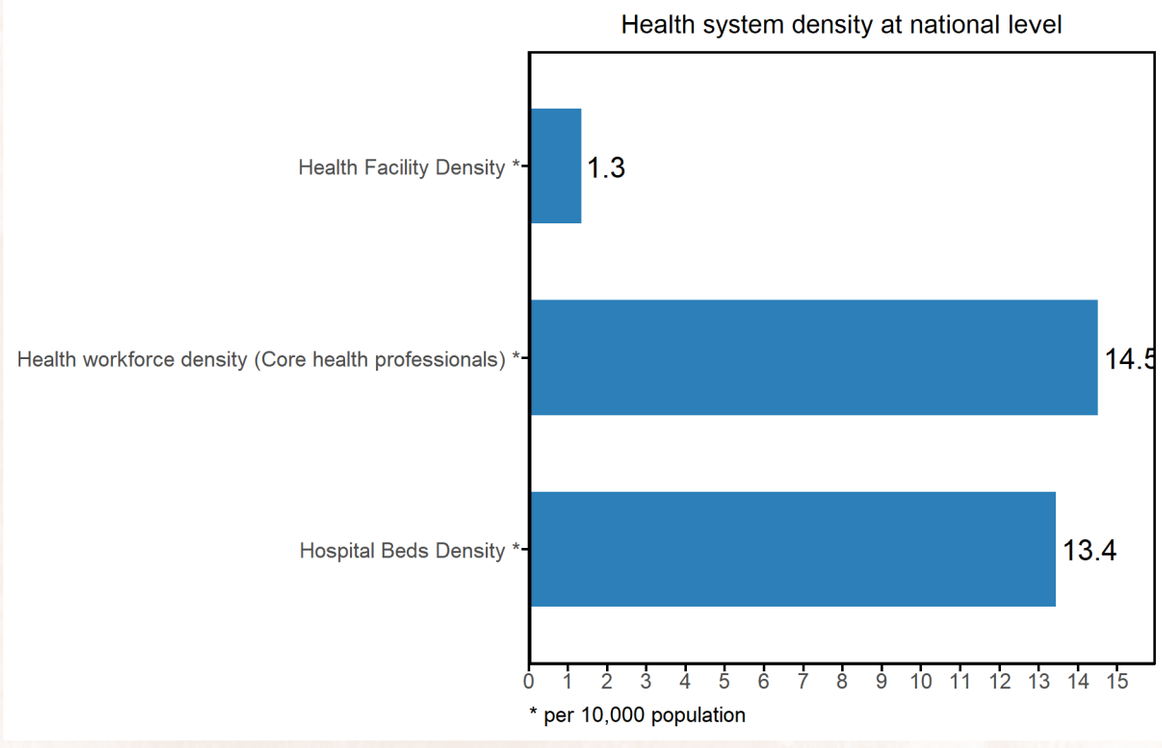


Interpretations

- **Provincial analysis of both curative and preventive maternal and child health (MCH) service utilization reveals a clear stratification in performance across the country and important inequities in access to and use of services.**
- The Midlands Province consistently recorded low utilization of both MCH curative and preventive services, indicating persistent challenges in service access and uptake in that region. This may reflect a mix of demand and supply-side barriers, including distance to care, affordability, workforce constraints, and limited service availability.
- Bulawayo Metropolitan Province demonstrated high utilization across both service categories, reflecting a comparatively stronger uptake of facility-based care and a more enabling environment for accessing and delivering MCH services.
- Women and children in lower-performing regions may face greater obstacles to accessing preventive services before conditions become severe, while health system constraints may further limit the availability and quality of care when curative services are sought.

6. Health system progress and performance

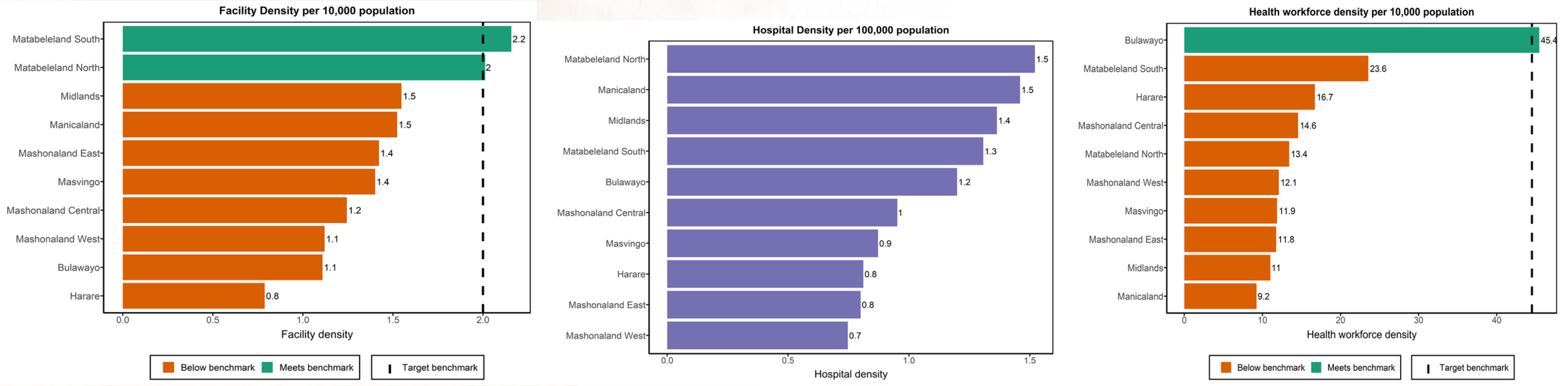
Health system inputs



Interpretations

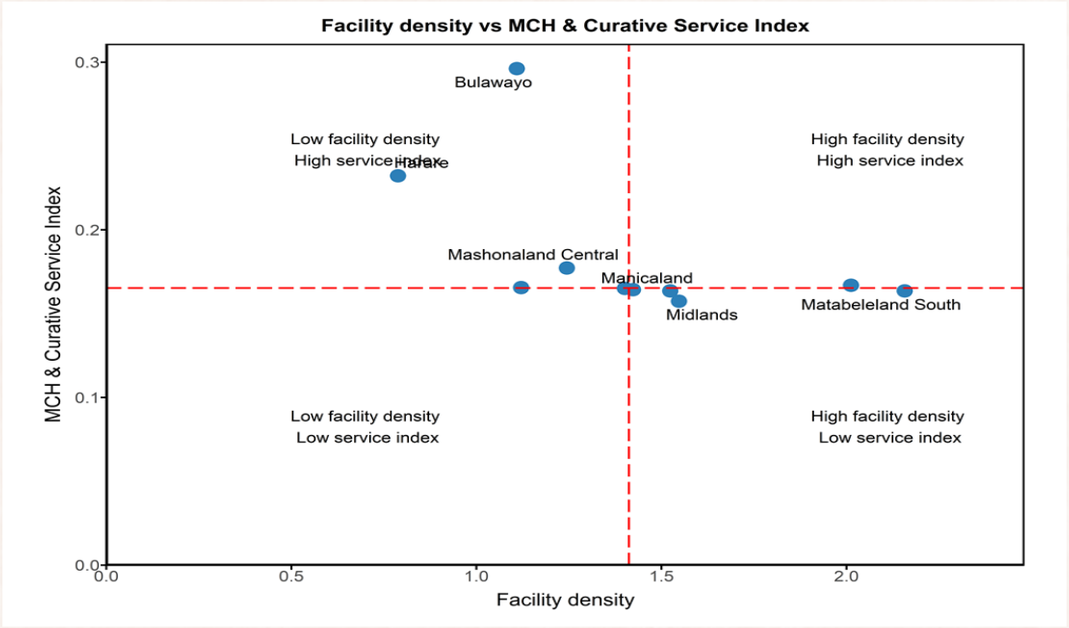
- Zimbabwe's health system faces significant capacity gaps constrained by shortages of facilities and health workers, with most key indicators falling below WHO benchmarks. Facility density stands at 1.3 per 10,000 population against a benchmark of 2, while bed density and health workforce density sit at 13.4 and 14.5 per 10,000 population respectively.
- From a gender lens, these gaps disproportionately affect women's access to timely, high-quality RMNCAH-N services for themselves and their children, particularly in underserved areas.
- These shortfalls are unevenly distributed across provinces.
- Increased and equitably distributed investment of infrastructure and health workers will be critical for improving both coverage and equity in maternal and child health outcomes, suggesting the need for increased domestic expenditure on health.

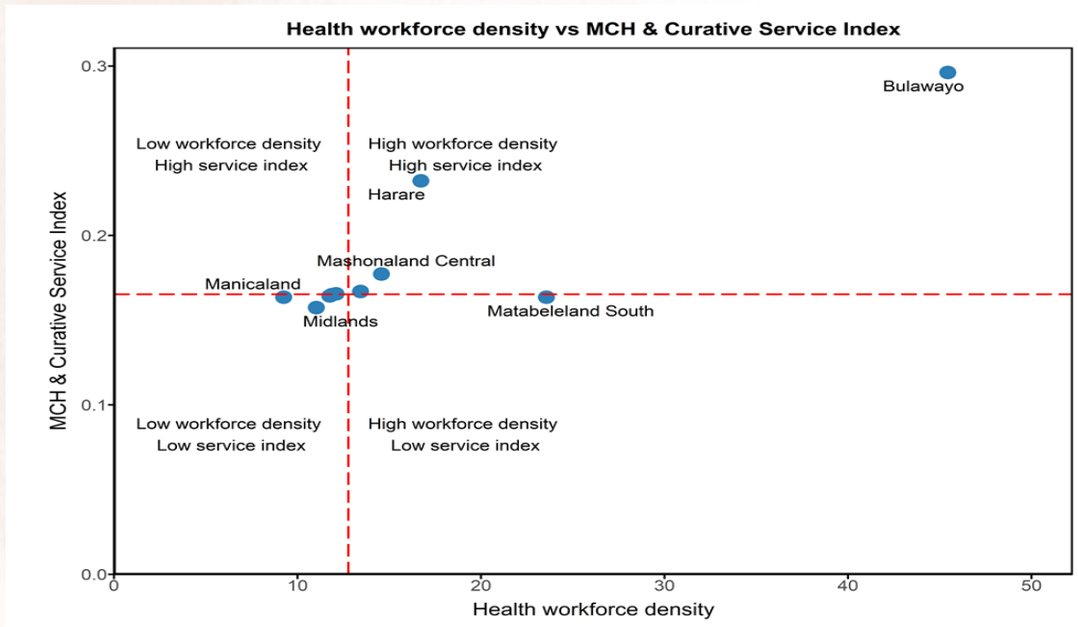
Health system inputs by region/province



- Marked provincial disparities in facilities, hospital beds, and health workers highlight inequities in health system capacity. Clients in under-resourced provinces may face longer travel times, reduced service availability, and lower-quality care. More equitable distribution of infrastructure and health workforce is essential for reducing geographic inequities in system capacity, and ultimately in health outcomes.
- Matabeleland North and South are the only provinces meeting the WHO facility density benchmark, though this is largely a function of their low population sizes rather than an abundance of facilities. Matabeleland North presents a particular challenge: as the country's largest province by land area, long distances to facilities remain a significant barrier to access, making travel time a more meaningful measure of service availability than facility density alone in such sparsely populated, geographically vast contexts.
- Harare and Bulawayo, by contrast, require additional secondary and tertiary facilities to improve health facility density ratios and reduce pressure on national quaternary-level facilities.
- Bulawayo Metropolitan stands out as the only province currently meeting WHO benchmarks for both bed density and health workforce density, highlighting the broader inequity in health resource distribution across the country.

Health system outputs by inputs at the subnational level

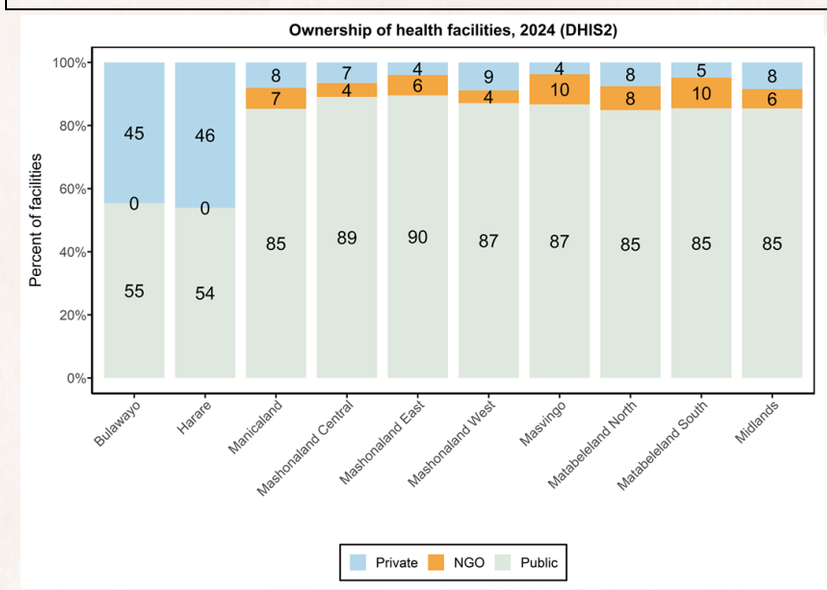


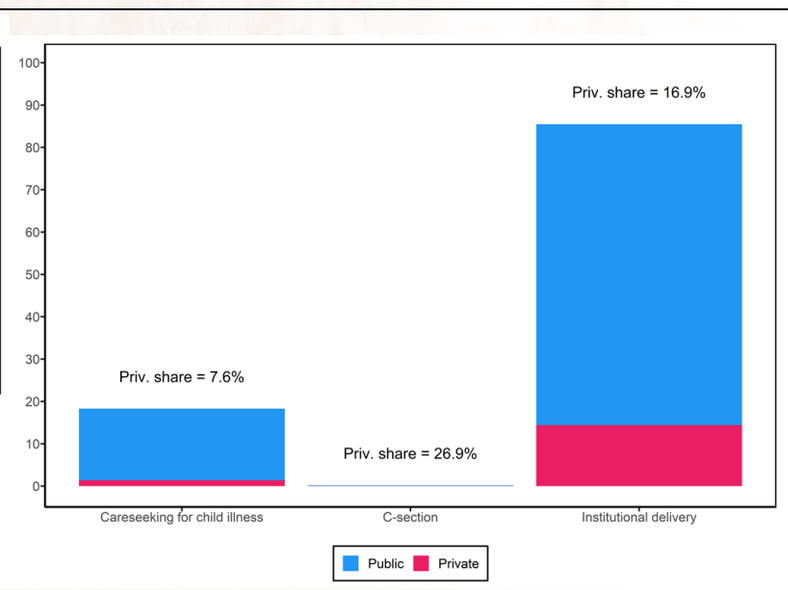


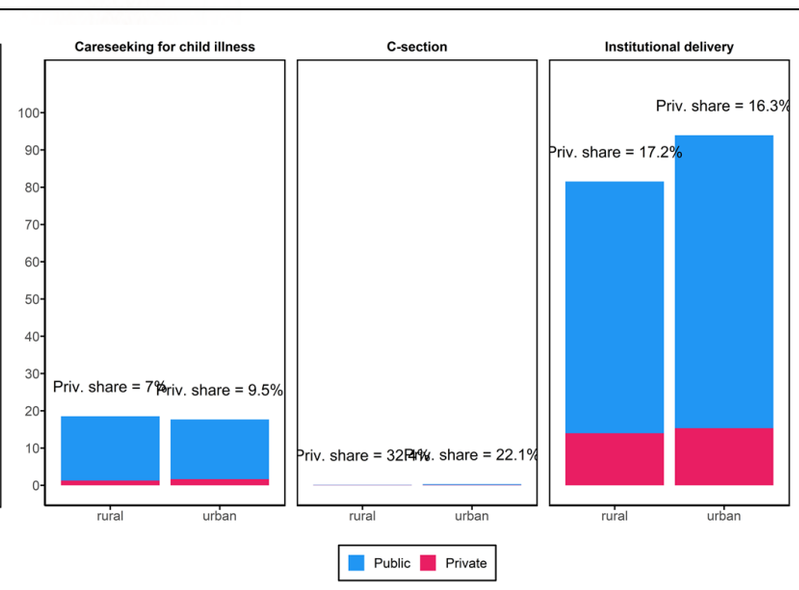
Interpretations

The analysis found an unexpected negative correlation between facility density and MCH & Curative service index. Therefore, facility density alone is not a reliable proxy for service quality. Matabeleland South, despite having the highest facility density in the country, records an unfavourable service index, while Manicaland's poor performance reflects the compounding effects of low workforce density, a large population, and geographic inaccessibility. Together, these cases highlight the need for a multi-dimensional approach to assessing health system capacity that goes beyond infrastructure figures alone. Harare has high health workforce density and high service index, plausible for a capital city. Manicaland's low workforce density and service index is consistent with its large population size and geographic inaccessibility, which likely dilutes workforce availability.

Private sector and RMNCAH services







Interpretations

The private sector plays a notable but unevenly distributed role in Zimbabwe's health facility landscape, with its influence concentrated in urban areas and resource-intensive services. Metropolitan provinces lead in private sector proportion of health facilities, with Harare at 46% and Bulawayo at 45%, far exceeding rural provinces, a pattern consistent with where private facilities tend to cluster. However, the full picture of private sector service delivery remains incomplete due to poor reporting rates from private facilities, a gap further compounded by higher user fees that render these services inaccessible to much of the general public. Among services analysed, caesarean section recorded the highest private sector share at 26.9%, reflecting both the resource-intensive nature of the procedure and its concentration in better-equipped private facilities, a trend that mirrors the broader urban skew in private sector presence.