MALARIA IN PREGNANCY COUNTRY PROFILE

ZIMBABWE

July 2018

BACKGROUND

Zimbabwe has adopted the World Health Organization (WHO)'s three-pronged strategy for combating malaria in pregnancy (MiP): (1) intermittent preventive treatment in pregnancy (IPTp)[1] via directly observed therapy (DOT), (2) distribution and use of insecticide-treated nets (ITNs), and (3) case management of MiP. The country began implementing IPTp in 2004.[2]

AT A GLANCE[3]

93% of pregnant women attended at least one ANC visit

76% of pregnant women attended at least four ANC visits

36% of pregnant women received at least two doses of IPTp

18% of pregnant women received at least three doses of IPTp

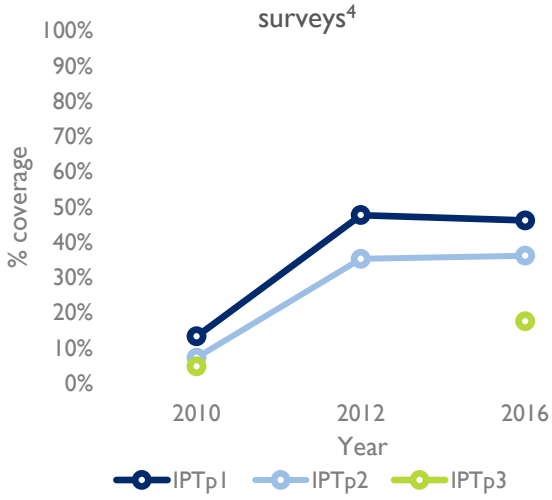
25% of pregnant women slept under an ITN

POLICY & IMPLEMENTATION

As of 2017, IPTp is implemented in 30 target districts in areas of high malaria transmission and may be deployed elsewhere in response to increases in confirmed cases.[5] Zimbabwe's IPTp policy stipulates that the first dose be given between 13 and 16 weeks' gestation from the health center or nearest community-based health worker. Dissemination of new policies and guidelines throughout the country lags behind; new guidelines are printed but may not be disseminated to lower-level facilities due to competing priorities.[6]

Some of the challenges preventing consistent administration of IPTp via DOT include lack of clean water and cups, and secondary-level facilities

Figure A. IPTp coverage from household surveys[4]



[1] IPTp1, IPTp2, and IPTp3 refer to at least one dose, at least two doses, and at least three doses, respectively, of IPTp with SP.

[2] Sande S, Zimba M, Mberikunashe J, Tangwena A, Chimusoro A. 2017. Progress towards malaria elimination in Zimbabwe with special reference to the period 2003–2015. *Malar J*. 16:295. doi: 10.1186/s12936-017-1939-0.

[3] Note these are subnational data representing IPTp- implementing areas only. (i) ANC data from: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International. 2016. *Zimbabwe Demographic and Health Survey 2015: Final Report*. Rockville, MD, USA: ZIMSTAT and ICF International. (ii) IPTp2 and ITN data from *Zimbabwe Malaria Indicator Survey 2016*. As per communication with the President's Malaria Initiative.

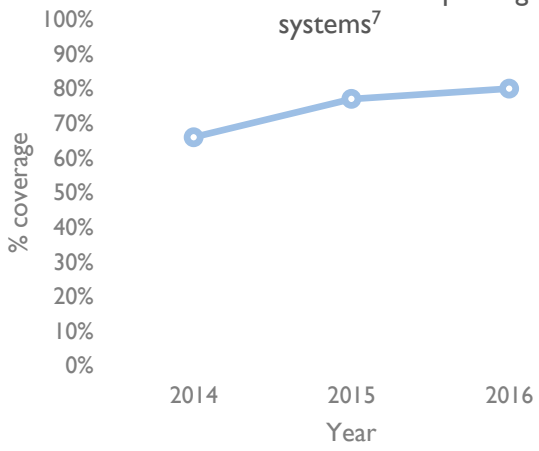
[4] The *y*-axis shows coverage for the most recent pregnancy resulting in a live birth—in the previous 5 years for ANC coverage and in the previous 2 years for IPTp—among women ages 15–49 who were interviewed for the survey. Note these are subnational data representing IPTp- implementing areas only. (i) ZIMSTAT and ICF International. 2012. *Zimbabwe Demographic and Health Survey 2010–11*. Calverton, MD, USA: ZIMSTAT and ICF International Inc. (ii) NMCP and ICF International. 2012. *Malawi Malaria Indicator Survey 2012*. Lilongwe, Malawi, and Calverton, MD, USA: NMCP and ICF International. (iii) *Zimbabwe Malaria Indicator Survey 2016*.

[5] President's Malaria Initiative. 2017. *Zimbabwe Malaria Operational Plan FY 2017*. Accessed June 25, 2018 at: https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy17/fy-2017-zimbabwe-malaria-operational-plan.pdf?sfvrsn=8

[6] Data is from an assessment of drivers and barriers for achieving target IPTp coverage in Chipinge and Mutare Districts, Manicaland Province, Zimbabwe. December 2017.

that dispense sulfadoxine-pyrimethamine (SP) at the pharmacy, not at point of service. In 2017, an MiP Technical Action Group was established to foster coordination between the National Malaria Control Program and the Family Health Directorate on an IPTp study, but its mandate has since been expanded to make it a permanent body to review evidence and further the prevention and control of MiP in Zimbabwe.

Figure B. IPTp2 coverage among ANC attendees from routine reporting systems[7]



SERVICE DELIVERY

Health workers have been trained on the revised IPTp guidelines and schedules, and on integrated malaria case management and MiP. Malaria health worker trainings are tracked through the TrainSMART database, which is housed and managed by the Ministry of Health and Child Care. The findings of a President's Malaria Initiative (PMI)-funded formative assessment on IPTp in Mutasa District found there was limited availability of updated national IPTp guideline documents at facilities, that antenatal care (ANC) services were provided at limited times, and that in private-sector facilities, IPTp was not provided as an integrated component of ANC services.[8] A 2015 NMCP case management audit showed that of the 13% of pregnant women who did not receive any SP at ANC, 57% were currently on co-trimoxizole prophylaxis, making them ineligible, and 29% were seen when SP was not available.[9] The reduction in MiP-related deaths may be attributed to a novel strategy of admitting all pregnant women with malaria as inpatients, irrespective of disease severity.[10]

In Manicaland Province, recent progress showed a reduction in MiP-related deaths from 21% in 2013 to 14% in 2015.[11]

COMMUNITY ENGAGEMENT

Village health workers play a key role in referring pregnant women to ANC early in pregnancy and in encouraging IPTp uptake and consistent use of ITNs. They also counsel on MiP warning signs and refer women to facilities immediately should they present with severe symptoms. The Manicaland assessment recommends that more attention be given to investigating community-level knowledge about IPTp, better understanding women's perceptions of ANC and IPTp services, and exploring male partner, family, and community leader support for IPTp uptake and early ANC attendance. In 2018, Zimbabwe updated its IPTp policy to include delivery of IPTp at community level.

COMMODITIES

A recent assessment found that 27% of surveyed facilities had experienced an SP stock-out. An ANC record review under the same assessment found that 10% of missed opportunities for IPTp were due to SP stock-outs, however nurses cited stock-outs as the most common cause of missed opportunities to receive IPTp.[12] It was found that poor stock management practices have prevented timely redistribution of SP from facilities with surplus to those with stock-outs. PMI has supported pharmaceutical and supply chain management for distribution of MiP commodities at primary care facilities using the old Zimbabwe Informed Push System and new Zimbabwe Assisted Pull System.

MONITORING & EVALUATION

The current Health Management Information System (HMIS) surveillance form only captures IPTp1 and IPTp2, although trainers and supervisors have advised health care workers to write in IPTp3 until the registers and forms can be revised. The HMIS does not track whether DOT is observed, disaggregate malaria cases among pregnant women, or record ITN distribution to pregnant women. In the

[7] The *y*-axis shows coverage of women who attended ANC at facilities reporting to the HMIS. Data source for this figure is from the HMIS 2014–2016. Estimates are for areas targeted for IPTp (which is not a national intervention in Zimbabwe).
[8] Mutseyekwa F, Mandigo RG, Mashizha S, et al. 2017. Performance of the intermittent preventive treatment in pregnancy (IPTp) intervention in Mutasa District of Manicaland Province, Zimbabwe: results from a formative enquiry to inform the main study on 'facilitators and barriers of IPTp uptake.' Presented at: American Society of Tropical Medicine and Hygiene Annual Meeting; November 5–9, 2017; Baltimore, MD, USA.
[9] *Zimbabwe Malaria Operational Plan FY 2018*.
[10] Data is from an assessment of drivers and barriers for achieving target IPTp coverage in Chipinge and Mutare Districts, Manicaland Province, Zimbabwe. December 2017.
[11] Ibid.
[12] Ibid.

Manicaland IPTp assessment, which conducted data quality assessments at facilities, 37% of facilities either under- or over-reported IPTp2 uptake,[13] possibly due to, among other factors, shortages of registers and inadequate staff for data capture and compilation, indicating that data quality may be a challenge. Zimbabwe is currently updating the National Malaria Monitoring and Evaluation Plan, to be finalized in spring 2018. The changes include disaggregating case management data by severity, pregnancy status, and community/facility level. In addition, it will track ITNs distributed to pregnant women through ANC.

This profile is made possible by USAID and the Maternal and Child Survival Program and does not reflect the views of USAID or the United States Government.

[13] Ibid.