



GOVERNMENT OF ZIMBABWE



United Nations  
Zimbabwe

# Zimbabwe Millennium Development Goals



2000-2015 FINAL PROGRESS REPORT

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**ZIMBABWE MILLENNIUM DEVELOPMENT GOALS (MDGs)**  
2000-2015 FINAL PROGRESS REPORT



# FOREWORD

The Millennium Development Goals (MDGs) 2000-2015 deadline ended on 31 December 2015 and has since been replaced by the Sustainable Development Goals (SDGs) 2016-2030, to be launched in 2016. The MDGs have served as a cornerstone of development policy around the globe since their adoption in 2000. The SDGs will take a step further in transforming the world to meet human development needs more effectively, and provide the necessities for economic transformation and poverty reduction.

The MDGs era coincided with one of the most difficult periods in Zimbabwe's economic history, as reflected by severe economic challenges in the country. A serious exogenous challenge came in the form of the HIV epidemic which affected all sectors of the economy, exerting great strain particularly on the country's health delivery system. Pervasive gender inequality, particularly in the economy, continued to marginalise women, while harsh climate change impacts have contributed to widespread food insecurity.

Despite these challenges, Zimbabwe has made significant progress on some MDGs, particularly in the reduction of HIV prevalence; gender equality; primary school enrolments and provision of core text books; tertiary enrolments; literacy; maternal health; child immunisation; information and communication technology (ICT); provision of essential drugs including

antiretroviral drugs (ARVs); cessation of the use of ozone depleting substances (ODS); and other areas. The SDGs are being introduced at a time when the MDGs have not been fully achieved and in an era of new local and global challenges which have emerged since the introduction of the MDGs. The unfinished agenda of MDGs lingers in the form of: weak economic performance, high income poverty, the need for agrarian reform following the land reform, high maternal mortality, high HIV prevalence, the need for sustainable provision of essential drugs, food insecurity, gender equality gaps particularly in the economy and in decision making, water and sanitation needs, and inadequate environmental management.

Economic challenges have been the primary obstacle to achieving the MDGs and, as such, Zimbabwe's vision, as articulated in the national development plan, the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset). ZimAsset is centred on achieving inclusive growth while reducing the levels of poverty for the population as a whole. Zimbabwe desires to build an empowered society, within the context of a broad-based, inclusive, pro-poor, gender-sensitive and dynamic economy that produces decent jobs and sustained high growth. As a country, therefore, Zimbabwe would like to achieve sustainable inclusive growth, human centred development, structural transformation, and poverty eradication in all its forms everywhere.

**HIS EXCELLENCY R.G. MUGABE**  
**President of the Republic of Zimbabwe**

# ACKNOWLEDGEMENTS

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- MDG1 Ministry of Public Service, Labour and Social Welfare (MPSLSW), and Ministry of Agriculture, Mechanisation and Irrigation Development (MAMID)
- MDG2 Ministry of Primary and Secondary Education (MOPSE)
- MDG3 Ministry of Women Affairs, Gender and Community Development (MWAGCD)
- MDG4 Ministry of Health and Child Care (MOHCC)

- MDG5 Ministry of Health and Child Care (MOHCC)
- MDG6 Ministry of Health and Child Care (MOHCC) and National AIDS Council
- MDG7 Ministry of Environment, Water and Climate (MEWC)
- MDG8 Ministry of Finance and Economic Development (MOFED)

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It is my sincere hope that this comprehensive report will contribute with lessons for the implementation of the Sustainable Development Goals (SDGs), and will underpin evidence-based policy making and programming in the country.

**Honourable Dr. Obert Mpofu, MP**  
**Minister of Macro-Economic Planning and Investment Promotion (MEPIP)**

**& WELDER**  
SHOP № 13 B



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# EXECUTIVE SUMMARY

The Millennium Development Goals (MDGs) era coincided with one of the most difficult periods in Zimbabwe's economic history. The severe economic challenges in the country saw gross domestic product (GDP) halve over the decade to 2008 along with low agricultural productivity, and hyperinflation reaching 231 million percent at its peak in July 2008. Company closures in this period were accompanied by urban unemployment of 30 percent, urban youth unemployment of 38 percent (2014), and informalisation of employment, with 14 percent of all employed persons being in the large informal sector. These factors placed strain on the fiscal space, leading to a reduction in social services provision and an increase in poverty. The majority (53 percent) of those in the informal sector are women, and the unemployment rate of urban women aged 15 to 34 years is the highest, at 47 percent, compared to 26 percent for young urban men.

Sanctions and the negative perceptions of the country arising from the Fast Track Land Reform Programme (FTLRP) of 2000 onwards, limited both foreign direct investment (FDI), and the Government's ability to obtain international funds, thus compounding the country's debt overhang. In addition, the global financial and economic crisis reduced official development assistance (ODA) commitments and export demand. With most of the remaining ODA being channelled outside government systems before 2009, it was difficult to align available funds with national priorities. The HIV epidemic represented a major exogenous challenge which affected all sectors of the economy, exerting great strain particularly on the country's health delivery system. Pervasive gender inequality, particularly in the economy, continued to marginalise women.

Despite these challenges, Zimbabwe has made significant progress on some MDGs, particularly in certain aspects

of HIV, gender equality, primary school enrolment and provision of books, tertiary enrolment, literacy, maternal health, child immunisation, information and communication technology (ICT), provision of essential drugs including antiretroviral drugs (ARVs), and cessation of the use of ozone depleting substances (ODS). The Sustainable Development Goals (SDGs) are being introduced at a time when the MDGs have not been fully achieved and in an era of new local and global challenges that have emerged since the introduction of the MDGs. The unfinished agenda of MDGs lingers in the need to address weak economic performance, high income poverty, agrarian reform following the land reform, high maternal mortality, high HIV prevalence, sustainability of the provision of essential drugs, food insecurity, gaps in gender equality in the economy and in decision making, water and sanitation inadequacies, and issues of environmental management.

## AREAS OF PROGRESS

**MDG 1 – Eradicate extreme poverty and hunger** The proportion of the population below the Food Poverty

Line (FPL) was more than halved from 42 percent in 2001 to 23 percent in 2011/12. However, the proportion

of the population living below the Total Consumption Poverty Line (TCPL) declined only marginally, from 75.6 percent in 1995, to 72.3 per cent in 2011/2012. Rural areas continued to register very high levels of income poverty, of 82.4 percent in 2001 and 84.3 percent in 2011/12, compared to urban areas, with 42.3 percent and 46.5 percent, respectively.

**MDG 2 – Achieve universal primary education** The net enrolment ratio (NER) remained high at 92.2 percent in 2014, with gender parity. Literacy rates for those aged 15 to 24 years remained around 99 percent, also with gender parity. The pupil-book ratio (PBR) reached 1:1 for the four core primary school subjects, while the proportion of trained primary school teachers remained high, at 89 percent in 2014. Grade 7 pass rates of 56 percent for girls and 47 percent for boys in 2012 were in the normal range, given the universality of primary education in Zimbabwe, and primary school dropout rates, (Grade 1 to 6), declined from 7.9 percent in 2011 to 4.8 percent in 2012. Almost all primary schools (99 percent) had early childhood development (ECD) classes in 2014.

**MDG 3 – Promote gender equality and empower women** Zimbabwe has made considerable progress under MDG3, with Zimbabwe achieving gender parity in both primary and secondary education. There was tremendous improvement in tertiary education enrolment (university, primary and secondary teachers' colleges, technical colleges and industrial training centres), with the Gender Parity Index (GPI) increasing from 60 percent in 2000, to 95 percent in 2012. Tertiary education enrolments increased by 288 percent, with women's enrolment increasing by 404 percent and men's enrolment by 218 percent. Secondary school (Form 1 to 4) enrolment increased by 11 percent from 2000 to 2014, with gender parity. The proportion of trained secondary school teachers remains high at 89 percent in 2014. The core text book-learner ratio for secondary education improved from around 2 in 2000 to 0.95 in 2013. The O' level pass rate remains satisfactory, at 24 percent in 2014, under a mass education system. Nationally, secondary school (Form 5 to 6) NER improved from 3.2 percent in 2000 to 7.2 percent in 2014. Secondary school A' level pass rates remained relatively high, at 84 percent in 2014, with gender parity in most years during the MDG period.

The Upper House of Parliament (the Senate), with its 'Zebra' system of representation, reached 45 percent share of women in 2013, up from 23.2 percent in 2008, against an MDG target of 50 percent, showing the effectiveness of the quota system in political decision making. The Lower House of Parliament saw the representation of women increasing from 9 percent in 2000, to 32 percent in 2013.

**MDG 4 – Reduce child mortality** Progress was registered in all the indicators of child mortality. The under-five mortality rate declined from 120 deaths per 1 000 live births in 1999, to 75 deaths in 2014, while the infant mortality rate declined from 65 deaths per 1 000 live

births to 55 deaths during the same period. Vaccination against measles, increased from 71 percent in 1999 to 83 percent in 2014. Stunting among children under five years of age declined from 36 percent in 2005/06 to 28 percent in 2014, while underweight remained moderate, at 11 percent in 2014. Exclusive breastfeeding for children for the first six months increased from 26 percent in 2009, to 41 percent in 2014.

**MDG 5 – Improve maternal health** The maternal mortality ratio declined significantly, from 1 069 deaths per 100 000 live births in 2002, to 526 deaths in 2012. The proportion of births attended by skilled health personnel increased from 69 percent in 2005/06 to 80 percent in 2014. Home deliveries in rural areas declined from 41 percent in 2005/06 to 22 percent in 2014.

**MDG 6 – Combat HIV and AIDS, malaria and other diseases** The decline in HIV prevalence among adults aged 15 to 49 years, from a peak of 29.6 percent in 1998 to 21.5 percent in 2005 was the first such decline in Southern Africa, and HIV prevalence had declined further, to 16.7 percent, by 2014. The incidence of HIV among adults declined from 2.6 percent in 2000 to 0.9 percent in 2014. Adult antiretroviral treatment (ART) coverage improved from 69 percent in 2011 to 77 percent in 2013 (using a CD4 count of 350), while prevention of mother-to-child transmission (PMTCT) coverage increased from 56 percent to 82 percent within the same period. As a result, total AIDS deaths fell, from 122 282 in 2000 to 38 616 in 2014, a 68 percent reduction. Similarly, the number of AIDS orphans declined, from 796 990 in 2006 to 567 480 in 2014, which is a reduction of 29 percent. Tuberculosis (TB) incidence declined from 809 cases per 100 000 population in 2004 to 552 in 2013. Clinical malaria incidence declined from 113 cases per 1 000 people in 2000 to 40 cases in 2014.

**MDG 7 – Ensure environmental sustainability** Despite financing challenges, the country has done commendably in reducing ODS ahead of the 2015 deadline under the Montreal Protocol. Zimbabwe remains among the best in the region in terms of biodiversity conservation. At national level, about 15 percent of land is designated to conservation of biological diversity of which, 2 percent is indigenous forest and 13 percent is Parks and Wildlife estates. Significant reforestation efforts are ongoing. Carbon dioxide emissions decreased from 13 000 tonnes in 2000 to 9 861 tonnes in 2011.

**MDG 8 – Develop a global partnership for development** Despite uneven economic growth, notable progress has been made in the ICT sector and in the supply of essential drugs. Following the adoption of the multi-currency system in 2009, the macroeconomic environment stabilised and inflation had reduced to 3.7 percent in 2012. The economy recovered to positive growth in 2009, and real GDP increased from about US\$8 billion in 2008 to US\$14 billion in 2014. Even in the midst of unprecedented economic challenges, Zimbabwe sustained its own domestic resource mobilisation in

support of MDG6 in the form of the National AIDS Trust Fund (NATF), commonly known as the AIDS levy, as a home-grown approach to funding the fight against the HIV epidemic, which has been acknowledged as international best practice in domestic resource mobilisation (SADC, 2008). A marked improvement in the availability of selected essential medicines was noted,

## DATA ISSUES

There has been tremendous improvement in the availability of statistical data from the National Statistical System (NSS) since 2009, in line with economic and social recovery, and re-engagement with most development partners, enabling the use of robust data in evidence-based policy making. The data improvement is noted in terms of quality, coverage, timeliness, adequacy, relevance, and disaggregation with regard to sex, urban-rural divide and other demographic characteristics, and this can be attributed in part to the requirements of the MDG monitoring and evaluation process. The Zimbabwe National Statistics Agency (ZIMSTAT) was the main producer of official statistics used in producing this report,

from 9 percent of the health facilities having at least 80 percent of the selected medicines in 2009 to 83 percent in 2013. Tremendous progress was registered in ICT, with mobile-cellular penetration increasing from 2 percent in 2000 to 81 percent in 2014, and the Internet penetration rate increasing from 0.4 percent in 2000 to 20 percent in 2014.

complemented by administrative records. Remaining issues of concern around data include: resource constraints and a non-conducive environment for data collection, particularly, during the recession period from 2000 to 2008; different methods of measurement, reference periods, and age groups; lack of data disaggregation on recalculation; changing definitions; not publishing data as stipulated in the internationally agreed MDG indicators; and absence of data in the NSS on some MDG indicators. Generally, gender disaggregated data on the economy, and also data on the environment and housing, is not readily available. Qualitative indicators of development remain a key data gap.

## UNFINISHED BUSINESS FROM THE MDGS PERIOD

### ***MDG 1 – Eradicate extreme poverty and hunger***

The main unfinished business here is the eradication of both structural and transient poverty in all its forms, everywhere, and the reduction of inequalities, in the context of a broad-based, inclusive, pro-poor, gender-sensitive and dynamic economy, capable of generating decent jobs and sustaining high growth. It is also necessary to address informality in employment and unemployment, particularly among urban youth and women. Challenges persist in terms of nurturing entrepreneurship through micro, small, and medium enterprises (MSMEs), and improving agricultural yields in order to ensure food security for the whole population, particularly children and women. Given the increasing negative impacts of climate change, there is a specific need to support irrigation development.

### ***MDG 2 – Achieve universal primary education***

The gains in primary education, in particular the supply of core text books which was achieved with effective partnerships, need to be sustained. In addition, there is still a need to reduce school dropouts, ensure gender equality in pass rates, and increase primary school electrification and computerisation. Although ECD has been introduced in almost all primary school, the facilities should be improved and enrolment increased.

### ***MDG 3 – Promote gender equality and empower women***

Secondary school enrolment should increase substantially from the current levels, with gender parity, and school dropouts should be reduced, paying special attention to marriage and pregnancy related cases among girls. There is a remaining challenge to ensure gender

equality in transition from Form 4 to Form 5, pass rates, and enrolment in 'hard' subjects such as sciences, alongside increasing secondary school electrification and computerisation. It is necessary also to sustain the increase in enrolment in tertiary education, ensuring gender parity, with an emphasis once again on increasing the enrolment of women in science disciplines. Underlying these challenges is further unfinished business in terms of achieving gender balance in political and economic decision making, and economic participation at all levels, and eliminating domestic violence.

### ***MDG 4 – Reduce child mortality***

The unfinished business includes continued reduction in child mortality, paying special attention to infant mortality including neonatal mortality. Universal vaccination and exclusive breastfeeding of infants under 6 months are yet to be dealt with. Across all these tasks, special attention must be paid to rural areas.

### ***MDG 5 – Improve maternal health***

Outstanding issues are continuing reduction in maternal mortality, universal attendance of births by skilled health personnel and eradication of home deliveries, ensuring universal antenatal care of at least four visits, and reducing adolescent pregnancies. Once again, special attention must be paid to rural areas.

### ***MDG 6 – Combat HIV and AIDS, malaria, and other diseases***

Sustained reduction in HIV prevalence and incidence, as well as behaviour change remain key in the fight against the HIV epidemic. Other issues to address are: achieving universal comprehensive knowledge of

HIV transmission and prevention; elimination of stigma and discrimination; and universal ART coverage and prevention of PMTCT. The reduction in the incidence of TB, malaria and other diseases needs to be sustained.

**MDG 7 – Ensure environmental sustainability** Access to safe water and sanitation remains a major issue, particularly in rural areas. There are outstanding issues around the environment in general and, specifically, sustained reforestation, prudent management of wetlands, and treatment of solid waste (particularly in urban areas). The provision of adequate housing and rural electrification are also unfinished business.

## LESSONS LEARNT FROM THE MDGS TOWARDS ACHIEVING THE SDGS

**Political will and national ownership** Political will at the highest level will be a critical success factor for the SDGs, as evidenced by the achievements in HIV, education and gender under the MDGs. Broad consultation of all stakeholders from community to national level is important to ensuring national ownership. Clear prioritisation of goals, including among the SDGs, is essential to optimising development efforts and impacts in a context of limited resources. While it is necessary to managing international relations and to continue with re-engagement initiatives, inter-sectoral collaboration at the national level will also be critical for the achievement of the SDGs.

**Prioritising the economy** Zimbabwe should prioritise those SDGs and targets that underpin economic success. The country must endeavour to build a sustainable, broad-based, inclusive, pro-poor and gender-sensitive economy that delivers decent jobs. These factors are central to poverty eradication, food security and sustained human development. The development of key economic enablers, such as energy, roads, rail, water, and ICT infrastructure, is a critical pre-condition for the growth of such an economy. An effective framework would address all the key facets of development, including: enlarging the economic cake; equitable re-distribution of the key means of production, such as land and minerals, to ensure inclusive economic transformation and the economic empowerment of indigenous people; governance; and other human rights issues. There is an urgent need to formalise economic activity in the country, in the context of supporting MSMEs, alongside the establishment of effective social protection mechanisms for vulnerable groups. The current re-engagement of willing international partners should be strengthened, while the ease of doing business could be improved for both the local private sector and for FDI. Zimbabwe needs to make an assertive move away from relying on primary commodity exports towards value added exports, in order to optimise the benefits of its abundant natural resources, and maximise its trade share in the relevant regional economic communities (RECs). Finally, finance and debt management should be prudent in the coming period.

**MDG 8 – Develop a global partnership for development** To ensure the generation of domestic resources for the sustainable financing of the SDGs, success in all facets of economic performance is a must for Zimbabwe. Prudent debt management; complete re-engagement with the international community; improving the business environment; attracting FDI, where it is needed; and value addition/beneficiation of the country's primary commodities remain as leading outstanding issues. Given that modern ICTs are changing the development terrain in terms of speed of and access to information, all sectors should embrace the benefits of ICTs, so that Zimbabwe can move into an e-economy within the next fifteen years.

**Comprehensive agrarian reform to support high agricultural productivity** In addition to the land reform, a comprehensive agrarian reform package is needed to enable farmers to attain high productivity. This would include: improving access to agricultural inputs such as credit, tillage and extension services; research and development innovation, development of markets; rehabilitation of irrigation systems (given the damaging impacts of climate change on rainfed agriculture); installation and maintenance of roads, dip tanks and communication infrastructure; and good access to basic social services in the newly resettled areas. These improvements would render agriculture viable and enhance household and national food security.

**Sustainable financing** Domestic financing, including public-private partnerships (PPPs) and joint ventures, is central in the achievement of the SDGs as it is highly sustainable. Nevertheless, it should be complemented and augmented by global partnership resources.

**Environment, water and sanitation, and housing** The demand-led water, sanitation and hygiene (WASH) model, supported by community based management of infrastructure and environmental management is considered to be more sustainable than demand-led models. In rural areas, there is an urgent demand for increased rural electrification, particularly using renewable sources of energy, and for reforestation programmes. Given the increase in urban and peri-urban populations, a need exists for increased construction of low-cost housing, including support to private house building initiatives.

**Monitoring and evaluation** The SDG baselines should be as close as possible to the time the programme is started to ensure relevant targets are set, and the indicators should be customised to the local circumstances. At the start of the programme, a comprehensive, stand-alone SDG database should be set up and this should be which updated continuously. Monitoring should be expanded from the current 'on-track' and 'off-track' assessments to track more subtle development progress, particularly in countries with low initial levels of human development



and other complexities, such as Zimbabwe. The capacity of the National Statistical System's (NSS) warrants development in order to ensure the efficient monitoring and evaluation of the SDGs.

***Gender and women's empowerment*** In addition to

having its own goal, gender should be mainstreamed in all the SDGs and at all levels. It should be borne in mind that on all outcomes the desired outcome is gender balance. Quota systems and affirmative action remain relevant in moving forward gender equality and women's empowerment in education, politics and the economy.

## **PRIORITY AREAS FOR THE POST-2015 SDG AGENDA**

As Zimbabwe moves towards the implementation of the SDG from 2016, Government has decided that it will implement all the 17 SDGs as all were deemed to be important to the country. However, the following ten SDGs have been identified as areas of focus:

- SDG 8 Promote sustained, inclusive and sustainable economic growth, full and productive employment
- SDG 7 Ensure access to affordable, reliable, sustainable, and modern energy for all
- SDG 2 End hunger, achieve food security and improved nutrition, and promote sustainable agriculture
- SDG 9 Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation
- SDG 6 Ensure availability and sustainable management of water and sanitation for all

- SDG 13 Take urgent action to combat climate change and its impacts
- SDG 17 Strengthen the means of implementation and revitalise the global partnership for sustainable development
- SDG 3 Ensure healthy lives and promote well-being for all at all ages
- SDG 4 Ensure inclusive and equitable quality education and promote life-long learning opportunities for all
- SDG 5 Achieve gender equality and empower all women and girls.

Focus on the priority SDGs will trigger activity in the remaining seven, leading to the ultimate achievement of **SDG 1 - End poverty in all its forms everywhere.**

# MDGS AT A GLANCE, ZIMBABWE 2000-2015

MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance	
MDG1: Eradicate extreme poverty and hunger	Target 1A: Halve, between 2002 and 2015, the proportion of people whose income is less than the TCPL	Population below the TCPL, %, total	1995	2011/12 72.3	36	Target not achieved. Rural areas worse off.	
		Employment-to-population ratio (15 years and above), total	2004	2014 80.5	..	However, quality of employment remains low in the form of informalised employment. Women worse off.	
	Target 1B: Achieve full and productive employment and decent work for all, including women and young people	Proportion of own-account and contributing family workers in total employment (15 years and above), both sexes, %	2004	2014 66.2	..	Worsening. Vulnerable employment remains high. Women worse off.	
		Youth (aged 15-24 years) unemployment rate, both sexes, %, (Current-broad)	15 (2004)	2014 (2014)	..	Worsening. Remains high. Women and urban areas worse off.	
	Target 1C (a) Halve, between 2002 and 2015, the proportion of people who suffer from hunger	Youth (aged 15-34 years) unemployment rate, both sexes, % (broad)	2004	2014 15.3	..	Worsening. Remains high. Women and urban areas worse off.	
		Population (15 years and above) employed in the informal sector, %	2004	2014 13.3	..	Remains high. Women slightly worse off.	
	Target 1C (b) Reduce by two-thirds, between 2002 and 2015, the proportion of malnourished (underweight) children under 5.	Population (15 years and above), in informal employment	2011	2014 94.5	..	Very high and increasing. Women worse off.	
		Population below the FPL, %	1995	2011/12 22.5	29	Achieved. More than halved. But could be from food aid. Rural areas worse off.	
		Children under 5 years, moderately or severely underweight (weight-for-age), % below -2SD	Children under 5 years, moderately or severely underweight (weight-for-age), % below -2SD	1999	2014 11.0	7	Moderate malnutrition remains.
				10.0			

MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance
		Population undernourished, %	2000 43.7	2013 31.8	..	Some progress
		Population undernourished, millions	2000 5.510	2013 4.523	..	Some progress
		Stunting (height-for-age), children aged under 5 years, % below -2SD	1999 34.0	2014 27.6	..	Slight progress
		Maize yield, tonnes per hectare	2000 1.2	2013 0.7	3	Not achieved
		Area under irrigation , hectares	2000 53 011	2014 35 183	240 000	Not achieved
MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance
MDG 2: Achieve universal primary education	Target 2A: Ensure that, between 2000 and 2015, all Zimbabwean children, boys and girls alike, will be able to complete a full programme of primary education	Total NER, primary education, %, both sexes	2000 96.2	2014 92.2	100	Target almost achieved, including gender parity Declining trend since 2013 is a cause for concern.
		Percentage of pupils starting Grade 1 who reach last grade of primary, both sexes	1994-2000 72.1	2006-12 69.3	100	Target not achieved. Remains low and is slightly worsening. Gender parity achieved up to 2010. From 2011 gender parity in favour of girls which is not good.
		Primary Completion Rate, %, both sexes	2000 95.1	2014 77.3		Worsening situation.
		Transition rate, Grade 7 to Form 1, %, both sexes	2000 74.7	2014 77.0	100	Target not achieved but some progress. Generally, gender parity over the years.
		Literacy rate of 15-24 year olds, both sexes, %	2002 99.0	2014 99.6	100	Target achieved, with gender parity. Highest literacy in sub-Saharan Africa.

MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance
		Primary schools with ECD classes, %	2000	2014	100	Achieved.
		ECD NER, both sexes, 3-5 years, %	2013	2014	100	Remains very low, with gender parity.
		Pass rate, Grade 7, %, both sexes	2000	2012	..	Acceptable, with automatic transition. Gender disparity in favour of girls.
		Pupil-teacher ratio, primary education, all teachers	2000	2014	28	Remains higher than the target.
		Pupil-teacher ratio, primary education, qualified teachers	2000	2014	28	Remains much higher than the target.
		Sets of core textbooks to learner ratio, primary	2012	2013	1	Target achieved, through the Education Transition Fund.
			2000	2014	1	
			99	101	97 - 103	Gender parity achieved
		GPI in primary level (Grade 1-7) enrolment	2000	2014	97 - 103	
		GPI in secondary level (Form 1-4) enrolment	2000	2014	97 - 103	Shifted in favour of girls. Enrolment remains low.
		GPI in secondary level (Form 1-6) enrolment	2000	2014	97 - 103	Gender parity achieved. Enrolment remains low.
		GPI in secondary level (Form 5-6) enrolment	2000	2014	90	Gender parity not achieved but significant progress. However, enrolment remains low.
		All tertiary level enrolment, GPI, %	2000	2012	95	Not achieved but significant progress
			60	95	97 - 103	
MDG 3: Promote gender equality and empower women	Target 3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015					



MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance
MDG 4: Reduce child mortality	Target 4A: Reduce by two-thirds, between 2000 and 2015, the under-5 mortality rate.	Children under 5 years, mortality rate, deaths per 1 000 live births, both sexes	1999 102	2014 75	34	Target not achieved but significant progress
		Infant mortality rate (0-1 year), deaths per 1 000 live births, both sexes	1999 65	2014 55	22	Target not achieved but some progress
		Neonatal mortality, deaths per 1 000 live births, both sexes	1999 29	2014 29	..	Remains high.
		Children age 12-23 months fully vaccinated, by 12 months of age, %	1999 67.3	2014 69.2	90	Target not achieved although slight progress.
		Median duration of exclusive breastfeeding (age in months when 50 percent of children 0-35 months received breastmilk during the previous day), both sexes	..	2	6	Target not achieved.
MDG5: Improve maternal health	Target 5A: Reduce by three-quarters, between 2000 and 2015, the maternal mortality ratio	MMR, maternal deaths per 100 000 live births, total (direct method-population censuses)	2002 1 069	2012 526	174	Target not achieved but significant progress
		Proportion of births attended by skilled health personnel, % (births in the 5 years preceding the survey)	1999 72.5	2014 80.0	100	Target not achieved, but some progress
		Proportion of births delivered at home, % (births in the 5 years preceding the survey)	1999 23.3	2014 17.6	0	Target not achieved but some progress, with rural areas at 22.3 and urban areas at 6.3 in 2014.
		Adolescent birth rate, per 1 000 women, total	1999 112	2010/11 120	..	Worsening.
		Antenatal care coverage, at least four visits, %, (last live birth in 5 years preceding the survey)	1999 64.3	2010/11 64.8	100	Target not achieved. Level remains constant

MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance		
MDG 6: Combat HIV and AIDS, TB and other diseases	Target 6A: Have halted, by 2015, and begun to reverse the spread of HIV and AIDS.	HIV prevalence, population aged 15-49 years, % (2014 estimates)	1998 peak 29.6 2000 28.4	2014 16.7	9	Target not achieved. Significant progress. First such decline in Southern Africa. Urban areas and women worse off.		
		HIV prevalence, population aged 15-49 years, % (ZHSSs)	2005/06 18.1	2010/11 15.2	9	Target not achieved. Significant progress. First such decline in Southern Africa. Women higher (17.7%) than men (12.3%) (2010/11). Urban areas worse off.		
		HIV prevalence, population aged 15-24 years, % (ZHSSs)	2005/06 7.8	2010/11 5.5	..	Progress. Urban areas and women worse off.		
		HIV incidence, population aged 15-49 years, %	2000 2.6	2014 0.9	..	Significant progress.		
		Total AIDS deaths, number	2000 122 282	2014 38 616	..	Significant progress. Deaths decreased by 68%.		
		Orphanhood prevalence, %	2005/06 23.9	2012 15.7	..	Significant progress at national and urban area levels (7.1%) in 2012. However, prevalence increasing for rural areas at 34.4% in 2012.		
		Ratio of school attendance of orphans to school attendance of non-orphans, 10-14 years, parity index, % (population census)	..	2012 97	97 - 1 03	Target achieved, parity in school attendance of orphans and non-orphans, in both rural and urban areas		
		Men 15-24 years old with comprehensive correct knowledge of HIV/AIDS, %	2005/06 45.6	2014 56.4	100	Target not achieved. Remains too low but with some progress. Rural areas worse off.		
		Women 15-24 years old with comprehensive correct knowledge of HIV/AIDS, %	2005/06 43.7	2014 51.7	100	Target not achieved. Remains too low but with some progress. Rural areas and women worse off.		
		ART coverage, %, adults aged 15-49 years (2013 estimates, based on CD count 350)	2011 68.6	2013 76.8	100	Target not achieved but some progress		

MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance
		PMTCT coverage, %, (2013 estimates, based on CD count 350)	2011 55.5	2013 82.1	100	Target not achieved but significant progress
		ART coverage, %, children aged 0-14 years (2013 estimates, based on CD count 350)	2011 36.5	2013 40.5	100	Target not achieved. Remains very low.
	Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	Clinical Malaria Incidence Rate, cases per 1 000 people	2000 113	2014 40	64	Target achieved.
		Children under 5 in households with at least 1 ITN, % who slept under an ITN last night	2005/06 2.9	2014 57.4	..	Significant progress.
		Incidence of Diarrhoeal/Dysentery, per 1 000 people	2004 38	2014 47	23	Not achieved. Worsening.
		TB incidence per year per 100 000 population (mid-point)	2000 725	2013 552	121	Not achieved but some progress.
		TB treatment success rate under DOTS, %	2000 69	2013 82	..	Some progress.
MDG7: Ensure environmental sustainability	Target 7.A: Integrate the principles of sustainable development into country policies and programmes, and reverse the loss of environmental resources	Proportion of land area covered by forest, %	2000 48	2015 36	..	Progress/declining
		Proportion of households using wood as main source of energy for cooking, %	2002 64.1	2012 62.6	..	Very little progress, remains high. Rural areas worse off at 88.5% in 2012, than urban areas at 15.7%.
		Proportion of households using electricity as main source of energy for cooking, %	2002 30.1	2012 30.9	..	Very little progress. Remains low. Rural areas worse off at 6.1% in 2012, than urban areas at 75.9%.
		Carbon dioxide emissions, thousand tonnes (UNFCCC)	2000 25 806	2006 12 016	..	Progress. Declining.
		Consumption of all ODS in ODP metric tonnes	2000 524.9	2011	..	Progress. Decreasing



<p>Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss.</p> <p>Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation</p> <p>Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers</p>	Terrestrial and marine areas protected to total territorial area, percentage	2000	2015	..	Has remained constant.	
	Proportion of the population using improved drinking water sources, %	2005/06	2014	76.1	Target not achieved. Remains high. Rural areas worse off at 67.5% in 2014, than urban areas at 98.4%, almost achieving. However, taps in urban areas have been dry for many years.	
	Proportion of the population using improved sanitation facilities (unshared), %	2005/06	2014	35	Target not achieved although some progress. Rural areas worse off at 30.3% in 2014, than urban areas at 47.3%.	
	Proportion of households with no toilet facilities (open defaecation), %	2002	2014	31.7	Target not achieved. Worsening particularly in rural areas. Rural areas worse off at 43.5% in 2014, than urban areas at 1.1%, almost achieving the target.	
	Proportion of households who are lodgers, %, urban	2002	2012	19.0	Remains high, particularly for urban areas at 47.2%, compared to rural ones at 3.4%.	
	Slum population as percentage of urban population	2000	2014	25.1	Worsening.	
					..	

MDG	Target	Main Indicator (s)	Baseline: 2000-2002	Current status	2015 Target	Situation at a Glance	
MDG8: Develop a global partnership for development	Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system  Target 8.B: Address the special needs of the least developed countries  Target 8.C: Address the special needs of landlocked countries and small island developing states  Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	Real GDP growth rate, %	2000 -8.2	2014 4.5	7	Target not achieved. Lowest in 2008 at -14.8%. With fragile recovery rose to a peak of 11.9% in 2011. During the recession the economy shrank by about half between 2000 and 2008. Situation worsening again since 2013	
		Net ODA, million US\$ (current US\$)	2000 176.64	2014 811.05	..	Remains low compared to other SADC countries.	
		Merchandise exports, as a % of GDP	2000 20.7	2013 30.4	..	Worsened. Estimated at 26.4 in 2015.	
		Merchandise imports, as a % of GDP	2000 15.9	2013 59.2	..	Worsened. Estimated at 44.2 in 2015.	
		Overall balance of payments, as a % of GDP	2000 -1.4	2013 -8.4	..	Worsened. Estimated at -1.3 in 2015.	
		Total bank deposits, US\$ million	June 2009 706	June 2015 5600		Improving, even though still largely demand deposits.	
		Total external debt US\$ million	2000 3422	2015 10839	..	Worsened.	
	Total arrears on external debt US\$ million	2000 471	2015 5556	..	Worsened.		
	Total debt as a % of GDP	2000 28.8	2015 79.3	..	Worsened.		
	Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	Availability of essential medicines, at least 80 % of health facilities	2009 8.8	2013 82.5	..	Significant progress.	
		Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	Mobile-cellular penetration rate, subscriptions per 100 inhabitants	2000 2.1	2015 80.8	100	Significant progress, when compared to other countries in SADC
			Internet users per 100 inhabitants	2000 0.4	2014 19.9	..	Progress.







## Chapter 1

# INTRODUCTION

The adoption of the Millennium Declaration in 2000 by 189 Member States of the United Nations (UN), including Zimbabwe, 147 of which were represented by their Heads of State and Government, was a defining moment for global cooperation in the twenty-first century. Since 1990, the UN has held a series of world summits and global conferences with a view to laying out a comprehensive rights-based development agenda. These culminated in the formulation of the Millennium Development Goals (MDGs), a set of quantified and time-bound targets for addressing extreme poverty, hunger and disease, and for promoting gender equality, education and environmental sustainability. They represent the most important global collective promise ever made to the world's most vulnerable people. The MDGs provided a framework for UN member countries to work coherently and collectively with the UN system, the world's leading development institutions, the private sector, civil society and academia, towards a common end.

Monitoring of the MDGs has been taking place at both global and national levels since 2000. At the global level, the UN Secretary-General reported annually to the General Assembly on the implementation of the Millennium Declaration. In Zimbabwe, five national MDG progress reports were produced, with four of them – the 2004 Progress Report, the 2000-2007 Mid-Term Progress Report, the 2010 Status Report, and the 2012 Progress Report.

Member States have recognised that the MDGs were useful in focusing efforts on a broad development vision and have been instrumental in reducing poverty and increasing access to education and health at a global scale. In June 2012, at the UN Conference on Sustainable Development (R10+20), the Heads of State and Government agreed that, as the MDGs come to a close in 2015, a new set of global development goals was needed. It was agreed that these goals should not only carry forward the unfinished business of the MDGs, but should also reframe the global development agenda

in a manner sustainable for both present and future generations. Thus, the MDGs will be succeeded by the Post-2015 Development Agenda, articulated as the 2030 Sustainable Development Goals (SDGs).

This Government of Zimbabwe's final national Progress Report on the MDGs, covering the period 2000 to 2015, includes a comprehensive evidence based analysis of the status and trends, successes and progress, supportive environment, challenges, and lessons learnt, in implementing the MDG agenda in Zimbabwe since 2000. In addition, the Report provides recommendations, to help with the country's transition into implementing the 2030 SDGs, starting in January 2016. The United Nations Country Team (UNCT), using its wealth of knowledge and expertise, supported the Government in this process, both financially and technically. Extensive technical support was also received from civil society organisations (CSOs), non-governmental organisations (NGOs), women's organisations, youth organisations, academics, private sector organisations and others.

## 1.1 ZIMBABWE'S MDG IMPLEMENTATION AND MONITORING STRUCTURE

Soon after signing on to the MDGs in 2000, the Government of Zimbabwe set up an MDG implementation and reporting mechanism, consisting of five levels. The highest level, the Parliament, received MDG progress reports from Cabinet, through the relevant Cabinet Action Committees, who in turn mandated the MDG National Taskforce to implement and monitor progress, see Figure 1.1. In reporting on progress, the MDG National Taskforce worked closely with the then Central Statistical Office, now, the Zimbabwe National Statistics Agency (ZIMSTAT), as well as sectoral data systems.

The MDG National Taskforce was subdivided into six MDG Thematic Groups chaired by relevant sector ministries, with participation of the UN (technical and financial backstopping), private sector, civil society and academia. The Ministry of Public Service, Labour and Social Welfare (MPSLSW), was the lead coordinating Ministry up until 2007, when the leadership was moved to the Ministry of Economic Planning and Investment Promotion (MEPIP), in recognition of the fact that the economy was key to effective poverty reduction. The broad MDG consultative processes were facilitated under the MDG Thematic Groups presented in Table 1.1.

During the preparation of the first MDG Progress Report in 2004, the Zimbabwe MDG Taskforce had to make several critical decisions pertaining to how the MDGs were to be rolled out up to 2015. Given the prevailing severe economic, social and governance challenges in the country, the Taskforce decided to take a pragmatic approach to implementation of the MDGs, involving:

- **Registering maximum development progress** In view of the harsh context within which Zimbabwe was going to embark on the MDG agenda, the agreed initial guiding principle was to make the maximum development progress possible under the circumstances, rather than necessarily achieving the set targets.
- **Prioritisation of three Goals at national level** It was then agreed that, while the country would implement all the MDGs, attainment of three of the Goals would underpin significant progress on the whole MDG agenda. Thus priority was given to, MDG 1 - Eradicate extreme poverty and hunger, MDG 6 - Combat HIV and AIDS, malaria, and other diseases, and MDG 3 - Promote gender equality and empower women.
- **Domestication of MDG baselines** The taskforce also felt that the 1990 baseline set at the global level for determining the MDG performance targets, was too outdated to reflect the reality of Zimbabwe at the start of the MDG era in 2000. Domestication of the MDGs in Zimbabwe included shifting the indicator baselines from 1990 to 2000-02 for national

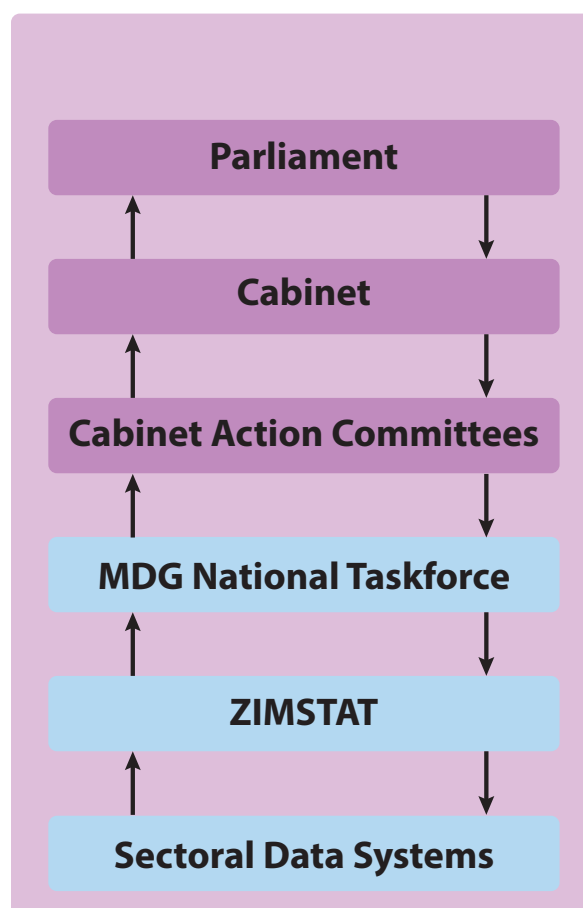
reporting and planning purposes.

- **Domestication of MDG indicators** Additional domestication included replacing indicators such as the \$1.25 per day international poverty line with the locally measured Food Poverty Line<sup>1</sup> (FPL) and the Total Consumption Poverty Line<sup>2</sup> (TCPL), as well as introducing other indicators that were appropriate for national planning purposes under each MDG.
- **Emphasis on halving general poverty, as measured by population below the TCPL** Drawing on the realisation that the population in extreme poverty and hunger can be halved simply by implementing effective food aid programmes (which are not necessarily developmental in nature) the MDG National Taskforce agreed that Zimbabwe should emphasise the halving of general poverty, measured as the proportion of the population below the TCPL.

<sup>1</sup> The Food Poverty Line (FPL) is the monthly consumption expenditure required for an individual to meet the basic food requirements of 2 100 kilocalories a day, for a month.

<sup>2</sup> The Total Consumption Poverty Line (TCPL) is derived by scaling up the Food Poverty Line (FPL) and it gives the monthly income required by an individual to meet their basic food and non-food requirements per month.

Figure 1.1 The Zimbabwe MDG and Poverty Monitoring Structure, 2000 to 2015



Source: Zimbabwe MDGs Progress Report, 2004

**Table 1.1 MDG Thematic Groups, Goals, Lead Sector Ministries and Backstopping UN Agencies**

Thematic Group	MDG	Lead Sector Ministry	UN Agencies
Social Development and Agriculture	1	<ul style="list-style-type: none"> <li>Public Service, Labour and Social Welfare (Dept of Social Welfare)</li> <li>Agriculture and Rural Development</li> </ul>	UNDP, UNICEF, UNFPA, UN WOMEN, ILO, FAO, UNIDO, World Bank, IMF
Education	2	<ul style="list-style-type: none"> <li>Primary and Secondary Education</li> </ul>	UNESCO, UNICEF
Gender	3	<ul style="list-style-type: none"> <li>Women Affairs, Gender and Community Development</li> </ul>	UN WOMEN, UNFPA
Health and HIV	4,5,6	<ul style="list-style-type: none"> <li>Health and Child Care</li> </ul>	WHO, UNFPA, UNICEF, UNAIDS
Environment	5	<ul style="list-style-type: none"> <li>Environment and Tourism</li> </ul>	UNDP
Global Partnerships	6	<ul style="list-style-type: none"> <li>Finance and Economic Development</li> </ul>	UNDP, World Bank, IMF

Source: Government of Zimbabwe (2004)

- Emphasis on domestic financing, complemented by available partner resources** Lastly, the Taskforce agreed that it was of paramount importance for the country to estimate the resources required to achieve the MDG targets by 2015 and the UNDP facilitated the hiring of an international expert on plan costing. The first 2004 MDG Progress Report highlights the required resources as, a sustained annual real

GDP growth rate of at least 7 percent per annum up to 2015, and a total of US\$ 2.2 billion for the social sectors only. Given the country's strained international relations, it was clear that the MDG agenda would have to be implemented largely using domestic resources, complemented by any partner resources that could be obtained.

## 1.2 DATA ISSUES

There has been tremendous improvement in the availability of statistical data from the National Statistical System (NSS) since 2009, in terms of quality, coverage, timeliness, adequacy, relevance and data disaggregation by sex, urban-rural divide and other demographic characteristics. This improvement can be attributed partly to the requirements of the MDG monitoring and evaluation process. The Zimbabwe National Statistics Agency (ZIMSTAT) was the main producer of official statistics used in producing this report, complimented by administrative records, for example, on health, education, agriculture and environment, from the relevant ministries and government departments. ZIMSTAT's Zimbabwe Statistics Database (ZIMDAT), which was set up during the period under review, includes all the MDG indicators, although not all have been updated.

### RESOURCE AND ENVIRONMENTAL CONSTRAINTS TO DATA COLLECTION, 2000 TO 2008

During the economic recession, and especially in 2007 and 2008, data gaps appeared which carry through to the present. For example, the hyperinflationary environment, which led to highly unstable exchange rates, resulted in gaps in economic data series, such as national accounts. The challenges encountered in the education and health delivery systems also resulted in statistical gaps in these areas, with trends in primary and secondary education generally missing data for the years 2008 to 2011. Some of routine surveys were deferred during the recession period or not conducted at all, for example, the 2007 Intercensal Demographic Survey (ICDS) which was deferred to

2008, and the Income, Consumption and Expenditure Survey (ICES), 2005/06, for which data were collected but not analysed or published.

### DIFFERENT MEASUREMENT METHODS, REFERENCE PERIODS AND AGE GROUPS

Data issues also arise from the different methods used to measure some indicators across different official surveys, for example, the Maternal Mortality Ratio (MMR) is estimated using the direct method for population censuses, while the Zimbabwe Demographic and Health Survey (ZDHS) uses the direct sisterhood methodology. The reference period also differs, for example, between the ZDHS 1999, which uses a four year period preceding the survey, and the 2005/06, 2010/11 and MICS 2014 which use the seven years preceding the survey, presenting comparability problems for time series analysis. Varying reference periods also present problems in the area of labour force characteristics. While population censuses present the usual (in the past 12 months) activity of the population, the Labour Force and Child Labour Survey (LFCLS) gives both usual and current (past 7 days) activities. Therefore, data on current activity from the LFCLSs cannot be combined with data from the censuses, on labour force indicators. With the International Labour Organisation (ILO) recently emphasising current activity, censuses now need to either collect information on both reference periods or concentrate on the current period. Similar disparities of reference period or sample group occur in relation to births taking place under antenatal care, child nutrition indicators, and child mortality.

#### **LACK OF DATA DISAGGREGATION ON RECALCULATION**

When indicators are recalculated backwards from new data, there is a tendency to not factor in different background characteristics, such as place of residence and sex, making trend analysis at these levels impossible.

#### **CHANGING DEFINITIONS**

Some indicator definitions changed over time, creating challenges in comparing data. For example, data on water and sanitation from the ZDHSs, MIMS and MICS surveys on one hand, and population censuses, ICDSs and other ZIMSTAT routine surveys are now only comparable in terms of the population or households with no toilet facilities. There is a need for PCs, ICDSs and other ZIMSTAT surveys to adopt the most recent definitions to allow comparability and adequate trend analysis.

Although data on HIV, including ART, are readily available and usually up-to-date from the MOHCC, ZDHS and MIMS, the estimates on children refer to age groups 0 to 14 years and 0 to 4 years only, with the age group 0 to 17 years not being computed. Special age groups such as adolescents should also be prioritised in these estimates.

The change of the CD4 count eligible for treatment from 350 to 500 in 2014, has implications for ART coverage trend analysis. For consistency, ART coverage analysis in this report has used the 2013 estimates, based on the 350 CD count, for 2011, 2012 and 2013.

#### **NOT PUBLISHING DATA AS STIPULATED IN THE INTERNATIONALLY AGREED MDG INDICATORS**

Some data producers in the NSS do not give priority to publishing indicators as stipulated in the United Nations MDG database, even though they have the raw data. Currently, mostly data on households is published, yet the MDG indicators require population data. In addition, population censuses, ICDSs and other ZIMSTAT routine surveys should publish water and sanitation data disaggregated by place of residence and also by sex of household head.

#### **ABSENCE OF DATA ON SOME MDG INDICATORS IN THE NSS**

In cases in which data are not available from the NSS, for example, some indicators on the environment, housing and the economy, MDG monitoring has to rely on international data sources.

## **1.3 THE CONSULTATIVE PROCESS OF PRODUCING THE FINAL MDG REPORT**

A broad consultative process led by the Ministry of Economic Planning and Investment Promotion (MEPIP) and a team of national consultants was set up, in order to facilitate the production of a nationally owned final MDG Progress Report. The five MDG national progress reports produced since 2004, together with other national policy documents and official national datasets, were used by the consultants to produce a zero draft report. During July 2015, sector ministries, UN agencies, CSOs, NGOs, women's organisations, youth organisations, academics and private sector organisations, among others, attended half-day consultation meetings on the MDGs relevant to them. The team of consultants a background and context presentation to each group of stakeholders before presenting the zero draft chapter for a particular MDG so that stakeholders could comment upon and provide

input to the relevant draft chapters to make these more representative and comprehensive.

The further drafting of the report by the team of national consultants took place in August and September, 2015. Continuous contact was maintained with the stakeholders who made additional inputs during this period, including on the first draft chapters for each MDG which were shared with them. Finally, two validation meetings were held on the report, one with senior officials and one general one, with all the stakeholder groups represented once again. The report was then finalised for publication, to play two roles, firstly, as the nation's MDG 2000-2015 Final Progress Report, and secondly, as the Baseline Report for the launch of the SDGs from the beginning of 2016.

## **1.4 REPORT OUTLINE**

This Introduction chapter has outlining the implementation of the MDG agenda in Zimbabwe, the institutional structures this necessitated, the strengths and weaknesses of the MDGs noted during implementation, and the process of producing this Report. Chapter 2 presents Zimbabwe's Development Context in the 15 year MDG period which underlies the progress that has been made the constraints that have been experienced.

Chapters 3 to 10, present each MDG, starting with a summary of Quick Facts for the whole goal, followed for each Target by Key Messages, Status and Trends, Successes and Supportive Environment, Challenges, Lessons Learnt, and Way Forward to address the Unfinished Business under the MDGs. Chapter 11 presents the Conclusions and Recommendations.



Keeping the Promise:  
United to achieve the  
Millennium  
Development  
Goals





## Chapter 2

# ZIMBABWE'S DEVELOPMENT CONTEXT

Among the unresolved contentious issues from the Zimbabwe liberation struggle at Independence in 1980 was the redistribution of land from about 4 500 white commercial farmers to 7.5 million black Zimbabweans (GoZ/UNCT, 2014). Up to 1980, large scale commercial farmers had held 15.5 million hectares of arable land, compared to 1.4 million hectares held by small scale communal farmers. After Independence, land reform focused on settling people on land acquired from white commercial farmers on a 'willing buyer-willing seller' basis, as per the 1979 Lancaster House Constitution. However, this provision proved relatively expensive and failed to provide land for the millions of Zimbabweans who needed it, especially the landless, rural and poor. During the first two decades after Independence, the Zimbabwean population became increasingly restive, demanding that land be more equitably redistributed.

The Government's land redistribution programme has been perhaps the most crucial and most bitterly contested political issue in Zimbabwe. It can be divided into two phases: from 1979 to 2000, during which the principle of willing buyer-willing seller was applied unsuccessfully,<sup>1</sup> and beginning in 2000, the Fast-Track Land Reform Programme (FTLRP), the objective of which was to alter the racial balance of land ownership in favour of the previously disadvantaged majority black Zimbabweans.

Following the non-delivery of the free market based economic reform model, which had been adopted under the Economic Structural Adjustment Programme (ESAP),

1991-1995, Zimbabwe found itself spontaneously going back to the core transformative agenda in 1999. This agenda focused primarily around the equity issues of land and minerals. The land invasions/occupations that occurred from 1998 took on official form as the Fast Track Land Reform Programme (FTLRP) in 2000, and the Revised Policy Framework for the Indigenisation of the Economy, 2004. The main objective of these interventions was to ensure democratisation of the major means of production and broad-based economic empowerment.

This bid for self-determination encountered a backlash in the form of severe unilateral international economic sanctions and general bilateral donor disengagement, which subsequently crippled the Zimbabwean economy during the years 2000 to 2008. The sanctions included the enactment of the Zimbabwe Democracy and Economic Recovery Act (ZDERA) in 2001 by the United States of America (USA), and sanctions being imposed by the European Union (EU) in 2002, as well as by Canada,

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<sup>1</sup> The Government's explanation for the slow-down in reform in the 1990s was that land acquisitions through the 'willing seller-willing buyer' approach had become too expensive. This approach also significantly limited the scope of matching land supply with the demand for resettlement. This slow redistribution of land contributed to the land occupations in 2000.

**Table 2.1 Total Number of Farmers Resettled in Zimbabwe, 1980-2009.**

Resettlement Phase	Number of Families Resettled	Targeted Families	Percent Families Resettled	Area (ha)	Targeted Area	Percent Area Settled
Phase I (1980 to 1998)	71 000	162 000	43.8	3 498 444	8 300 000	5.0
Inception Phase (1998-2000)	4 697	110 000	4.3	168 264	5 000 000	3.4
Phase II (2000 – 2008/FTLRP)	*162 161	-	-	10 816 886	11 000 000	98.3
TOTAL	237 858	-	-	14 483 594	-	-

Source: Ministry of Lands and Rural Resettlement, 2009

\* MLRR estimates that 145 775 families are settled under A1 occupying 6 562 864 hectares and 16 386 under the A2 model settling under 4 254 022 hectares.

Australia and their allies.

The resultant economic meltdown led to a serious skills flight or brain drain, and the social sectors, particularly, health, education, water and sanitation, and social protection, experienced an unprecedented near collapse. However, the minimum social infrastructure that was retained, combined with innovative livelihoods, including informal cross border trade, seeking tertiary education abroad and general resilience, somehow sustained the population until recovery began from 2009 onwards.

Table 2.1 shows the number of people resettled between 1980 and 2009 and the area they occupy.<sup>1</sup> By 2010, the FTLRP had transferred 96 percent of agricultural land into the hands of indigenous black Zimbabweans, thereby consolidating the transformative repossession outcome of the programme.

However, only 10 to 11 percent of the land allocated under FTLRP went to women, while special groups such as war veterans acquired between 15 and 20 percent of the allocated land. In addition, land tenure problems

<sup>1</sup> MLRR, 2009 - Communal farmers remained unchanged at 1.1 million as at 1980. The small to medium scale commercial farm category increased from 8 000 in 1980 to 22 000 in 2009, with the introduction of small to medium scale A2 farmers under leasehold tenure. According to the GoZ, there were approximately 145 775 A1 allocations, and A2 beneficiaries numbered 16 386 households. These families have been resettled on 10 816 886.11 hectares of land, generally in the higher potential provinces.

and the negative impact on farm workers continued to haunt the land reform programme. Furthermore, the Reserve Bank of Zimbabwe (RBZ) scaled up quasi-fiscal activities in support of the FTLRP, through crop inputs, farm mechanisation, support to horticulture producers, among other initiatives, over the period 2005 to 2008, which fuelled hyperinflation, while agricultural output cumulatively declined by more than 60 percent during the decade of recession.

The implementation of the Indigenisation and Economic Empowerment policy followed a multiple speed trajectory from 2010 to 2015. This programme has increased focus on opportunities for previously disadvantaged Zimbabweans and there has been increased optimism around its efficacy of in transforming livelihoods. The Ministry of Youth, Indigenisation and Economic Empowerment (MYDIEE) and the National Indigenisation and Economic Empowerment Board (NIEEB), made Community Share Ownership Trusts (CSOTs) and Employee Share Ownership Trusts (ESOTs) integral vehicles for broad-based economic empowerment. From 2010 to 2015, more than 1 470 companies were successfully processed for indigenisation across all sectors of the economy, including more than 536 mining sector companies. Transactions in the mining sector resulted in the disposal of 10 percent shareholding to 21 CSOTs with pledges of \$134 million, of which \$38 million has been paid as seed capital. Notable progress has also been recorded in promoting the empowerment of employees through ESOTs.

## 2.1 MDG CONTEXTUAL CHALLENGES

### ECONOMIC AND POVERTY CHALLENGES

The major contextual challenges existing before the start of the MDG agenda in 2000 included structural poverty, and economic and social inequalities, including pervasive gender inequalities, left behind by the dualistic enclave economy inherited at Independence in 1980. The situation was worsened by the unprecedented economic recession of 2000 to 2008 and, more recently, the decline in economic

growth of 2013 to 2015, against the background of the FTLRP of 2000 onwards, economic sanctions starting around 2001, protracted governance challenges starting around 1998, and the promulgation of the 2008 Indigenisation and Economic Empowerment (IEE) Act and 2010 IEE Regulations. Negative perceptions of the country were associated, particularly, with the FTLRP and perceived human rights abuses. In addition, the

HIV epidemic has caused high morbidity and mortality, especially, maternal and child mortality, and an increased number of orphans. In the context of an over-reliance on rain-fed agriculture, frequent climate change related droughts and floods have had a negatively impact on the agricultural and other sectors. All of these more recent factors have exacerbated the already challenging situation into which the MDGs were introduced.

The first recession of 2000 to 2008 was characterised by hyperinflation, which reached 231 million percent in July 2008. Key economic enablers, namely, power, water and sanitation, roads and rail, were threatened by the economic downturn generally and, in particular, a severe shortage of foreign currency, while basic food and non-food commodities were also in short supply.

During the MDG period, 2000-2015, several macroeconomic frameworks were formulated and, in most cases, only largely partially implemented, in an effort to rescue the fast sliding economy. These included the:

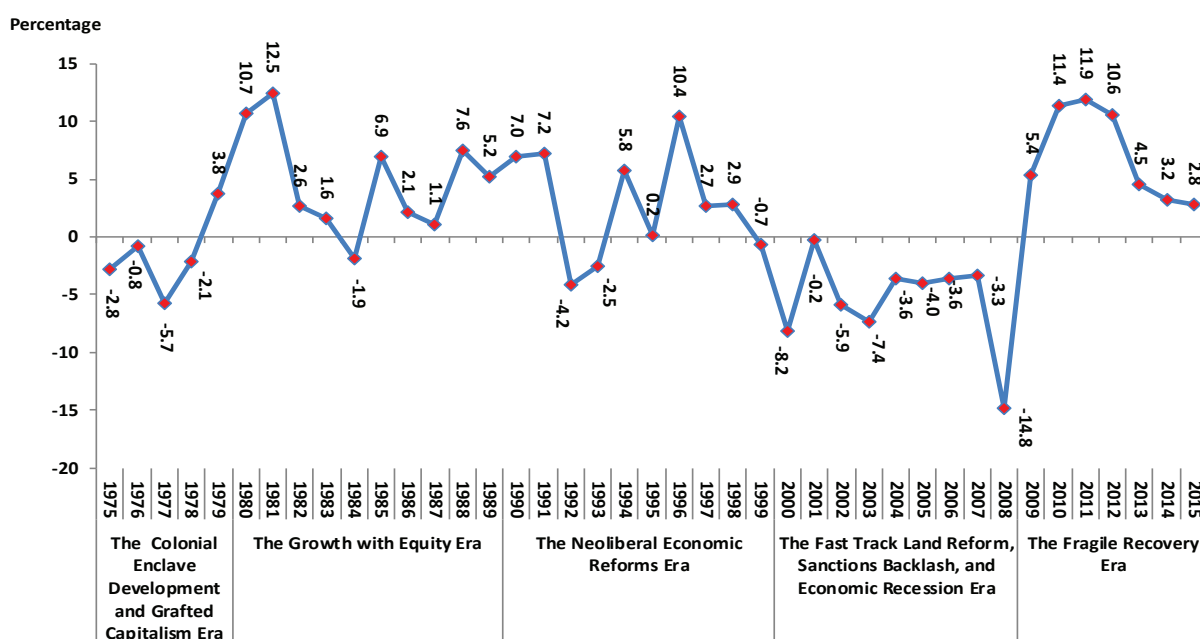
- Millennium Economic Recovery Programme (MERP), launched in August 2001 as a short term (18 month) economic recovery programme;
- National Economic Revival Programme (NERP): Measures to Address the Current Challenges, of February 2003, a 12 month stabilisation programme;
- Macro-Economic Policy Framework (MEPF), 2005-2006: Towards Sustained Economic Growth;

- National Economic Development Priority Programme (NEDPP), 2008-2009;
- Short-Term Stabilisation Programme (STSP), 2008-2009; and the
- Zimbabwe Economic Development Strategy (ZEDS), 2009-2013, which was abandoned with the coming in of the Inclusive Government in 2009.

Following its formation in February 2009, the Inclusive Government launched the Short Term Emergency Recovery Programme (STERP 1), March, 2009 to December, 2009 to stabilise the economy and anchor economic recovery after a decade long economic decline. The STERP 11 was introduced as a Three Year Macro-Economic Policy and Budget Framework, 2010-2012, aiming to consolidate and build upon the macroeconomic stability attained under STERP 1 and foster robust economic recovery. The Medium Term Plan (MTP), 2011-2015, which marked the step on from short term planning, sought to buttress the gains of STERP 1 and STERP II and continued guiding the economy on the path of economic recovery. The MTP, was abandoned halfway through, in 2013, as the new Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset, 2013-2018) economic blueprint was adopted following the end of the Inclusive Government era. Each of these macroeconomic frameworks was backed up by several sector-specific policies.

Figure 2.1 summarises the performance of the Zimbabwean economy from 1975 to 2015, showing that the MDG agenda was introduced at the time when the

Figure 2.1 Annual Real GDP Growth Rate, 1975 to 2015



Source: ZIMSTAT and Reserve Bank of Zimbabwe, 2015

economy was at its weakest, from 2000 to 2008, with a cumulative economic decline of -51 percent during this period.

Zimbabwe has remained in the low human development category, with HDI value increasing only slightly, from 0.437 in 1980, to 0.509 in 2014.

By 2014, Zimbabwe's Human Development Index (HDI) rank was 155 out of 188 countries globally. The HDI rose during the first five years of Independence, declining during the economic reforms era, 1991 to 1999, and reaching its lowest in the recession period, 2000 to 2008, before improving again under the recovery phase, 2009 to 2014.

During the period of recession and hyperinflation, once fully functional social sectors, including education, health, pension systems, and other social protection programmes, lost all financial support and were rendered dysfunctional. Poverty increased and deepened. The proportion of the population below the TCPL remained high, at 71 percent in 2001 (ZIMSTAT, 2001), while the portion below the FPL was 42 percent in 2001. The income Gini Coefficient, measuring income disparity, was relatively high, at 0.49 in 2001.

In the recovery period, the proportion of the population below the TCPL remained relatively high, at 73 percent in 2011/12 (ZIMSTAT, 2012). The proportion of the population below the FPL, nearly halved, from 42 percent in 2001, to 23 percent in 2011/12. Although declining, income inequality in Zimbabwe, as measured by the Gini Coefficient, remained relatively high at 0.42 in 2011/12. This small reduction in inequalities could probably be attributed to the land reform and the dollarisation of the economy.

Food insecurity was one of the major challenges in Zimbabwe during the decade of economic recession, with the country needing humanitarian food assistance in most of the recession years. Women often carried the heaviest burden of the socioeconomic crisis by virtue of their reproductive roles and/or household division of labour. The economic recession exacerbated women's workload by increasing their participation in informal labour markets, including informal cross border trade, as well as shifting the burden of the care economy to them, under the HIV epidemic. Zimbabwe had a structural unemployment rate of 63 percent in 2003 and, by 2008, it was estimated that structural unemployment had risen to 80 percent or more, with even university graduates operating in the informal sector. Migration and remittances became a major social protection tool as people left for perceived greener pastures in the region and abroad.

The other economic factors that militated against MDG progress included: massive de-industrialisation and weak foreign direct investment (FDI) flows in most sectors; high structural and urban youth unemployment and under-employment, particularly in the rural areas, in the context of a lack of inclusive, job creating economic

growth and investment; extensive informalisation of the economy; the negative impact of the global financial and economic crisis of 2007/8 to 2010; high domestic and foreign debt levels and debt servicing arrears; and a persistent liquidity crunch since the adoption of the multi-currency system from 2009. Together, these factors amounted to an economy in deep crisis.

The dollarisation of the economy in January 2009 ushered in a new economic dispensation of relative price stability and improved business confidence, resulting in the increase in capacity utilisation from around 10 percent during the recession to around 40 percent by the end of 2009, and positive economic growth of 5.7 percent in 2009. This policy stance, undermined parallel market activities, eliminated arbitrage opportunities and dissipated inflation expectations, immediately killing off hyperinflation. Goods became available in the formal market. However, the economic recovery remained highly fragile because the infrastructure and other macroeconomic fundamentals remained off-track. The introduction of the multi-currency system saw the country lose its monetary policy autonomy, while all Zimbabwe dollar denominated financial accounts were reduced to zero, meaning that genuine savers (businesses, pensioners, smallholder farmers, and others) were caught in the grand loss crossfire.<sup>1</sup>

As earlier noted, the Inclusive Government launched the STERP 1 in February 2009 as a short term plan to stabilise the economy and anchor economic recovery after a decade of economic decline in February 2009.<sup>2</sup> However, perceived high country risk, a low savings base, a liquidity crunch, poor performance by utilities and external debt overhang, acted against the full achievement of the STERP I objectives. Then came STERP II, under which the economy grew by 11.4 percent in 2010 and 10.6 percent in 2012, before declining to 4.5 percent in 2013, 3.2 percent in 2014, and an estimated 2.8 percent or less in 2015. While annual inflation was contained at 3.5 percent in January 2011, by 2013, inflation had dropped to 1.6 percent, amidst fears that the economy was fast sliding into a deflationary mode, which became reality in 2014 with inflation at -0.2 percent, dropping to -2.81 percent in July 2015 (ZIMSTAT, 2014, 2015).

The MTP, 2011-2015, which marked the return to medium term planning, sought to buttress the gains of STERP 1 and STERP II and continued to guide the

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*1 So far the only compensation received by the general public in urban areas has been the cancellation of water utility bills and credits to all personal electricity accounts of around US\$169.*

*2 The formation of the Inclusive Government created political stability and an environment conducive to the formulation of comprehensive macroeconomic policies. Policy measures under STERP included: price and foreign currency liberalisation; duty free importation of basic products; social protection, especially of vulnerable groups; deregulation of restrictive exchange controls; increased support to the productive sectors; and strict adherence to a cash budgeting system.*

economy on a recovery path. However, it was viewed as an economic policy framework of the Inclusive Government and was abandoned following the 2013 election outcome, by which time the economy was already losing steam in terms of real GDP growth.

The various Confederation of Zimbabwe Industries (CZI) Manufacturing Sector Surveys suggest that industrial capacity utilisation increased to 33.0 percent in 2009, 43.7 percent in 2010 and 57.2 percent in 2011, before declining again to 44.2 percent in 2012, 39.6 percent in 2013, and 36.3 percent in 2014.<sup>1</sup> According to CZI (2014), “Industries in Zimbabwe are under serious threat. Deindustrialisation has reached catastrophic levels, with dire consequences to the state of the economy.” The economy is being choked, with businesses saddled with high debts, high cost of doing business (particularly high finance charges), high labour costs, antiquated or obsolete plant and equipment, and a dearth of long term international financial inflows. This has led to further company closures with related retrenchments and increased unemployment, low production, rising imports,<sup>2</sup> and further narrowing of the tax base and revenues. According to the 2015 Budget Statement, 4 610 companies closed between 2011 and 2014, resulting in 55 443 employees losing their jobs.

<sup>1</sup> Confederation of Zimbabwe Industries (CZI) Manufacturing Sector Surveys, (various years).

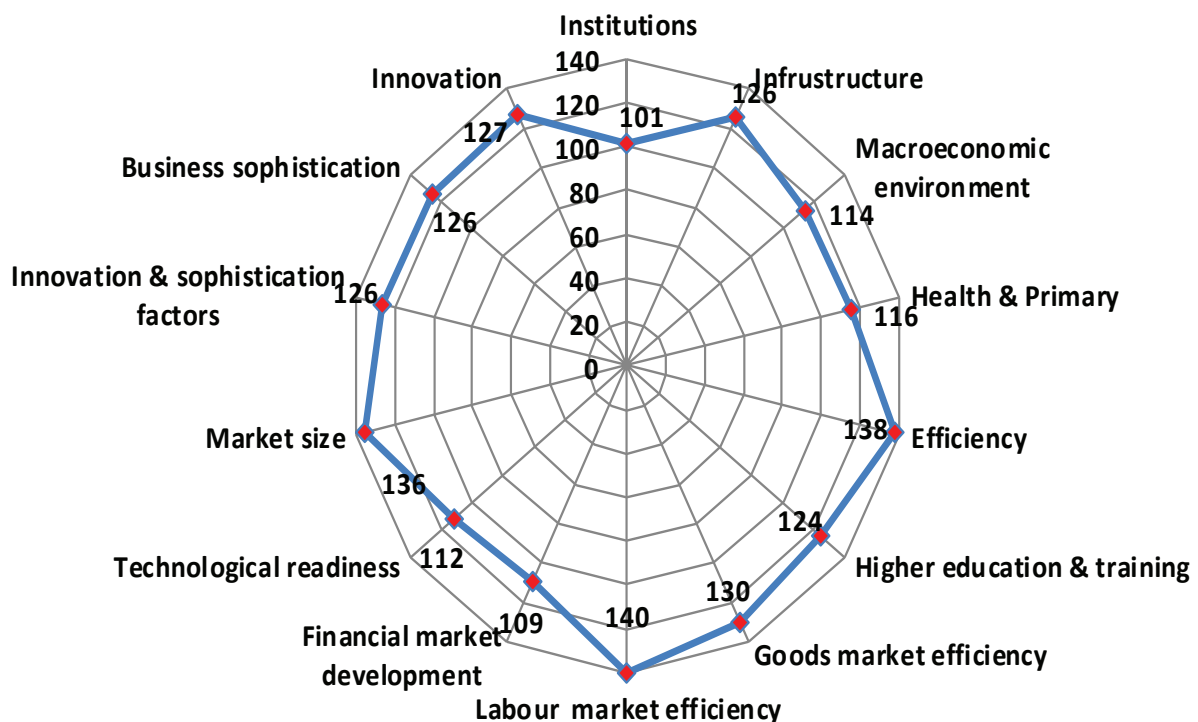
<sup>2</sup> Trade balance was estimated at US\$4 billion in September, 2014 (RBZ, November, 2014).

Primary commodities (mining and agriculture) accounted for 93.5 percent of export earnings during the period 2009 to 2013. It is concerning that diamond revenues did not make any meaningful contribution to the fiscus, despite increasing production levels during the Inclusive Government period.

The financial sector continued to experience structural vulnerabilities arising from low confidence among depositors, liquidity constraints, high non-performing and insider loans, high lending rates and low deposit rates, the absence of an active inter-bank market, and the lack of an effective lender of last resort. As of 31 December 2013, total banking sector deposits amounted to US\$4.7 billion, increasing to US\$5.6 billion in July 2015 (RBZ, 2015). The bulk of deposits were demand deposits, thus, affecting the ability of banks to provide the long term funding required by the productive sectors. Moreover, lending remained skewed in favour of consumption, as opposed to production.

Starting a business in Zimbabwe remains a cumbersome, costly and time consuming exercise. In the World Bank report, Ease of Doing Business 2014, Zimbabwe was ranked 170 out of 189 in economies in terms of overall ease of doing business. In 2013, starting a business required nine procedures and took 90 days. Zimbabwe is ranked 131 out of 148 countries in the World Economic Forum’s Global Competitiveness Report 2013/14 rankings. Public institutions continue to receive a poor assessment, although overall this has improved somewhat in recent years (see Figure 2.3 for component specific rankings). Major concerns remain with regard to the protection of

Figure 2.2 Zimbabwe GCI Pillars by Rank, 2013/14



property rights, where Zimbabwe is among the lowest ranked countries, reducing the incentive for businesses to invest. Economic corruption has continued.<sup>1</sup>

In order to strengthen debt management, the Government established the Zimbabwe Aid and Debt Management Office (ZADMO) within the Ministry of Finance in December 2010, and adopted the Zimbabwe Accelerated Arrears Clearance, Debt and Development Strategy (ZAADDS). This Strategy aims to accelerate re-engagement with creditors, including the international financial institutions. In June 2013, the Government adopted the IMF Staff Monitored Programme (SMP), an informal agreement between country authorities and IMF staff to monitor the implementation of the authorities' economic programme.

### THE SOCIAL SECTORS AND HIV CHALLENGES

This harsh economic environment had severely negative effects on the social sectors, particularly during the recession period of 2000 to 2008. Inadequate financing of education and health remained a major constraint in the delivery of high quality services. While education consistently received the highest share of resources and health was also a high priority in the national budget in nominal terms up to 2008, these resources were inadequate in real terms to maintain the desired quality of education and health. The withdrawal of most bilateral donors, between 2000 and 2008, also had a negative impact on these two social sectors, as well as water and sanitation. By 2008, there was a near collapse of the health and education delivery systems, worsened by severe brain drain into the diaspora.

The deterioration in the education sector was evidenced in poorly maintained physical infrastructure, brain drain,<sup>2</sup> shortage of teaching and learning materials, and declining standards of performance in schools (Chipika and Malaba, 2014). According to the Ministry of Primary and Secondary Education (2015), the Grade 7 pass rate decreased from 47.5 percent in 2000 to 33.1 percent in 2005, before improving to 49.6 percent in 2012 under general economic and social sector recovery. Although A' Level pass rates remained generally high, at 73.7 percent in 2005, increasing to 84.2 percent in 2014, O' Level pass rates hit a record low of 11.9 percent in 2007, down from 18.3 percent in 2005, and 25.4 percent in 2000, before recovering to 23.8 percent in 2014. The severity of the near collapse is even reflected in the data gap on school

<sup>1</sup> Examples such as, the Airport Road scandal (2008-2014), Asiagate Match-fixing Scandal (2012), and Salarygate (2013-2014) have made headlines.

<sup>2</sup> According to the, Education Medium Term Plan (EMTP), 2011-2015, in 2008, some 20 000 teachers left their positions in the greatest brain-drain the sector has ever experienced. The economic and governance crises third decade (2000 to 2008), characterised by economic recession and hyperinflation, resulted in the near collapse of the public education system by 2008, with rural areas experiencing a temporary shut-down of most schools.

### Peak of Economic Recession: Key Macroeconomic Indicators, 2008

- Annual real GDP growth declined by 14.8 percent in 2008, giving a cumulative decline of 54.8 percent to the economy from 1999 to 2008.
- Money supply growth accelerated to 431 quintillion percent in December 2008. (18 zeros are read as quintillion)
- Annual inflation reached 231 million percent in July 2008.
- External payment arrears stood at US\$3 071.4 million.
- The external debt to GDP ratio was 110.5 percent, significantly higher than the international benchmark of 50 percent.
- A vibrant parallel market for foreign exchange, characterised by 'currency burning', developed from 2001 on the back of foreign currency shortages.
- The parallel market exchange rate stood at Z\$60 quintillion per US\$1 in December 2008, against an official exchange rate of Z\$40.9 quadrillion per US\$1. (15 zeros are read as quadrillion)
- Zimbabwe experimented with seven exchange rate regimes during the recession period.
- Cumulatively, Zimbabwe had currency redenomination/re-basing in which 25 zeros were removed between August 2006 and January 2009.

Source: Chipika and Malaba, 2011

enrolments and other indicators for 2007 and 2008. As the economic crisis deepened, the education system became increasingly informalised and privatised with the mushrooming of many low quality private colleges and an increase in private tutoring commonly referred to as 'extra lessons', imposing a double payment burden on parents.

Double digit prevalence of HIV increased the disease burden, putting a strain on already inadequate health resources. The economic meltdown made access to health services unaffordable and negatively affected the acquisition of drugs and other equipment, as well as leading to an exodus of health professionals to 'greener pastures' in the region or abroad. Infant, child and maternal mortalities, and home deliveries increased during the decade of recession, with the HIV epidemic



underlying all these negative health trends. For example, although maternal mortality, according to the Zimbabwe Population Censuses, declined from 1 069 maternal deaths per 100 000 live births in 2002 to 526 in 2012, the latter figure is still unacceptably high.

Although HIV prevalence among the population aged 15 to 49 years, had declined from 29.6 percent in 1998 to 18.6 percent in 2005/06 and further to 15.2 percent in 2010/11,<sup>1</sup> the first such decline in Southern Africa, this was still very high. In the presence of the HIV epidemic the number and proportion of orphans in the population is also high at 24 percent in both 2005/06 and 2009 (ZIMSTAT, 2009). Despite a decline to 15.7 percent in 2012 (ZIMSTAT, 2012), The burden of orphanhood remained high for an economy in recession. The epidemic is highly gendered, with women having higher HIV prevalence than men, and bearing a far greater burden of care of the sick and orphans, by virtue of their reproductive roles. Life expectancy, estimated at 44.2 years in 2002, had dropped by 17 years from 61 years in 1990 and this decline was also largely attributable to the impact of HIV, exacerbated by widespread poverty which weakened national and individual responses to the pandemic. According to the 2012 Zimbabwe Population Census, life expectancy had rebounded to 60.7 years in 2012, following successful measures to combat and reverse the HIV and its impacts in Zimbabwe. Behaviour change, combined with increased access to antiretroviral therapy (ART) among adults aged 15 years and above, from 73.8 percent in 2011 to 83.6 percent in 2013, largely explains the success. Zimbabwe's National AIDS Trust Fund (the AIDS levy) is acknowledged as international best practice in domestic resourcing and the country has also obtained financial resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the STOP TB Global Drug Facility.

During the recession, revenues from both raw and treated water declined drastically, development partner support was withdrawn and there was inadequate funding for dam maintenance and the operation of water treatment and sewage plants. Economic sanctions further aggravated the situation in the water sector by limiting access to external funds. Water quality deteriorated as untreated sewage and waste from industry and mining were discharging directly into rivers and reservoirs. The worsening water and sanitation situation in Zimbabwe culminated in a cholera outbreak in 2008/09 which, according to the Ministry of Health and Child Welfare, affected around 100 000 people and resulted in an estimated 4 300 deaths. The systemic failure of city councils to provide water resulted in proliferation of private boreholes and wells, some of which also provided unsafe water.

In 2014, 76 percent of the population had access to an

improved drinking water source, which showed no rise since 2005/06. Access to an improved drinking water source was higher in urban areas (98.4 percent) than rural areas (67.5 percent) in 2014. However, in urban areas, during the MDG period, access to safe water largely meant having piped water infrastructure, even though often the taps had no running water or had running water of poor quality.

Zimbabwe suffers a huge housing backlog, estimated at around 1.25 million new units needed across all housing types in 2012, with the Ministry of Local Government, Public Works and National Housing (MLGPWNH) constructing on average 10 000 to 15 000 units, against a target of 250 000 housing units per year. Investment levels in housing by the state and non-state sectors have been low. During the MDG period, macroeconomic constraints and sector specific constraints slowed land delivery, dried up housing finance, made expansion of trunk services nearly impossible and drained capacity in key institutions, while during the economic recession period, housing loan schemes collapsed under hyperinflation.

With economic recovery, the social sectors, particularly health, education, water and sanitation, and social protection have slowly crept out of near collapse but this has been fragile because it is largely supported by donors, using multi-donor trust funds. The Zimbabwe Multi-Donor Trust Fund (ZimFund) is supporting the implementation of the US\$29.65 million Urgent Water Supply and Sanitation Rehabilitation Project (UWSSRP). Other key partnerships with the United Nations and international donors include; the Education Transition Fund (ETF) I, 2009-2010 and ETF II, 2011-2015; the Health Transition Fund (HTF), 2011-2015; and the World Bank Multi-Donor Trust Fund for Health Results Innovation (MDTF for HRI), 2011-2013 and 2013 onwards.

Key government interventions in social protection for the period 2013 to 2015 were underpinned by the National Action Plan for Orphans and Vulnerable Children Phase II (NAP for OVC II), 2011-2015, including the Basic Education Assistance Module (BEAM) and the Social Transfer Policy Framework (STPF), 2011. Other social protection programmes include: the Food Deficit Mitigation Strategy; Assisted Medical Treatment Orders; Agricultural Inputs Support Programme/Vulnerable Households Input Support; and livelihoods support programmes implemented by NGOs.

From 2009 to 2013, hospitals were once again functional, with essential drugs readily available. According to the Ministry of Health and Child Care (MOHCC), essential medicines availability improved from 8.8 percent of health facilities having at least 80 percent of the selected essential medicines in 2009 to 82.5 percent in 2013. However, most essential drugs were supplied with development partner support, raising sustainability concerns. Since 2009, schools have operated relatively normally, with

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<sup>1</sup> Zimbabwe Demographic and Health Survey (ZDHS) 2005/06 and 2010/11.

books being supplied at a 1:1 ratio in both primary and secondary schools under the ETF. Social protection allowances, which were pegged at around US\$30 to US\$40 a month in 2009, had increased to around US\$90 per month by 2013, becoming more meaningful in providing for the basic needs of vulnerable recipients. Improvements in water and sanitation were observed, particularly in urban areas where tap water was generally available and relatively safe. Although wages remained low, rising from an average of US\$100 in 2009 to around US\$ 350 in 2013, with the low levels of inflation and availability of basic goods in the shops, people's welfare improved.

Although, in the achievement of these gains, Zimbabwe has become increasingly reliant on assistance from donors for the provision of basic social services, there is a recognition of the need for Government and funding partners to focus on development interventions aimed at building the resilience of local systems for the delivery of social services to the Zimbabwean population.

#### GOVERNANCE CHALLENGES

Between 1980 and 2013, nineteen amendments to the Lancaster House Constitution were effected, including Constitutional Amendment Number 18, of December 2007 which ushered in a new era of harmonised elections. During the MDG period, Zimbabwe held nine national elections and two Constitutional Referenda. Following the disputed outcomes of the parliamentary elections of 2000 and presidential elections of 2002, the stability enjoyed prior to this period shifted towards polarisation of the country between the two major political camps.<sup>1</sup> The ensuing instability contributed to the international isolation of the country as relations with the western countries and international institutions became strained. This phase saw a perceived blurring of the distinction between party politics and Government. As a result, national integrity systems like the parliament, judiciary, law enforcement, watch-dog institutions and civil servants in general were seen to have lost their autonomy, professionalism and accountability to the nation for service delivery.

Following Zimbabwe's controversial presidential election (and concurrent parliamentary election) and presidential re-run in 2008, the United States and European Union called for increased sanctions, while the African Union and the Southern African Development Community (SADC) called for a 'government of national unity', as a means to stabilise the country. It was against this background that Zimbabwe's main political actors increased dialogue which had begun around 2006 to find common ground and achieve the much needed political stability. These negotiations which were brokered by the

SADC and the African Union, culminated in the Global Political Agreement (GPA) of 2008 and the subsequent formation of an Inclusive Government in 2009. Although this brought some level of both political and economic stability, especially in the first year and a half, thereafter the governance position resembled a gridlock, in which nothing could move forward on the development policy front.

One of the most notable achievements of the country during the MDG period was the crafting and adoption of the 2013 Zimbabwe Constitution, with new legal and institutional provisions that seek to improve governance, delivery of justice and human rights, sustainable development, gender equality, youth and women's empowerment and the creation of an enabling environment which attracts funding, creates confidence and improves competitiveness for economic growth. In the Constitutional Referendum of March, 2013, 94.5 percent of the voting population voted in favour of the new Constitution, the preamble of which reads, "We, the people of Zimbabwe, are united in our diversity by our common desire for freedom, justice and equality, and our heroic resistance to colonialism, racism and all forms of domination and oppression."

Zimbabwe conducted a second round of peaceful harmonised elections in July 2013, which saw the end of the Inclusive Government. As Zimbabwe has moved forward politically since 2008, so have relations with the west improved. In recognition of the Inclusive Government's commitments and implementation of the GPA, the European Union, for example, removed and suspended a host of measures against a number of top Zimbabwean officials and the regional bloc said it would work with any Government formed as a result of free and fair elections.<sup>2</sup> The United States has generally followed suit, but has so far left the problematic ZDERA in place.

#### LAND REFORM AND INDIGENISATION, AND ECONOMIC EMPOWERMENT CHALLENGES

Although Government heightened the political profile of land reform from 2000 under the FTLRP, and acted to transfer and place beneficiaries (indigenous people) on the land, this was done with minimal support for production, leading to a near collapse of the agriculture sector. Thus, since 2000, the country has experience chronic food insecurity, due to initial land reform problems, among other policy and climate change related causes. The non-availability and unaffordability of agricultural inputs, limited credit facilities to all farmers, tenure security, and the deterioration of irrigation infrastructure, remain issues of great concern, requiring urgent attention.

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<sup>1</sup> The Zimbabwe African National Union - Patriotic Front (ZANU-PF) which had ushered in the country's Independence in 1980, and the Movement for Democratic Change (MDC) formed in 1999.

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<sup>2</sup> Hartwell H. 2013 - *The USA also sent a long-time friend of Zimbabwe, American civil rights activist, Andrew Young, to deliver a message from Secretary of State, John Kerry on the USA's readiness to normalise relations with Zimbabwe following free, fair and credible elections. Even Reverend Jesse Jackson paid a 'private' visit to the President and the Prime Minister.*

According to Moyo and Yeros (2011), Zimbabwe's FTLRP represents the only instance of radical redistributive land reforms since the end of the Cold War. It reversed the racially skewed agrarian structure and discriminatory land tenure inherited from colonial rule, transferring 96 percent of agricultural land into the hands of indigenous Black Zimbabweans by 2010. The successful redistribution of land under the FTLRP places Zimbabwe at the forefront of an emergent nationalism in the South and, despite the liberal democratic deficit and economic policy contradictions that accompanied it, the FTLRP is most likely to be remembered in Zimbabwe and Africa as the culmination of the anti-colonial struggle. There is a broad consensus that Zimbabwe's land reform is irreversible and the 2013 Zimbabwe Constitution clarifies the modalities for compensation. Land reform has created the social and economic foundation and potential for broad-based transformative development and democratisation of the key means of production, as borne out in emerging forms of rural mobilisation and accumulation.

The historical land question in Zimbabwe also underpins the economy-wide Indigenization and Economic Empowerment (IEE) drive in the country, which addresses historical inequalities in other areas of ownership, particularly of mineral resources. The IEE policy was revised in October, 2004 and adopted by Cabinet as the Revised Policy Framework for the Indigenisation of the Economy, paving the way the formulation of IEE legislation, culminating in the Indigenisation and Economic Empowerment Act (Chapter 14:33) in March, 2008 and the 2010 IEE Regulations. However, the IEE programme has been criticised for largely redistributing existing wealth in order to empower the indigenous majority, instead of creating a conducive environment for the creation of new wealth, particularly by indigenous people.

## CONCLUSION

The MDGs were implemented during a period of severe socioeconomic difficulty in Zimbabwe. Despite the challenges experienced, Zimbabwe has made significant progress on some MDGs, particularly in relation to HIV, with prevalence falling from 29.6 percent in 1998 to 15.2 percent in 2010/11, along with increasing ART and PMTCT coverage. The education sector has recorded increased and gender-balanced primary school enrolment, improved provision of books for core subjects in primary and secondary education, increased enrolment of girls in tertiary education, and the achievement of universal literacy among those aged 15 to 24 years. In health, the maternal mortality ratio has been cut by half and 82.5 percent of the health facilities had at least 80 percent of essential medicines in 2013. Comprehensive mobile phone coverage had been achieved by 2014 and the use of ozone depleting substances had effectively ceased.

Nevertheless, there have been challenges in some areas, particularly in terms of the economy and its interrelationships with gender inequity, poverty levels, sanctions, unemployment and underemployment, agricultural productivity, and the impacts of HIV and AIDS. The unfinished agenda of MDGs persists in the need to address weak economic performance, high income poverty, issues of agrarian reform following the land reform, high maternal and child mortality, high HIV prevalence, unsustainable availability of essential drugs which are largely funded by development partners, food insecurity, gaps in gender equality, particularly in the economy and in decision making, water and sanitation issues, and environmental management.



## Chapter 3

# MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

## SUMMARY OF PROGRESS

### Target 1A

Halve, between 2002 and 2015, the proportion of people whose income is less than the TCPL

Income poverty in Zimbabwe remained high and generalised at 75.6 percent in 1995, declining to 70.9 percent in 2001, and slightly increasing to 72.3 percent in 2011/12.

Rural areas continued to register very high levels of income poverty, of 82.4 percent in 2001, and 84.3 percent in 2011/12, compared to urban areas, with 42.3 percent and 46.5 percent respectively.

The population below the Food Poverty Line (FPL) declined from 41.5 percent to 22.5 percent; those who could not meet non-food expenditure increased from 29.4 percent to nearly 50 percent in 2011/12.

Nationally, the depth of poverty remains relatively high, but has declined from a Poverty Gap Index (PGI) of 38.3 percent in 1995, to 35.4 percent in 2001, and 34.1 percent in 2011/12.

The rural population had a PGI of 47.1 percent in 1995, which fell to 42.8 percent by 2011/12; urban population PGIs were 20.2 percent in 1995, down to 15.5 percent in 2011/12.

Nationally, the severity of poverty has remained relatively high, but declined from a Poverty Severity Index (PSI) of 23.2 percent in 1995, to 21.4 percent in 2001, and 19.6 percent in 2011/12.

The rural areas PSI was 29.6 percent in 1995, down to 27 percent in 2001 and 25.4 percent in 2011/12; urban population PSIs were 10 percent in 1995, 7.6 percent in 2001, and 7.2 percent in 2011/12.

Zimbabwe had a relatively low Multidimensional Poverty Index (MPI) of 0.181 in 2010 due to its high living standards, declining infant and under-5 mortality, and mild child malnutrition.

The Gini Coefficient decreased from 0.50 in 1995, to 0.49 in 2001, and to 0.42 in 2011/12.

### SUCCESSSES

No success in reducing income poverty, but improvements occurred in tandem with economic and social recovery, combined with a relatively low MPI of 0.181 in 2010.

### CHALLENGES

1. Creating an enabling environment for broad-based, inclusive economic growth and job creation.
2. Rehabilitation and expansion of infrastructure and service delivery.
3. Reversing de-industrialisation and underutilisation of industry capacity to stem company closures and job losses.
4. Expansion of the Government's fiscal space in order to reclaim monetary policy autonomy.
5. Continuing to fight HIV to reduce its economic impacts.
6. Expanding and consolidating social protection and security systems and strengthening disaster management and preparedness.

### LESSONS LEARNT

Sustained income poverty reduction is not possible without sustained broad-based and inclusive economic success.

## Target 1B

Achieve full and productive employment and decent work for all, including women and young people.

- Employment in the formal sector declining from 1.4 million to just under 1 million by the end of 2014, with over 400 000 employees having been retrenched at some time between 2005 and 2014.
- Among paid employees, 83.7 percent received incomes lower than US\$500, with women being disproportionately highly represented among the lowest income earners.
- The quality of employment is low (mainly rural subsistence agriculture), therefore, high employment-to-population ratios (EPRs) coexist with high income poverty levels.
- The proportion of the total employed population in informal employment in Zimbabwe increased from 84.2 percent in 2011 to 94.5 percent in 2014.
- A very high proportion (85.9 percent) of those currently employed in the informal sector were unskilled, with 54.4 percent of the unskilled being women.
- Women make up a higher proportion, at 70.4 percent, of the population in vulnerable employment than men, at 61.2 percent.
- Men have a higher Precarious Employment Rate (PER), of 17.1 percent, than women, with 9.4 percent.
- Own account workers contributed the highest share, of 86 percent, to underemployment.
- The highest urban unemployment rates, of 23 to 55 percent, occurred among youths, and relatively high rates, of 21 to 29 percent, occur among those aged 50 years and above.
- Nationally, in 2014, the current broad youth unemployment rate for youth aged 15 to 34 years was 15.3 percent, with young women at 20.3 percent and young men at 9.8 percent.
- The urban youth unemployment rate was 37.5 percent, compared to rural areas, with 4 percent, with higher figures for young urban women (46.6 percent) than young urban men (26.3 percent).
- In 2014, there were 164 656 discouraged job seekers in Zimbabwe, 72.3 percent of whom were women.

### CHALLENGES

1. Improving the quality of employment, as reflected in the high income poverty levels despite Zimbabwe's high EPR, which indicates progress in achieving full and productive employment for all.
2. Addressing the problem of youth unemployment, particularly in urban areas.
3. Addressing underemployment in rural agriculture and other own account work.

Given that Target 1B outcomes are largely a function of the economic performance of the country, all the challenges discussed under target 1A apply to this target as well.

### LESSONS LEARNT

There is an urgent need to formalise economic activities and provide effective support for job-creating economic growth, including through a major reindustrialisation drive.

Zimbabwe needs to capitalise on its demographic dividend of a youthful population and women as these groups remain largely unemployed and underemployed.

The area of employment is so central that it requires special attention on its own or under the economy goals in the SDGs.

## Target 1C

- (a) Halve, between 2002 and 2015, the proportion of people who suffer from hunger;
- (b) Reduce by two-thirds, between 2002 and 2015, the proportion of malnourished children under 5.

By 2011/12, Zimbabwe had more than halved the proportion of the population below the FPL, from 41.5 percent in 2001, to 22.5 percent in 2011/12, against an MDG target of 29 percent.

The proportion of undernourished population declined

from 43.7 percent in 2000 to 31.8 percent in 2013, still leaving 4.523 million people undernourished in 2013.

Under-5 stunting declined from 36 percent in 2005/06, to 32 percent in 2010/11, and 27.6 percent in 2014, with the highest levels among boys and in rural areas.

Under-5 underweight remained in the moderate range, showing a slight overall rise to 11.2 percent by 2014, made up of a decline in urban areas, offset by a rise in rural areas.

Maize yields fluctuated between 0.5 and 1.3 tonnes/hectare, against an MDG target of 3 tonnes/hectare.

The proportion of area irrigated declined continuously from 55.3 percent in 2000 to 24.9 percent in 2014.

Overall, 95 percent of maize production came from communal areas, A1 and A2 and old resettled farmers.

Drought is the most common natural disaster, with the 2001 drought affecting 6 million people.

#### CHALLENGES

1. Formulation and implementation of a relevant and well defined policy and institutional framework,

and clear development strategy for the agriculture sector.

2. Creation of broad-based, inclusive and equitable economic growth to ensure the viability of food production and supply.

#### LESSONS LEARNT

Pursuing sustained, broad-based and inclusive economic growth that delivers decent work is central to poverty reduction and the eradication of hunger.

In addition to land redistribution, comprehensive agrarian reform is required, with a full package of support to farmers to ensure high productivity.

Effectively implemented food and nutrition policies and programmes, in the context of overall social sector strengthening, are central to addressing hunger.

#### Target 1A

(a) Halve, between 2002 and 2015, the proportion of people whose income is less than the Total Consumption Poverty Line (TCPL)

### 3.1 THE SITUATION – TARGET 1A

Zimbabwe's historical context, combined with a challenging economic and social context over the three and half decades of Independence, underlie the four-fold challenges of poverty, inequality, unemployment and underemployment, being experienced in Zimbabwe.

Income poverty in Zimbabwe is largely structural, but is also exacerbated by transient factors such as those triggered by economic policy and political factors, as well as exogenous factors, such as the HIV epidemic and climate change. Income poverty remained high and generalised over the MDGs period, reaching 72.3 percent in 2011/12. Rural areas continued to register very high levels of income poverty, at rates almost twice as high as those for urban areas.

There has been a shift in poverty dynamics in Zimbabwe in the past 15 years, from largely food poverty in 1995 and 2001, to non-food poverty in 2011/12. Whilst the population below the FPL<sup>1</sup> more than halved between 2001 and 2011/12, the population who could not meet non-food expenditure increased over this period. This

is a reflection of income erosion during the economic recession of 2000 to 2008 and the still constrained incomes under the fragile recovery that has occurred with dollarisation of the economy. Female-headed households (widowed, divorced, and never married) experienced disproportionately high levels of general income poverty.

Nationally, the depth of poverty, declined slightly, yet remained relatively high. The rural population is in much deeper poverty, recording a PGI nearly three times higher than that of their urban counterparts in 2011/12. Likewise, the severity of poverty at national level is declining but remains relatively high and is also considerably higher in rural than in urban areas, and has declined faster and further in urban areas.

Zimbabwe has relatively high living standards in terms of assets, housing flooring, electricity, and other measures. Alongside declining infant and under-5 mortality and mild child malnutrition this enabled the country to register a relatively low Multidimensional Poverty Index (MPI) score of 0.181 in 2010, implying that 18 percent of Zimbabwe's population was facing acute deprivation in health, education and standard of living.

Income inequalities are decreasing, with the Gini Coefficient having decreased by about 15 percent

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<sup>1</sup> Food Poverty Line (FPL) - is the monthly income required for an individual in a household to meet their basic food requirements. The FAO and WHO recommend a minimum food energy intake of 2 100 kilocalories per person per day for an average active person.

between 1995 and 2011/12. However, reducing and finally eradicating income poverty requires sustained economic ‘success’, which would entail the following: key economic infrastructure rehabilitation; economic transformation from an enclave economy to one that is broad-based, inclusive, pro-poor, gender-sensitive, environmentally sustainable and capable of generating decent jobs and sustained economic growth and development; halting and reversing the cycle of de-industrialisation and increasing industry capacity utilisation; supporting MSMEs to formalise and grow.

Although MDG1 was a top priority for Zimbabwe, it did not receive the corresponding resources to ensure successful implementation, highlighting the point that the country needs to implement its various macroeconomic blueprints comprehensively and effectively.

Sustained agriculture, food and nutrition success, and effective social protection will be key for poverty reduction into the future.

## 3.2 STATUS OF TARGET 1A AND TRENDS

Zimbabwe inherited, at Independence in 1980, a particular type of capitalist social and economic formation. There was no transformation of the economy as a whole, but only of a small formal enclave, which then coexisted with a highly marginalised, largely poor rural sector that employed about 80 percent of the labour force. The resultant economic and social dualism has consistently undermined dynamic growth and development. The same historical context also underlies the complex interplay of chronic structural poverty<sup>2</sup> combined with transient poverty<sup>3</sup>, experienced in the country to date. Transient factors that have contributed to high poverty levels in Zimbabwe include: the failure of the Economic Structural Adjustment Programme (ESAP) of 1991 to 1995 to deliver on its promises of dynamic growth; the economic recession of 2000 to 2008 in which almost half of the country’s real GDP was lost; suspension of support from the major international Financial Institutions, which was followed by general bilateral donor withdrawal during the economic recession period; and exogenous factors such as the negative impact of climate change on agriculture, and the HIV epidemic.

poverty in Zimbabwe as measured by the proportion of the population below the TCPL was very high at 75.6 percent in 1995 and 70.9 percent in 2001. Halving poverty by 2015, therefore, meant setting a target of 36 percent, based on the 2001 baseline. However, the 2011/12 Poverty Income Consumption and Expenditure Survey (PICES) showed the proportion of the population below the TCPL was 72.3, indicating that general income poverty had remained high and increased slightly over the MDG period.

Rural areas continued to register very high levels of income poverty of 82.4 percent in 2001 and 84.3 percent in 2011/12, compared to urban areas with 42.3 percent and 46.5 percent respectively. However, urban income poverty has increased faster than rural poverty, probably because of the severe economic hardships (relating to the availability of cash and goods) had a greater impact on the urban than the rural population.

There has been a shift in poverty dynamics in Zimbabwe in the past fifteen years, moving from largely food poverty in 1995 and 2001, to non-food poverty in 2011/12. While the population below the FPL more than halved between 2001 and 2011/12, from 41.5 percent to 22.5 percent,

### INCOME POVERTY

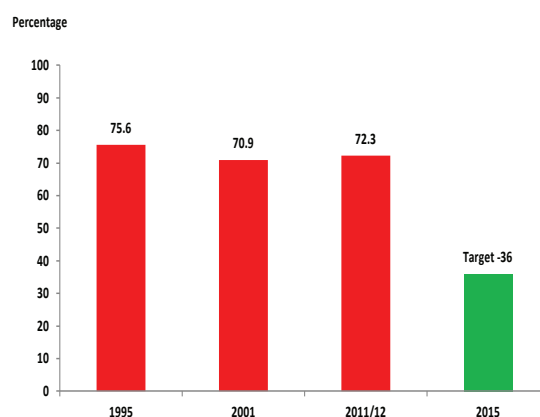
#### *Income Poverty Prevalence*

At the onset of the MDG agenda in 2000, income

<sup>2</sup> Structural poverty - is rooted in socioeconomic, political and cultural institutions and, experienced over the long term and is often transferred inter-generationally. A typical example is provided by the majority of rural populations in developing countries in general and Zimbabwe in particular, with little or no access to land and other productive resources, facing chronic underemployment and/or unemployment. Gendered dimensions of structural poverty are often rooted in a legal and cultural framework that denies women access to productive resources.

<sup>3</sup> Transient poverty - is due to cyclical or temporary factors and is experienced over shorter periods of time. Typical examples include poverty caused by macroeconomic policy shifts, such as under economic reform programmes, economic recession, natural disasters, cyclical unemployment, inflation or technological changes. It is important to note that structural and transient poverty often coexist and are not mutually exclusive.

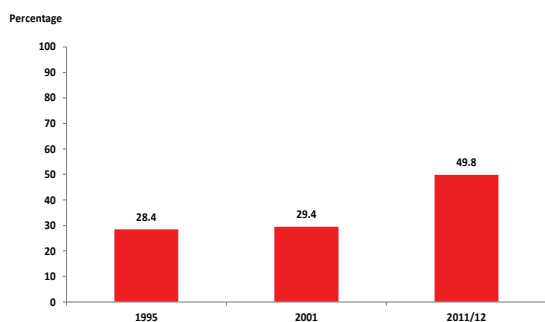
Figure 1A.1 Proportion of Population Below the TCPL, 1995, 2001, 2011/12 and 2015 Target



Source: ZIMSTAT, ICES 1995, 2001; PICES 2011/12

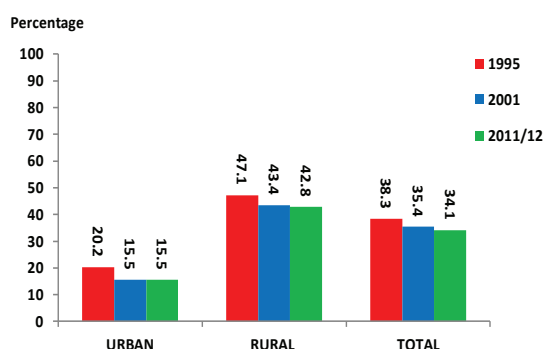


**Figure 1A.2 Proportion of Population Not Able to Meet Basic Non-Food Expenditure, 1995, 2001 and 2011/12**



Source: ZIMSTAT, ICES 1995, 2001; PICES 2011/12

**Figure 1A.3 Poverty Gap Index by Place of Residence, 1995, 2001 and 2011/12**



Source: ZIMSTAT, ICES 1995, 2001; PICES 2011/12

respectively, Figure 1A.2 shows that the proportion of the population that could not meet non-food expenditure increased from 29.4 percent in 2001 to nearly 50 percent in 2011/12. This is largely a reflection of the income erosion during the economic recession of 2000 to 2008 and the fact that incomes have not increased markedly under the fragile economic recovery brought on by the dollarisation of the economy.

Matabeleland North province had the highest proportion (89.9 percent) of its population below the TCPL, whilst Bulawayo province had the lowest proportion, at 43.2 percent, followed by Harare province with 43.7 percent.

Overall, in 2011/12, nearly, two thirds of all households were experiencing general income poverty, with a slightly higher proportion of de-facto male-headed households doing so than de-facto female-headed ones, see Figure 1A.3. This could be partly because, the latter have spouses earning an income somewhere and sending remittances. In the meantime, female-headed households were somewhat more likely than male-headed ones to experience income poverty in de-jure widowed (female-headed at 68.9 percent; male-headed at 54.7 percent), de-jure divorced (female-headed at 49.5 percent; male-headed at 35.6 percent) and never married (female-headed at 34.4 percent; male-headed at 30.8 percent) set-ups.

### Poverty Gap and Poverty Severity

Where a household falls below the TGPL it is categorised as poor. This category is further disaggregated according to how far below the TGPL their income level falls and, therefore, how great an intervention is needed to bring them out of poverty. The depth or intensity of poverty is measured by the Poverty Gap Index (PGI)<sup>4</sup>.

Nationally, the depth of poverty is declining but has remained relatively high. It declined from 38.3 percent in 1995, to 35.4 percent in 2001, and to 34.1 percent in 2011/12. The rural population experiences the deepest poverty, recording a PGI of 47.1 percent in 1995, which reduced to 43.4 percent in 2001 and slightly further to 42.8 percent in 2011/12. The corresponding urban PGI figures were 20.2 percent in 1995, coming down to 15.5 percent in 2001 and 2011/12, see Figure 1A.3. All the predominantly rural provinces except Masvingo had PGIs above the national average, with Matabeleland North province having the highest PGI of 53.3 percent and Harare province the lowest at 13.2 percent.

The Poverty Severity Index (PSI)<sup>5</sup>, also called the Squared Poverty Gap Index, takes into account not only the distance separating the poor from the TCPL, but also the inequality among the poor. In the PSI, a higher weight is placed on those people who are further away from the TCPL, that is to say, society should concern itself first with improving the living conditions of the poorest.

In line with the depth of poverty, the severity of poverty is declining nationally but remains relatively high. It declined from 23.2 percent in 1995, to 21.4 percent in 2001, and to 19.6 percent in 2011/12. The rural population's severity of poverty is much higher than that of the urban population, with the rural PSI being at 29.6 percent in 1995, reducing to 27 percent in 2001, and to 25.4 percent in 2011/12. In the meantime, the urban population PSIs were 10 percent in 1995, declining to 7.6 percent in 2001, and slightly further to 7.2 percent in 2011/12. The provincial characteristics are the same as for the PGI, that is, the predominantly rural provinces except Masvingo having PSIs above the national average, with Matabeleland North province having the highest PSI of 35.2 percent and Harare province the lowest of 5.9 percent.

However, Zimbabwe has relatively high living standards in terms of assets, housing, flooring, electricity and the like. Both infant and under-5 mortality are declining and the country has only mild child malnutrition. As such, it

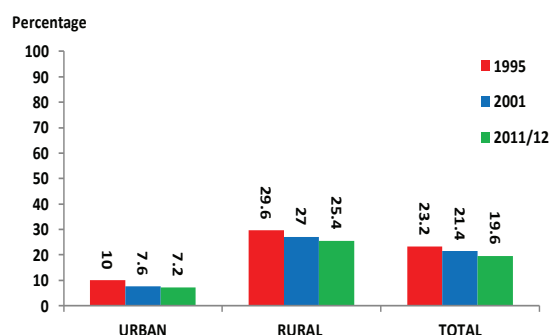
<sup>4</sup> The Poverty Gap Index (PGI) is the average poverty gap in the population as a proportion of the TCPL. Under this measure, the poverty gaps are equally weighted. The greater the gap (the closer the PGI is to 100), the deeper the poverty.

<sup>5</sup> The Poverty Severity Index (PSI) is a weighted sum of the poverty gaps as a proportion of the TCPL. Each of the poverty measures, namely, the prevalence or headcount index, PGI, and PSI belong to the group of poverty indices known as the Foster, Greer, Thorbecke (FGT) indices.

is relatively low on the Multidimensional Poverty Index (MPI), with a ranking of 0.181 in 2010, compared to Madagascar with the highest in the Southern African Development Community (SADC) region at 0.42 in 2010 and Democratic Republic of Congo (DRC) with 0.399 in 2009 (UNDP, 2014). This means that in 2010, 18 percent of the Zimbabwean population continued to face deprivations in health, education and standard of living.

According to the Zimbabwe Poverty, Income, Consumption and Expenditure Survey (PICES), 2011/12, income inequalities are decreasing, with the Gini Coefficient decreasing from 0.50 in 1995, to 0.49 in 2001, to 0.42 in 2011/12.

**Figure 1A.4 Poverty Severity Index by Place of Residence, 1995, 2001 and 2011/12**



Source: ZIMSTAT, ICES 1995, 2001; PICES 2011/12

### 3.3 SUCCESSES AND THE

### SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 1A

Although there was no progress in reducing the proportion of people whose income is below the TCPL, many attempts were made during the MDG period to resuscitate the economy through the formulation and implementation of macroeconomic frameworks. The non-delivery of most of these because they were not implemented effectively is concerning. These frameworks included the:

- Millennium Economic Recovery Programme (MERP), 2001 (18 months);
- National Economic Revival Programme (NERP I), 2003 (12 months);
- Macro-Economic Policy Framework (MEPF), 2005-2006;
- Ten Point Plan, 2007-2008;
- National Economic Development Priority Programme (NEDPP), 2008-2009;
- Short-Term Stabilisation Programme (STSP), 2008-2009;
- Zimbabwe Economic Development Strategy (ZEDS), 2009-2013 (aborted during formulation);
- Regular and broad-based consultative monetary and fiscal policy reviews;
- Short Term Emergency Recovery Programme (STERP 1), March, 2009 to December, 2009;
- Three Year Macro-Economic Policy and Budget Framework, 2010-2012 (STERP II);
- Medium Term Plan (MTP), 2011-2015; and

- Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset), 2013-2018.

Despite all of these, economic recession deepened in the period 2000 to 2008, registering the worst real GDP decline of -14.8 percent in 2008. The economy recovered to positive but fragile growth since 2009 under the Inclusive Government, dollarisation of the economy and implementation of the last four macroeconomic frameworks, starting with STERP I, but this was short-lived, with economic growth declining again since 2012.

Other initiatives in support of economic growth included the following:

- The FTLRP from 2000 onwards, the objective of which was to alter the racial balance of land ownership in favour of the previously disadvantaged majority lacks. It reversed the racially-skewed agrarian structure and discriminatory land tenure inherited from colonial rule, transferring 96 percent of agricultural land into the hands of indigenous Zimbabweans by 2010<sup>6</sup>, although only about 11 percent of the land redistributed under the FTLRP went to women<sup>7</sup>.
- The Poverty Monitoring Mechanism, which included the Poverty Assessment Study Survey, 2003; Income Consumption and Expenditure Survey (ICES), 2001; PICES, 2011/12; vulnerability assessments; and food and nutrition surveillance systems.
- Social Security and Protection Policies, including

<sup>6</sup> Ministry of Lands, Land Reform and Resettlement, 2009

<sup>7</sup> GoZ, 2004; Utete Report, 2003; Ministry of Lands, Land Reform and Resettlement, 2009

the National Social Protection Strategy (NSPS), 2002; Enhanced Social Protection Strategy (ESPS), 2002 with its Basic Education Assistance Module (BEAM) and Children in Especially Difficult Circumstances (CEDC) programme; National Action Plan for Orphans and Vulnerable Children (NAP I for OVC), 2004-2010; NAP II for OVC, 2011-2015; National HIV and AIDS Policy, 1999; Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) I, 2006-2010 and ZNAPS II, 2011-2015; Social Transfer Policy Framework (STPF), 2011; and Food and Nutrition Security Policy for Zimbabwe (FNSPZ), 2012.

In addition to emergency aid by different international development partners, NGOs and CBOs also implemented different kinds of social service and social protection programmes that tried to meet different social needs and target different vulnerable groups.

### 3.4 CHALLENGES IN ACHIEVING TARGET 1A

Although a few of the poverty related challenges were resolved during the implementation of the MDGs, many key ones continued to 2015. These include:

#### Creation of an Enabling Economic Environment

Creating broad-based, inclusive, pro-poor and equitable economic growth and decent jobs remains, building upon greater political and economic stability but also recognising that the economy has been in deflationary mode since 2014.

**Infrastructure and Service Delivery** Arresting the deterioration of economic infrastructure through strategic investment in the energy, water and sanitation, transport (road, rail and air) and communication sectors, to improve services to the productive sectors, thereby reversing the trend of company closures and job losses.

**Government Fiscal Space** It is necessary for Zimbabwe to reclaim monetary policy autonomy, which was lost with the dollarisation of the economy and introduction of the multi-currency system, in order to address issues liquidity and fiscal constraints.

**Decent Employment** Encouraging broad-based job-creating economic growth and investment, for example by supporting MSMEs to graduate into the formal sector where they can pursue a reasonable business growth path, while becoming accountable in terms of social protection, health and safety, and environmental protection.

**Agricultural Viability** Supporting and building upon the agrarian reform process to make agriculture viable and enhance household and national food security, through a comprehensive agrarian reform package, of improved access to inputs, credit, tillage, extension services, research and development and markets, rehabilitation of

#### Children Reached under the Programme of Support for the NAP for OVC, 2004 to 2010

##### Number of OVC...

• provided with school related assistance	249 314
• provided with medical support	26 778
• living with HIV on antiretroviral therapy	533
• provided with food/nutritional assistance	73 365
• receiving psychosocial support	94 459
• who obtained birth certificates	2 055
• who completed vocational training	8 324
• provided with legal assistance	2 674
• children reunited with their families	5 413

Source: UNICEF PoS Monitoring Unit, 2010

irrigation systems, roads, dip tanks and communications infrastructure, and provision of basic social services in the newly resettled areas.

**Climate Change Impacts** Expanding irrigation development to smallholder and communal farmers, so as to reduce their vulnerability and increase their productivity.

**HIV** Continuing to design and implement effective policies to further reduce the negative impact of HIV on all development efforts, in particular, poverty reduction.

**Social protection and security, and disaster management** Increasing the capabilities of households to manage risks such as droughts, floods and HIV, while strengthening institutional arrangements and coordination of social protection programmes, to improve national level resilience, avoid duplication of efforts and waste of resources, and maximise impacts.

## 3.5 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGET 1A

Zimbabwe's experience with MDG1 Target 1A generated two major lessons:

1. Sustained income poverty reduction is not possible without sustained broad-based and inclusive economic success.

2. The three Targets areas under MDG1, namely poverty (1A), employment (1B), and hunger (1C), are separate major areas of development the progress of which should be reported on in detail individually.

## 3.6 THE WAY FORWARD – TOWARDS THE SDGS

The following issues and ambitions from MDG1 Target 1A should be carried forward into implementation of the 2030 SDGs:

- Halving the proportion of the population whose income is below the TCPL, that is, reducing by half the population experiencing general income poverty.

- Eradicating extreme poverty, that is, having no people with income below the FPL.
- Ensuring that both domestic and development partner resources are directed to supporting the country's development priorities under the SDGs, to avoid failure to register notable progress in the areas of greatest need.

### Target 1B

Achieve full and productive employment and decent work for all, including women and young people

## THE SITUATION – TARGET 1B

Sustained economic growth and development that creates decent jobs is essential to poverty reduction but an unstable macroeconomic environment resulted in weak economic performance by Zimbabwe during the MDG period. This had negative impacts on the labour market, notably massive retrenchments due to company closures or downsizing, a marked fall in employment in the formal sector, and massive retrenchments continuing up to 2014.

Despite relatively high overall employment levels, the quality of employment is low, meaning that a high employment-to-population ratios (EPRs) coexist with the high income poverty levels discussed under Target 1A. Thus Zimbabwe faces serious challenges in terms of providing decent employment. A very high proportion of paid employees received monthly incomes below US\$500, with women being disproportionately represented in the lowest income groups. Slightly more than half of paid employees received an income below the individual TCPL, that is to say, they were the working poor, while only 3.3 percent received an income above the average household TCPL.

Informal employment is very high in the country and a little over half of those employed in this sector are women. Of those currently employed in the informal sector, the great majority are unskilled, with slightly more than half of the unskilled also being women. In addition, during the MDG period, nearly two-thirds of the employed

population aged 15 years and above were in vulnerable employment, as own account workers or unpaid contributing family workers, with women once again representing a higher proportion than men. Furthermore, of the 6.3 million currently employed people, 13 percent are in precarious employment, that is, without contract security, seasonal or casual. Men have a PER nearly twice as high as that for women.

Underemployment is another major challenge, particularly in rural agriculture. Own account workers (communal, resettlement and peri-urban farmers) make up the greatest proportion of underemployed persons, followed by other own account workers, giving a total share of 86 percent from these two groups alone.

Those most affected by the persistent economic challenges and company closures are the youth and those in middle age. High urban unemployment rates exist among 15 to 34 year olds, and among urban women, and rates among those over 50 years are also relatively high. The urban youth unemployment rate is more than eight times that for rural areas. Youth unemployment causes the country to lose out on its demographic dividend in development and also has the potential to create social instability. Nationally, in 2014, young women had a higher chance than young men of being unemployed, while those who had completed Form 6 have the highest level of unemployment, followed by those with Form

4. The proportion of unemployed women in these two groups is twice as high as the proportion of men. In 2014,

there were 164 656 discouraged job seekers in Zimbabwe, nearly three-quarters of whom were women.

### 3.8 STATUS OF TARGET 1B AND TRENDS

The International Labour Organisation (ILO) Labour Force Framework, classifies the population aged 15 years as either economically active<sup>8</sup> or economically inactive<sup>9</sup>. The economically active population includes paid employees, employers<sup>10</sup>, unpaid family workers<sup>11</sup>, own account workers<sup>12</sup> and those who are unemployed. The economically inactive population includes homemakers<sup>13</sup>, students<sup>14</sup> and those who are retired, sick or too old to work.

Nationally, according to the 2014 Labour Force and Child Labour Survey (LFCLS), 90.8 percent of the population aged 15 years and above (7 784 770 people) were economically active, with 52.3 percent being communal and resettlement farmers, 36.4 percent being other employed and 11.3 percent being unemployed. The economically active population had increased from 87 percent in 2011. On the other hand, 8.9 percent of the population aged 15 years and above (684 122 people) were economically inactive, with 48.4 percent students, 18.4 percent homemakers and 32.2 percent being retired, sick or too old. The economically inactive population had decreased from 12 percent in 2011

According to the MPSSLWS, over 400 000 employees were retrenched at some time between 2005 and 2014. Employment in the formal sector declined from 1.4

million to just under 1 million by the end of 2014.

#### EMPLOYMENT AND UNEMPLOYMENT

Employment is the basis of wealth creation, economic empowerment and human wellbeing. The proportion of the population aged 15 years and above who are employed (paid employees, employers, unpaid family workers, own account workers) is measured as the employment-to-population ratio (EPR). The EPR for Zimbabwe remained high during the MDG period, at 79 percent in 2004, 78 percent in 2011, and 80.4 percent in 2014, see Figure 1B.1. However, these figures do not reveal anything about the quality of work and whether or not it yields a decent income. Under normal circumstances, paid employment and being an employer are the most secure forms of employment but in the case of Zimbabwe, a high EPR coexists with high income poverty levels, as discussed under Target 1A. The EPR was much higher in rural areas, with 87.9 percent in 2011, than in urban areas, with 59.4 percent. This, in particular, may mask high levels of underemployment in the rural areas. The 2012 Zimbabwe Population Census shows that the EPR gender parity indices (GPIs) were less than 97 percent for most districts in Zimbabwe, confirming that higher proportions of men than women were employed.

#### LINKS BETWEEN WORK-RELATED INCOME AND POVERTY

Paid employment is generally considered a form of economic empowerment and a route out of poverty but the realisation of this desirable outcomes depends on the level of remuneration, conditions of work, and security of work, among factors.

According to the 2014 LFCLS, one-third (32.9 percent) of the 1 532 641 persons nationally who were paid employees received a monthly income of less than US\$100, while 83.7 percent of paid employees received less than US\$500 per month, as broken down in Table 1B.1. A much higher proportion (40 percent) of women employees received under US\$100 than men with 29.2 percent. This illustrates the disproportionately high representation of women in low paid jobs.

Given that the FPL for an individual in May 2014 was US\$ 31.70, about 67 percent of the paid employees were above the FPL, or out of extreme poverty. The estimated TCPL for May 2014 was US\$102, indicating that 48.5 percent of the paid employees received an income above the TCPL, or were not income poor. However, the FPL and TCPL for a family of five persons for the month of May 2014 were US\$158.5 and US\$508.0, respectively. Assuming one paid employee per household, 48.4 percent

*8 A person is considered currently economically active if they were either employed for at least one hour during the 7 days preceding the interview, or usually work but were temporarily absent from work, or were without work and available for work (unemployed).*

*9 The currently economically inactive population are those who in the 7 days preceding the interview were neither employed nor unemployed.*

*10 Employer is a person who operates their own economic enterprise (not a household) or engages independently in a profession or trade, and continuously hires one or more employees.*

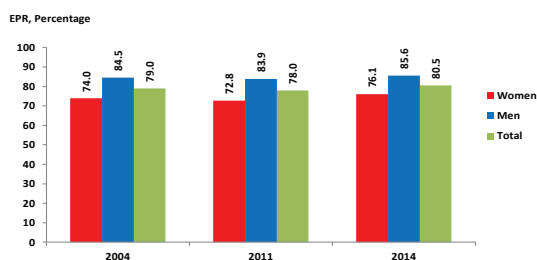
*11 Unpaid (contributing) family worker is a member of the household who works without pay in a market-oriented enterprise operated by the household, but is regarded as a partner because their degree of commitment is not at the level comparable to that of the head of the establishment, e.g. in family shops, vehicle repair enterprises, etc. but not, which is classified as own account work.*

*12 Own account worker operates their own economic enterprise, for example, petty trader, carpenter, communal, resettlement or peri-urban farmer, who, with or without paid employees, work for own consumption or profit.*

*13 Homemaker is a person of either sex, involved in housework in their own household (not paid domestic workers), for example, cooking, child care, etc. who do not work for pay or profit.*

*14 Student is a person who attends a formal, public or private, educational institution, either full-time or part-time and is not usually engaged in any economic activity.*

**Figure 1B.5 Unemployment Rate (broad) for Youth Aged 15 to 24 Years, by Place of Residence and Sex, 2014**



Source: LFCLS 2004, 2011, 2014

of the paid employees received an income above the average household FPL, whilst only 3.3 percent received an income above the average household TCPL.

### THE INFORMAL SECTOR AND INFORMAL EMPLOYMENT

Informal employment is generally associated with high vulnerability to poverty. The informal sector comprises those enterprises that are neither registered with the registrar of companies nor licensed, or are licensed only. Enterprises engaging in agricultural activities are not considered as part of the informal sector. Employment in the informal sector is determined by the characteristics of the job a person does, and includes: own account work and employment in one's own informal sector enterprise; unpaid family work in formal or informal sector enterprises; membership of informal producer cooperatives; and paid employment without entitlement to pension fund contributions by the employer, paid annual, maternity or sick leave or a written employment contract. Generally, the incomes of people in informal employment are not taxed.

The proportion of the total employed population aged 15 years and above in informal employment in Zimbabwe is very high and increased from 84.2 percent in 2011 to 94.5 percent in 2014, see Figure 1B.2. In 2014, a higher proportion of women, at 95.9 percent, were in informal employment than men with 93 percent. Specifically, in May 2014, of the total 1.5 million paid employees, 1.4 million (93 percent) were in informal employment. A relatively large proportion (36.5 percent) of these received a cash income below US\$100 per month, while 67 percent earned US\$300 or less. A higher proportion of women (45.1 percent) than men (32.1 percent) who were paid employees in informal employment received cash income of less than US\$100.

A high proportion (78 percent) of those currently employed in the informal sector are aged 20 to 44 years. In terms of education and skills, 46.4 percent of those employed in the informal sector had completed Form 4, while 11.1 percent had gained a diploma or certificate after secondary education, 18.6 percent had reached between Form 1 Form 3, and 18.3 percent were educated only to Grade 7 or lower. A very high proportion (85.9 percent) of those employed in the informal sector were unskilled, with 54.4 percent of the unskilled being women.

### VULNERABLE AND PRECARIOUS EMPLOYMENT

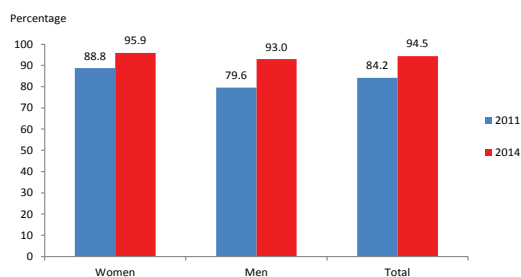
The two categories of own account workers and unpaid contributing family workers, generally constitute vulnerable employment. During the MDG period, nearly two-thirds (66.2 percent in 2014) of the employed population aged 15 years and above were in vulnerable employment, with women representing a higher proportion, at 70.4 percent, than men, at 61.2 percent, see Figure 1B.3. The trend remained relatively stable since 2004.

**Table 1B.1 Proportional Distribution of Paid Employees by Cash Received during May 2014 in their Main Job, by Income Category and Sex**

Cash Received from Main Job	Percentage		Total
	Women	Men	
No work done	2.1	1.3	1.5
Zero	1.7	1.3	1.4
US\$1 - 100	40.0	29.2	32.9
US\$101 - 200	12.5	16.2	14.9
US\$201 - 300	10.2	16.8	14.5
US\$301 - 400	9.9	10.8	10.5
US\$401 - 500	11.5	10.6	10.9
US\$500 - 1 000	8.5	9.5	9.2
US\$1 001 - 3 000	2.5	3.2	3.0
US\$3 000 and above	0.1	0.5	0.3
Not stated	1.0	0.8	0.8
Total	100.0	100.0	100.0
Total Number	530 391	1 002 248	1 532 641

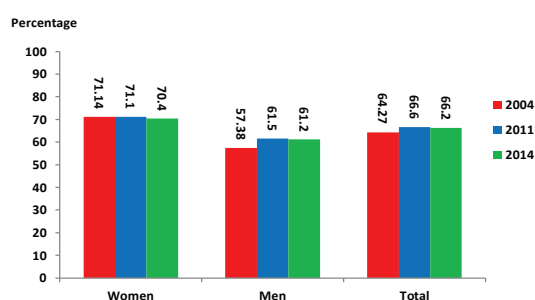
Source: ZIMSTAT, 2014 LFCLS

**Figure 1B.2 Informal Employment as a Proportion of Total Employment, by Sex, 2011 and 2014**



Source: LFCLS 2011, 2014

**Figure 1B.3 Proportion of Own Account and Contributing Family Workers in Total Employment, 2004, 2011 and 2014**



Source: LFCLS 2004, 2011, 2014

Persons in precarious employment are those whose contract of employment, whether verbal or written, is of relatively short duration or whose contract can be terminated at short notice. Examples include casual, seasonal and short term workers. Precarious employment has serious decent work deficits and is unstable and insecure. The 2014 LFCLS revealed that, of the 6.3 million currently employed population, 13 percent (827 632 persons) were in precarious employment, with men having a higher PER, of 17.1 percent, than women, with 9.4 percent.

## UNDEREMPLOYMENT

The 2014 LFCLS defines time-related underemployment<sup>15</sup> as all those employed persons aged 15 years and above, involuntarily working less than 40 hours a week, who wanted to work additional hours during the 7 days preceding the survey. Nationally, 970 112 persons (16 percent) of the total employed persons were underemployed, and the proportions were almost the same for women and men. Own account workers (other than communal, resettlement and peri-urban farmers) had the highest rate of underemployment, at 30 percent,

<sup>15</sup> According to the ILO (1990), underemployment exists when a person's employment is inadequate in relation to specified norms or alternative employment, account being taken of their occupational skill (training and working experience). For example, university graduates selling airtime are underemployed.

while own account workers (communal, resettlement and peri-urban farmer) contributed the highest share (58.7 percent) to total underemployed persons. Further detail is provided in Table 1B.2.

According to the Zimbabwe 2014 Child Labour Report, there were 168 760 children aged 5 to 14 years engaged in economic activities for at least 21 hours per week, and 97.42 percent of these resided in rural areas, with the remaining 2.58 percent in urban areas. Children aged 15 to 17 years who, by law, are allowed to work in non-hazardous economic activities, are already part of the labour force discussion presented in this report.

## UNEMPLOYMENT

### Overall Unemployment

The current broad unemployment data presented in this section refer to persons aged 15 years and above, who during the 7 days preceding the LFCLS were without work and available for work. Nationally, in 2014 the current broad unemployment rate<sup>16</sup> was 11.3 percent, with men having a higher unemployment rate, of 14.9 percent, than women, with 7.3 percent, see Figure 1B.6. Unemployment was more prevalent in urban areas, with a rate of 29.5 percent, than in rural areas, with 2.6 percent. The low rural area unemployment rate could be indicative of the nature of rural agricultural activities that mask under-employment and magnify employment. In urban areas, women had a much higher unemployment rate, of 39.1 percent, than men, with 19 percent. There was a similar pattern in rural areas but with smaller percentages.

The highest urban unemployment rates are among those aged 15 to 34 years, and there are also relatively high rates of 21 to 29 percent among those aged 50 years and above. Thus, those most affected by the persistent economic challenges and company closures are the youth and those in middle age. In terms of education, those who had completed Form 6 have the highest level of unemployment, at 30.2 percent (women at 40.2 percent; men at 23.9 percent), followed by those with Form 4, with 17.8 percent (women at 25.6 percent; men at 10.6 percent)<sup>17</sup>.

In line with the findings above, the highest provincial rates of unemployment are found in the two provinces with major urban centres, that is, Bulawayo province with 31.1 percent, followed by Harare province with 30.2 percent, while Matabeleland North had the lowest rate, of 2.3 percent. Women in Harare province had the highest unemployment rate, at 41.2 percent, followed by women in Bulawayo province, at 38.7 percent, compared to their male counterparts, with 18.8 percent in Harare province and 22 percent in Bulawayo province.

<sup>16</sup> Unemployment rate is the percentage of unemployed persons in the economically active population.

<sup>17</sup> ZIMSTAT, 2014 LFCLS Table 7.4b, page 145.

Table 1B.2 Time Related Underemployment for Population Aged 15 Years and Above as a Proportion of Total Employment, by Employment Status and Sex, 2014

Employment Status	Number Underemployed			Total Number Employed			Underemployment Rate		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
Paid Employee – permanent	14 809	35 836	50 645	330 065	640 081	970 146	4.5	5.6	5.2
Paid Employee – casual, temporary, contract, seasonal	24 575	43 323	67 898	199 578	361 909	561 487	12.3	12.0	12.1
Employer	1 248	3 209	4 457	11 505	34 535	46 040	10.8	9.3	9.7
Own Account – peri-urban, communal, resettlement	305 855	263 896	569 751	2 102 835	1 590 757	3 693 592	14.5	16.6	15.4
Own Account – other	156 504	108 286	264 790	467 617	414 632	882 249	33.5	26.1	30.0
Unpaid family worker	3 875	6 969	10 844	57 793	38 220	96 013	6.7	18.2	11.3

Source: ZIMSTAT, 2014 LFCLS

### Youth Unemployment

Youth are divided into those aged 15 to 24 years and those aged 15 to 34 years. While Zimbabwe and Africa as a whole uses the second broader youth definition for planning purposes, the MDG process monitors the first group.

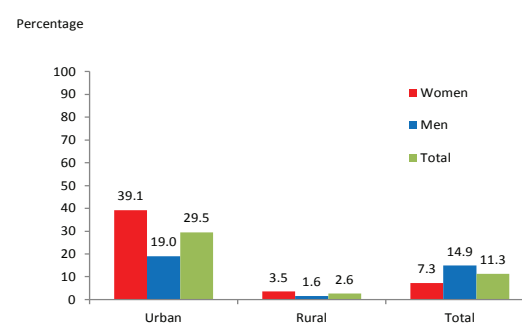
Youth unemployment is an issue of great concern in that, not only does it cause the country lose out on demographic dividend of a youthful population in development, but also it presents a risk of social instability. Zimbabwe has a high youth unemployment rate especially in urban areas. Nationally, in 2014, the current broad youth unemployment rate for youth aged 15 to 24 years was 16.4 percent, with 11.7 percent for young women and 8.9 percent for young men, see Figure 1B.8. The corresponding figures for the broader group of youth (15 to 35 years) were 15.3 percent overall, with women at 20.4 percent and men at 9.8 percent. Urban areas had a very high overall youth (15 to 24 years) unemployment rate of 50.1 percent compared to rural areas with 4.6 percent. The unemployment rate of young urban women was the highest (55.4 percent), compared to young urban men, with 42.9 percent.

In 2014, nationally, unemployed youth aged 15 to 24 years constituted a relatively high proportion (44.2 percent) of the total unemployed persons, with young men having a higher proportion than young women. In urban areas, the share of youth in total unemployed was 41.7 percent, whilst it was 57.4 percent in rural areas. In 2014, nationally, unemployed youth aged 15 to 34 years constituted a very high proportion (77.1 percent) of the total unemployed persons, although in this broader group the proportions were almost similar for women and men. In urban areas, the share of youth in total unemployed was 75.5 percent, while it was 85.2 percent in rural areas. The high youth shares in unemployment in the broader 15 to 34 years group compared to those aged 15 to 24 years indicates the seriousness of the youth unemployment problem between the ages of 25 and 34 years after school and tertiary training.

### DISCOURAGED JOB SEEKERS

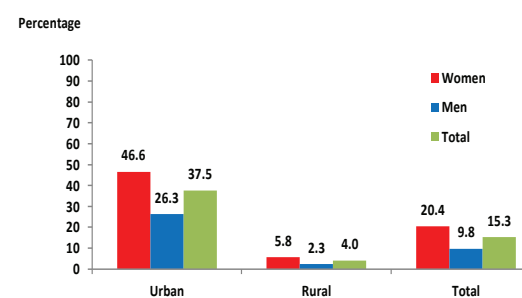
The 2014 LFCLS estimated that there were 164 656 discouraged job seekers in Zimbabwe, 72.3 percent of whom were women. In all age groups, except for the 65 years and above, women made up the majority of discouraged job seekers. It is of concern that a high proportion (71.6 percent) of all discouraged job seekers are the youth aged 15 to 34 years, who should be at the peak of productivity in the economy.

Figure 1B.4: Unemployment Rate (broad) for Population Aged 15 Years and Above by Place of Residence and Sex, 2014



Source: ZIMSTAT, 2014 LFCLS

Figure 1B.5 Unemployment Rate (broad) for Youth Aged 15 to 24 Years, by Place of Residence and Sex, 2014



Source: ZIMSTAT, 2014 LFCLS



## 3.9 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 1B

### SUCCESSES

There were no successes. Although Zimbabwe has high employment-to-population ratios, indicating some progress in achieving full and productive employment for all, including women and young people, the quality of employment is very low as reflected in the high income poverty levels. In addition, the problem of youth unemployment remains a major challenge, particularly in urban areas, while underemployment is still rife in rural agriculture and other own account work.

### SUPPORTIVE ENVIRONMENT

Given that Target 1B outcomes are largely a function of the economic performance of the country, all the supportive environment factors discussed under Target 1A also apply to this target.

According to the MPSSLW, the Zimbabwe National Employment Policy Framework (ZiNEPF), 2010 was approved by Government in recognition of the need for an explicit employment policy, in which social and economic goals are integrated to ensure that economic growth leads to more employment opportunities and poverty reduction. The ZiNEPF emphasises the pursuit of active labour market policy measures, such as training and skills development, targeting the groups most affected by unemployment, namely the youth and women, as well as the promotion and development of SMEs and cooperatives.

Zimbabwe has implemented three Decent Work Country Programmes (DWCPs), 2005-09 and 2008-11, as well

as the current one 2012-15, with assistance from the ILO. The DWCPs focus on the promotion of productive employment and decent jobs, strengthening of social dialogue capabilities and increased social protection of the working population. Yet there is a great deal more to be done in Zimbabwe with regard to the decent work agenda.

Government is working with stakeholders in effecting an overhaul of the country's labour legislation under the Labour Amendment Act, 2015. The labour law reforms recognise that the labour market is dynamic, and that some aspects of the legal regulatory framework governing the labour market in Zimbabwe were creating rigidities that had a negative impact on the investment environment. The reforms cover retrenchment procedures, flexibility of employment contracts and the wage determination system.

The Government of Zimbabwe (GoZ) recognises that the engagement of all social partners – Government, business (employers) and labour (workers) – to build consensus on key economic and social issues is essential to fostering industrial harmony and productivity, leading to economic growth and creation of sustainable employment opportunities. In this regard, His Excellency, the President launched the Kadoma Declaration in 2010, in which the social partners committed themselves to working towards the enhancement of social dialogue structures and processes. The partners have already agreed to the legislation for the Tripartite Negotiating Forum (TNF), as a formal structure for tripartite consultations and the TNF Bill is set to go before Parliament.

## 3.10 CHALLENGES IN ACHIEVING TARGET 1B

Similarly, given that Target 1B outcomes are largely a function of the economic performance of the country, all the challenges discussed in relation to Target 1A also apply to this target.

### LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGET 1B

Zimbabwe's experience with MDG1 Target 1B generated the following lessons:

1. Pursuing sustained, broad-based and inclusive economic growth that delivers decent work is central to poverty reduction and the eradication of hunger. Therefore it is imperative to formalise economic activities and provide effective support for job-creating economic growth.
2. There is an urgent need for a re-industrialisation

drive.

3. Zimbabwe needs to capitalise on its demographic dividend of a youthful population and women who remain largely unemployed and underemployed.
4. The area of employment is so central that it requires special attention on its own or under the economy goals in the SDGs.

### THE WAY FORWARD – TOWARDS THE SDGS

MDG1 Target 1B has the following unfinished business and issues which should be carried forward into the 2030 SDGs:

- The pursuit of broad-based, inclusive and sustainable economic growth that creates decent jobs.

- Improving the quality of productive employment in all sectors.
- Effective implementation of long overdue re-industrialisation strategies, including formalisation
- Addressing youth and female unemployment and underemployment.

### Target 1C

(a) Halve, between 2002 and 2015, the proportion of people who suffer from hunger (b) Reduce by two-thirds, between 2002 and 2015, the proportion of malnourished (underweight) children under five

#### THE SITUATION – TARGET 1C

Zimbabwe continues to face high levels of chronic child malnutrition, which are exacerbated by recurring food insecurity and widespread poverty. In addition, there are emerging threats such as climate change and a fragile global food security situation.

Nevertheless, Zimbabwe had more than halved the proportion of the population below the FPL by 2012, exceeding the MDG target. However, this achievement needs to be acknowledged with caution as hunger and food insecurity remain major challenges in Zimbabwe and despite a notable decline in the proportion of the population that is undernourished the absolute figure remained at 4.523 million people in 2013.

Generally, boys experienced higher levels of stunting in Zimbabwe than girls, while rural areas had higher levels of stunting than urban areas. A slow but consistent reduction in under-5 stunting was recorded between 2005/06 and 2014, in both rural and urban areas.

The underweight (weight-for-height) proportion of the under-5 population remained in the moderate range, with small shifts in both directions and a slight rise overall across the period under review. Boys were also more likely to be underweight than girls, and rural areas had higher proportions of underweight under-5s than urban areas. The proportion of underweight children increased in rural areas between 2010/11 and 2014, declining in urban areas over the same period.

Maize yields have remained low, fluctuating well below the MDG target of 3 tonnes/hectare. The low yields were largely caused by poor rainfall seasons and widespread use of retained seed but inadequate irrigation facilities, particularly in the face of under negative climate change impacts, also played a role. Despite a stated desire to irrigate large areas, both the proportional and the absolute area under irrigation declined continuously throughout the MDG period. Overall, 95 percent of maize production came from communal areas, A1 and A2 and old resettled farmers.

The food security situation is closely linked to the overall macroeconomic situation in that when the economy is performing well, generally the population is able to

of the informal sector and provision of support to MSME.

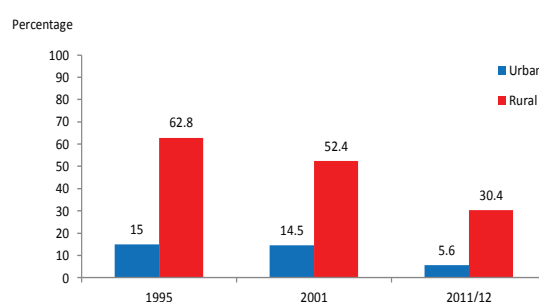
- Addressing youth and female unemployment and underemployment.

secure food either from production or purchases. During the economic recession years, 2003/04 to 2008/09, food insecurity was high, while during the economic recovery era, from 2009/10, food insecurity in the population was low but it rose again with the decline in economic growth experienced in 2013/14.

Drought is the most common natural disaster affecting food production. The 2001 drought stands out as affecting the highest number of people, that is, close to half of the country's population. The impacts of droughts are multiple and long lasting, affecting all facets of the economy and cuts across all sectors.

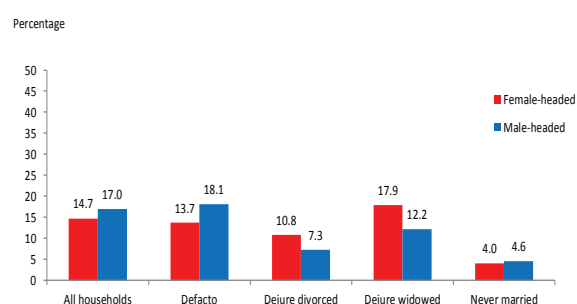
The agriculture sector has suffered from the lack of a clear agriculture and land policy to provide overall development strategy to the agricultural sector, and inadequate support

**Figure 1C.1 Proportion of the Population below the FPL, by Place of Residence, 1995, 2001 and 2011/12**



Source: ZIMSTAT, ICES 1995, 2001, and PICES 2011/12

**Figure 1C.2 Proportion of Households Below the FPL, by Sex of Household Head, 2011/12**



Source: ZIMSTAT, ICES 1995, 2001, and PICES 2011/12

to the land reform programme to make agriculture a viable business (agrarian reform). The challenges have included limited access to inputs such as seed and fertilisers; inefficient of research and agricultural extension services and utilisation, and a failure to reduce dependency on

rain-fed agriculture by expanding irrigation (particularly as a response to climate change). Some farmers have also move away from low prized maize (a key nutrition crop) to cash crops, such as tobacco.

### 3.14 STATUS OF TARGET 1C AND TRENDS

The availability of food is not only a function of agricultural production, but also of pricing, marketing, affordability and access. These interdependencies mean that any policy shift in one area will affect the other areas. Generally, several years of deteriorating agricultural infrastructure and government services during the MDG period, combined with severe climate change impacts, contributed to reduced domestic food production, although some seasons, such as the 2013/14 season, produced a food surplus under favourable rainfall.

#### POPULATION BELOW THE FPL AND UNDERNOURISHED POPULATION

The population below the FPL comprises those people who cannot meet basic food needs, who suffer from hunger, who are in extreme poverty, or who experience food poverty. Reducing extreme/food poverty can be achieved through several strategies which could include, increasing food production and availability (even though

importation), efficient delivery of food aid, and effective implementation of official and traditional community-level food safety nets. Targets 1A and 1C required the proportion of people who suffer from hunger to be halved by 2015.

By 2011/12, Zimbabwe had more than halved the proportion of the population below the FPL, from 41.5 percent in 2001, to 22.5 percent in 2011/12, against an MDG target of 29 percent. The population in rural areas consistently suffered more from hunger than the population in urban areas, see Figure 1C.1, despite the fact that the former are engaged in food production. The proportion of the rural population below the FPL declined from 52.4 percent in 2001 to 30.4 percent in 2011/12, whilst the corresponding movement in urban areas was from 14.5 percent to 5.6 percent, respectively. Thus, proportions of people in food poverty were significantly reduced but not halved in rural areas where the majority reside, but in urban areas the proportion was more than halved.

Defacto female-headed households had lower proportions in food poverty than defacto male-headed ones, but households headed by widows and divorced women were more vulnerable to food poverty, see Figure 1C.2.

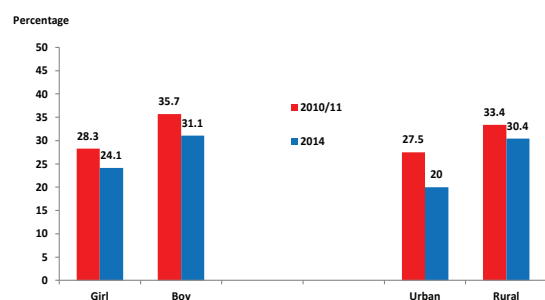
The proportion of undernourished population declined from 43.7 percent in 2000, to 31.8 percent in 2013. This translates into 5.510 million people who were undernourished in 2000 down to 4.523 million people in 2013, and means that despite the proportion of people whose income is below the FPL being halved, hunger and food insecurity remain major challenges in Zimbabwe.

Matabeleland North province had the highest proportion (49 percent) of the population below the FPL, while among the predominantly rural provinces, Masvingo province had the lowest proportion, at 19.2 percent and the rest are in the range 20 to 30 percent. Harare province had the lowest proportion (4.3 percent) of population below the FPL, followed by Bulawayo province with 5.5 percent.

#### CHILDREN UNDER-5 NUTRITION

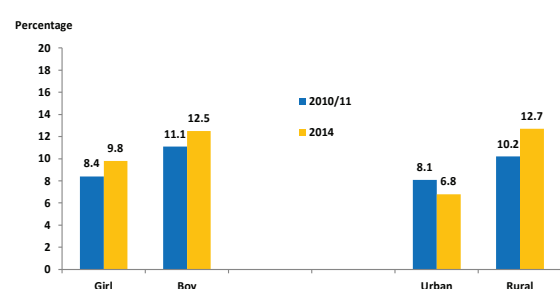
Zimbabwe continues to face persistent levels of chronic child malnutrition which are exacerbated by recurring food insecurity and widespread poverty, alongside emerging threats such as climate change and a fragile global food security situation. As part of its efforts to

Figure 1C.3 Proportion of Children Under 5 Years Moderately or Severely Stunted (Below -2SD), by Sex and Place of Residence, 2010/11 and 2014



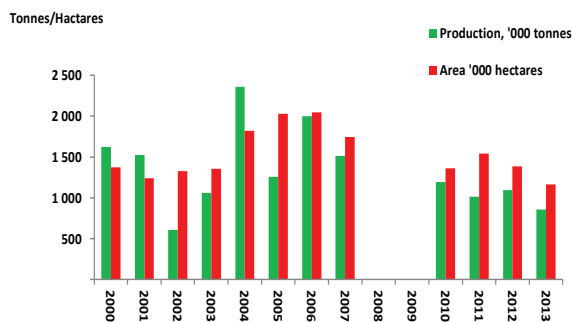
Source: ZIMSTAT, ZDHS 2010/11 and MICS 2014

Figure 1C.4 Proportion of Children Under 5 Years Moderately or Severely Underweight (below -2SD), by Sex and Place of Residence, 2010/11 and 2014



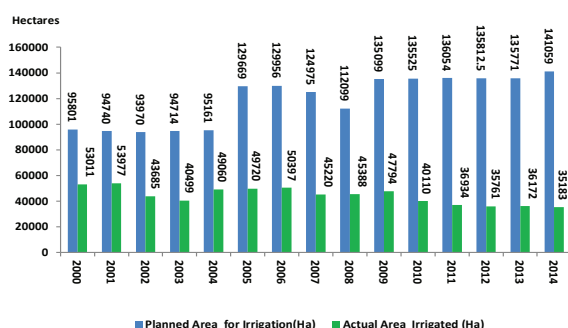
Source: ZIMSTAT, ZDHS 2010/11 and MICS 2014

**Figure 1C.5 Maize Production (tonnes) and Area Planted (hectares), 2000 to 2015**



Source: GoZ, MAMID 2015

**Figure 1C.6: Planned Area and Actual Area Irrigated (hectares), 2000 to 2014**



Source: GOZ, MAMID 2015

prevent child mortality resulting from malnutrition and related diseases, Zimbabwe has always had a comprehensive package of nutrition programmes. These programmes include the Community-Based Nutrition Care Programme, Infant and Young Child Feeding Programme, Child Supplementary Feeding Programme, and Therapeutic Feeding Programme. With the high prevalence of HIV, some of these nutrition programmes are specifically targeted at HIV positive pregnant mothers, as well as infants born with, or at high risk of contracting HIV.

According to the Zimbabwe Demographic Health Survey (ZDHS), 2010/11, 32 percent of children under 5 years of age were stunted, with 11 percent being severely stunted.

However, the Multiple Indicator Monitoring Survey (MICS), 2014, showed that although still high, stunting for under-5s had declined to 27.6 percent. Therefore, under-5 stunting declined from 36 percent in 2005/06 to 32 percent in 2010/11 to 27.6 percent in 2014. Generally, boys experienced higher levels of stunting than girls with boys registering 31.1 percent stunting in 2014, compared to girls with 24.1 percent, see Figure 1C.3. Rural areas had higher levels of under-5 stunting, at 30.4 percent, than urban areas, with 20 percent stunting in 2014. Stunting declined in both rural and urban areas between 2010/11 and 2014.

Under-5 underweight (weight-for-height) remained in the moderate range, at 10 percent in 1999, rising to 13 percent in 2005/06, declining to 9.7 percent in 2010/11, and up to 11.2 percent in 2014. Once again, boys were more likely to be underweight than girls, with boys registering 12.5 percent underweight in 2014, compared to girls, with 9.8 percent, see Figure 1C.4. Rural areas had higher proportions of underweight under-5s than urban areas, with rural areas having 12.7 percent and urban areas 6.8 percent underweight children 2014. The proportion of under-5s who were underweight increased in rural areas between 2010/11 and 2014, but declined in urban areas during the same period.

In 2014, Manicaland province had the highest under-5 stunting level, of 34 percent, with Bulawayo province having the lowest, at 20 percent, followed by Harare province, with 21 percent. The occurrence of underweight was highest in Matabeleland South province, with 13.9 percent, and lowest in Harare province, with 7 percent, followed by Bulawayo, with 9.6 percent.

## AGRICULTURAL PRODUCTION

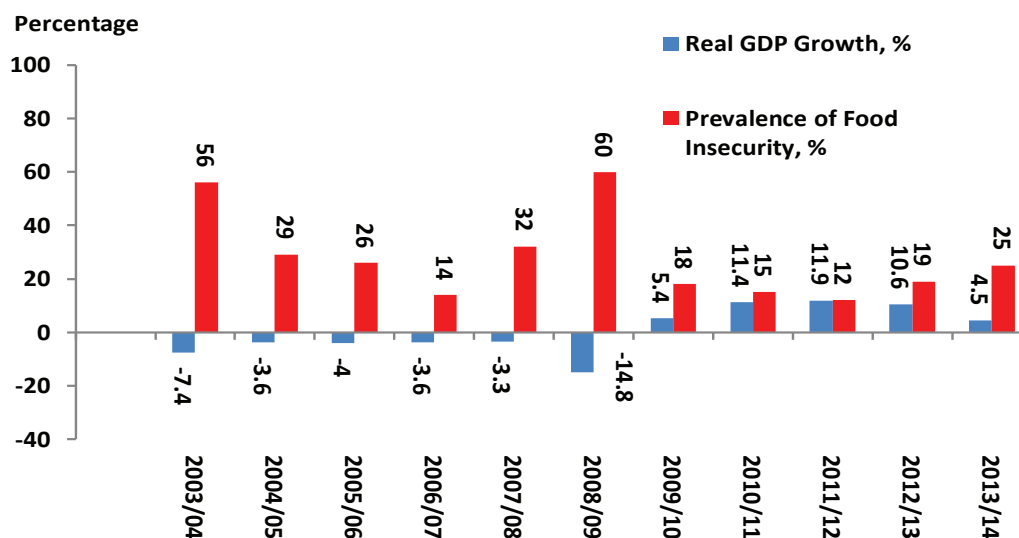
Maize is Zimbabwe's staple food and the crop most commonly grown by rural households. It is partly for this reason that food security is usually associated

**Table 1C.1 Sectoral Contribution to Maize Production (tonnes), 2012/13 and 2013/14 Seasons**

Sector	Production (tonnes)		Percentage Increase 2013/14	Percentage Contribution
	2012/13	2013/14		
Communal	303 521	636 274	110.0	44
Old Resettlement	78 500	131 137	67.0	9
Small Scale Commercial	28 571	47 103	65.0	3
A1 Resettlement	188 120	322 663	72.0	22
A2 Resettlement	179 811	285 667	59.0	20
Peri-Urban	20 073	18 644	-7.0	1
TOTAL	798 596	1 441 488	81.0	100

Source: GoZ, MAMID, 2014

Figure 1C.7 Relationship between Real GDP Growth and Prevalence of Food Insecurity, 2003/04 to 2013/14



Source: ZimSTAT and RBZ, 2015; ZIMVAC reports

with maize production. Figure 1C.5 shows the maize production and area planted trend from 2000 to 2013. The area planted remained subdued between 2000 and 2003, at the start of the FTLRP, increased from 2004 to 2008, at the peak of the Reserve Bank of Zimbabwe's quasi-fiscal support to the then newly resettled farmers, and declined from 2010 to 2013, when dollarisation was introduced and there was no special support to farmers. Maize yields have remained low, fluctuating between 0.5 and 1.3 tonnes/hectare against an MDG target of 3 tonnes/hectare, and also generally following the same pattern as the production trends. Zimbabwe is experiencing high productivity gaps compared to regional averages, for example, 2.54 tonnes/hectare in Zambia, 2.21 tonnes/hectare in Malawi and 4.16 tonnes/hectare in South Africa. Several crop assessment reports showed that low yields were largely a function of a poor rainfall season and widespread use of retained seed.

Yields are also a function of irrigation, particularly given the negative impacts that Zimbabwe is experiencing from climate change. However, Figure 1C.16, illustrates that, despite the desire to irrigate large areas, the proportion of area irrigated declined continuously and steadily, from 55.3 percent in 2000, to 24.9 percent in 2014. In absolute terms the area under irrigation fell from 53 011 hectares in 2000, to 35 183 hectares in 2014, which is a 34 percent decline.

The greatest contribution to national maize production comes from communal areas, which contributed 44 percent of total production in 2013/14, followed by A1 farmers, with 22 percent, and A2 farmers, with 20 percent, see Table 1C.1. Overall, 95 percent of maize production came from communal areas, A1 and A2 and old resettled farmers. The volume of maize produced in the communal areas more than doubled during the 2013/14 season, compared to the 2012/13 season, although the

yields in this sector are still very poor. The average maize productivity in small scale farming areas averaged 0.79 tonnes/hectare between 2009 and 2012. Total national maize production was 81 percent higher in 2013/14 than in 2012/13, largely because of the good rainfall season.

Total area planted to small grains (sorghum, rapoko and millet), although fluctuating, generally increased, from 268 638 hectares in 2000, to 425 586 hectares in 2013, which is a 58 percent increase. For the same group of small grains, production fluctuated with rainfall, declining during drought years but increasing from 77 000 tonnes in 2000, to a peak of 230 000 tonnes in 2004, before declining to 105 000 tonnes in 2013. In the 2013/2014 season, Zimbabwe had a surplus of 306 301 tonnes in grain and cereal production, with deficits only in roundnuts, sugarbeans and cowpeas.

#### DISASTER RISK MANAGEMENT

Closely related to the issue of hunger, is that of the risk of natural disasters and how these are managed. Zimbabwe faces disaster risks which are triggered by natural and human made hazards. Drought is the most common natural disaster and accounted for six of the ten most serious disasters between 1991 and 2013, with the most recent, in 2013, affecting 2.2 million people while the most severe was in 2001 and affected 6 million people. Evidence suggests that the frequency and magnitude of extreme events such as droughts and floods will increase in future in association with global warming. The impacts of droughts are multiple and long lasting, with impacts on all facets of the economy and across all sectors. The most vulnerable areas are those found in natural regions IV and V, with women and children, single headed and child headed families likely to suffer the worst effects.

Floods, which occur in most years, also present challenges.

The number affected by floods was significant in 2000 and 2001. Records show that, in 2000, floods caused by Cyclone Eline in the Zambezi Basin left 90 people dead and over 250 000 people affected, and resulted in approximately US\$7.5 million in economic losses. The same groups – women and children, single headed and child headed families – are the most vulnerable, while homes, roads, telephone and electricity supply equipment, agricultural assets, crops, domestic and wild animals can also be washed away.

#### FOOD SECURITY AND THE ECONOMY

The food security situation is closely linked to the overall

macroeconomic situation, see Figure 1C.7. During the economic recession years 2003/04 to 2008/09, food insecurity was also high, reaching 56 percent in 2003/04 and peaking at 60 percent in 2008/09, whilst during the economic recovery era 2009/10 to 2013/14, food insecurity in the population was low. As economic growth reduced to 4.5 percent in 2013/14, there was a corollary increase in food insecurity to 25 percent. Thus, all the factors associated with economic and social challenges – high levels of poverty, unemployment, seasonally fluctuating prices, HIV, poor access to basic social services – act to exacerbate food insecurity and hunger in the population.

## 3.15 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 1C

#### SUCCESSES

By 2011/12, Zimbabwe had more than halved the proportion of the population below the FPL, from 41.5 percent in 2001, to 22.5 percent in 2011/12, against an MDG target of 29 percent.

Notable progress was also made in several other areas, namely: the proportion of undernourished population declined between 2000 and 2013; under-5 stunting (height-for-age) declined between 2005/06 and 2014, whilst underweight (weight-for-height) remained in the moderate range; the greatest contribution (95 percent) to national maize production came from communal areas, A1 and A2 and old resettled farmers; in the 2013/14 season, Zimbabwe had a surplus of 306 301 tonnes in grain and cereal production; and during the economic recovery era, 2009/10 to 2013/14, food insecurity in the population was low.

#### SUPPORTIVE ENVIRONMENT

There were many initiatives pursued to create a supportive environment for the achievement of Target 1C.

In support of agricultural production, these were:

- *The FTLRP*, from 2000 onwards, the stabilisation and success of which is indicated by the production of a grain and cereal surplus in some years, with the bulk of production coming from communal, previously resettled and newly resettled farmers;
- *The Constitutional Referendum* of March, 2013, which facilitated stabilisation of the FTLRP by defining the rationale and mechanisms for compensation of the displaced former farmers;
- *Agriculture policies*, including a draft Agricultural Policy currently going through approval processes as

well as components of the ZimAsset, 2013-2018, the Zimbabwe Agriculture Investment Plan, the Land Reform Policy, the Environmental Management Act and other sectoral plans;

- *An Irrigation Policy*, which being finalised, as a basis for rehabilitation and increased utilisation of small to medium sized dams and currently dilapidated small irrigation schemes that could be used to increase productivity and production of high value commodities by smallholders.
- *Creation of the Ministry of Environment, Water and Climate*, in 2013, in recognition of the threat of climate change to the economy and livelihoods, and particularly agriculture, land and the environment, to manage the Environmental Management Act and a forthcoming Climate Change Response Strategy.

Disaster risk management initiatives have focused on addressing the impact of drought through structured institutional systems that run through all levels of national government, provincial and local government. These include the Drought Relief and Civil Protection Committees. There is also strong collaboration between several government ministries and development partners. For example, the FAO country programme framework for Zimbabwe runs from 2012 to 2015.<sup>18</sup> Under this Framework, FAO will work to strengthen the capacities of the national and sub-national structures of the FNC and early warning systems as part of its disaster risk reduction and management priority area. The Government's commitment to DRM led to the development of the Draft 2011 Disaster Risk Management Strategy, 2012-

<sup>18</sup> *Government of the Republic of Zimbabwe, and FAO Country Programme Framework 2012-2015.*

2015, and the Draft 2011 Disaster Risk Management Bill and Policy which are meant to strengthen and transform the Department of Civil Protection into the Department of Disaster Risk Management.

Food and nutrition security has been addressed through:

- *The FNSPZ* (Promoting Food and Nutrition Security in Zimbabwe in the Context of Economic Growth and Development, 2012), and the accompanying Implementation Plan/Matrix for the Food and Nutrition Security Policy for Zimbabwe, 2012, as key implementation frameworks, with a National Taskforce on Food and Nutrition Security provide implementation oversight;
- *The FNC*, established in 1998 and mandated to, “promote a cohesive national response to the prevailing household food and nutrition insecurity through coordinated multi- sectoral action”, which encompasses guidance by a multi-stakeholder Advisory Group for Food and Nutrition Security, and ZIMVAC, as well as Nutrition Security Committees at all levels.

The nutrition programmes in place include:

- *The Child Supplementary Feeding Programme* (CSFP), which was started around 1981, was almost continuous from 2002 to 2008, due to the prolonged droughts of the 2000s and the subsequent severe economic recession;
- *A Therapeutic Feeding Programme (TFP)*, introduced at district health facilities.

- *A Community Based Nutrition Care Programme (CBNCP)*, established in eight districts, two major cities and three central hospitals, with the introduction of Community Therapeutic Care (CTC), and being instrumental in the revival of the customary community-based Zunde RaMambo<sup>19</sup> system.
- *The Infant and Young Child Feeding Programme (IYCFP)*, promoting exclusive breastfeeding for six months, which incorporates the Baby Friendly Hospital Initiative (BFHI).
- *Programmes for micronutrients*, including the achievement of universal salt iodisation, while Vitamin A deficiency control is taking place both through supplementation and food fortification.
- *A Nutrition and HIV Programme* for infants, established under the ART roll-out programme and implemented jointly by the Government and the National AIDS Council of Zimbabwe.

Finally, the Harmonised Social Cash Transfer Scheme, designed by the MPSLSW in partnership with UNICEF, is a programme pillar under the implementation of the 2nd Phase of the National Action Plan for Orphans and Vulnerable Children Programme (NAP II), 2011-2015.

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<sup>19</sup> Zunde raMambo is a custom whereby a plot of land is planted, tended and harvested by the community. Produce from this plot is stored and used by the community when food is short or to supplement the food supply of poor, vulnerable households.

### 3.16 CHALLENGES IN ACHIEVING TARGET 1C

The lack of a relevant and well defined policy and institutional framework, and clear development strategy is probably the underlying cause for most of the challenges faced in the agriculture and land sectors, and therefore in the provision of adequate food and nutrition to the population. The specific challenges consequent upon this include:

- Ensuring on-time and unaffordable access to inputs such as seed, fertilisers, water for irrigation and, in the case of livestock farming, vaccinations for the prevention of diseases, as well as adequate credit facilities to support farming in the context of an overall agrarian reform package;
- Supporting the viability and potential of local farmer production by avoiding cheap maize imports which undermine the market, and rebuilding confidence in the Grain Marketing Board (GMB) as the chief buyer, thereby averting the move away from growing maize (the major nutrition crop) to growing cash

crops such as tobacco;

- Expanding access to and utilisation of agricultural extension, primarily by facilitating and incentivising the work of extension officers;
- Reducing dependency on rain-fed agriculture by expanding irrigation, particularly to smallholder and communal farmers, in order to increase agricultural productivity and enable farmers to cope effectively with the impacts of climate change;
- Development of information systems, including a land information and natural resource database on the basis of an up-to-date audit, and an integrated disaster risk management framework;
- Prioritising the rehabilitation and improvement of infrastructure such as roads and electricity to rationalise the current high costs and marketing issues involved in agricultural production.

In addition, the broader challenge of creating broad-based, inclusive and equitable economic growth must be met in order to ensure the viability of food production and supply, effective interlinkages between agriculture

and other sectors, and the capacity of the economy to provide adequate and sustainable social services to address nutritional as well as other needs.

### **3.17 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGET 1C**

Zimbabwe's experience with MDG1 Target 1B generated the following lessons:

1. Pursuing sustained, broad-based and inclusive economic growth that delivers decent work is central to poverty reduction and the eradication of hunger. Therefore it is imperative to formalise economic activities and promote job-creating economic growth that is capable of supporting social services for the most vulnerable.
2. In addition to land redistribution, comprehensive agrarian reform is required, with a full package of support to farmers to ensure high productivity
3. Effectively implemented food and nutrition policies and programmes, in the context of overall social sector strengthening, are central to addressing hunger.

### **3.18 THE WAY FORWARD – TOWARDS THE SDGS**

Sustainable economic growth, employment creation and the elimination of hunger should be the top priority under the SDGs, with specific attention paid to:

- Protection and strengthening the agriculture sector through facilitation essential imports for agricultural production, while avoiding the direct import of basic food products, and improvement of rural infrastructure;
- Improved management and information systems.

A reliance on rain-fed agriculture has become a huge risk to the whole country in the face of climate change, meaning that promotion of and support to irrigation will be central under the SDGs.







## Chapter 4

# MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

## SUMMARY OF PROGRESS

### Target 2A

Ensure that, between 2000 and 2015, all Zimbabwean children, boys and girls alike, will be able to complete a full programme of primary education

Primary school Net Enrolment Ratio (NER) remained high, at 92 percent in 2014, with gender parity.

Practically all primary schools had had Early Childhood Development (ECD) classes in 2014, although the ECD NER is low, at 25 percent.

The primary school completion rate declined, from 94.5 percent in 2000, to 77.3 percent in 2014, with gender parity achieved during the greater part of the period, 2003 to 2014.

Dropout rates declined, from 6.3 percent in 2000, to 4.8 percent in 2012, with boys more likely to drop out of school than girls in 2002, 2005, 2011 and 2012.

Transition rates from Grade 7 to Form 1 improved, from 74.7 percent in 2000, to 77 percent in 2014, with gender parity achieved during the period 2000 to 2014, except for 2006.

Literacy rates for young people remained around 99 percent, with gender parity.

The proportion of orphaned and vulnerable children (OVC), in primary school education, remained stagnant at around 26 percent in 2014.

The proportion of OVC on the Basic Education Assistance Module (BEAM) was 52 percent in both 2013 and 2014.

The proportion of primary school trained teachers has remained constant at 89 percent since 2000.

Pupil-teacher ratio (PTR) for qualified teachers, although declining, has remained high at 40 in 2014, from 43 in

2000, well above the MDG target of 28.

The pupil-book ratio (PBR) reached 1:1 for the four core primary school subjects and was maintained up to 2014.

The proportion of schools with computers for pupils was 12 percent in 2013, ranging from 66 percent in Harare, to 9.2 percent in Midlands province.

The number of pupils per computer worsened from 51 in 2013 to 169 pupils per computer in 2014, ranging from 55 pupils per computer in Harare to 434 per computer in Masvingo province.

### SUCCESSSES

1. The NER remained high, at above 90 percent.
2. Literacy rates for young people were around 99 percent during the MDG period, with gender parity.
3. The PBR reached 1:1 for the four core primary school subjects.
4. The proportion of trained primary school teachers was high, at 89 percent in 2014.
5. Grade 7 pass rates of 56 percent for girls and 47 percent for boys in 2012, were in the normal range.
6. Primary school dropout rates declined, from 7.9 percent in 2011, to 4.8 percent in 2012.
7. Ninety-nine percent of all primary schools had ECD classes in 2014.

## CHALLENGES

1. Securing adequate financing of education, noting that the education sector consistently receives the highest share of resources from the national budget.
2. Improving the quality and efficiency of education, particularly PTRs, transition rates, dropouts occurring because of financial constraints, inadequate school infrastructure – science laboratories, libraries, electricity, computers, safe sanitation – and school supervision.
3. Sustaining the HIV decline and mitigating the impact of HIV, for those children orphaned by the epidemic, as well as other pupils, parents and teachers.
4. Overcoming low teacher morale and brain drain arising from low salaries, inadequate staff accommodation and unfavourable working conditions.
5. Addressing the impact of general poverty and hunger on enrolments in urban and rural areas, school attendance and dropouts, to build upon the inputs of the BEAM and school feeding programmes.
6. Increasing enrolment in existing ECD facilities, alongside improved ECD training and enhancement of the facilities.
7. Strengthening public private partnership (PPPs) in the education sector as a way of financing and maintaining quality education.
8. Upgrading satellite schools to fully fledged schools, to cater for the population movements that occurred during land reform.

## LESSONS LEARNT

Education, as with other sectors, will benefit from a strategic mix of government and other – private sector and development partner – resourcing.

Strengthened and consistent collection of data on education will enhance the Ministry of Primary and Secondary Education's capacity to track key indicators.

Political will at the highest level was critical to success in the education sector under the MDGs and will remain so in the implementation of the SDGs.

### Target 2A

Ensure that, between 2000 and 2015, all Zimbabwean children, boys and girls alike, will be able to complete a full programme of primary education.

## 4.1 THE SITUATION – TARGET 2A

Although the net enrolment ratio (NER) in primary schools remained high throughout the MDG period, it has been falling since 2012 and there was an overall decline, from 96.2 percent in 2000, to 92.2 percent in 2014. Gender parity in primary school NER was retained throughout the period 2000 to 2015. While practically all primary schools had early childhood development (ECD) classes by 2014 the enrolment in these classes was low, at a NER of 25 percent.

The primary school completion rate declined, from 94.5 percent in 2000, to 77.3 percent in 2014, meaning that the MDG target of 100 percent was not achieved. The proportion of pupils starting Grade 1 in 2006 who reached the last grade of primary school in 2012 was 69.3 percent. This represented a decline from 72.1 percent for those who started Grade 1 in 1994 and reached the last grade in 2000. A higher proportion of boys than girls reached the last grade of primary in 2000 and 2001; there was gender parity among those who started in 2000 and completed in 2005, then the trend swung in 2011 and 2012 where a slightly higher proportion of girls than boys who had started Grade 1 in 2006 reached the last grade of primary school.

Overall, dropout rates declined, from 6.3 percent in 2000, to 4.8 percent in 2012. The major reasons for dropping out of school were inability to pay school fees and absconding. Boys were more likely to drop out of school than girls in some years, specifically 2002, 2005, 2011 and 2012.

The transition rate from Grade 7 to Form 1 improved by just over two percentage points from 74.7 percent in 2000 to 77 percent in 2014. Gender parity in transition rates was achieved during the period 2000 to 2014, except for the 2006 when the Gender Parity Index (GPI) was 105.

The literacy rate among the 15 to 24 year olds is almost universal in Zimbabwe, with a rate of 99.4 percent in 2014, and this rate was maintained between 2000 and 2014. Thus the MDG target of 100 percent can be said to have been achieved. Gender parity in literacy rate among young people aged 15 to 24 years was achieved in 2000 and has been maintained up to 2014.

The proportion of OVC attending primary school remained relatively constant, at 26.8 percent in 2013, and 26 percent in 2014, with the urban provinces of Harare

and Bulawayo having the lowest attendance (14.1 percent and 18 percent, respectively), and Matabeleland North and Matabeleland South provinces having the highest attendance (31.8 percent and 32.5 percent, respectively). About half of OVC in school received BEAM assistance, with Mashonaland East province having the highest proportion in 2014, at 60.5 percent, and Bulawayo province having the lowest proportion, at 37 percent.

In terms of school resourcing, most targets have been reached or exceeded. The proportion of primary school teachers with training was 89.2 percent in 2014, showing no improvement since 2000. The pupil-teacher ratio qualified teachers, despite declining, from 43 in 2000,

to 40 in 2014, has remained high, and is well ahead of the MDG target of 28. A pupil-book ratio of 1:1 was achieved in 2012 for the four core subjects – mathematics, English, environmental science and a local language (Shona/Ndebele/Tonga) – and has been maintained up to 2014. However, proportion of schools with computers for pupils was low and stagnant at 12 percent in 2013 and 2014, with the predominantly urban provinces of Harare and Bulawayo having both the highest proportion of schools with computers and the most favourable pupil-to computer ratios in 2014, while Matebeleland North and Masvingo provinces scored worst on both these measures, experiencing a huge increase in the number of pupils per computer between 2013 and 2014.

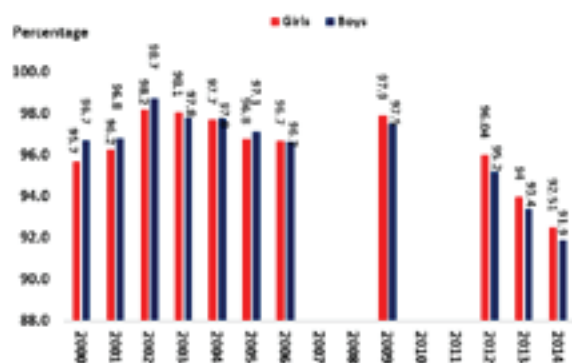
## STATUS OF TARGET 2A AND TRENDS

### NET ENROLMENT RATIO

Zimbabwe has consistently maintained relatively high levels of primary school enrolment since Independence, although within the MDG period, episodes of decline were registered between 2002 and 2006, and 2009 and

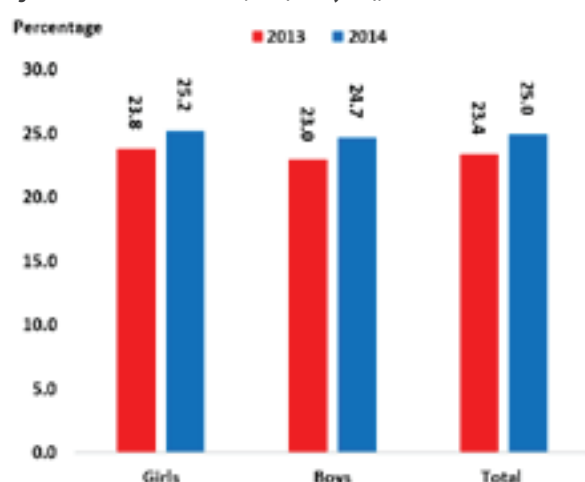
2014. The primary school NER was 92.2 percent in 2014, showing a decline from 96.2 percent in 2000, Figure 2A.1. However, the decline has not been entirely steady, with NER increasing from 2000 to a peak of 98.5 percent in 2002.

Figure 2A.1: Primary School NER, by Sex, 2000 to 2014



Source: MOPSE

Figure 2A.2 Net Enrolment Ratio, ECD (3 to 5 years), 2013 and 2014



Source: MOPSE

Education has been one of the sectors worst hit by the economic meltdown of 2000 to 2008. The Ministry of Primary and Secondary Education (MOPSE) was unable to provide data for the periods 2007 to 2008 and 2010 to 2011. Even with the recovery of the economic sector in 2009, due to the introduction of dollarisation and the coming in of the Inclusive Government, the NER continued to decline. Other factors, such as the resettlement of new farmers in areas where there were no schools may have also played into this. Despite the decline in NER and the recent slight difference in NER between boys and girls, the country largely maintained gender parity in primary school enrolment between 2000 and 2014. Primary school NER was highest in Manicaland province, at 99.1 percent, and lowest in Harare province, at 76.1 percent. No significant differences in NER exist between girls and boys in any province.

Pre-school education is important to the readiness of children for school. In 2014, of a total of 5 863 primary schools in Zimbabwe, 5 815 schools offered ECD, which is almost universal (99.2 percent). However, ECD facilities remain inadequate and ECD enrolment is still low, with a NER of only 25 percent in 2014.

### COMPLETION RATES

Although, ideally all children who start the first grade should complete grade seven, the proportion of children who started Grade 1 and completed the full primary cycle to Grade 7, has generally worsened. It is of concern that the primary school completion rate has declined over the years, from 95.1 percent in 2000, to 77.3 percent in 2014, well below the MDG target of 100 percent. There was near gender parity in primary school completion in

the years, 2003 and 2006 and in 2014, while boys had a marginally higher completion rate than girls between 2000 and 2005, but this was reversed in 2012 and 2013 with the rate for girls being slightly higher. This contradicts widely known practice in which, when family resources are limited, boy children are given priority over girl children to continue with education. The efforts by gender activists on gender equality may have contributed to this new phenomenon.

### DROPOUT AND TRANSITION RATES

The economic situation experienced during the period 2000 to 2008 has had a direct negative impact on the ability of families to send their children to school and to pay for school fees and uniforms. According to the Ministry of Primary and Secondary Education Annual Statistical Report, 2013, the major reasons for dropping out of school were school fees and absconding. At the same time, there was greater pressure on children during the economic downturn to contribute to the family economy in order to make ends meet. Another reason behind the high dropout rates may have been poor nutrition, as some children from poor families may seldom have had enough to eat to be able to manage school.

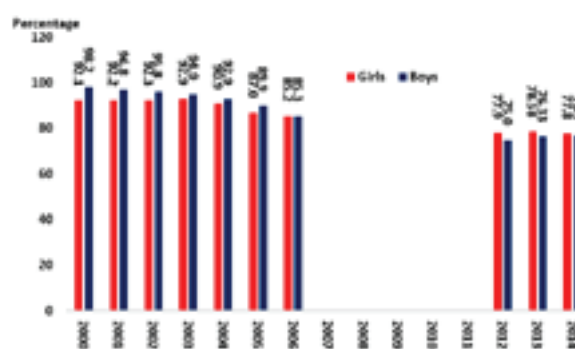
A smaller proportion of children in rural areas attend school than do children in urban areas. Overall, the dropout rates<sup>1</sup> for primary school declined, from 6.3 percent in 2000, to 4.8 percent in 2012. However, the rates increased continuously from 2000 to a peak of 8.7 percent in 2005. A greater proportion boys, at 5.3 percent, than girls, at 4.2 percent, dropped out of primary school in 2012, and this was also true for 2002, 2005 and 2011, see Figure 2A.4.

Transition from Grade 7 to Form 1 increased only slightly, from 74.7 percent in 2000, to 77 percent in 2014, Figure 2A.5. This is of great concern to Government as it means that nearly a quarter of pupils do not continue with education after Grade 7. There were no significant differences in Grade 7 to Form 1 transition rates between girls and boys, Figure 2A.5, that is, gender parity in transition rates from Grade 7 to Form 1 was achieved during the period 2000 to 2014, except for 2006 which had a GPI of 105.

### LITERACY RATES

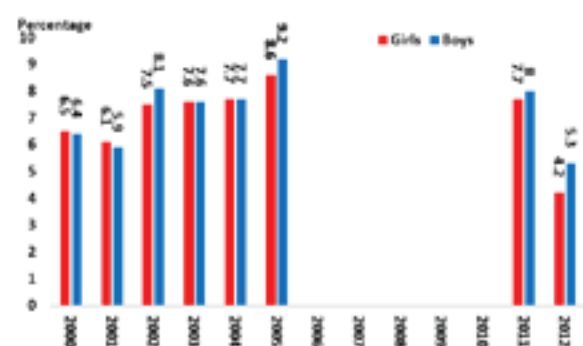
Zimbabwe has one of the highest literacy rates in Africa. According to the Zimbabwe National Statistics Agency (ZIMSTAT), the literacy rate among 15 to 24 year olds is almost universal in Zimbabwe, with a rate of 99.4 percent in 2014, which had been maintained over the period since 2000, see Figure 2A.6. The MDG target of 100 percent can be said to have been achieved. Gender parity in literacy rate among those aged 15 to 24 years was achieved over the period under review.

Figure 2A.3 Proportional Primary School Completion Rate by Sex, 2000 to 2014



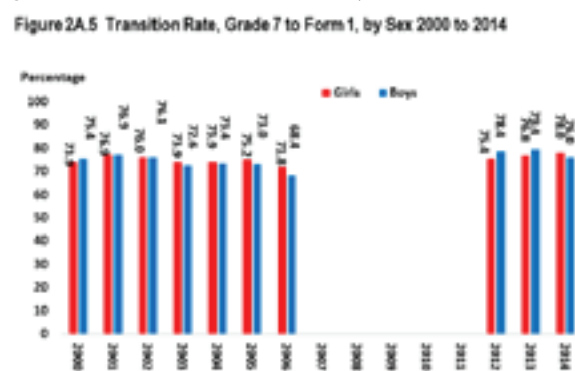
Source: MOPSE

Figure 2A.4 Primary School Dropout Rate (average Grade 1 to 6), by Sex, 2000 to 2012



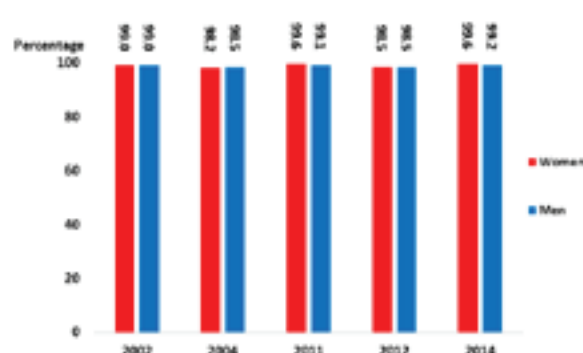
Source: MOPSE

Figure 2A.5 Transition Rate, Grade 7 to Form 1, by Sex 2000 to 2014



Source: MOPSE

Figure 2A.6 Literacy Rate (completion of Grade 3) for Population Aged 15 to 24 Years, by Sex, 2002, 2004, 2011, 2012, 2014



Source: ZIMSTAT Population Censuses and Labour Force Surveys

<sup>1</sup> Average Grade 1 to Grade 6

## SCHOOL ATTENDANCE OF ORPHANS AND VULNERABLE CHILDREN

The proportion of OVC in primary schools remained relatively constant, at 26.8 percent of the total school population in 2013, and 26 percent in 2014. The urban provinces of Harare and Bulawayo had the least number of children considered as OVC attending primary school between 2013 and 2014, at 14.1 percent and 18 percent, respectively, while Matabeleland North and Matabeleland South provinces had the highest percentages, of 31.8 percent and 32.5 percent, respectively see Figure 2A.7.

The BEAM, under the Enhanced Social Protection Programme provides financial support to vulnerable children through a basic education package that covers levies, tuition and examination fees for indigent children. The proportion of OVC on BEAM remained more or less constant in 2013 and 2014, at 52.2 percent and 51.5 percent, respectively, Figure 2A.20. The highest percentage of OVC who were on BEAM was recorded in Mashonaland East province, at 60.5 percent in 2014, and Bulawayo had the lowest percentage, at 37.5. There was a slightly higher proportion of girls than boys on BEAM (52.1 and 50.9 percent, respectively). The difference in the percentage of OVC on BEAM between girls and boys was highest in Mashonaland East, with a figure of 62.1 percent for girls, compared to 58.9 percent for boys.

## TEACHING STAFF AND RESOURCES

Despite high NERs, the quality of education remains a challenge. Indicators of quality include, teacher qualifications, pupil-teacher ratio (PTR) and pupil-book ratio (PBR). The proportion of trained teachers in primary schools has remained stagnant, at around 89 percent, over the period 2000 to 2014, with an increase between 2000 and 2006, to a peak of 96.7 percent in 2006, followed by a decline, to 85.9 percent in 2013. There are significant differences in the proportions of trained teachers by sex, with more trained female teachers than trained male teachers in schools over the period 2012 to 2014, see Figure 2A.8. The PTR for qualified teachers remained high at 40 in 2014, which is far from the MDG target of 28. However, this was a decline from a PTR of 43 in 2000. This ration remained high as a result of exodus of teachers to neighbouring countries during the economic crisis in search of higher wages and better conditions of service. The Ministry of Primary and Secondary Education has no capacity to sustain teachers' salaries if it implements the recommended PTR. The improvement in PTR between 2012 and 2013 was a result of the re-joining of the teaching service by teachers who had left the civil service during the economic recession period.

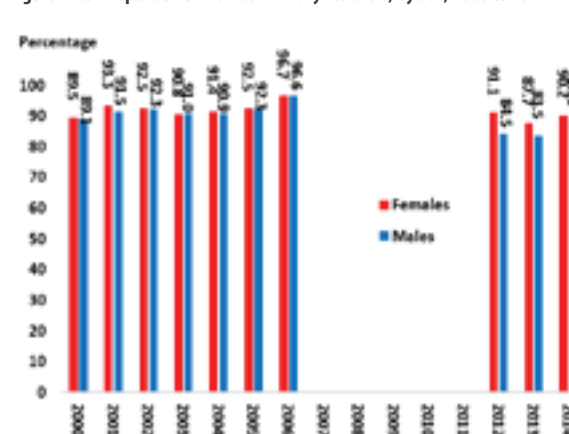
With the Education Transition Fund, which assisted in procurement of textbooks in the four core subjects, a PBR of 1:1 was achieved in 2012 for these subjects – mathematics, English, environmental science and a local language (Shona/Ndebele/Tonga). This compared favourably with earlier years, for example 2006, when

Figure 2A.7 Primary School Attendance of OVC, by Province, 2013 and 2014



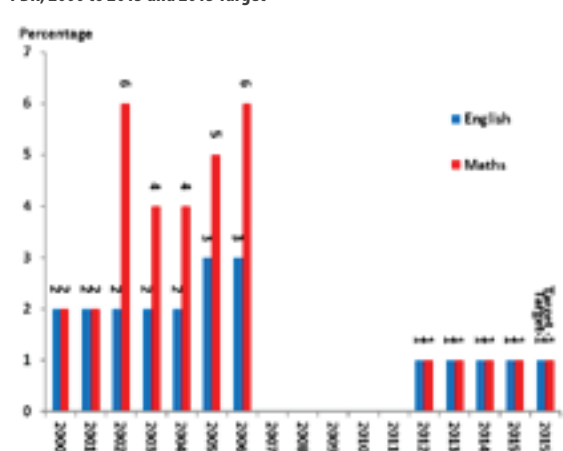
Source: MOPSE

Figure 2A.8 Proportion of Trained Primary Teachers, by Sex, 2000 to 2014



Source: MOPSE

Figure 2A.9 Primary School English and Mathematics PBR, 2000 to 2015 and 2015 Target



Source: MOPSE

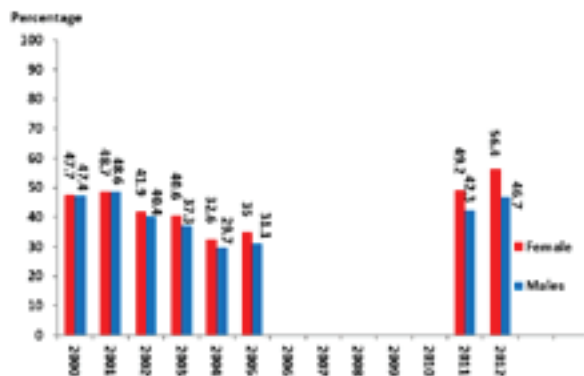
the PBRs for mathematics and English were 6:1 and 3:1 respectively, see Figure 2A.9

## GRADE 7 PASS RATES

Zimbabwe has an automatic primary to secondary school progression system. At the end of Grade 7, the last year of primary education, pupils' achievements in four subjects are tested in a series of examinations. However, the proportion of Grade 7 pupils who obtained a grade of 5 or better was very low, at around 50 percent. Grade 7 pass rates improved only slightly, from 47.5 percent in 2000 to 49.6 percent in 2012 and this masks a marked deterioration in some years and high pass rates in others. Grade 7 pass rates fell from 48.7 percent in 2001, to 31.1 percent in 2004, before rising to 70.5 percent in 2007. They declined again, to 39.7 percent in 2009, before increasing to 49.6 percent in 2012. The increase in pass rates in 2009 coincided with the recovery of the economy. According to the MOPSE, the pass rate for 2013 was estimated at 55 percent and that projected for 2015 is 65 percent. Figure 2A.10 shows that Grade 7 pass rates were higher for girls than boys, with a clear difference seen in 2011 and 2012. Gender parity was achieved in 2000 and 2001, while from 2003 onwards, girls had higher Grade 7 pass rates than boys.

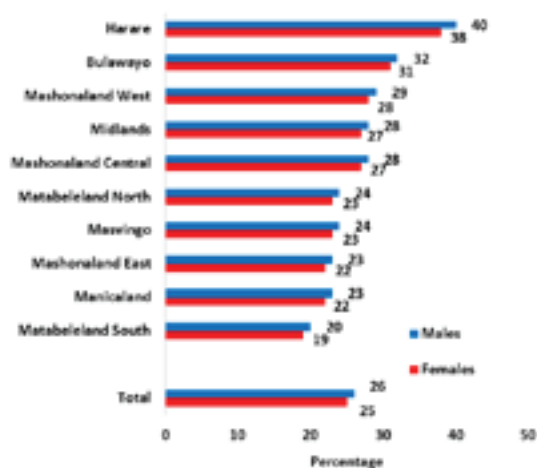
Matabeleland North province recorded the lowest pass rates, with girls at 35.3 percent, and boys at 24.5 percent,

Figure 2A.10 Proportional Grade 7 Pass Rates by Sex, 2000 to 2012



Source: MOPSE

Figure 2A.11 Primary School Pupil-Toilet Ratio, by Sex and Province, 2014



Source: MOPSE

and the second lowest was Matabeleland South, with girls at 40.7 percent and boys at 25.8 percent. Low Grade 7 pass rates in the Matabeleland provinces were, at least in part, a result of the language policy, which compels the use of Ndebele as the main local language in those provinces, even for pupils whose mother tongue is not Ndebele. This affects the comprehension of most concepts by these pupils. An improvement has been noted since 2013, when there was a broader redefinition of vernacular languages in the new Constitution. Girls registered much higher Grade 7 pass rates than boys in all provinces in 2012. The greatest disparities between boys and girls were seen in Matabeleland South and Matabeleland North provinces, and these are reflected in very high GPIs, of 158 and 144, respectively in these two provinces. It has been observed that many boys in this region do not aspire to learn as they are more motivated to pursue economic activities in neighbouring countries.

## EDUCATIONAL FACILITIES

The pupil-classroom ratio (PCR) increased from 31.4 pupils per classroom in 2000 to 45 in 2014. The primary school pupil-toilet ratio for both girls and boys has seen a minor reduction in the past fourteen years, indicating decreased crowding. Specifically, the ratio for girls declined from 26 in 2000, to 25 in 2014, while for boys, it declined from 29 in 2000, to 26 in 2014. This is probably due to an increase in resources available from the UN and international partners, via Government, for water sanitation and hygiene (WASH), including for construction of toilets. The slight increase in the primary pupil to toilet ratio between 2012 and 2013 reflects increased enrolments as pupils return to the education system. Boys had a higher pupil/toilet ratio than girls. There is considerable variation between provinces for the pupil/toilet ratio with Harare and Bulawayo provinces having the lowest ratios, see Figure 2A.11.

More than half of primary schools do not have access to electricity. However, the proportion declined, from 55.6 percent in 2013, to 52.1 percent in 2014. The decline is due to the rural electrification programme. Matabeleland North province had the highest proportion of schools without electricity in 2014, at 67.4 percent, followed by Masvingo, at 65.6 percent, while Harare and Bulawayo had the least, with 0.9 percent and 4.6 percent, respectively, see Figure 2A.12. Among primary schools with access to electricity, the main source between 2013 and 2014 was from the national grid, although the proportion using this source decreased, from 40 percent in 2013, to 37 percent in 2014.

Water is available in most schools, with only 1.2 percent of the primary schools throughout the country reporting no access to any water source. However, the proportion of primary schools with access to safe drinking water was relatively low, at 86.3 percent in 2014, an improvement from its level of 81.9 percent in 2013. Bulawayo and Harare had the highest proportions of schools with access to safe drinking water in 2014, with 98.5 percent and



97.8 percent, respectively, and Midlands had the lowest proportion, at 79.4 percent, see Figure 2A.13. The main sources of water supply for primary school in Harare and Bulawayo provinces is piped water, while for the other eight provinces it is boreholes.

It is believed that ICTs play a crucial role in education and the MOPSE is keen to promote the use of ICTs in schools. The proportion of schools with computers available for pupils remained constant at 12 percent in 2013 and 2014. Harare and Bulawayo, which are predominantly urban provinces, have higher proportions of schools with computers for pupils, at 66.2 percent and 64.4 percent, respectively in 2014, while Matabeleland North province had the lowest proportion of schools with computers for pupils, at 4.8 percent in the same year. The number of pupils per computer across all schools was 169 in 2014, worsening from 51 in 2013, and ranging from 55 pupils per computer in Harare province, to 434 pupils per computer in Masvingo province.

### 4.3 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 2A

#### SUCCESSSES

Gender parity was achieved or maintained across a number of indicators, namely, the NER, literacy rates, primary school completion, Grade 7 pass rates (although girls had overtaken boys by 2003), transition from Grade 7 to Form 1, and OVC school attendance.

Other successes were in the NER, which remained high, peaking at 97.7 percent in 2009, achievement of 99 percent literacy among those aged 15 to 24 years, Grade 7 pass rates being maintained in the normal range, and a significant decline in primary school dropout rates.

In terms of facilities and services, the PBR reached 1:1 for the 4 core primary school subjects, and the proportion of primary school teachers with teacher training remained high at 89 percent in 2014. Practically all primary schools had ECD classes by 2014, although questions remain about the quality of ECD education and enrolment in these classes is low.

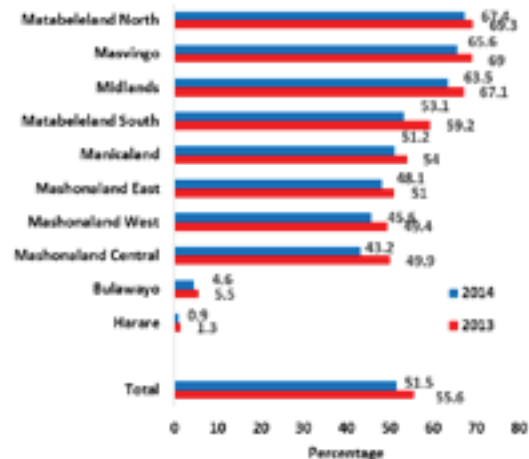
#### SUPPORTIVE ENVIRONMENT

##### Macroeconomic Policy Frameworks

The following are in place in support of improved and equitable educational opportunities and outcomes for Zimbabweans:

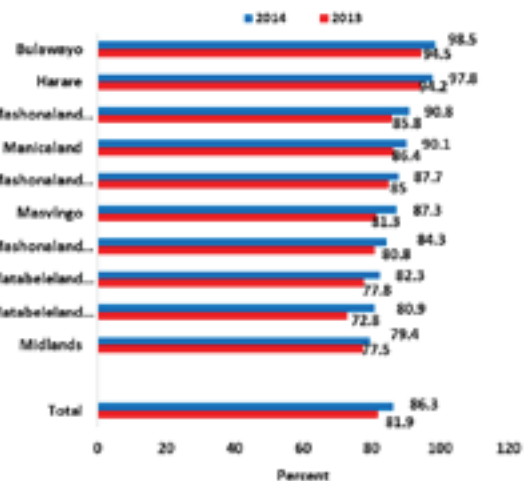
*The Zimbabwe Education Act 2004 [Chapter 25:04]*, recognises the right of all children to education as a prerequisite for poverty eradication, women's

Figure 2A.12 Proportion of Primary Schools Without Access to Electricity by Province, 2013 and 2014



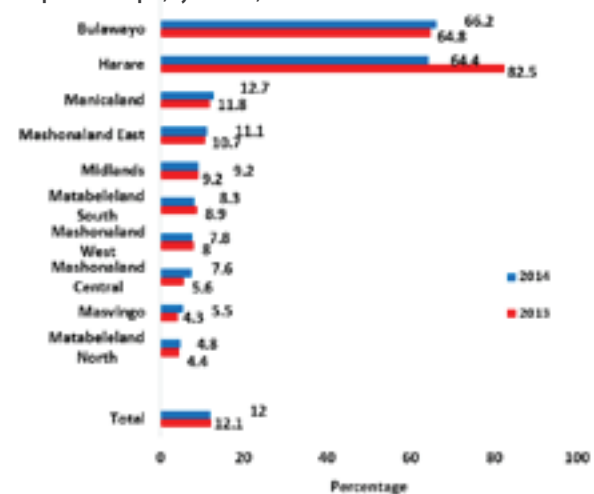
Source: MOPSE

Figure 2A.13 Proportion of Primary Schools with Access to Safe Water, by Province, 2013 and 2014



Source: MOPSE

Figure 2A.14 Proportion of Primary Schools with Computers for Pupils, by Province, 2013 and 2014



Source: MOPSE

empowerment, protection labour and sexual exploitation, promotion of human rights and democracy, environmental protection and informed reproductive choices.

*Education for All (EFA)*, focuses on universal access to primary education as a basic human right.

*Policy Circular P77 of 2006*, calls for children to leave school with at least one skills path way, as a foundation for further training in tertiary institutions.

*Education for All, 1980*, the Independence era recognition of the people as the nation's most important resource, and the links between education and development.

*The Zimbabwe National Strategic Plan for the Education of Girls and OVC 2005-2010*, a GoZ/National AIDS Council/UNICEF programme to empower girls with leadership skills in out-of-school activities.

*The Non-Formal Education Policy, 2015*, aiming to provide children who are not enrolled in school with a complementary basic education through 'alternative school' strategies.

*The Early Childhood Development Policy, 2004*, requiring primary schools to offer a minimum of two ECD classes for children from 3 to 5 years old, and providing complementary diploma level ECD teacher training.

### **Programmes**

In addition, the following initiatives have been undertaken:

*The BEAM, 2001*, an enhanced social protection programme is to reduce the number of OVC dropping out of primary school by providing targeted financial assistance.

*The Education Transition Fund (ETF), 2009*, a multi-donor funding mechanism to bridge the funding gap in the education sector during the transition period, from emergency to recovery.

*The Presidential Commission of Inquiry into Education and Training (1999)*, into the relevance and quality of education, which recommended preparing children for the world of work by equipping them with basic survival, technical and vocational skills.

*The Schools Feeding Programme*, (since 1981) to reduce dropout rates among primary school children.

*The Second Chance Education Programme, 2012*, an accelerated learning programme to help out-of-school children catch up in an integrated package of academic skills, life skills, and case management support.

## **4.4 CHALLENGES IN ACHIEVING TARGET 2A**

Although the education sector consistently received the highest share of the national budget, financing remains a constraint in meeting all of the following challenges:

- Improving the quality and efficiency of education, including improving PTRs, school infrastructure and transition rates, lowering dropout rates and diversifying the curriculum to ensure greater relevance,
- Sustaining the HIV decline and mitigating the educational impacts of HIV, especially for those children orphaned by the epidemic;
- Overcoming low teacher morale and brain drain;
- Keeping up and expanding school feeding

programmes to boost enrolments, minimize dropouts and improve educational performance;

- Improvement of the quality of ECD facilities and encouragement of ECD enrolment;
- Strengthening PPPs in the education sector as a way of financing and maintaining quality education;
- Provision of safe learning environments in schools for children, particularly for girls
- Upgrading satellite schools to fully fledged schools, given the population movements that occurred during land reform.

## **4.5 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGET 2A**

Zimbabwe's experience with MDG2 Target 2A generated the following lessons:

1. Funding of education is inadequate, despite the high budgetary priority the sector is given, implying a need for innovative complementary financing

approaches, such as PPPs and joint ventures.

2. Strengthened and consistent collection of data on education will enhance the MOPSE's capacity to track key indicators.

3. Political will at the highest level, as well as family and community level commitment, have been critical success factors in the implementation of the

Education Goal under the MDGs and will remain so in implementing the SDGs.

## 4.6 THE WAY FORWARD – TOWARDS THE SDGS

Successes in the education sector in terms of enrolment rates, literacy, dropout rates, textbook provision and the achievement of gender parity will need to be consolidated and sustained, while specific and sustainable efforts will be required to:

- Boost completion rates and Grade 7 Pass rates,
- Improve educational outcomes by incentivising teaching to retain trained teachers, and enhanced provision of teaching resources;

- Develop and maintain school infrastructure, especially in farming communities; and
- Increase the quality and utilisation of ECD facilities.

Funding considerations for the MOPSE in tackling a new set of goals include the need to ensure that externally funded programmes are sustainable, and that all funding arrangements are regularised and transparent.



## Chapter 5

# MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

## SUMMARY OF PROGRESS

### Target 3A

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

#### *Primary Education*

Gender parity was achieved in ECD enrolment, primary school enrolment and primary school completion, while girls had Grade 7 pass rates of 56.4 percent in 2012, compared to boys, at 46.7 percent.

#### *Secondary Education (Form 1 to 4)*

Children in secondary school (Form 1 to 4) increased by 11 percent over the MDG period, with 47 percent of the roll being girls in 2000 and 50 percent in 2014.

From 2000 to 2009, there was gender parity or near gender parity in secondary school (Form 1 to 4) NERs, with a GPI of 112 from 2012 to 2014, showing a recent bias in favour of girls.

Nationally, boys had higher Form 4 completion rates than girls, with all GPIs below 100 percent and boys having a completion rate of 66.1 percent in 2014, compared to girls, with 62.3 percent.

Higher proportions of boys than girls who started Form 1, remained in secondary school to reach Form 4, with 87.9 percent of boys and only 84 percent of girls who had started in 2011 still at school by 2014.

Generally, boys performed better than girls at O' Level, with pass rate GPIs below 100 percent, except in 2007, 2008, and 2010, and a 2014.

Higher proportions of girls than boys dropped out of secondary school, with the secondary school dropout GPIs all being well above 100 percent and 2012 registering the

highest GPI of 153 percent.

#### *Secondary Education (Forms 5 and 6)*

During the MDG period, the number of pupils in Forms 5 and 6 increased by 150 percent from 27 398 in 2000, of whom 41.5 percent were girls, to 68 330 in 2014, of whom 43.1 percent were girls.

Higher proportions of boys than girls enrolled in Forms 5 and 6, translating into GPIs of less than 100.

There was gender parity in A' level pass rates in most of the MDG years, with girls performing better than boys in recent years – 2009, 2010, 2013 and 2014.

#### *Literacy*

Literacy rates for those aged 15 to 24 years remained universal around 99 percent, with gender parity, while rates for the entire population above 15 years were around 97 percent, also with gender parity.

#### *Tertiary Education*

The GPI for tertiary education increased from 60 in 2000, to 95 in 2012, with women's enrolment increasing from 10 103 to 50 958 over the same period, a 404 percent increase.

University enrolments increased by 362 percent from 2000 to 2012, with women accounting for the greatest increase, of 576 percent.

Between 2000 and 2012, the share of women in university enrolment increased from 30.1 to 44.1 percent and in

technical colleges from 17.6 percent to 41.4 percent, against an MDG target of 50 percent by 2015.

The share of women in both university and technical college enrolment is above 50 percent in non-Science disciplines but generally low, in subject such as Sciences, Commerce, Law and Engineering.

Women's 155 percent increase in enrolment in primary and secondary teachers' colleges (against an increase for men of 3 percent) left women with a 69 percent share, against an MDG target of 50 percent.

### SUCCESSSES

1. *Literacy (completed at least Grade 3)* – gender parity in the context of universal literacy.
2. *Primary education* – gender parity in NER and completion rates, with higher Grade 7 pass rates for girls than for boys.

3. *Secondary education (Form 1 to 4)* – gender parity achieved in NERs.

4. *Secondary education (Forms 5 and 6)* – an increase in the proportion of girls at this level and gender parity in A<sup>1</sup> level pass rates in most years.

5. *Tertiary education* – marked improvements in gender parity in enrolments in all types of tertiary institute with a 404 percent increase in female enrolment in tertiary education.

### CHALLENGES

1. Elimination of remaining gender disparities in higher and tertiary education, including enrolment of women in 'hard' science subjects and disciplines.
2. Addressing the high dropout rate for girls in secondary school.

## Target 3B

Increase the participation of women in decision-making in all sectors and at all levels (to 40 percent for women in senior civil service positions and to 30 percent for women in Parliament) by 2005, and to 50:50 balance by 2015.

### *Women in Parliament*

Women held 34.9 percent of the seats in National Parliament (lower and upper houses combined), in 2013, up from 9.3 percent in 2000, against a 2015 MDG target of 50 percent.

The Senate reached a 45 percent share of women in 2013, up from 23.2 percent in 2008.

The Lower House saw the women's share increasing from 9.3 percent in 2000, to 31.9 percent in 2013.

### *Civil Service and Judiciary*

The presence of women in top government decision-making positions in key areas such as defence, finance and economic planning, police, and the central bank, is rare.

In the civil service, women are 19.2 percent of Cabinet Ministers, 24.4 percent of Ambassadors, 30 percent of Permanent Secretaries; 25 percent of Principal Directors; 28.2 percent of Directors; and 25 percent of Deputy Directors, against an MDG target of 50 percent.

Women were 34.8 percent of High and Supreme Court Judges, 37.7 percent of Magistrates, 19.6 percent of Public Prosecutors and 58.3 percent of Labour Court Presidents, but the Judge President is a woman.

### *Economy*

Zimbabwe has a Gender Inequality Index (GII) of 0.544, ranking 116th of 146 countries globally in 2012.

Women dominate the 'soft', low paid sectors and occupations, including services, agriculture, education, and clerical work, while men dominate the 'hard', high paid sectors at a rate of 93 percent, in 2012.

Women are over-represented in vulnerable employment, making up 53.6 percent of own account workers and 56.8 percent of unpaid family workers in 2012.

In 2012, only 33.2 percent of all paid employees and 29.4 percent of employers were women.

Of the 1.1 million in non-agricultural work, 34 percent were women, against an MDG target of 50 percent.

Of the 1 131 848 homemakers in the country in 2012, 89.4 percent were women.

### *Agricultural Land*

Under the FTLRP, about 11 percent of the redistributed land went to women in their own right, and women remain under-represented in agricultural land ownership, in all subsectors.

### SUCCESSSES

1. *Women in Parliament* – 45 percent share of women in the Upper House in 2013 and a significant increase in the proportion of women in the Lower House.
2. *Civil service and judiciary* – some progress in the representation of women in the judiciary and 53.6

percent of Commissioners being women from 2013 to 2015.

### CHALLENGES

1. Building political will to follow through on the gender requirements in policies and the Constitution, including domestication and implementation of international gender equality instruments.
2. Mainstreaming gender in all national policies and programmes, including by funding a gender audit.
3. Systematic collection and use of gender disaggregated data in decision-making.

4. Effective implementation of national legislation for reducing gender inequality by providing a legal framework to deal with issues such as domestic violence, inheritance and child marriage.

5. Driving attitudinal change, including through the education of women and girls and their exposure to non-traditional role models.

### LESSON LEARNT

Gender policies and the gender machinery require both political will and adequate funding to ensure gender equitable outcomes in education, the economy and society.

### Target 3A

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

## 5.1 THE SITUATION – TARGET 3A

### *Primary Education*

There was gender parity throughout the MDG period in primary school NER, as well as in the proportion of pupils starting Grade 1 who reached Grade 7 from 2000 to 2005 and near gender parity in 2012. Girls have registered higher Grade 7 Pass Rates generally than boys since 2002 and this was true in all provinces in 2012. More recently, in 2011 and 2012, there were higher proportions of boys than girls dropping out of primary school, in the context of dropout rates increasing from 2002 to 2011, before declining sharply in 2012. Although the overall NER in ECD classes within primary schools was low, gender parity was achieved.

### *Secondary Education (Form 1 to 4)*

During the MDG period children in Forms 1 to 4 increased by 11 percent, with girls making up 47 percent of students at this level in 2000 and 50 percent in 2014. The predominantly rural provinces had higher proportions of girls than boys enrolled in Forms 1 to 4, while the reverse was true in the predominantly urban provinces of Harare and Bulawayo.

Nationally, boys had higher Form 4 Completion Rates than girls throughout the MDG period, with all GPIs below 100 percent, and a higher proportions of boys than girls who started Form 1 remained in secondary school to reach Form 4. Boys generally performed better than girls at O' level, and the transition rates from Form 4 to Form 5 GPIs were nearly all in favour of boys.

Throughout the period under review, higher proportions of girls than boys dropped out of secondary school, with the secondary school dropout rate GPIs all being well above 100 percent, and 2012 registering the highest GPI

of 153 percent. Secondary school dropouts are largely a function of financial constraints but, for girls, they may also be due to pregnancy or early marriage.

### *Secondary Education (Forms 5 and 6)*

The proportion of girls in Forms 5 and 6 increased from 41.5 percent in 2000 to 43.1 percent in 2014 and the GPIs were below 100 for the MDG period. There was gender parity in A' level pass rates in most of the years, with girls performing better than boys in 2009, 2010, 2013 and 2014.

### *Literacy*

During the period under review, literacy rates for those aged 15 to 24 years remained universal around 99 percent period, and those for the entire population aged 15 years have been around 97 percent since 2002, with gender parity in both cases except in 2004. In 2011, for both women and men, literacy rates were lower in rural than in urban areas.

### *Tertiary Education*

The GPI for enrolment in universities, primary and secondary teachers' colleges, technical colleges and industrial training centres increased from 60 in 2000, to 95 in 2012, while women's enrolment across these institutions rose by 404 percent, nearly double the percentage rise in enrolment for men. The proportion of women in university enrolment reached 44.1 percent by 2012, against an MDG target of 50 percent by 2015, but this is unevenly spread across disciplines, with women being under-represented in the 'hard' science subjects, as well as commerce and law. This is likely to have ongoing impacts as these are the subjects that offer the greatest earning potential in the job market.

Women's enrolment in technical colleges and industrial training centres increased by 3 634 percent between 2000 and 2012, more than three times the percentage increase among men. The share of women in these colleges and centres was 41.4 percent in 2012, against an MDG target of 50 percent, with a corresponding positive shift in the GPI. Women are once again over-represented in the so-called 'soft' disciplines and under-represented in the 'hard' (and well paid) disciplines in technical and industrial training.

Against an overall increase in enrolment in primary and secondary teachers' colleges of 76 percent, women experienced an increase of 155 percent, while the increase for men was only 3 percent between 2000 and 2012. The proportion of women students in teachers colleges had increased to 69.9 percent by 2012, against an MDG target of 50 percent by 2015, suggesting that the education sector is becoming increasingly feminised.

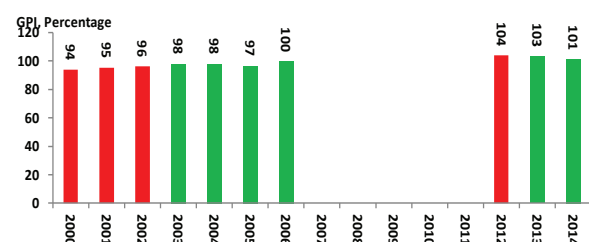
## 5.2 STATUS OF TARGET 3A AND TRENDS

### *Gender Equality in Primary School*

Primary school net enrolment ratio (NER) remained high, at over 90 percent, with gender parity throughout the MDG period, as well as gender parity or near gender parity in the primary school completion rate from 2003

to 2006 and 2012 to 2014 (with data not available for 2007 to 2011), see Figure 3A.1. There was also gender parity in the proportion of pupils starting Grade 1 who reached Grade 7 from 2000 to 2005 and near gender parity in 2012 (with data not available for 2006 to 2010 or 2013 to 2014).

Figure 3A.1 Primary Completion Rate GPI, 2002 to 2014



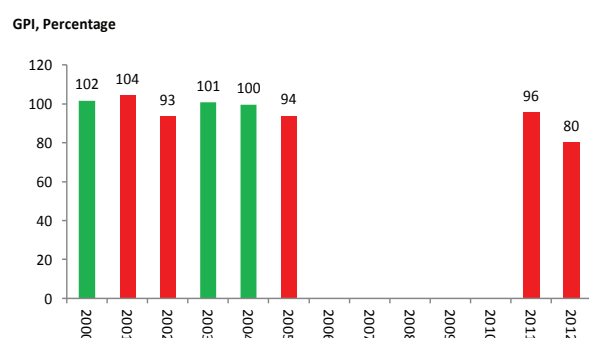
Source: EMIS, MOPSE, 2015

Figure 3A.2 Primary School Grade 7 Pass Rate GPI, 2000 to 2014



Source: EMIS, MOPSE, 2015

Figure 3A.3 Primary School Dropout Rate (average Grade 1 to 6) GPI, 2000 to 2012



Source: EMIS, MOPSE, 2015

Girls have had higher Grade 7 pass rates than boys since 2002, and this applied to all provinces in 2012, see Figure 3A.2. Grade 7 pass rates of 56.4 percent for girls and 46.7 percent for boys in 2012 were in the normal range. There has been gender parity or near gender parity in the transition rate from Grade 7 to Form 1 since 2000 in the context of an overall transition rate increase, from 74.7 percent in 2000, to 77 percent in 2014.

More recently, in 2011 and 2012, there were higher proportions of boys than girls dropping out of primary school, see Figure 3A.3. This is thought to be mainly for financial reasons.

Nationally, in the context of low overall ECD enrolment and attendance, higher proportions of girls than boys attended pre-school, with this pattern being true in all the predominantly rural provinces, while the urban provinces of Harare and Bulawayo had gender parity.

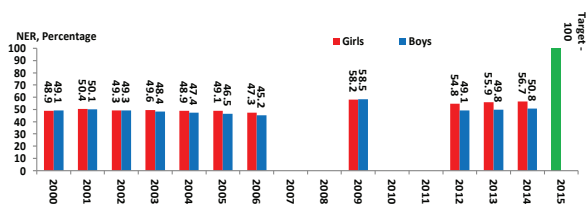
### *Gender Equality in Forms 1 to 4*

According to the MOPSE, during the MDG period children in secondary school (Form 1 to 4) increased by 11 percent, from 817 830 in 2000, of whom 47 percent were girls, to 911 314 in 2014, of whom 50 percent were girls. Since 2012, there have been higher proportions of girls than boys enrolled in Forms 1 to 4, with a NER of 56.7 percent for girls, and 50.8 percent for boys in 2014, see Figure 3A.4. Generally, from 2000 to 2009, there was gender parity or near gender parity in secondary school (Forms 1 to 4), with a GPI of 112 from 2012 to 2014, showing a bias in favour of girls. In 2013, all the predominantly rural provinces had higher proportions of girls than boys enrolled in Forms 1 to 4, while the predominantly urban provinces of Harare and Bulawayo had the reverse.

The secondary school Form 4 completion rate, measured as the children enrolled in Form 4, as a proportion of

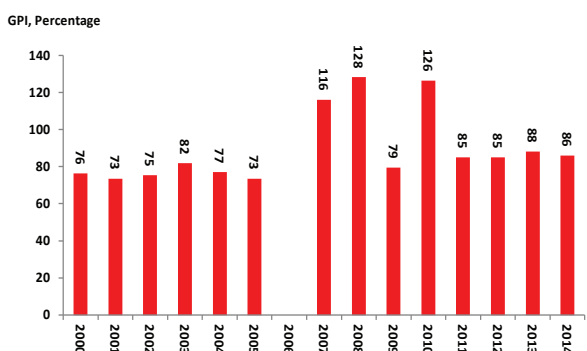


Figure 3A.4 Secondary School (Form 1 to 4) NER, by Sex, 2000 to 2014



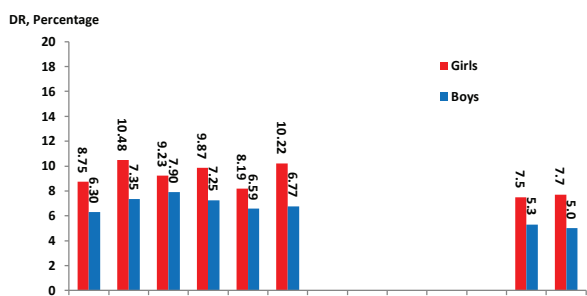
Source: EMIS, MOPSE, 2015

Figure 3A.5 Secondary School (Form 1 to 4) O' Level Pass Rates GPI, 2000 to 2014



Source: EMIS, MOPSE, 2015

Figure 3A.6 Secondary School (Form 5 and 6) NER GPI, 2000 to 2014



Source: EMIS, MOPSE, 2015

the children aged 16 years who should be in Form 4, is higher for boys than for girls during the MDG period, with all GPIs below 100 percent, and boys having a completion rate of 66.1 percent in 2014, compared to girls with 62.3 percent. However, there were variations across the provinces. In 2014, six of the provinces had completion rate GPIs below 100 percent, indicating a bias against girls, while the two Matabeleland provinces and Midlands had a bias against boys, with only Mashonaland East achieving gender parity, Table 3A.1.

Generally, boys performed better than girls at O' level during the MDG period, having a pass rate of 25.5 percent in 2014, compared to girls with 22.1 percent. Thus, O' level pass rate GPIs were all below 100, except in 2007, 2008, and 2010 when they were well above, see Figure 3A.5.

The transition rate from Form 4 to Form 5 steadily improved from 8.4 percent for girls, and 9.2 percent for boys in 2000, to 16.7 percent for girls and 18.1 percent for boys 2014. The transition rate GPIs were all in favour of boys, except those in 2012 and 2013.

Throughout the MDG period, higher proportions of girls than boys dropped out of secondary school, with 7.7 percent of girls dropping out in 2012 compared to 5 percent of boys, see Figure 3A.6. Thus, the secondary school dropout rate GPIs are all well above 100 throughout the period under review, with 2012 registering the highest GPI of 153 percent. Secondary school dropouts are largely due to financial constraints, but for girls they may also be a result of pregnancy or early marriage.

### Gender Equality in Forms 5 and 6

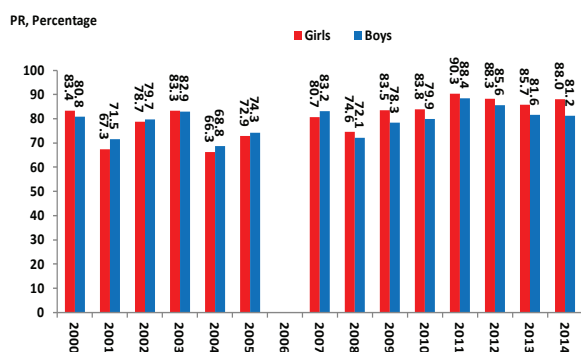
According to the MOPSE, during the MDG period pupils in secondary school (Form 5 to 6) increased by 150 percent from 27 398 in 2000, of whom 41.5 percent were girls to 68 330 in 2014, of whom 43.1 percent were girls.

Throughout the MDG period, there have been higher proportions of boys than girls enrolled in Forms 5 and

Table 3A.1 Total and Proportional and Secondary School (Form 4) Completion Rate, by Province and Sex, 2014

Province	Form 4 Enrolment			Population Aged 16 Years			Completion Rate (%)			GPI
	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total	
Mashonaland East	11 298	12 744	24 042	14 784	16 725	31 509	76.4	76.2	76.3	100
Masvingo	12 870	14 009	26 879	17 830	18 310	36 140	72.2	76.5	74.4	94
Manicaland	14 144	16 652	30 796	20 299	21 719	42 018	69.7	76.7	73.3	91
Midlands	12 359	12 544	24 903	18 037	19 066	37 103	68.5	65.8	67.1	104
Bulawayo	5 666	4 926	10 592	8 817	6 983	15 800	64.3	70.5	67.0	91
Mashonaland West	9 494	11 695	21 189	16 446	17 006	33 452	57.7	68.8	63.3	84
Mashonaland Central	6 833	8 208	15 041	12 018	13 286	25 304	56.9	61.8	59.4	92
Matabeleland South	5 433	4 594	10 027	8 408	9 353	17 761	64.6	49.1	56.5	132
Matabeleland North	5 020	4 387	9 407	8 274	9 121	17 395	60.7	48.1	54.1	126
Harare	10 155	9 909	20 064	24 837	19 270	44 107	40.9	51.4	45.5	80
National	93 272	99 668	192 940	149 751	150 837	300 588	62.3	66.1	64.2	94

**Figure 3A.7 Proportional Secondary School A' Level Pass Rates, by Sex, 2000 to 2014**

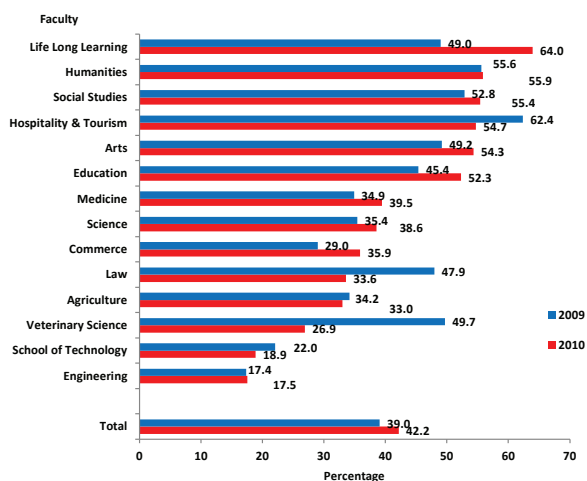


Source: EMIS, MOPSE, 2015

6, with an NER of 7.6 percent for boys and 6.8 percent for girls in 2014, translating into a GPI of less than 100 percent, see Figure 3A.7. In 2014, seven provinces had higher proportions of boys than girls enrolled in Form 5-6, with the three provinces of Matabeleland North, Matabeleland South, and Mashonaland East having a bias against boys.

Relatively high A' level pass rates are partly explained by the fact that the best students at O' level are usually the ones who proceed to Form 5. Thus, in terms of absolute numbers, the performance of girls at A' level can expect to be affected by their lower O' level pass rates and lower rates of transition from Form 4 to Form 5. However, generally, there was gender parity in proportional performance in most of the years, with girls performing better than boys in some recent years, like 2009, 2010, 2013 and 2014, see Figure 3A.8. In 2013, girls performed better in all the provinces, except in Midlands and Masvingo provinces where there was gender parity.

**Figure 3A.8 Proportion of Women in Total University Enrolment, by Faculty, 2009 and 2010**



Source: MHTESTD, 2015

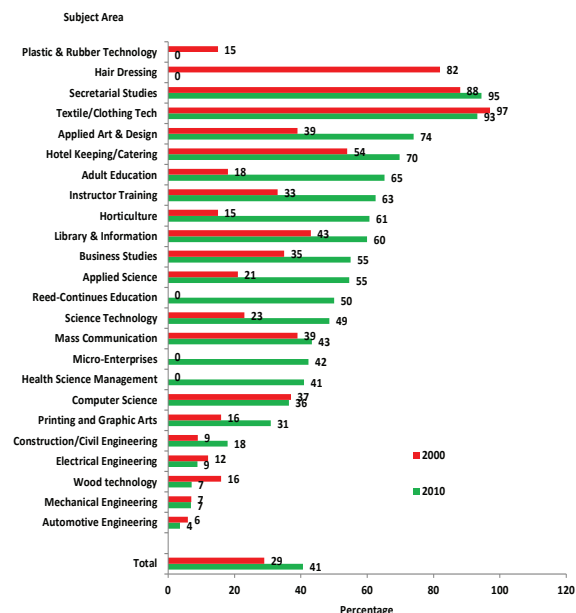
### Literacy

Literacy rates, measured as having completed at least Grade 3, for those aged 15 to 24 years remained universal around 99 percent during the MDG period, implying inevitable gender parity. Similarly, literacy rates remained very high for the population aged 15 years and above at around 97 percent since 2002, with gender parity, except in 2004 when the literacy figure was a little higher for men.

### Gender Equality in Tertiary Education

According to the Ministry of Higher and Tertiary Education, Science and Technology Development (MHTESTD), in the context of tremendous improvement in tertiary education – universities, teachers' colleges, technical colleges and industrial training centres – enrolment, the GPI rose, from 60 percent in 2000, to 95 percent in 2012. Women's enrolment in tertiary education rose from 10 103 to 50 958 during the same period, which was a 404 percent increase, while men's enrolment rose by 218 percent.

**Figure 3A.9 Proportion of Women in Technical College Enrolment, by Subject Area, 2000 and 2010**



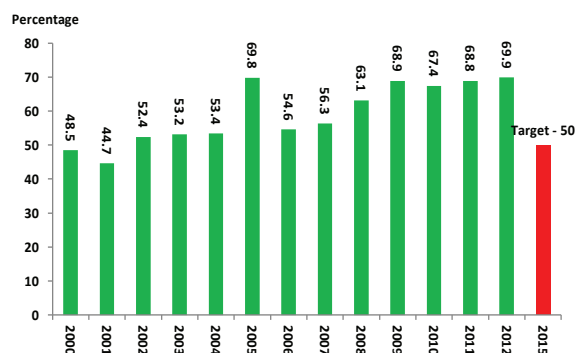
Source: MHTESTD, 2015

University enrolment specifically saw huge increases over this period, with women experiencing the greatest increase, of 576 percent, in university enrolment, from 4 298 students in 2000, to 29 045 in 2012 while men experienced an increase of 269 percent, from 9 960 students in 2000, still ending up with higher student numbers, of 36 776 in 2012. The proportion of women in university enrolment increased, from 30.1 percent in 2000, to 44.1 percent in 2012, against an MDG target of 50 percent by 2015, which is very good progress. Correspondingly, the university enrolment GPI, although still showing a bias against women, improved from 43 percent in 2000, to 79 percent in 2012. However, Figure 3A.9 shows that the proportion of women in university enrolment is highest (above 50 percent) in non-Science disciplines, and generally low in the science disciplines, as well as in commerce and law.

The number of women in technical colleges and industrial training centres has also increased significantly since 2000. Women experienced the greatest share of an overall increase of 1 485 percent, with an increase in enrolment of 3 634 percent, from 205 students in 2000 to 7 654 in 2012. Men's enrolment increased by 1 027 percent, from 961 students in 2000 to 10 828 in 2012. Given these figures, the share of women in technical college and industrial training centre enrolment increased, from 17.6 percent in 2000, to 41.4 percent in 2012, against an MDG target of 50 percent by 2015. Correspondingly, the technical colleges and industrial training centres enrolment GPI, although still showing a bias against women, improved from 21 percent in 2000 to 71 percent in 2012. However, women's participation in the 'hard', science disciplines, such as engineering, in these facilities is also generally low, see Figure 3A.9, a fact that is likely to have ongoing and possibly inter-generational impacts on their earning capacity as these are the best remunerated fields in the job market.

The share of women in primary and secondary teachers colleges has increased significantly since 2000, in the context of an overall enrolment increase from 11 558 students in 2000, to 20 395 in 2012, which is 76 percent increase, see Figure 3A.11. Women experienced the greatest increase, of 155 percent, in enrolment, from

**Figure 3A.10 Proportional Share of Women in Primary and Secondary Teachers College Enrolment, 2000 to 2012**



Source: MHTESTD, 2015

5 600 students in 2000, to 14 259 in 2012, while the increase in men's enrolment was just 3 percent. With this increase, the share of women in primary and secondary teachers college enrolment increased from 48.5 percent in 2000 to 69.9 percent in 2012, against an MDG target of 50 percent by 2015, making education a highly feminised sector, see Figure 3A.11. Correspondingly, the primary and secondary teachers college enrolment GPI, increased from 94 in 2000, to 232 in 2012.

### 5.3 SUCCESSES IN THE IMPLEMENTATION OF TARGET 3A

There were successes in achieving gender equality in education at all levels, as follows:

- *Literacy* – Existing high (near universal) levels were maintained throughout the MDG period, thereby ensuring that gender parity was also maintained;
- *Primary Education* – Gender parity was achieved in terms of NERs, in the context of high NERs overall, as well as in primary school completion rates, while girls achieved somewhat higher pass rates than boys at Grade 7;
- *Secondary School (Form 1 to 4)* – there was gender parity in NERs was established over the MDG period, 2012 when the GPI swung in favour of girls;
- *Secondary School (Forms 5 and 6)* – The proportion of girls in the Form 5 and 6 group rose without quite reaching parity but there was gender parity in A' Level pass rates in most years;
- *Tertiary Education* – increases in women's enrolment in all types of tertiary education were higher than those for men, thereby bringing the NERs closer to gender parity, although this has not yet been achieved.

#### Target 3B

Increase the participation of women in decision-making in all sectors and at all levels (to 40 percent for women in senior civil service positions and to 30 percent for women in Parliament) by 2005, and to 50:50 balance by 2015.

### 5.4 THE SITUATION – TARGET 3B

Despite ratifying and domesticating many international and regional treaties, conventions, protocols and declarations on gender equality and women's

empowerment, Zimbabwe still ranks poorly in gender equality globally, with a high Gender Inequality Index (GII) of 0.544, at number 116 out of 146 countries

globally in 2012. Given adequate resources, the country has the potential to achieve positive gender outcomes but Zimbabwe's gender machinery remains under-resourced from central Government, which militates against its effective impact. Additionally, data on women and their participation in the different sectors of the economy remains inadequate.

### ***Parliament, Government and the Judiciary***

Women's participation in political decision-making as full and equal partners with men, although improving, is not complete, with women holding 34.9 percent of the seats in the National Parliament (lower and upper Houses combined), in 2013, against a 2015 MDG target of 50 percent. Thus, even though women make up half of the electorate and have attained the right to vote and hold public office, they continued to be under-represented at this level. The Upper House of Parliament, or the Senate operates a 'zebra list' system and this resulted in women achieving 45 percent representation in 2013, more than doubling their previous representation level. Women achieved less well in the Lower House of Parliament, with their representation being 31.9 percent in 2013. One explanation for this is the fact that political campaigns are generally expensive and frequently characterised by violence.

In Government, the presence of women in top decision-making positions in key areas, such as defence, finance and economic planning, police, and the central bank, is rare. Despite concerted efforts, the share of women in top decision making positions in the civil service falls far short of gender equality, with women constituting well under half of Cabinet Ministers, Ambassadors, Permanent Secretaries, Principal Directors, Directors and Deputy Directors between 2013 and 2015, against an MDG target of 50 percent. However, 53.6 percent of Commissioners were women over the same period.

In 2009, the share of women among High Court and Supreme Court Judges, Magistrates and Public Prosecutors was also well under half, although the Judge President was a woman and 58.3 percent of Labour Court Presidents were women.

## **5.5 STATUS OF TARGET 3B AND TRENDS**

### **WOMEN IN DECISION MAKING**

Women and men do not participate equally in either political or economic decision making (United Nations, 2013). Even though women turn out in large numbers to vote in political elections, their representation in Parliament remains well below that of men. In Government, they are rarely seen in top decision-making positions and particularly not in the key strategic sectors – defence, finance and economic policy, police, and the central bank. The 2012 Population Census, included two measures of the share of women in decision-making,

### ***The Economy***

The employment-to-population ratio (EPR) for men is consistently higher than that of women, with

34 percent of those employed in non-agricultural work in 2011 being women, against an MDG target of 50 percent. Generally, the growth of non-agricultural sectors represents economic development and hence, those who participate in that growth are more economically empowered than those who do not. Women's economic and social marginalisation is also evidenced by their over-representation in the 'homemaker' category, a role in which they to carry the unpaid burden of social reproduction. Women were under-represented in the student category, nationally, in 2012, with 53.9 percent of all students aged 15 years and above, being men, suggesting that the marginalisation of women in the labour market is likely to continue into the future.

Flowing on from the education trends discussed under target 3B, women and men tend to hold different occupations and have different career opportunities, and hence income levels. Often the occupations taken up by women are those that most easily fit with their social reproductive roles. Women usually dominate the 'soft' and less well remunerated sectors and occupations, including the services industries, the life science professionals, agriculture, education, social work, and clerical and secretarial. Despite their proportional dominance in the agriculture sector, only about 11 percent of the land redistributed under the FTLRP went to women in their own right, while other women gained access to land with their spouses, and women are under-represented in agricultural land ownership in all the different subsectors.

Both paid employment and being an employer are considered economically empowering employment categories but, in 2012, only one-third or less in each of these categories were women.

Additionally, women are over-represented in vulnerable employment (own account worker and unpaid family worker), making up over half the population in each of these categories.

namely Government and Senior Officials (which was 18.8 percent) and Directors/Managers and Company Secretaries (at 31.2 percent).

### ***Women in Parliament***

Zimbabwe held four Parliamentary Elections during the MDG period, in 2000, 2005, 2008 and 2013. The outcomes of these elections showed that, women's participation in political decision making as full and equal partners with men, although improving, has not

yet been achieved. Even though women are half of the electorate, they continue to be under-represented in National Parliament (lower and upper houses combined), holding 34.9 percent of the seats in 2013, against a 2015 MDG target of 50 percent, see Figure 3B.1. In 2000, of the total 150 seats in the National Parliament, only 14 (9.3 percent) were held by women, while in 2005, of the total 216 seats, only 48 (22.2 percent) were held by women, falling to 55 out of 303 seats (18.2 percent) in 2008, but rising again in 2013, when women gained 122 of the total 350 seats (34.9 percent).

The Upper House of Parliament/Senate with its zebra list system of representation reached a 45 percent share of women in 2013, up from 23.2 percent in 2008, showing the effectiveness of the quota system in political decision-making, see Figure 3B.2.

### Women in the Civil Service

The share of women in decision-making positions in the civil service falls far short of gender equality. From 2013 to 2015, as detailed in Table 3B.1, women made up less than a third of Cabinet Ministers, Ambassadors, Permanent Secretaries, Principal Directors, Directors, and Deputy Directors, against an MDG target of 50 percent. The only decision-making level in which women were strongly represented (at 53.6 percent) was that of Commissioner.

During the same period, of the 1 644 Councillors in local authorities, 323 (19.7 percent) were women; of the 100 Chief Executive Officers of Parastatals/State Enterprises, 23 were women; and three of the eleven (27.3 percent) Vice Chancellors of State Universities were women.

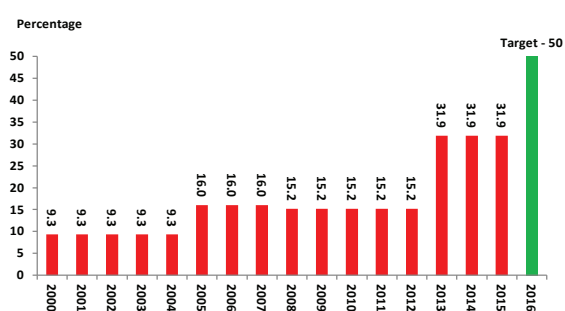
### Women in the Judiciary

In 2009, the share of women among High Court and Supreme Court Judges was 34.8 percent, among Magistrates, 37.7 percent, and among Public Prosecutors, 19.6 percent. Women were 58.3 percent of Labour Court Presidents, and there is one Judge President who was a woman from 2006 to 2009 and a man prior to that. Table 3B.2 shows that there has been an overall decline in the proportional share of women in most of these roles since 2000.

## WOMEN IN THE ECONOMY

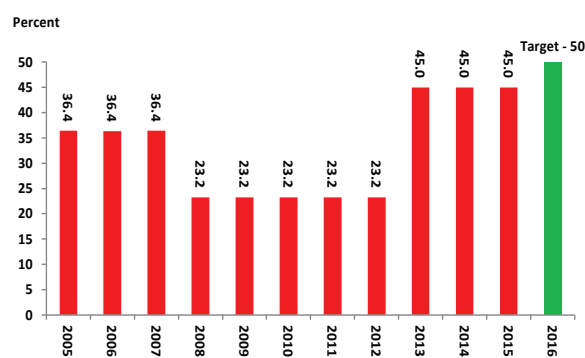
Despite the ratification and domestication of many international and regional treaties, conventions, protocols and declarations on gender equality and women empowerment, Zimbabwe still ranks poorly in gender equality globally. Zimbabwe had a high Gender Inequality Index (GII) of 0.544, placing the country at 116 out of 146 countries globally in 2012. This indicates generally low status and marginalisation of women with respect to reproductive health, empowerment, access, control and ownership of economic resources and economic opportunities, and participation in decision-making, in comparison to their male counterparts. There is a lack of

Figure 3B.1 Proportional Share of Women in the Lower House of Parliament, 2005 to 2015



Source: Parliament of Zimbabwe, 2015

Figure 3B.2 Proportional Share of Women in the Upper House/Senate, 2000 to 2015



Source: Parliament of Zimbabwe, 2015

Table 3B.1 Proportional Share of Women in Decision-Making Positions in the Civil Service, 2009 to 2015

Share of Women among...	2009	2010	2012	2013	2014	2015 Target
Cabinet Ministers	14.0	13.6	14.6	14.6	19.2	50
Deputy Ministers	15.0	10.0	9.1	12.5	16.7	50
Governors	23.5	23.5	23.5	23.5	-	50
Ambassadors	10.0	10.0	11.1	11.1	24.4	50
Commissioners	44.4	44.4	39.1	39.1	53.6	50
Permanent Secretaries	26.2	26.2	26.2	28.2	30.0	50
Principal Directors	18.9	20.9	25.6	25.6	25.0	50
Directors	27.9	27.5	29.2	28.0	28.2	50
Deputy Directors	24.0	24.0	23.5	24.7	25.0	50

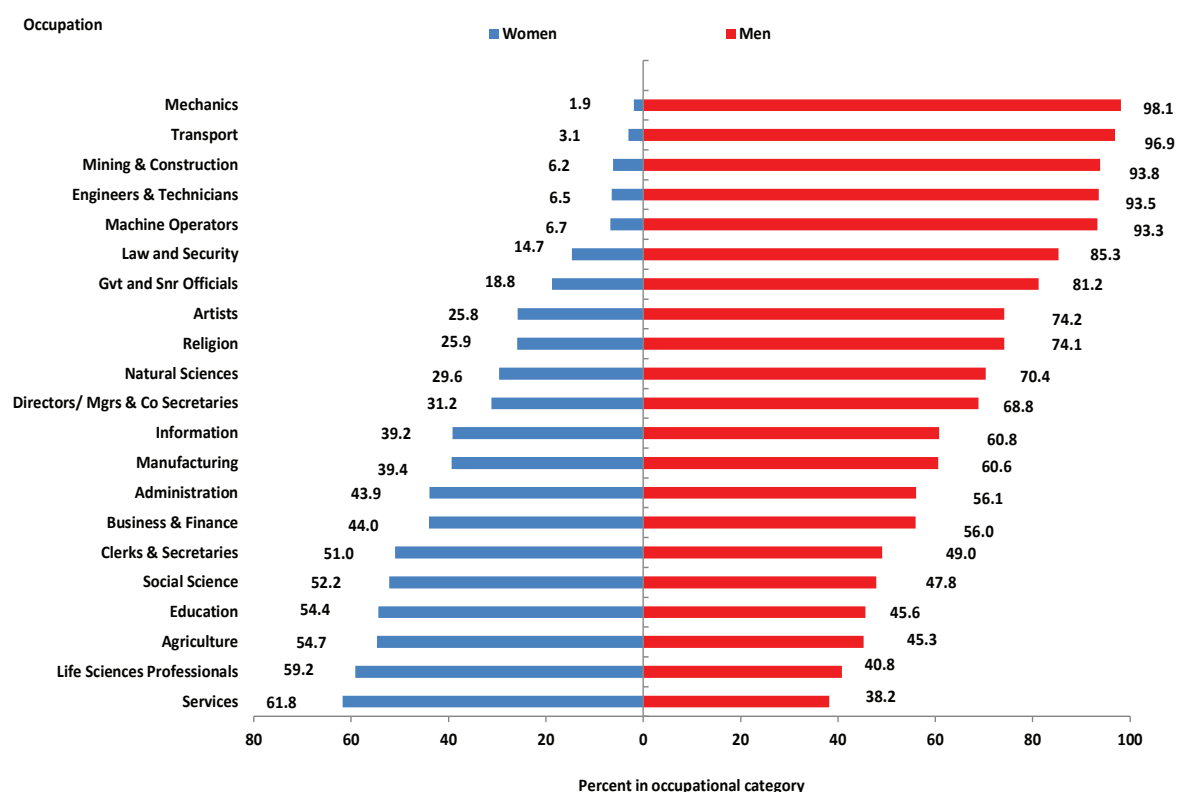
Source: MWAGCD, 2015

Table 3B.2 Proportional Share of Women in Decision-Making Positions in the Judiciary, 2000 to 2009

Share of Women among...	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
High/Supreme Court Judges	-	26.1	33.3	36.4	36.4	36.4	34.8	34.8	34.8	34.8
Administrative Court Presidents	-	66.7	85.7	83.3	83.3	80.0	50.0	50.0	50.0	50.0
Labour Court Presidents	-	75.0	75.0	75.0	60.0	45.5	46.2	50.0	50.0	58.3
Magistrates	-	28.2	28.2	35.6	33.9	36.4	41.3	44.1	40.1	37.7
Public Prosecutors	23.3	-	-	-	-	-	-	21.2	21.0	19.6

Source: Public Service Commission, 2010

Figure 3B.3 Occupational Classification, by Sex, 2012



Source: ZIMSTAT, 2012 Population Census

data available on women and their participation in the different sectors of the economy.

### Women and Employment

In 2012, the usual employment-to-population ratio for men was higher than that of women in all provinces. As a result of the different subjects or disciplines that women and men tend towards during secondary and tertiary education, they gravitate towards one or another group of careers. As noted, women are likely to end up in the 'soft' sectors and occupations – services, life sciences, agriculture, education, social work, and clerical and secretarial – in line with their training and also their social reproductive duties. At least 51 percent of employed women were in these sectors in 2012. Men, on the other hand constitute at least 93 percent of employed people in occupations in the 'hard' science sectors, and are equally over-represented in senior positions within these sectors, see Figure 3B.3. These different groups of occupations offer differential opportunities in terms of

career opportunities and, in particular, potential income, resulting in men generally being better paid than women.

Women are over-represented in vulnerable employment, as own account workers and unpaid family worker categories. In 2012, nationally, women constituted 53.6 percent of all the own account workers and 56.8 percent of all the unpaid family workers. Women also dominated the own account worker and unpaid family worker categories in all provinces in 2012.

Paid employment and being an employer are considered economically empowering employment categories but nationally, in 2012, only 33.2 percent of all paid employees were women, while 29.4 percent of employers were women. This under-representation of women in paid employment was true in all provinces.

### Women and Economic Inactivity

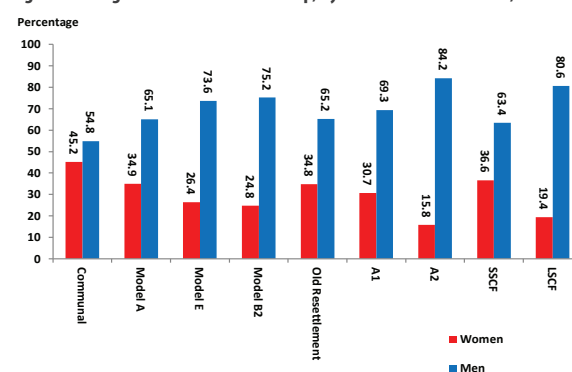
The economically inactive population is divided into

homemakers, students, retired persons/sick/too old, and others. The gender issue of concern is that women are usually over-represented in the homemaker category, at 89.4 percent in 2012, reflecting their unpaid social reproduction roles and, hence their overall economic marginalisation. This is the case across all provinces. The fact that, when that same work is done by a paid domestic worker, it is classified as an economic activity and recognised in the System of National Accounts raises serious classification and analytical problems (United Nations, 2013). Furthermore, women are under-represented in the student category within which people become empowered through education to enter the higher ranks of the labour market, with 53.9 percent of all students in 2012 being men.

### Women in Agriculture

Although women produce 80 percent of the country's food, contribute 50 percent of agricultural labour, and are the day-to-day farmers, particularly, in communal areas, they are seriously disadvantaged in terms of agricultural land ownership. Overall under the FTLRP of 2000 onwards, about 11 percent of the redistributed land went to women in their own right, while other women gained access to land with their spouses. Figure 3B.4 shows that, in 2010, women were under-represented in agricultural land ownership, in all the different subsectors, that is, A1 (30.7 percent), A2 (15.8 percent), old resettlement (34.8 percent), and communal (45.2 percent).

Figure 3B.4 Agricultural Land Ownership, by Sex of Household Head, 2010



Source: ZIMSTAT, ALS

### Women in Employment in the Non-Agricultural Sector

Generally, the growth of non-agricultural sectors represents economic development and therefore individual economic empowerment is, to some extent, a function of engagement in these sectors. According to the Labour Force and Child Labour Survey (LFCLS), of the 4.5 million employed persons in 2011, 1.1 million were in paid employment in the non-agricultural sector, of whom 34 percent were women, against an MDG target of 50 percent. This proportion has remained fairly constant over the years.

## 5.6 SUCCESSES IN THE IMPLEMENTATION OF TARGET 3B

Some successes were recorded in women's participation in decision-making, as follows:

- *Women in Parliament* – the Senate with its zebra list attained 45 percent share of women in 2013, while the proportional share of women trebled, from 9.3 percent in 2000, to 31.9 percent in 2013;
- *Civil Service* – Between 2013 and 2015, 53.6 percent of Commissioners and 30 percent of Permanent Secretaries were women during 2013-2015;
- *Judiciary* – There was some progress, with a woman

Judge President, and 58.3 percent of Labour Court Presidents, 34.8 percent of High and Supreme Court Judges and 37.7 percent of Magistrates being women in 2009.

Although a commendable effort has been made in ratifying and domesticating a number of international and regional women's rights and empowerment instruments, there has been no notable success in women's economic empowerment. Despite their contribution to agriculture as workers and producers, women have little access to the means of agricultural production, particularly land.

## 5.7 THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGETS 3A AND 3B

As a member of the United Nations, Zimbabwe specifically subscribes to the following as part of the global response to the gender inequality challenge (along with other general human rights instruments, such as the Universal Declaration of Human Rights (UDHR), 1948:

- The United Nations Global Conference on Women, Mexico, 1975;
- The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), 1979;

- The Equal Remuneration Convention, 1951 (C100);
- The Convention on Prohibition of Discrimination in Occupations, 1958 (C111); and
- The Fourth World Conference on Women held in Beijing, China, and Beijing Platform for Action, 1995.

In addition, as a member of the African Union (AU), the Southern African Development Community (SADC), and the Common Market for Eastern and Southern Africa (COMESA), Zimbabwe is a party to the following regional instruments:

- The Nairobi Forward Looking Strategies Plan of Action, 1985;
- The AU Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (Maputo Protocol), 2003;
- The Kampala Declaration to Prevent Gender-Based Violence in Africa, 2003;
- The 2004 Solemn Declaration on Gender and Equality in Africa;
- The AU Gender Policy, 2008;
- The SADC Declaration on Gender and Development, 1997, Protocol on Gender and Development, 2008, and Gender Policy, 2008; and
- The COMESA Gender Policy, 2002.

Following independence in 1980, Zimbabwe's response to the challenge of gender inequality started with the enactment of the Legal Age of Majority Act (LAMA), 1982. This was complemented by other pieces of legislation dealing with Matrimonial Causes (1985), Customary Law (1981) Family Maintenance (1987), and Equal Pay (1980).

The Zimbabwe Constitution, 2013, is widely acknowledged for its firm commitment to gender equality, including, the establishment of a Gender

Commission, which is now in place. The country has in place a National Gender Policy, (2013-2017) whose overall goal is to eradicate gender discrimination and inequalities in all spheres of life and development. Zimbabwe's National Gender Machinery, the Ministry of Women Affairs, Gender and Community Development, (MWAGCD), coordinates and implements programmes and projects aimed at advancing gender equality and the rights of women. The Inter-Ministerial Committee on Gender consists of gender focal persons, at Director level, so that they are able to influence policy.

Other policy and programme initiatives put in place during the MDG period to support gender equality and women's empowerment include:

- The BEAM, under which 50 percent of beneficiaries are girls attending primary to secondary school;
- The National Action Plan for Women and Girls to reduce vulnerability to HIV and AIDS;
- The National Gender-Based Violence (GBV) Strategy (2010-2015);
- The 2004 Public Sector Gender Policy;
- The Affirmative Action Policy for tertiary education;
- Financing windows for women and youth to obtain loans for empowerment programmes;
- The Gender-Responsive Economic Policy Management initiative, 2011;
- The Broad-Based Women's Economic Empowerment Framework of 2012;
- The appointment of a woman Vice President who took office for a decade.

After ratifying CEDAW in 1991, Zimbabwe enacted further constitutional amendments and legislation, including the Domestic Violence Act, 2007. In reality, however, gender sensitive legislation exists side by side with widespread gender discrimination.

## 5.8 CHALLENGES IN ACHIEVING TARGETS 3A AND 3B

Given the conducive institutional and legislative setting, the major challenge is to build the political will to follow through on the gender requirements in national policies and the Constitution, as well as domestication and effective implementation of regional and international gender commitments.

Related challenges are to:

- Adequately fund the MWAGCD as the driver of the gender mainstreaming agenda, and ensure gender mainstreaming in all national policies and programmes;



- Improve coordination of the gender management system – Ministry, focal points, Parliamentary Portfolio Committee, Parliamentary Women’s Caucus, and Inter-Ministerial Committee;
- Facilitate and encourage attitudinal change among women to enable them to break out of culturally stereotyped roles;
- Eliminate cultural practices and norms that constrain women’s rights and limit their opportunities;
- Overcome gender disparity in higher and tertiary education;
- Support women, including financially to take their place in a competitive political system;
- Bring males on board in the fight for gender equality; and
- Enhanced generation and utilisation of gender disaggregated data in decision-making.

## 5.9 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGETS 3A AND 3B

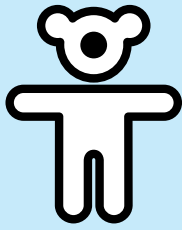
Zimbabwe’s experience with MDG3 Targets 3A and 3B generated the following lessons:

1. Having a gender policy does not guarantee that gender mainstreaming will be implemented, in the absence of political will, adequate financing and gender disaggregated data to support effective decision-making.
2. It is necessary to scale up efforts to consolidate current successes towards gender parity in education, particularly to ensure that educational choices do not constrain women’s livelihood opportunities in the future.

## THE WAY FORWARD – TOWARDS THE SDGS

Future targets need to be comprehensive, to direct development efforts towards the immediate factors in gender equitable development, such as educational and economic opportunities, as well as the underlying cultural and social factors that constrain women’s full realisation of their development rights.

The need for enhanced generation of gender disaggregated data has been emphasised. This needs to take place across all sectors and the outputs utilised in policy and decision making at all levels, in all sectors.



## Chapter 6

# MDG 4: REDUCE CHILD MORTALITY

## SUMMARY OF PROGRESS

### Target 4A

Reduce by two-thirds, between 2000 and 2015, the under-5 mortality rate.

Health budget allocation was 8.2 percent in 2014, below the 15 percent Abuja target, and has fluctuated between 7 percent and 9.8 percent since the inception of the multi-currency economy in 2009.

The number of doctors increased, from 667 in 2007 to 1 122 in 2013, an improvement from 0.0546/1 000 population in 2007 to 0.081/1 000 population in 2012.

The number of nurses increased from 14 768 in 2007 to 18 677 in 2013, an improvement from 1.2080/1 000 population in 2007, to 1.189/1 000 population in 2012.

Under-5 mortality remained at 75 deaths per 1 000 live births in 2014, more than double the MDG target of 34 deaths per 1 000 live births.

Under-5 mortality is higher in rural areas by 12 deaths per 1 000 births than urban areas, and higher among boys than among girls.

Infant mortality declined but remains at 55 deaths per 1 000 live births, more than double the MDG target of 22 deaths per 1 000 live births, and highest in rural areas and among boys.

Neonatal mortality was 29 deaths per 1 000 live births in 1999 and 2014, increasing to 31 deaths in 2010/11, and was higher among boys than girls and higher in rural than urban areas.

Vaccinations against measles among children aged 12 to 23 months increased, while the proportion with no vaccinations declining to a low of 4.5 percent.

The proportion of children undernourished declined during the economy recovery from 2009 to 2015.

Underweight among under-5s was moderate at 11.2 percent in 2014, following an increase during the crisis period.

Stunting among under-5s declined from 36 percent in 2005/06 to 28 percent in 2014, following an increase during the economic crisis from 2000.

Children under six months who were exclusively breastfed increased from 26 percent in 1999 to 41 percent in 2014.

### SUCCESSSES

- Progress was registered in the indicators of child mortality – under-5 mortality down from 120 deaths per 1 000 live births in 1999 to 75; infant mortality rate down from 65 deaths per 1 000 live births to 55.
- Vaccination against measles, increased from 71 percent in 1999 to 83 percent in 2014.
- Stunting among children under 5 years of age declined from 36 percent in 2005/06 to 28 percent in 2014, whilst underweight remained moderate at 11 percent in 2014.
- Exclusive breast feeding for children for the first six months increased from 26 percent in 2009 to 41 percent in 2014.

### CHALLENGES

- Meeting the Abuja recommendation of 15 percent of national budget allocation to the health sector, in the context of an expanding budget, and ensuring timely disbursement of resources.
- Continuing efforts to combat HIV, particularly to avoid mother-to-child transmission.
- Prioritisation of the nutrition and other needs of children in the context of overall economic stabilisation and growth that is also responsive to and prepared for potential disasters such as drought.

- Strengthening the health delivery system in terms of human resources and career opportunities in health, and availability of drugs and equipment.
- Addressing water and sanitation needs in all parts of the country to avoid further disease outbreaks.
- Continued and enhanced protection of orphaned children.
- Addressing sociocultural factors that affect children negatively, such as resistance to immunisation and modern drugs among some religious groups.
- Ensuring that under-5 are attended for free in public

health institutions, in line with current policy.

#### LESSONS LEARNT

While political will is needed to ensure that child health and survival is prioritised in national budgeting (in line with the Abuja Target), more funding is needed, through an increase in the size of the overall national budget and/or dedicated resource mobilisation by Government and international partners.

Policies and initiatives that have had positive impacts, such as free treatment for under-5s and prevention of mother-to-child-transmission of HIV, need to be continued and expanded.

#### Target 4A

Reduce by two-thirds, between 2000 and 2015, the under-5 mortality rate.

## 6.1 THE SITUATION – TARGET 4A

Although the Abuja target for health budget allocation is 15 percent, Zimbabwe's allocation has not been above 10 percent during the MDG period and was sometimes considerably lower than this. Nevertheless, some improvements have been recorded over the period, including increases in the number and density of both doctors and nurses

Likewise, the MDG target to reduce under-5 mortality by two-thirds, between 2000 and 2015 was not achieved, although all indicators showed some progress, despite the severe economic recession from 2000 to 2008.

Both under-5 mortality and infant mortality are higher in rural than in urban areas, and higher among boys than among girls by a factor of around 1.1 in each case. Overall under-5 mortality declined dramatically to 75 deaths per 1 000 live births by 2014, against an MDG target of 34 deaths per 1 000 live births, while the infant mortality rate (IMR) declined consistently as well. At the same time, neonatal mortality fluctuated but was unchanged overall 1999 and 2014. Neonatal mortality is also higher among boys than among girls.

The proportion of children aged 12 to 23 months vaccinated against measles by 12 months of age increased to 82.6 percent by 2014, while those with no vaccinations declined to one-fifth of its 2006 level by 2014.

There was a marginal increase in the proportion of under-5 children who were moderately or severely underweight (below -2SD). According to the Multiple Indicator Cluster Survey (MICS) of 2014, for all years, boys were more likely than girls to be moderately or severely underweight, and those from rural areas were more likely to be moderately or severely underweight

than urban children. Moderate or severe stunting was also higher among boys than among girls but declined for both girls and boys over the period under review.

Health seeking behaviours rose, with the proportion of children aged 0 to 59 months with episodes of diarrhoea for whom advice or treatment was sought from a health facility or provider increasing from by about one-third between 2009 and 2014. Advice was sought from a health facility or provider for nearly a third of children aged 0 to 59 months with Acute Respiratory Infection (ARI) symptoms in 2014, while the percentage of those with episodes of fever for whom advice or treatment was sought had increased markedly by 2014. The majority who received advice or treatment from a health facility or provider were given antibiotics in 2014.

In the context of the Ministry of Health and Child Care's promotion of exclusive breastfeeding within the first six months of life to reduce child mortality and malnutrition, the proportion of children under 6 months who were exclusively breastfed increased, the proportion of last-live born children who were born in the previous two years who were ever breastfed remained high, and the median duration of exclusive breastfeeding was two months for all infants and children. Infants from rural areas were more likely to have ever been breastfed than those from urban areas and, although exclusive breastfeeding increased in both rural and urban areas, infants and young children from rural areas were breastfed for longer than those from urban areas.

## 6.2 STATUS OF TARGET 4A AND TRENDS

### Health Care Financing

The government is the major financier of the public health sector, with taxation being the main source of income, but it has not met the Abuja target of an allocation of 15 percent of the national budget. The Health budget allocation has fluctuated since the introduction of a multi-currency economy in 2009 from 8.7 percent in 2009, to 7 percent in 2010, 9.3 percent in 2011, 8.2 percent in 2012, 9.8 percent in 2013, and 8.2 percent in 2014.<sup>1</sup> In 2010, a total of US\$1 173 billion was spent on health. Public health funds are sourced by central Government, municipalities and other public funds, while private funds are sourced by the private corporate sector, non-profit organisations and the international funding partners. The low MOHCC budget means that individuals (through fees) make a substantial contribution to health funding.

<sup>1</sup> Human Resources for Health Country Profile 2013, Health Service Board and MOHCW, 2014.

### Human Resources

The number of public health workers increased by 19 percent, from 25 251 in 2007 to 31 347 in 2013, see Table 4A.1. This was made up of a rise in the number of doctors, by 68 percent, from 667 in 2007 to 1 122 in 2013, and a 26 percent rise in the number of nurses, from 14 768 in 2007 to 18 677 in 2013. This is reflected in an improvement in the density of doctors, from 0.05/1 000 population in 2007 to 0.08/1 000 population in 2012, while the density of nurses remained constant, at about 1.2/1 000 population in 2007 and 2012. The vacancy rate remained high, above 50 percent, in some critical health occupation categories, including radiography and orthopaedic, at 50 percent each, research officers, at 44 percent, pharmacists, at 34 percent, and doctors, 37 percent. The least problematic category is nurse, although there is a vacancy rating of 10 percent even in this category (MOHCC Staff Returns, 2013). However, this is against a background of general staff increases, from 27

Table 4A.1 Health Workers and Health Worker-Population Ratios, National Level, 2007 to 2013

Category	2007		2008		2009		2012		2013
	Total	/1 000	Total	/1 000	Total	/1 000	Total	/1 000	Total
Doctors	667	0.0546	738	0.0598	827	0.0669	1 000	0.0810	1 122
Nurses	14 768	1.2080	13 699	1.1095	16 668	1.3490	16 458	1.1890	18 677
Environmental health	1 220	0.0998	1 157	0.0937	1 141	0.0923	1 758	0.1460	1 902
Pharmacy	318	0.0260	332	0.0269	363	0.0310	443	0.0290	391
Radiography	154	0.0126	261	0.0211	251	0.0203	239	0.0180	237
Radiation protection	0	0	0	0	0	0	0	0	0
Physiotherapy	355	0.0290	368	0.0298	336	0.0272	374	0.0029	422
Nutrition	761	0.0622	787	0.0637	774	0.0626	839	0.0650	843
Orthopaedics	33	0.0027	35	0.0028	41	0.0033	28	0.0020	26
Oral Health	192	0.0157	181	0.0147	182	0.0147	255	0.0180	236
Laboratory and pathology	320	0.0262	317	0.0257	274	0.0222	349	0.0270	341
Research officers	21	0.0017	36	0.0029	33	0.0027	23	0.0020	14
Traditional medicine	0	0	0	0	0	0	1	0	2
Health information	100	0.0082	145	0.0117	157	0.0127	158	0.0120	132
Health promotion and PR	42	0.0034	38	0.0031	33	0.0027	51	0.0040	55
Hospital equipment	72	0.0059	85	0.0069	87	0.0070	108	0.0070	87
Administration general	6 207	0.5077	5 879	0.4761	6 606	0.5346	6 925	0.5120	6 749
Programme management	8	0.0007	9	0.0007	8	0.0006	41	0.0050	64
Top management	13	0.0011	16	0.0013	42	0.0034	42	0.0030	47
TOTAL	25 251	2.0655	24 083	1.9505	27 840	2.2532	29 092	2.1229	31 347

840 in 2009, to 31 347 in 2013 (not including mission hospitals).<sup>2</sup>

### Child Mortality

Child mortality is measured by age group. Mortality<sup>3</sup> for children is measured according to the neonatal mortality rate (NMR), post-neonatal mortality rate, infant mortality rate (IMR), child mortality rate and under-5 mortality rate.

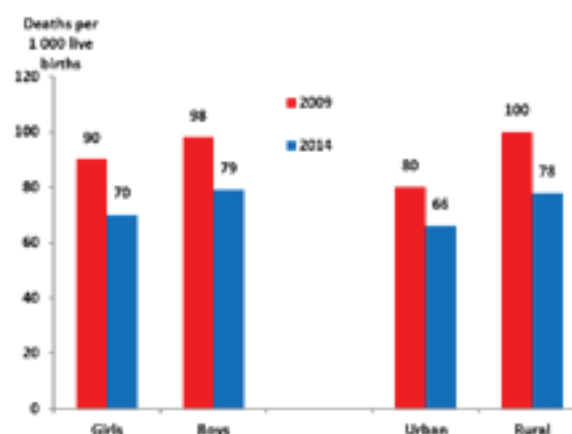
The leading causes of under-5<sup>4</sup> mortality in Zimbabwe are neonatal, mainly pre-term birth complications, birth asphyxia and sepsis, congenital anomalies and diarrhoeal conditions, contributing 34 percent of all child deaths (WHO Child Health Epidemiology Reference Group, 2012, MOHCW 2007). The other major causes include acute respiratory infections (ARIs), pneumonia, diarrhoea, measles, malnutrition, HIV-related conditions, malaria and skin disease. Underlying determinants of child mortality include the child's HIV and nutritional status, access to and functioning of the health system, family, household and community care practices, and availability of preventative services including immunisations, and safe sanitation and hygiene education. Malnutrition is an underlying factor in most of the deaths (GoZ, 2010) and it has been established that most of these deaths could be prevented through simple, cost-effective interventions (MICs, 2014). Although mortality rates for children have remained high, they have declined since 2000, despite the economic challenges that the country has gone through. Boys had higher mortality rates than girls and rural areas were worse off than urban areas throughout the reporting period. Mortality rates for children in the five years preceding the 2014 MICS were as follows: NMR of 29 deaths per 1 000 live births; post-neonatal mortality of 25 deaths per 1 000 live births; an IMR of 55 deaths per 1 000 live births; child mortality at 21 deaths per 1 000 children surviving to the first birthday; and an under-5 mortality rate of 75 deaths per 1 000 live births.

The under-5 mortality rate has generally improved, declining from 102 deaths per 1 000 live births in 1999, to 75 deaths in 2014. However, the rate has fluctuated in between, firstly declining to 82 deaths per 1 000 live births in 2005/06, and later increasing to 94 deaths in 2009, before declining again to 84 deaths per 1 000 live births in 2010/11, and to 75 deaths per 1 000 live birth in 2014. The overall decline is still far from achievement of the MDG target of 34 deaths per 1 000 live births by year 2015. Inevitably, one of the impacts of the HIV epidemic has been increased under-5 mortality, while the increase to a high of 94 deaths per 1 000 live births in 2009 was largely due to the economic crisis that was at its worst in

<sup>2</sup> *Ibid.*  
<sup>3</sup> Mortality for all age groups refers to death in the five years preceding the survey.

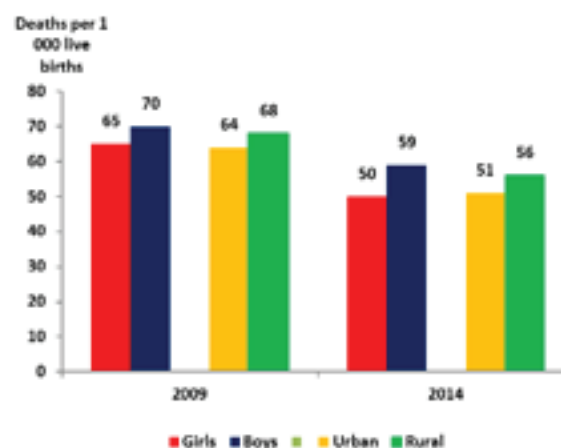
<sup>4</sup> Neonatal mortality - the probability of dying within the first month of life; Post-neonatal mortality - the difference between infant and neonatal mortality; Infant mortality - the probability of dying between birth and the first birthday; Child mortality - the probability of dying between age 1 and the fifth birthday; Under-5 mortality - the probability of dying between birth and the fifth birthday.

Figure 4A.1 Under-5 Mortality Rate, by Sex and Place of Residence, 2009 and 2014



Source: ZIMSTAT - ZDHS, MIMS, MICS

Figure 4A.2 Infant Mortality Rate, by Sex and Place of Residence, 2009 to 2014



Source: ZIMSTAT - ZDHS, MIMS, MICS

2008, in which year there was a GDP growth figure of -4.7 percent.

In the five years preceding the 2014 MICS, the under-5 mortality rate was higher among boys, at 79 deaths per 1 000 live births, than among girls, with 70 deaths per 1 000 live births. Under-5 mortality was higher in rural areas, with 78 deaths per 1 000 live births, than in urban areas, at 66 deaths per 1 000 live births, in the same year, see Figure 4A.1.

The IMR was 55 deaths per 1 000 live births in 2014. For the five years preceding the Zimbabwe Demographic and Health Survey (ZDHSs), IMR improved from 65 deaths per 1 000 live births in 1999, to 60 deaths per 1 000 live births in 2005/06, then to 57 deaths per 1 000 live births in 2010/11, Figure 4A.2. As such, Zimbabwe is far from achieving the MDG target of 22 per 1 000 by 2015. The IMR is higher for boys, at 59 deaths per 1 000 live births, than for girls, at 50 deaths per 1 000 live births.

In 2014, the neonatal mortality rate was 29 deaths per 1 000 live births, having maintained this level since 1999,

although with a decline to 24 deaths per 1 000 live births in 1999, and an increase to 31 deaths in 2010/11. The MOHCC's concerted efforts to reduce neonatal deaths by improving services to manage expectant mothers, difficult labour, neonatal infections, congenital problems and premature deaths, appear to have had little impact at this point. Neonatal mortality is also higher among boys, at 32 deaths per 1 000 live births, than among girls, at 26 deaths per 1 000 live births.

### Vaccinations

The percentage of children aged 12 to 23 months vaccinated against measles by 12 months of age generally improved, from 71 percent in 1999, to 83 percent in 2014, see Figure 4A.3. However, a decline in vaccination was registered between 1999 and 2006, when the economy was at its worst, from 77 percent to 69 percent, respectively. Despite these improvements, the MDG target of 90 percent was not met. Vaccination coverage rebounded after the dollarisation of the economy in 2009, and the proportion of children aged 12 to 23 months with no vaccinations dropped to a low of 4.5 percent, having peaked at 22 percent in 2009, Figure 4A.8.

### Nutritional Status

Children's nutritional status is a reflection of their overall health. Food and nutrition insecurity leads to a vicious cycle of malnutrition, increased susceptibility to disease, and impaired mental and physical development. The MDG target is to reduce, by half, the proportion of people who suffer from hunger between 1990 and 2015. In 2014, nationally 27.6 percent of children aged 0 to 59 months were stunted,<sup>5</sup> 3.3 percent were wasted,<sup>6</sup> 11.2 percent were underweight,<sup>7</sup> and 3.6 percent were overweight.<sup>8</sup> This means that Zimbabwe had severe stunting, mild wasting and moderate underweight malnutrition.<sup>9</sup>

Rural areas had higher levels of malnutrition than urban areas according to these three indices, while the reverse was true for the overweight indicator. The stunting level in rural areas was 30.4 percent, compared to 20 percent in urban areas, while wasting was 3.5 percent and 2.5 percent for rural and urban areas, respectively. Underweight in rural areas was 12.7 percent, compared to 6.8 percent in urban areas, while overweight was 4 percent for urban areas compared to 3.4 percent for rural areas. Figure 4A.4.

5 Children whose height-for-age Z-score is below minus two standard deviations (-2SD) from the median of the reference population are considered too short for their age (stunted) or chronically malnourished.

6 Children whose Z-scores are below minus two standard deviations (-2SD) from the median of the reference population are considered thin (wasted) or acutely malnourished.

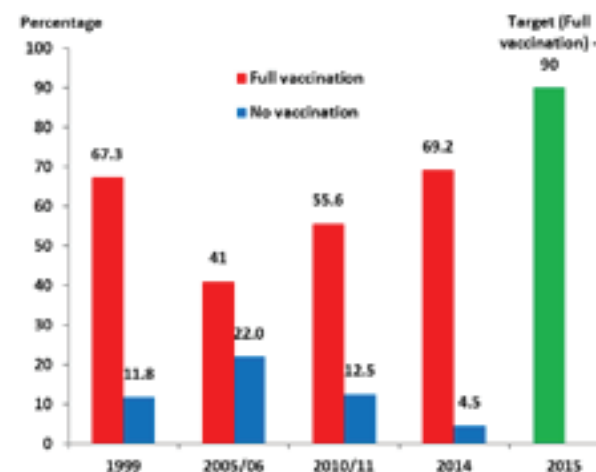
7 Children whose weight-for-age is below minus two standard deviations (-2SD) from the median of the reference population are classified as underweight.

8 Children whose Z-scores are plus two standard deviations (+2SD) above the median for weight-for-height are considered overweight.

9 Overall, in order to assess the extent of underweight, stunting and wasting, the following cut-off points are used: Mild malnutrition - below 10 percent; Moderate malnutrition - 10 to 20 percent; Severe malnutrition - above 20 percent.

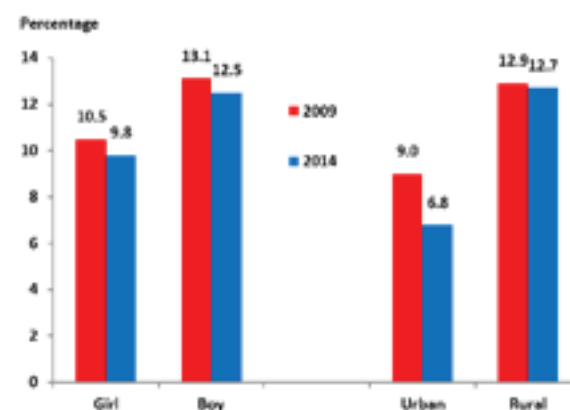
Various nutrition surveys in Zimbabwe find that, in 2014, males had higher malnutrition levels than females, as follows: stunting (males - 31.1 percent, females - 24.1 percent); wasting (males - 3.7 percent, females - 2.9

Figure 4A.3 Proportion of Children Aged 12 to 23 Months Fully Vaccinated and those with No Vaccinations by 12 Months, 1999, 2005/06, 2010/11, 2014 and 2015 Target



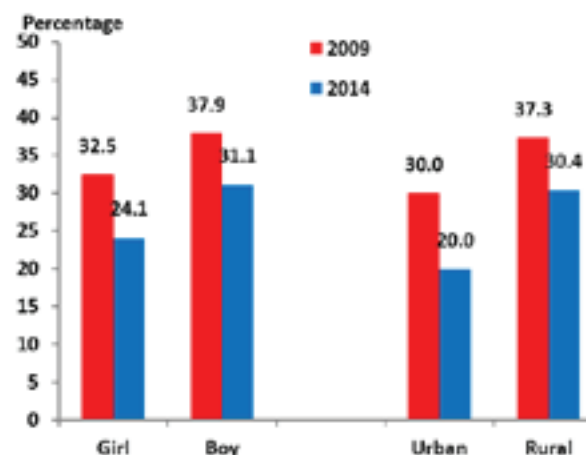
Source: ZIMSTAT - ZDHS, MIMS, MICS

Figure 4A.4 Proportion of Under-5s Moderately or Severely Underweight, by Sex and Place of Residence, 2009 and 2014



Source: ZIMSTAT - MIMS, MICS

Figure 4A.5 Proportion of Under-5s Moderately or Severely Stunted, by Sex and Place of Residence, 2009 and 2014



Source: ZIMSTAT - MIMS, MICS

percent); and underweight (males - 12.5 percent, females - 9.8 percent). Also, a slightly higher proportion of males, at 3.6 percent, were overweight than females, at 3.5 percent.

The overall proportion of under-5 children who are moderately or severely underweight (below -2SD) increased by a percentage point from 10 percent in 2000 to 11.2 percent in 2014, well above the MDG target of 3 percent. Moderate or severe underweight was higher among boys, at 12.5 percent, than among girls, at 9.8 percent in 2014. In the same year, rural areas had higher proportions of under-5 children who were moderately or severely underweight, with 12.7 percent, than urban areas, with 6.8 percent, in the same year. There was a gradual decline in children under 5 years of age who are moderately or severely stunted, from 34 percent in 1999, to 27.6 percent in 2014, although an increase was registered in 2005/06.

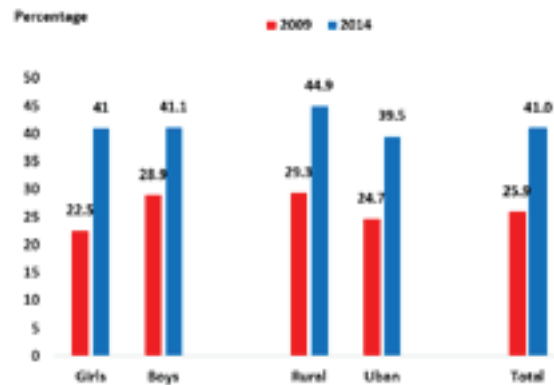
Figure 4A.5 presents the percentage of children under five years moderately or acutely stunted by sex and place of residence. Boys were more likely to be stunted (31.1 percent) than girls (24.1 percent). Under-five children in rural areas were more likely to be moderately or severely stunted (30.4 percent) than urban children (20 percent), Figure 4A.15.

### Breastfeeding, and Infant and Young Child Feeding

Feeding practices of infants and young children are determinants of health status, as poor nutritional status exposes young children to greater risk of morbidity. Breastfeeding is recognised as the best source of nourishment for infants and young children, and breastfeeding a child for the first years of life protects them from infection. The United Nations Children's Fund (UNICEF) and WHO recommend that infants be breastfed within one hour of birth, breastfed exclusively for the first six months of life and continue to be breastfed up to 2 years of age and beyond (WHO, 2003). Breastfeeding is almost universal in Zimbabwe, as 98.1 percent of the last live-born children who were born in the two years prior to the survey had been breastfed at some point of their life time. The proportion of last-live born children who were ever breastfed increased from 96.6 percent in 2010/11, to 98.1 percent in 2014. Infants from rural areas were more likely to have ever been breastfed than those from urban areas in both years.

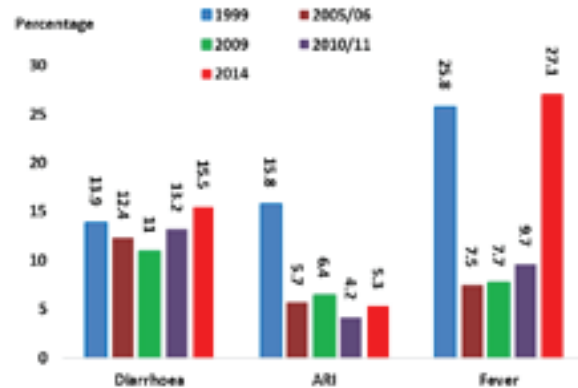
The proportion of infants breastfed within one hour of birth was 58.9 percent, an increase from 51.2 percent in 2009, with a peak of 65.2 percent having been reached in 2010/11. The same trend was observed in both urban and rural areas. The practice of giving pre-lacteal feeds limits the frequency of suckling by infants and exposes them to the risk of infection. The median duration of exclusive breastfeeding was 2 months. The proportion of infants under 6 months who were exclusively breastfed was 41 percent in 2014, an increase from 25.9 percent in 2009, Figure 4A.6. Exclusive breastfeeding increased in both urban and rural areas, and also among both girls and

Figure 4A.6 Proportion of Infants Under 6 Months who were Exclusively Breastfed, by Sex and Place of Residence, 2009 and 2014



Source: ZIMSTAT - ZDHS, MICS

Figure 4A.7 Proportion of Children Aged 0 to 59 Months having an Episode of Diarrhoea, ARI or Fever in the 2 Weeks Preceding the Survey. 1999, 2005/06, 2010/11 and 2014



Source: ZIMSTAT - ZDHS, MIMS, MICS

boys. The median duration of breastfeeding<sup>10</sup> was 17.7 months in 2014, up slightly from 17.3 months in 2009. Infants and young children from rural areas are breastfed for longer than those in urban areas.

### Diseases and Management

Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among young children. The proportion of children aged 0 to 59 months having had an episode of diarrhoea increased slightly, from 13.9 percent in 1999, to 15.5 percent in 2014. The percentage of children aged 0 to 59 months who had an episode of diarrhoea and for whom treatment was sought from a health facility or provider increased from 32.1 percent in 2009, to 35.8 percent in 2010/11, and to 44.3 percent in 2014. The majority of children (56.4 percent) aged 0 to 59 months who had diarrhoea in the two weeks preceding the survey received ORT (ORS packet, pre-packaged ORS fluid, recommended homemade fluid or increased fluids) and continued feeding during the episode of diarrhoea, while 13.8 percent received ORS and Zinc (ZIMSTAT: MICS, 2014). Diarrhoeal diseases are exacerbated by environments in which sanitation is poor.

<sup>10</sup> Age in months when 50 percent of the children aged 0 to 35 months did not receive breastmilk during the previous day.



Cholera outbreaks have become a common phenomenon in the country since 1998. An outbreak occurred in 2008 and 2009 which affected mostly urban areas and major cities like Harare and Chitungwiza, with reported national cases of close to 100 000 and more than 4 000 deaths. Again, cholera cases were reported in 2011, a total of 1 140 cholera cases and 45 deaths were reported, giving a crude fatality rate of 4 percent. Also an outbreak of measles was reported in 2009 to 2010 and an outbreak of typhoid was reported in 2014. These outbreaks coincided with the challenges municipalities experience in providing a continuous supply of water to their residents.

The proportion of children aged 0 to 59 months with symptoms of ARI in the two weeks preceding the survey declined from 15.8 percent in 1999 to 5.7 percent in 2005/06 and the low levels were maintained in 2010/11, with 4.2 percent, and 2014, with 5.3 percent. The proportion of children with symptoms of ARI for whom advice or treatment was sought from a health facility or

provider declined from 49.8 percent in 2009, to 24.9 percent in 2005/06, before increasing to 58.6 percent in 2014.

The proportion of children aged 0 to 59 months who had experienced an episode of fever in the two weeks preceding the survey were high in 1999, at 25.8 percent, and 2014, at 27.1 percent, and low in 2005/06, at 7.5 percent, 2009, at 7.7 percent, and 2010/11 at 9.7 percent. The percentage of children aged 0 to 59 months with fever in the two weeks preceding the survey for whom advice or treatment was sought from a health facility or provider increased from 26.8 percent in 1999, to 36.7 percent in 2010/11, and 47.1 percent in 2014. Almost all (92.1 percent) of the children aged 0 to 59 months with fever who received advice or treatment at a health facility or provider were given antibiotics. The proportion of children with fever who were given anti-malarial drugs increased from 4.7 percent in 1999, to 13.9 percent in 2005/06, before declining to 3 percent in 2014.

## 6.3 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 4A

### SUCCESSES

Although no targets were met under MDG4, some significant progress has been made. Despite the severe economic recession from 2000 to 2008, the indicators of child mortality, vaccinations, nutrition, breastfeeding, and infant and child feeding generally improved.

Progress was registered in the indicators of child mortality, with under-5 mortality dropping from 120 deaths per 1 000 live births in 1999, to 75 deaths in 2014, and the IMR declining from 65 deaths per 1 000 live births to 55 deaths during the same period.

Vaccination against measles, increased from 71 percent in 1999 to 83 percent in 2014.

Stunting among children under five years of age declined from 36 percent in 2005/06, to 28 percent in 2014, whilst underweight remained moderate, at 11 percent in 2014.

Exclusive breast feeding for children for the first six months increased from 26 percent in 2009, to 41 percent in 2014.

### SUPPORTIVE ENVIRONMENT

#### *The Institutional Framework*

The Zimbabwe health system comprises the public sector and the private sector, including traditional medicine practitioners. The Health Services Act provides for the establishment and operation of private and public hospitals, and Medical Aid Societies. The public sector provides services through health facilities under the

Ministries of Health and Child Care, Local Government, Higher and Tertiary Education, Science and Technology Development, Defence, and Home Affairs, and the Prison Services. The private health sector includes private for-profit facilities, while not for profit health organisations include church related hospitals and faith-based organisations (FBOs) and other non-governmental organisations (NGOs).

The public health sector has the following four levels:

1. Primary Care, the first contact between the community and the formal health system, with around 1 339 facilities, comprising health centres and a network of village health workers (VHWs) who are the first line for treatment of simple conditions, disease surveillance and enhancement of the health information system.
2. First Referral, with around 179 facilities in the form of District hospitals, providing access to doctors and referral and supervisory support to the primary care centres.
3. Provincial Tertiary (second referral), provincial hospitals to which patients are referred from District hospitals and in which they can consult a specialist.
4. Quaternary (third referral), central hospitals in Bulawayo, Chitungwiza and Harare, providing more sophisticated of health services.<sup>11</sup>

<sup>11</sup> Human Resources for Health Country Profile, 2013 Update

## POLICIES

Besides the strong institutional framework, a number of national policies and strategies promote child health and welfare. Some of these policies are pro-poor in order to cushion vulnerable children. Examples are:

1. *The National Orphan Care Policy*, established in response to the orphan crisis as a result of AIDS-related deaths among adults to cover free healthcare and food subsidies/supplements to under-5s, while recognising the role of traditional leaders in orphan care.
2. *The Zimbabwe Expanded Programme on Immunisation Policy*, one of the key interventions aimed at reducing preventable diseases such as pneumonia, diarrhoea and measles.
3. *The National Infant and Young Child Feeding Policy*, guides infant feeding practices, including counselling for HIV positive women on safe infant feeding options.
4. *The Food and Nutrition Security Policy*, the goal of which is to “promote and ensure adequate food and nutrition security for all people at all times in Zimbabwe”, particularly amongst the most vulnerable.
5. *Post-Natal Care Guidelines*, including a recommendation that women who deliver in a health facility stay for at least 48 hours for the mothers and infants to be monitored by skilled personnel.
6. *The Water and Sanitation Policy*, aimed at protecting children from diarrhoeal diseases.
7. *The National Sanitation and Hygiene Strategy*, 2010, based on community management approaches for sustained elimination of open defecation.
8. *The Maternal and Neonatal Health Road Map 2007-2015*, a national framework for activities to improve maternal and new-born health services at institutional and programme levels.
9. *The National Health Strategy for Zimbabwe*, 1997-2007; 2009-2013, to improve access to basic medical equipment and essential medicines in order to promote universal access to Primary Healthcare.
10. *National Child Survival Strategy for Zimbabwe*, 2010-2015, a framework for addressing child health challenges using the life cycle continuum of care concept, from home environment to health facility.
11. *The Nutrition and HIV Strategy*, protects the right to health, life, food and nutrition of women and children, including through the protection of breastfeeding and regulations for marketing of breastmilk substitutes.

In addition, the following programmes are in place:

1. *The Health Transition Fund*, 2011-2015, a multi-donor pooled fund created to improve the health status of the nation after the health collapse around 2008.
2. *The Health Service Board*, created in 2005 to develop more conducive conditions for health workers which are responsive to the specific needs of the health service delivery system.
3. *The PMTCT programme*, aiming to eliminate new HIV infections in children by 2015.
4. *The Expanded Programme on Immunisation*, the main objective of which is to vaccinate all children below the age of one year against six killer diseases – polio, diphtheria, tuberculosis, pertussis (whooping cough), measles and tetanus.
5. *The Integrated Management of Neonatal and Childhood Illnesses Programme*, to improve the case management skills of health workers, strengthening health systems and addressing family and community practices.
6. *Free Treatment of the Under-5s and Pregnant Women in Public Institutions*, at this point operating in rural areas, while Municipal health institutions charge fees for pregnant mothers.
7. *Community-Based Management of Acute Malnutrition Services*, 2014, the primary strategy for managing malnutrition.
8. *The Malaria Control Programme*, which supports communities with insecticide treated nets, complemented by indoor residual spraying.
9. *The National Plan of Action for Orphans and Other Vulnerable Children*, a series of programmes in response to the orphan crisis, fuelled mainly by the HIV pandemic.
10. *Child Supplementary Feeding Programmes*, and Nutritional Sentinel Surveillance site, established to monitor the nutritional status of children and women.

A number of programmes are also in place to provide supplementary food for under-5 children, particularly during periods of food shortages. Some of these are: nutrition garden programmes; community-based nutrition care programmes; nutrition and HIV programmes; information, education and communication on appropriate young child feeding; a vitamin A supplementation programme; distribution of micronutrient vitamin A; provision of iron and iodised salt to manage nutrition status among under-5s; and the exclusive breastfeeding programming.

## 6.4 CHALLENGES IN ACHIEVING TARGET 4A

The HIV epidemic remains a major challenge, despite the reduction in both incidence and prevalence, and the emerging ART. In concert with the economic crisis between 2000 and 2008, this underlies most of the development challenges the country faces, with particular implications for child mortality. In this context, the following challenges still exist in terms of achieving Target 4A:

- Continuing and strengthening PMTCT programming, in the context of the broader HIV response and, in particular, increasing male involvement.
- Consolidation of economic recovery and greater prioritisation of health within the national budget (to meet the Abuja target), to ensure progressively improved health delivery systems, adequate health personnel, equipment and supplies, in particular for child and maternal health.
- Promotion of safe motherhood, including provision of emergency obstetric care, and maternity waiting homes, to avoid maternal and neonatal deaths, as well as expanding primary healthcare facilities/clinics to rural populations.
- Ensuring that the policy of waiving health services user fees for under-5s is applied in all health facilities in all parts of the country.
- Improving health referral and communication systems, as well as ambulance and other transport provision.
- Building financial and strategic resistance to increase food security and enable the population to cope better with the impacts of drought and other natural disasters, to lessen the effects of such events on the nutritional status of children.
- Continuing and up-scaling the response to water and sanitation issues towards enhanced general health of children and adults and to avoid further outbreaks of waterborne diseases.
- Keeping up progress towards universal immunisation of children against all child killer diseases, including addressing the sociocultural factors that lead to some children not being immunised or treated with modern medicines.
- Continuing and enhancing the protection of orphaned children.
- Building capacity and commitment towards the generation of comprehensive health information for monitoring and evaluation, at district, provincial and national levels.

## 6.5 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGET 4A

Zimbabwe's experience with MDG4 Target 4A generated the following lessons:

1. Positive health outcomes for children will only be attained in the context of dealing with several of the country's development challenges, in particular those around the economy, food and nutrition, and disaster preparedness.
2. Political will is needed at the highest level to ensure that the Abuja target of 15 percent of the national budget is allocated to the health sector.
3. In addition, higher levels of funding, from both the national budget and international partnerships, are needed for the continuation and expansion of the programmes already in place and strengthening of the health delivery system.

## 6.6 THE WAY FORWARD – TOWARDS THE SDGS

Targets under the SDGs to drive inclusive economic growth, health sector prioritisation in line with the Abuja target, health sector strengthening, food security, and

enhanced HIV prevention and mitigation will be vital to Zimbabwe's continued and increased improvement of child health and prevention of child mortality.



## Chapter 7

# MDG 5: IMPROVE MATERNAL HEALTH

## SUMMARY OF PROGRESS

### Target 5A

Reduce by three quarters, between 2000 and 2015, the Maternal Mortality Ratio (MMR)

According to the 2012 Population Census, the MMR declined significantly, from 1 069 deaths per 100 000 live births in 2002, to 526 deaths in 2012.

The proportion of births attended to by skilled health personnel increased from 69 percent in 2005/06, to 80 percent in 2014, and was higher in urban areas (92.9 percent) than rural areas (74.6 percent) in 2014.

Births delivered at a health facility increased from 72.2 percent in 1999 to 79.6 percent in 2014, with a higher proportion in urban areas, at 92.7 percent, than in rural areas, at 74.2 percent, in 2014.

Despite the recent decline, home deliveries still occur, and are higher in rural areas, at 22.3 percent, than in urban areas, at 6.3 percent, in 2014.

### Target 5B

Achieve, by 2015, Universal Access to Reproductive Health

Contraceptive use of any method among married women aged 15 to 49 years is relatively high, at 67 percent in 2014, increasing from 53.5 percent in 1999, and is highest among urban women.

Use of modern contraceptive methods among married women aged 15 to 49 years increased from 50.4 percent in 1999, to 66.5 percent in 2014, with urban women being the most likely to use modern methods.

The proportion of married women 15 to 49 years using condoms remained low, at 3.5 percent in 2014, and it is higher among urban women, at 4.3 percent, than among rural women, at 3.1 percent.

Unmet need for family planning among women currently married or in union was 10.4 percent in 2014, declining from 12.8 percent in 2005/06.

The proportion of girls aged 15 to 19 years, who were married or in union increased from 21.3 percent in 1999, to 24.4 percent in 2014 with rural girls being more than twice as likely to be in this category.

The adolescent birth rate was 120 births per 1 000 women in 2014, and is higher among rural adolescents (143 births per 1 000 women) than among urban adolescents

(75 births per 1 000 women).

The proportion of women aged 15 to 19 years who had begun childbearing, increased from 20.5 percent in 1999, to 23.5 percent in 2010/11, and was higher in rural (28 percent) than in urban areas (16.4 percent).

The proportion of women aged 15 to 49 years, who had at least four antenatal care visits was 70.1 percent in 2014, 71.9 percent for urban women and 69.3 percent for rural women.

There was a marked increase in the number of facilities offering free full maternity services, from 53.6 percent in 2009, to 81.5 percent in 2013.

### SUCCESSSES

- The MMR declined significantly, from 1 069 deaths per 100 000 live births in 2002, to 526 deaths in 2012.
- The proportion of births attended to by skilled health personnel increased between 2005/06 and 2014, while home deliveries in rural areas almost halved between over the same period.

- Contraceptive use among women aged 15 to 49 years, currently married or in union, is relatively high and the use of modern contraceptive methods increased between 1999 and 2014.
- The number of facilities offering free full maternity services increased from 53.6 percent in 2009, to 81.5 percent in 2013.
- Promotion of safe motherhood, including through provision of adequate emergency obstetric care (EOC), and maternity waiting homes, to avoid maternal and neonatal deaths.
- Improving collection of health information and correcting inconsistencies in data collection methods for responsive policy making, planning, resource mobilisation, and monitoring and evaluation.

## CHALLENGES

- Continuing and up-scaling effective HIV response to further reduce maternal mortality.
- Strengthening the health delivery system in terms of human resources, drug and equipment availability, referral systems, logistics such as ambulance transport.
- Addressing inadequate health financing and budgeting through higher prioritisation in national budgets in combination with increased mobilisation of external funding.
- Overcoming the negative sociocultural factors affecting mothers to allow them greater control over their sexuality and reproductive rights.
- Full and consistent implementation of the policy waiving health services user fees for pregnant women.

## LESSONS LEARNT

- Political commitment is needed to address maternal mortality, in the context of continued economic growth initiatives, ongoing efforts to combat HIV, and measures to address gender equality, food security and disaster risk reduction.
- Adequate financing of the health system requires a mix of government (budgetary) spending, strengthening of public-private partnerships (PPPs) and joint ventures, and development partner funding that is directed towards areas of national priority.
- It is important to address the negative sociocultural and religious factors that hinder development generally, and their particular impact on women as mothers.

### Target 5

Reduce by three quarters, between 2000 and 2015, the Maternal Mortality Ratio

## 7.1 THE SITUATION – TARGET 5A

According to the 2012 Population Census, the MMR was 526 deaths per 100 000 live births in 2012, which is far from the MDG target of 174 deaths per 100 000 live births, although it represents a reduction of 50 percent in the decade prior to the census. Maternal mortality is higher in rural areas than in urban areas.

The proportion of births attended by skilled health personnel declined during the period 1999 to 2010/11, before increasing again to 80 percent in 2014, with

rural areas once again being worse off than urban ones. Women in urban areas are also more likely to deliver in a health facility than are rural women, while there has been about a 10 percent increase nationally in deliveries in a health facility. This increase is matched by a decline in the proportion of deliveries taking place at home or in the community although this remains high, at 17.6 percent, with home deliveries more likely to take place in rural areas than in urban areas.

## 7.2 STATUS OF TARGET 5A AND TRENDS

### *Maternal Mortality*

Maternal mortality remains a major challenge in Zimbabwe. Most maternal deaths are related to inadequate maternal care, which takes the form of delays in seeking medical care, receiving care, and referral to an upper level hospital, in combination with shortages

of skilled personnel, obstetric care equipment, essential drugs and other supplies. The main causes of maternal mortality are HIV-related, at 25.5 percent, postpartum haemorrhage, at 14.4 percent, hypertension/eclampsia, at 13.1 percent, and puerperal sepsis, at 7.8 percent. Abortion and malaria each contributed 6 percent of all

maternal deaths in 2007 (Munjanja et al, 2007). The situation has been compounded by the prevalence of HIV, which compromises women's immunity during and after pregnancy. Due to the economic hardships, households continue to experience serious financial constraints in attending to their health needs. Women's limited decision making power about their reproductive health and their perceived low status in society also contribute to complications in maternal health.

According to the 2012 Population Census, MMR was 526 deaths per 100 000 live births in 2012, which is three times the MDG target of 174 deaths per 100 000 live births. Although the target was not met, MMR has declined by half from 1 069 deaths per 100 000 live births in 2002, to the 2012 figure of 526 deaths per 100 000 live births. Maternal mortality was higher in rural areas, with 599 deaths per 100 000 live births, than in urban areas, with 410 deaths per 100 000 live births), in 2012, Figure 5A.1. In 2012, the MMR was highest in Matabeleland South, at 677 deaths per 100 000 live births, and lowest in Harare, with 371 deaths per 100 000 livebirths. The decline in maternal mortality is partly due to a reduction in HIV prevalence, as HIV has been a major contributor to maternal deaths and, when HIV declined, maternal deaths also went down.

### ***Births Attended by Skilled Health Personnel***

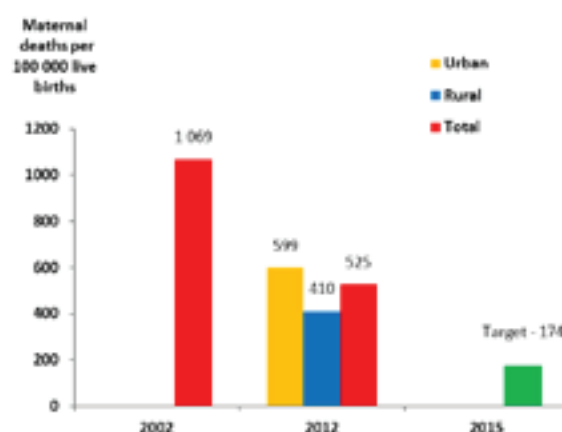
Delivery in health institutions plays a major role in reducing the risk of complications and infection for mothers and their new-born children. Previously, traditional birth attendants helped women deliver in their homes. However, the policy on the training and equipping of traditional birth attendants was changed because it was not seen to have any major positive impact and it was felt that the resources could be used more appropriately elsewhere. According to the Multiple Indicator Cluster Survey (MICS), 2014, 80 percent of births were attended by skilled health personnel (a doctor or midwife) in 2014, not reaching the 100 percent MDG target, see Figure 5A.2. Zimbabwe experienced a decline in the proportion of births attended by skilled health personnel, from 72.5 percent in 1999, to 66.2 percent in 2010/11, before it increased again by 2014. The decline was due to the economic challenges experienced during that period, while the increase recorded in 2014 was due to the economic recovery that took place after the dollarisation of the economy in 2009. Women in urban areas were more likely to be attended to by a skilled health personnel, at 92.9 percent, than were rural women, at 74.6 percent, in 2014. This holds true for all the other years in which data are available from the Zimbabwe Demographic and Health Surveys (ZDHSs) and, Multiple Indicator Monitoring Survey (MIMS)/ MICS series.

The proportion of births delivered at a health facility was 79.6 percent in 2014, increasing from 72.2 percent in 1999, although a decline occurred on this indicator between 1999 and 2010/11. A higher proportion of urban area deliveries took place at a health facility in

2014, at 92.7 percent, than those in rural areas, at 74.2 percent. This also holds true for all the other years in which data are available from the ZDHSs and, MIMS/ MICS series.

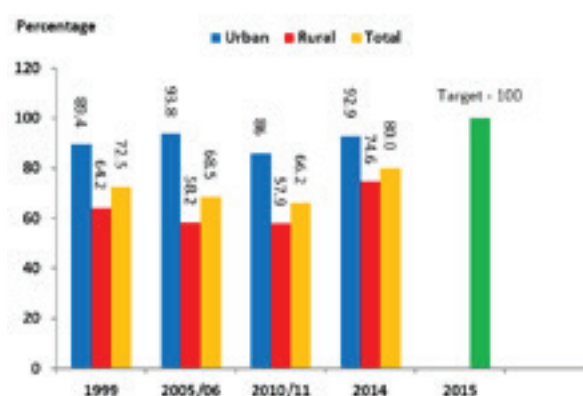
Despite the recent overall decline, a high proportion of deliveries still take place at home or in the community.

**Figure 5A.1 Maternal Mortality Ratio, by Place of Residence, 2000, 2012 and 2015 Target**



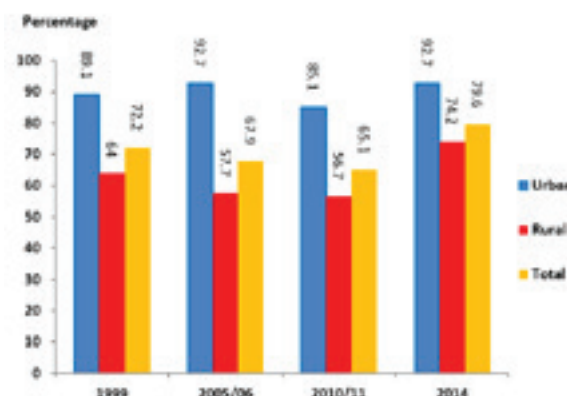
Source: ZIMSTAT Population Censuses

**Figure 5A.2 Proportion of Births Attended by Skilled Health Personnel, by Place of Residence, 1999, 2005/06, 2010/11, 2014 and 2015 Target**



Source: ZIMSTAT - ZDHS, MICS

**Figure 5A.3 Proportion of Deliveries at a Health Facility, by Place of Residence, 1999, 2005/06, 2010/11 and 2014**



Source: ZIMSTAT - ZDHS, MICS

The number of deliveries at home increased, from 23.3 percent in 1999, to 33.5 percent in 2010/11, before declining to 17.6 percent by 2014, Figure 5A.3. Home

deliveries were higher in rural areas than in urban areas for all the years in which data were collected.

### 7.3 SUCCESSES IN THE IMPLEMENTATION OF TARGET 5A

Although Target 5A, to reduce maternal mortality by three-quarters was not met, progress was made on the following indicators:

- Maternal mortality declined significantly, from 1 069 deaths per 100 000 live births in 2002, to 526 deaths in 2012;
- The proportion of births attended to by skilled health personnel increased, from 69 percent in 2005/06, to 80 percent in 2014; and
- Home deliveries in rural areas were reduced from 41 percent in 2005/06, to 22 percent in 2014.

#### Target 5B

Achieve, by 2015, Universal Access to Reproductive Health

### 7.4 THE SITUATION – TARGET 5B

The proportion of married women, aged 15 to 49 years, currently using any method of contraception is relatively high compared to other African countries, at 67 percent in 2014, an increase from 53.5 percent in 1999. Urban women were more likely than rural women to use any contraceptive method. Use of modern contraceptive methods among married women aged 15 to 49 years increased in a similar manner with urban women also being more likely than their rural counterparts to use modern contraception methods. Condom use among married women aged 15 to 49 years remains low, although it is higher among women in urban areas, at 4.3 percent, than those in rural ones, at 3.1 percent.

The unmet need for family planning among women currently married or in union was 10.4 percent in 2014, declining from 12.8 percent in 2005/06.

The proportion of married women aged 15 to 49 years who were not using contraceptives declined between 1999 and 2014 and rural women were more likely not to use contraceptives than urban women for all the years.

The proportion of girls aged 15 to 19 years who were married or in union increased from 21.3 percent in 1999 to 24.4 percent in 2014, with adolescent girls in rural areas being more than twice as likely to be married or in union than urban ones. The adolescent birth rate was somewhat higher in 2014 than in 1999 and was highest among rural adolescent girls. The proportion of women in this age group who had begun childbearing, increased from 20.5 percent in 1999 to 23.5 percent in 2010/11, with adolescent childbearing also being higher in rural areas than in urban areas.

The proportion of women aged 15 to 49 years who had at least four ANC visits was 70.1 percent in 2014, more or less unchanged since 1999, with a slightly higher percentage for urban than for rural women. 71.9 percent among urban women and 69.3 percent rural.

According to the Vital Medicines Availability and Health Services Survey conducted in 2013, there was a marked increase in the number of facilities offering free full maternity services between 2009 and 2013.

### 7.5 STATUS OF TARGET 5B AND TRENDS

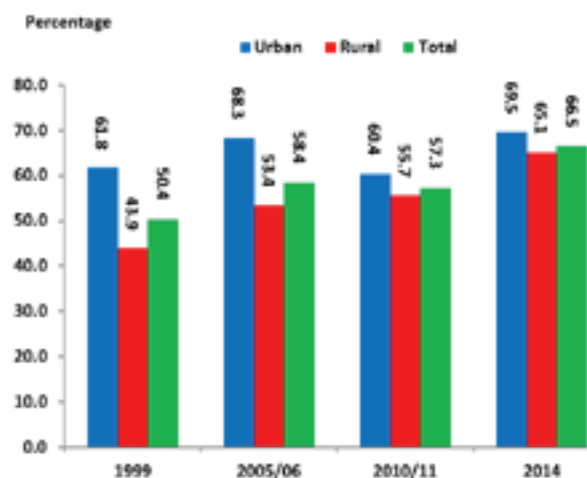
#### *Contraceptive Use among Married Women*

Contraceptive use of any method among married women aged 15 to 49 years remains relatively high, at 67 percent in 2014, showing a significant increase from 53.5 percent in 1999. According to the MICS 2014, contraceptive use of any method is higher among urban women, at 70 percent, than among rural women, at 65.6 percent. This is also observed in the other years under review. Similarly, use of modern methods of contraception among married

women aged 15 to 49 years was 66.5 percent in 2014, increasing from 50.4 percent in 1999, see Figure 5B.1. This shows that modern methods of contraceptives are almost universal among women using contraceptives, although use of modern methods of contraception are higher among urban women, at 69.5 percent, than among rural women, at 65.1 percent. Condom use among married women in this age group remains low, at 3.5 percent, although it is higher among women in urban



**Figure 5B.1 Proportional Use of Modern Methods of Contraception Among Married Women Aged 15 to 49 Years, by Place of Residence, 1999, 2005/06, 2010/11 and 2014**

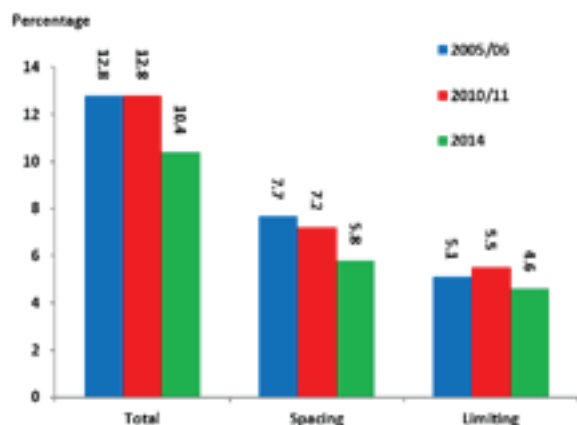


Source: ZIMSTAT - ZDHS, MICS

areas, at 4.3 percent, than among rural women, at 3.1 percent. The proportion of married women aged 15 to 49 years not currently using contraceptives declined from 46.5 percent in 1999, to 41.5 percent in 2014, with rural women more likely not to use contraceptives than urban women for all the years of the MDG period.

The unmet need<sup>1</sup> for family planning gives an indication of the extent to which the family planning programme in Zimbabwe is meeting the demand for services. Unmet need for family planning services among women currently married or in union, whether for spacing or limiting, declined from 12.8 percent in 1999, to 10.4 percent in 2010/11, Figure 5B.2. Similar declining trends were also observed in unmet need for spacing or limiting. The proportion of women currently married or in union who had an unmet need for spacing declined from 7.7 percent in 1999, to 5.8 percent in 2010/11, while for limiting the proportions declined from 5.1 percent in 1999, to 4.6 percent in 2010/11.

**Figure 5B.2 Proportional Unmet Need for Family Planning, by Reason for Demand, 2005/06, 2010/11 and 2014**



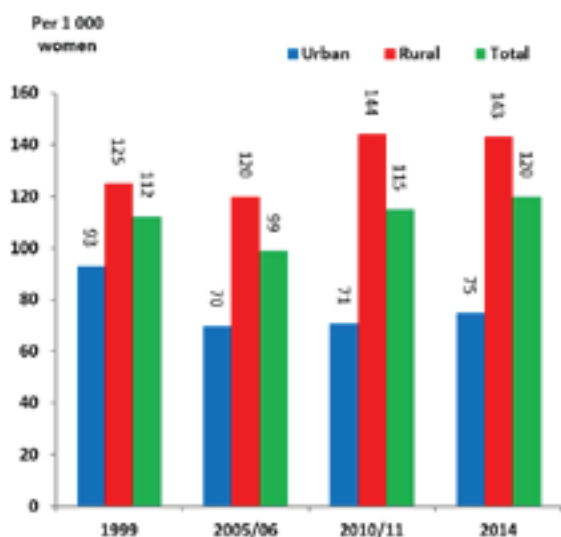
Source: ZIMSTAT - ZDHS

### Adolescent Marriage and Birth Rate

Adolescent marriage generally means the start of child bearing. Early sexual activity and childbearing early in life are associated with health risks for young people. Early childbearing is associated with unsafe abortions, maternal death and higher morbidity and mortality levels among the children of adolescent mothers.

The proportion of girls aged 15 to 19 years who were married or in union was 24.4 percent in 2014, an increase from 21.3 percent in 1999. A higher proportion of girls were married or in union in rural areas, at 29.2 percent, than urban areas, at 13.9 percent, in 2014. The increase in young girls marrying early could also explain the increase in the adolescent birth rate. Increase in adolescent pregnancy is a major concern as early childbearing is associated with health risks to both the mother and baby. The adolescent birth rate was 120 births per 1 000 among those aged 15 to 19 years in 2014, increasing from 112 births per 1 000 women in 1999, Figure 5B.3. In 2014, the adolescent birth rate was also higher in rural areas, at 143 births per 1 000 women, than in urban areas, at 75 births per 1 000 women, and this was true for all the years under review. The proportion of women aged 15 to 19 years, who had begun childbearing, increased from 20.5 percent in 1999 to 23.5 percent in 2010/11. Adolescent childbearing was higher in rural areas, at 28 percent, than urban areas, at 16.4 percent.

**Figure 5B.3 Proportional Adolescent Birth Rates, by Place of Residence, 1999, 2005/06, 2010/11 and 2014**



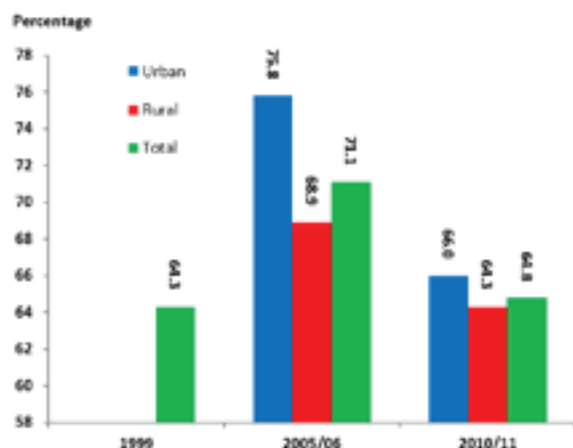
Source: ZIMSTAT - ZDHS, MICS

### Antenatal Care

Most maternal deaths are preventable through increased access to antenatal, delivery, and postnatal care. Antenatal care is important to monitor pregnancy and reduce the risks for mother and child during pregnancy and delivery. It is more effective in preventing adverse pregnancy

<sup>1</sup> Women who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not using a contraceptive method are said to have an unmet need for family planning.

**Figure 5B.4 Proportion of Pregnant Women having At Least Four Antenatal Care Visits in the Five Years Preceding the Survey, 1999, 2005/06 and 2010/11**



Source: ZIMSTAT - ZDHS

outcomes when sought early in the pregnancy and continued through to delivery.

According to the MICS 2014, 94.2 percent of the women aged 15 to 49 years who had a live birth in the two years preceding the survey had at least one antenatal care visit, with no significant differences between urban areas, with 95.3 percent, and rural areas, with 93.9 percent. However, the WHO recommends at least four visits for a woman without complications and 70.1 percent of women had at least four antenatal care visits in 2014, as recommended, with 71.9 percent for urban areas, and 69.3 percent for rural areas, see Figure 5B.4. The proportion of women not attending antenatal care was 4.8 percent in 2014,

with a lower percentage for urban women (3.9 percent) than for rural women (5.1 percent).

The ZDHSs shows that antenatal care coverage, of at least one four visit increased from 64.3 percent in 1999 to 71.1 percent in 2005/06, before declining to 64.8 percent in 2010/11. The proportion of women not attending antenatal care increased from 5.5 percent in 1999 to 10 percent in 2010/11. There were differences in the proportion of women not attending antenatal care according to rural or urban residence.

#### **User Fees for Pregnant Women**

The government pronounced free health services for pregnant women in rural health institutions in February 2013. According to the Vital Medicines Availability and Health Services Survey conducted in 2013, there was a marked increase in the number of facilities offering free full maternity services, from 53.6 percent in 2009, to 81.5 percent in 2013. Overall, rural facilities were more likely to offer free full maternity services, at 96.8 percent, than urban facilities, at 74.3 percent. The least likely facilities to offer free full maternity services were rural mission hospitals, at 77.2 percent, urban mission hospitals, at 66.7 percent, rural local authority facilities, at 76.9 percent, and urban local authority facilities, at 38.3 percent. The average fee for full maternity services was US\$10.59, with urban facilities charging an average of four times (US\$28.12) the fee charged by rural facilities (US\$6.47). In addition, the number of facilities that offered paid new-born delivery services continued to decline, from 11.8 percent in 2012, to about 10.2 percent in 2013, and to 3.7 percent in 2014. On average about US\$14.30 was being levied for this service.

## **7.6 SUCCESSES IN THE IMPLEMENTATION OF TARGET 5B**

Progress has been made on the following indicators:

- Contraceptive use among women aged 15 to 49 years, currently married or in union, remains relatively high compared to other African countries, while the use of modern contraceptive methods

among women in this group increased between 1999 and 2014; and

- There was a marked increase in the number of facilities offering free full maternity services, from 53.6 percent in 2009 to 81.5 percent in 2013.

## **7.7 THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGETS 5A AND 5B**

The Government has adopted a number of policies in support of the goal of improving maternal health. These include the following:

- *The National AIDS Policy, 1999*, which highlights PMTCT of HIV as one of the strategies to both reduce the HIV epidemic and reduce maternal mortality; and Guiding Principle 10 of the policy,

couples considering marriage or having children should have access to accurate information about HIV infection and pregnancy and HIV voluntary counselling and testing.

- *The HIV and AIDS Emergency Declaration, 2003*, declaring HIV a national emergency, which allowed the government to issue compulsory licences for the

importation and production of generic drugs.

- *The Sexual Offences Act, 2003*, to empower women to make informed decisions on their reproductive health, and providing for the prosecution of offences relating to rape, marital age, sexual violence and willful transmission of HIV.
- *The International Campaign on the Roadmap to Safe Motherhood Policy, 2007-2015*, the domestication of which enables the adoption of an essential obstetric care package designed to save the lives of women with obstetric complications, to lower the current MMR.
- *The Health Services Board, 2005*, established to ensure retention of skilled health workers through improved working conditions.
- *The National Sanitation and Hygiene Strategy, 2010*, accelerates access to sanitation and hygiene through community management strategies to reduce morbidity and mortality from waterborne, communicable diseases.
- *The National Health Strategy for Zimbabwe, 1997-2000, 2009-2013*, promoting universal access to primary healthcare by vulnerable populations which include mothers and children.
- *The Reproductive Health Policy, 2003*, provides a framework for the provision of integrated maternal health, family planning, HIV and STI services.
- *The National Post-Natal Care Guidelines, 2013*, promote the provision of post-natal care immediately after birth and three further visits thereafter by midwives or other skilled health providers.
- *The Maternity Waiting Homes Programme, 2012*, to revitalising maternity waiting homes to make it possible for mothers who might otherwise be discouraged by distance to give birth in health facilities rather than at home.
- *Safe Motherhood Programmes such as Antenatal and Post-Natal Care*, providing routine services as well as opportunities to identify women with high-risk pregnancies.
- *Basic Emergency Obstetric and Neonatal Care Services*, for the provision of treatment for complications that may arise during pregnancy.
- *Free Health Services to Pregnant Women in the Public Sector*, assists women, especially the poor in both urban and rural areas, to obtain prenatal and postnatal medical services.
- *The Change of Immunisation Schedule Introduced in 2012*, provides a new vaccination schedule for children following the introduction of the new child health card and the pneumococcal conjugate vaccine which prevents pneumonia and meningitis.
- *Maternity Leave with Full Pay*, creating a conducive environment for the good health of mothers and children.
- *Determining Life-Saving Functions that May Be Performed by Nurses*, such as vacuum aspirations, to manually remove the placenta, and inserting contraceptive implants.
- *Availability of Ambulances*, has been increased, along with availability of early treatment of conditions that aggravate complications during pregnancy, such as malaria and HIV.

The Government also put in place a number of supportive programmes to improve maternal health, including the following:

- *The Health Transition Fund, 2011-2015*, a partnership between GoZ, the UN and donor community to address HIV and reproductive health rights, and support health worker retention.
- *The Campaign on Accelerated Reduction of Maternal Mortality in Africa 2010-2015*, seeking improved accessibility of basic and comprehensive maternal health services at rural clinic and district level, towards the goal of reducing maternal mortality by half by 2015.

## 7.8 CHALLENGES IN THE IMPLEMENTATION OF TARGETS 5A AND 5B

A central challenge in the implementation of maternal mortality targets has been the weakened state of Zimbabwe's health delivery system which, despite a comprehensive institutional framework is both under-prioritised in the national budget and under-funded in real terms. Against this backdrop, the specific challenges to be met are:

Ensuring adequate health personnel through new

appointments and arresting the migration of Zimbabwean trained health professionals;

- Continuing to improve the availability of drugs and medical equipment;
- Strengthening outreach and referral systems;
- Entrenching thorough and timely collection and

- reporting of health information, including maternal mortality data;
- Consistent implementation of the policy waiving health service user fees for pregnant women;
- Building upon and expanding the relatively successful response to the HIV epidemic to further lessen its contribution to maternal mortality;
- Promotion of safe motherhood, including through the provision of adequate emergency obstetric care and maternity waiting homes, to avoid maternal and neonatal deaths; and
- Addressing the negative sociocultural factors affecting mothers.

## 7.9 LESSONS LEARNT IN THE IMPLEMENTATION OF TARGETS 5A AND 5B

Genuine political commitment to addressing maternal mortality needs to be established alongside commitment to inclusive and equitable economic growth, to increase both the proportional and real funding of the health sector.

A strategic combination of government, private sector and development partner funding is needed to provide

sufficient funding for the health sector to maximise the institutional framework that is in place and fully implement the many policies and programmes developed for maternal health.

Zimbabwe's response to HIV has yielded considerable success but must be sustained and expanded to further protect maternal health.

## 7.10 THE WAY FORWARD – TOWARDS THE SDGS

The SDG targets could usefully cover a similar range of indicator to those under the MDGs but need also to be cogniscent of the interlinkages between different goal areas. In terms of maternal health, such interlinkages exist between economic development and health sector

strengthening, between HIV responses and maternal health and mortality outcomes, and between women's economic and social empowerment and their capacity to exercise their sexual and reproductive health rights.





## Chapter 8

# MDG 6: COMBAT HIV AND AIDS, TB AND OTHER DISEASES

## SUMMARY OF PROGRESS

### Target 6A

Have halved, by 2015, and begun to reverse the spread of HIV and AIDS

The MDG target of an HIV prevalence of 9 percent was not achieved, although prevalence declined from a peak of 29.6 percent in 1998, to 21.8 percent in 2005, and to 16.7 percent in 2014.

The estimated number of people living with HIV was 1 550 250 in 2014.

There were an estimated 38 616 HIV-related deaths across all age groups in 2014.

The estimated number of AIDS orphans was 567 480 in 2014.

### Target 6B

Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it.

People with HIV now live longer due to increased Antiretroviral Therapy (ART) coverage, at 83.6 percent for 15 to 49 year olds, 63.9 percent for children, and 78 percent PMTCT.

The number of adults in need of ART has increased as people living with HIV survive longer, while the number of children and mothers in need of ART and PMTCT, respectively, has declined.

### Target 6C

Have halted, by 2015, and begun to reverse the incidence of Malaria and other major diseases

There was an overall decline in clinical malaria incidence from 113 cases per 1 000 people in 2010, to 40 cases per 1 000 people in 2014, surpassing the MDG target of 62 cases per 1 000 people.

The proportion of children aged 0 to 59 months having an episode of diarrhoea for whom advice or treatment was sought was 44 percent in 2014, an increase from 32.1 percent in 1999.

Tuberculosis (TB) incidence declined during the period 2000 to 2014, to 552 cases per 100 000 people in 2013,

well off the MDG target of 178 by 2015.

### SUCCESSSES

- A decline by nearly half in both HIV prevalence and around two-thirds in HIV incidence among adults aged 15 to 49 years between 1998 and 2014, as well as a decline in prevalence among young people.
- An improvement in adult ART coverage and notable increase in PMTCT coverage.

- A 68 percent reduction in HIV related deaths, and resultant 29 percent fall in the number of AIDS orphans.
- Clinical malaria incidence declined from 113 cases per 1 000 population in 2010 to 40 cases in 2014, surpassing the MDG target of 62 cases.
- TB incidence declined from 809 cases per 100, 000 population in 2004 to 552 in 2013, along with demonstrable improvement in the TB treatment success rate.
- and essential drugs, including reliable and consistent availability of ARVs.
- Addressing the need for additional human resources to combat the epidemic in the context of high attrition in the health sector.
- Ensuring universal PMTCT coverage.
- Recognising and combatting the high risks associated with HIV-TB co-infection and drug resistant strains of TB.

#### CHALLENGES

- Overcoming the constraints of the health delivery system arising from the fact that the worst effects of HIV were felt in what was also a time of severe economic crisis.
- Sustaining behavioural change in the face of a more relaxed attitude to HIV given fairly reliable availability of effective ARVs.
- Improving and sustaining access to timely diagnosis,

#### LESSONS LEARNT

- Political commitment and prioritization of this Goal helped in the mobilisation of resources, including through the well regarded 'AIDS levy', and reduction of HIV prevalence.
- Much behavior change arose out of the highly visible impacts of the HIV epidemic in concert with information, communication and advocacy strategies.

### Target 6A

Have halted, by 2015, and begun to reverse the spread of HIV and AIDS

## 8.1 THE SITUATION – TARGET 6A

Adult HIV prevalence in Zimbabwe, although declining, remains high and the MDG target of an HIV prevalence rate of 9 percent was not achieved. However, the shift from a peak of 29.6 percent in 1998, to 21.8 percent in 2005 was the first such decline achieved in Southern Africa. A combination of behaviour change, including delaying sexual initiation, reduction in number of sexual partners and condom use, an increase in adult mortality and successful programme interventions by the government, international community and local players, account for the decline in HIV prevalence.

There has also been a decline in HIV incidence following a peak in 1994. The number of new HIV infections overall declined among all age groups during the period 2000 to 2014, (MOHCC, 2015).

The number of HIV-related deaths among adults and

children registered a 71.5 percent between 2003 and 2014 across all age groups. There were fewer deaths among people on ART than among those not on ART, indicating the important role played by ART in saving the lives of people living with HIV. The decline in the number of AIDS orphans is attributable to improved HIV treatment and the provision of ARVs to parents, enabling them to live longer.

Correct knowledge on HIV transmission and prevention is important for avoiding infection. Although women exhibited greater knowledge than men, neither group was anywhere near the MDG target of 100 percent knowledge. Nevertheless, condom use at last high risk sex increased among both women and men aged 15 to 49 years, and, although it remains high, there was a decline in stigma and discrimination against people living with HIV.

## 8.2 STATUS OF TARGET 6A AND TRENDS

### *HIV Prevalence*

Globally, Zimbabwe is one of the countries most severely affected by HIV. According to the Ministry of Health

and Child Care (MOHCC, 2015), the HIV prevalence for the adults aged 15 to 49 years was 16.7 percent in 2014 having increased from 0.01 percent in 1978, to



a peak of 29.6 percent in 1998, before falling to 21.8 percent in 2005, and to the 2014 level of 16.7 percent. The same trend is noted in the 2005/06 and 2010/11 ZDHS reports as shown in Figure 6A.1. A comprehensive review of epidemiological data in Zimbabwe determined that the decline in HIV prevalence resulted from the combination of an increase in adult mortality in the early 1990s, a decline in HIV incidence, behaviour change and successful programme interventions starting in the mid-1990s (UNAIDS, 2005). While the decline is encouraging, the prevalence remains high and is far from the 9 percent under MDG6.

Nevertheless, the 2005 decline to 21.8 percent was the first such decline in Southern Africa and one of the explanations for continued double-digit prevalence is the successful introduction of ART which has meant that many more of those already infected are staying alive. In addition, those on ARV treatment can be expected to have low viral loads, creating knock-on effects in terms of reduced incidence because they are very unlikely to infect others. The long term impact of this will be lower prevalence.

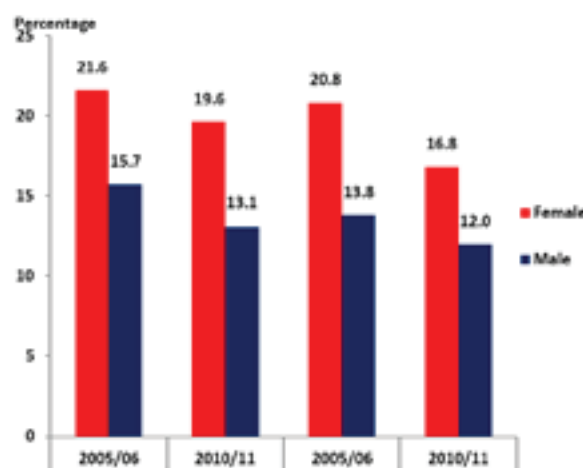
HIV prevalence is higher among women, with prevalence of 17.7 percent, than it is among men, with 12.3 percent, Figure 6A.1. Transgenerational sex is one of the major drivers of HIV among women, and also accounts for age group trends in which HIV prevalence rate increases with age and is highest among women aged 30 to 34 and 35 to 39 years, while it is highest among men aged 45 to 49 years, see Figure 6A.2. Intergenerational sex between older men and younger women increases the risk of HIV infection for young women and girls. Physiological factors, as well as negative cultural factors and gender inequality – sexual violence and the limited ability of women to negotiate safe sex – also contribute to higher prevalence among women. Poverty may also force women to engage in risky sexual behaviour, thereby increasing their chances of contracting HIV.

The ZDHS report notes that HIV prevalence among young people aged 15 to 24 years was 5.5 percent in 2010/11, declining from 7.8 percent in 2005/06. In 2010/11, HIV prevalence was higher among young females, at 7.3 percent, than among young males, at 3.6 percent.

Although it had declined in both, HIV prevalence was higher in urban areas, at 16.7 percent, than in rural areas, at 14.6 percent, in 2010/11, which may be attributable to the difference in lifestyles between the two areas. Specifically, HIV prevalence among people aged 15 to 24 years was higher in urban areas, at 7 percent, than in rural areas, at 4.8 percent, in 2010/11, although there had been no appreciable urban-rural differential in HIV prevalence in 2005/06.

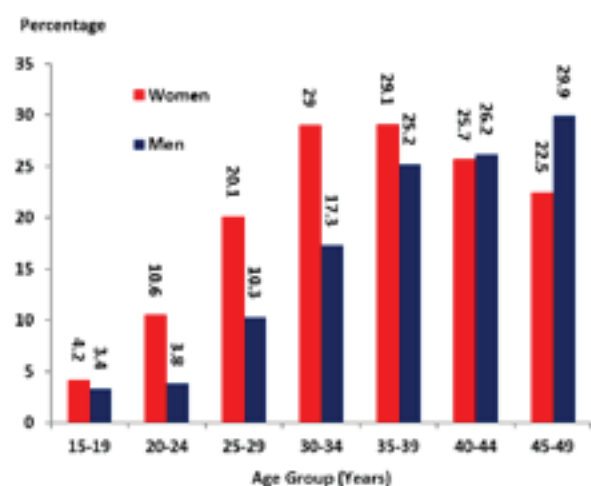
Matabeleland South has the highest HIV prevalence among both women and men, and Harare the lowest. Bulawayo and Matabeleland North also have high HIV

Figure 6A.1 Proportional HIV Prevalence among Population Aged 15 to 49 Years, by Sex, 2005/06 and 2010/11



Source: ZIMSTAT - ZDHS

Figure 6A.2 Proportional HIV Prevalence, by Age and Sex, 2010/11



Source: ZIMSTAT - ZDHS

prevalence. High prevalence throughout Matabeleland region is due to high HIV prevalence in the border towns of Beitbridge, Plumtree and Victoria Falls, which is attributable to a lot of mobility, transactional sex and formal and informal activities that take place in these border towns.

#### People Living with HIV and New HIV Infections

Zimbabwe experienced a sharp increase in the number of people living with HIV from 1985 to 1999, and then declined up to 2009. Since then, a gradual increase has been noted in the number of people living with HIV in the country. This increase is due to less HIV positive people dying because they have access to ART. It is estimated that 1 550 250 adults and children were living with HIV in 2014 (MOHCC, 2015), that is, fewer than the 2000 total of 1 916 933 but a rise from the 2009 figure of 1 388 261. Of the total number of people living with HIV in 2014, 12 percent (146 824) were children 0 to 14 years of age, and 77 percent (1 191 423) were adults aged 15 to 49 years. The number of children aged 0 to 14 years living with HIV increased from 2000 to 2004, and

since then has declined significantly up to 2014, while that of adults aged 15 to 49 years declined between 2000 to 2010 and thereafter comprised the bulk of the overall significant increase. Antiretroviral programmes began in 2005, therefore, decreases before that year are assumed to be the result of behaviour change.

New HIV infections were estimated at 63 848 in 2014, of which 9 086 (12 percent) were in children 0 to 14 years old. Generally, there has been a decline in the number of new HIV infections among both adults and children over the years, and new HIV infections among young people aged 15 to 24 years follow the same downward trend. Declining prevalence also mirrors a decline of the HIV incidence. The HIV incidence for the population aged 15 to 49 years increased from 1 percent in 1978, to a peak of 5.95 percent in 1993, before falling to the 2014 level of 0.92 percent, and a 2015 estimate of 0.88 percent (MOHCC, 2015). This decline may be related to behaviour change, including delaying sexual initiation, reducing the number of sexual partners and increase in condom use. The many interventions by Government, the international community and local players have contributed to these encouraging results.

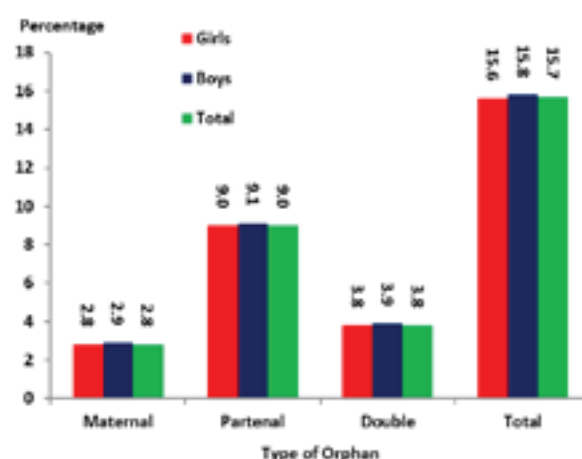
### ***HIV-Related Deaths and Orphans***

The number of HIV-related deaths among the total population was 38 616 in 2014, having increased sharply from 12 641 in 1990, and reached a peak of 135 314 deaths in 2003 (MOHCC, 2015). It is estimated that the number of HIV-related deaths will decline further, to 2 981 in 2015. A similar trend was observed in the number of HIV-related deaths across all age groups. The number of HIV-related deaths among children aged 0 to 14 years also increased sharply, from 4 821 in 1990, reaching a peak of 19 984 deaths in 2001, before decreasing to 6 713 in 2014, and to an estimate of 5 674 in 2015. A similar trend is also observed among children aged 0 to 4 years. In 2014, there were few deaths among people on ART, at 8 622, compared to those among people not on ART, at 23 240, highlighting the importance of ART in reducing HIV-related deaths. There were more deaths among males than females, whether on ART or not, which is thought to reflect poor health-seeking behavior among men.

Orphans and Vulnerable Children (OVC) are more prone to poverty, food insecurity, malnutrition, HIV, and various forms of abuse than are non-OVC. According to the 2012 Population Census, there were 982 839 orphans in Zimbabwe, with equal proportions of girls and boys,<sup>1</sup> see Figure 6A.3 The prevalence of orphanhood was 15.7 percent in 2012, with more paternal orphans (9 percent) than maternal orphans (2.8 percent) or double orphans (3.8 percent). The high occurrence of paternal orphanhood compared to maternal orphanhood could also be attributed to men's poor health-seeking behavior and the fact that men often to present themselves

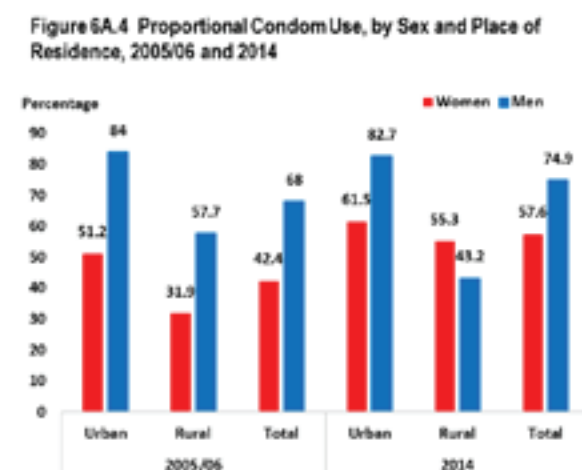
<sup>1</sup>The orphans reported in the Population Census include AIDS orphans and others.

**Figure 6A.3 Proportional Orphanhood Prevalence, by Type and Sex, 2012**



Source: ZIMSTAT - Population Census, 2012

**Figure 6A.4 Proportional Condom Use, by Sex and Place of Residence, 2005/06 and 2014**



Source: ZIMSTAT - ZDHS, MICS

for treatment when it is too late for any meaningful intervention. It has also been observed that men do not go for HIV testing early.

Orphanhood has declined from 23.8 percent in 2009 to 15.7 percent in 2012. The MOHCC, 2015 HIV estimates also show a similar trend among AIDS orphans. The number of AIDS orphans increased sharply, from 34 074 in 1990 to a peak of 796 990 in 2006, before declining to 567 480 in 2014, and is estimated to decline further, to 525 696 by the end of 2015. The decline in AIDS orphans is due to improved HIV treatment and the provision of ARVs to parents, which enables them to live longer. Orphanhood is higher in rural areas, at 34.4 percent, than in urban areas, at 7.1 percent.

### ***Condom Use***

Condom use has been universally accepted as one of the most effective means of protection against HIV and other sexually transmitted infections (STIs), if used correctly and consistently (Cayley 2004; Koumans et al. 2005). One of the reasons cited for reduction in HIV prevalence

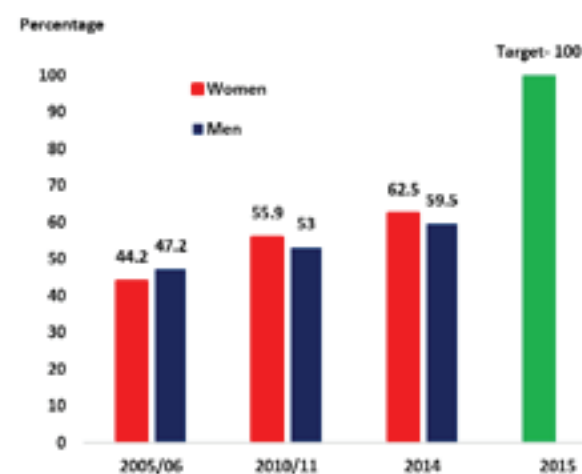
in Zimbabwe is an increase in condom use. This is supported by ZDHS and MICS reports which note that condom use at last high risk sex among women and men aged 15 to 24 years increased for both women and men from 2005/06 to 2014. Condom use at last high risk sex was higher among men, at 74.9 percent, than among women, at 57.6 percent, in 2014, in both urban and rural areas (MICS, 2014), see Figure 6A.4.

### Comprehensive Knowledge about HIV and AIDS

Correct knowledge on HIV transmission and prevention is vital for avoiding infection. It is particularly important for HIV positive people to have an accurate understanding of how HIV is transmitted and prevented, in order to avoid or reduce risk of transmitting the infection to their sexual partners. It is also important for HIV negative people to have correct information to avoid becoming infected. Comprehensive knowledge about HIV and AIDS was 62.5 percent among women aged 15 to 49 years and 59.5 percent among men aged 15 to 54 years in 2014, both well below the MDG target of 100 percent, although this represented a rise from 44.2 percent for women and 47.2 percent for men in 2005/06, see Figure 6A.5. Thus, men had higher levels of comprehensive knowledge about HIV and AIDS than women in 2005/06 but were overtaken by women in 2010/11 and 2014. Comprehensive knowledge about HIV and AIDS among women aged 15 to 49 years and men aged 15 to 54 years was higher in urban than in rural areas for both women and men in 2010/11. Comprehensive knowledge about HIV and AIDS among young people aged 15 to 24 years is lower than that of older adults, that is, 56.4 percent and 51 percent for women and men, respectively, which is hardly above half of the MDG target of 100 percent. Comprehensive knowledge of HIV and AIDS among young people aged 15 to 24 years was higher in urban areas than rural areas for women and men.

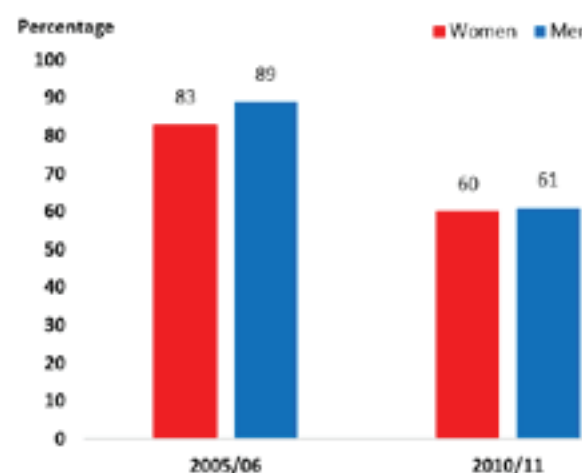
Stigma and discrimination deter people living with or affected by HIV from talking openly about the epidemic or disclosing their status. Although stigma and discrimination are declining, they remain high in Zimbabwe. The reported experience of stigma discrimination among women declined from 83 percent in 2005/06 to 60 percent in 2010/11, see Figure 6A.6,

Figure 6A.5 Proportional Comprehensive Knowledge about HIV and AIDS among Women Aged 15 to 49 Years and Men Aged 15 to 54 Years, 2005/06, 2010/11, 2014 and 2015 Target



Source: ZIMSTAT - ZDHS

Figure 6A.6 Proportional Reported Stigma and Discrimination Against People Living with HIV, by Sex, 2006/06 and 2010/11



Source: ZIMSTAT - ZDHS

while although a higher proportion of men reported experiencing stigma or discrimination in 2005/06, at 89 percent, this declined to almost the same level as women, at 61 percent, in 2014.

## Target 6B

Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it

## 8.3 THE SITUATION – TARGET 6B

People living with HIV survive longer if they are on ART. As discussed above, the death rate was lower among people with HIV who were on treatment than among those who were not. There was an overall increase in ART coverage among both between 2011 and 2014, and PMTCT coverage increased by over 50 percent in the same period.

At the same time, the number of adults aged 15 to 49 years who needed ART increased five-fold, with the increase beginning in 2004, thereby coinciding with the introduction of ART provision. The estimated number of children aged 0 to 14 years needing ART decreased between 2000 and 2014, reflecting decline in new child

infections due to mother-to-child transmission. The estimated number of mothers needing PMTCT also declined by about one-third over the MDG period.

## STATUS OF TARGET 6B AND TRENDS

### ART Coverage

The introduction of ART in 2004 has seen a decline in the number of AIDS-related deaths. The coverage of ART among adults aged 15 years and over increased from 73.8 percent in 2011, to 83.6 percent in 2013, but declined to 62.7 percent in 2014.<sup>2</sup> The estimated number of children 0 to 14 years on ART increased from 55.8 percent in 2011, to 63.9 percent in 2014, although a decline was recorded in 2013, see Figure 6B.1. There was an overall increase in PMTCT coverage from 50 percent in 2011, to 78 percent in 2014.

The estimated number of adults 15 to 49 years in need of ART increased from 205 396 in 2004, to 1 168 451 in 2014. The adoption of the CD4 350 criteria has seen more people being eligible for ART, hence the increase in the number of adults defined as being in need of ART. However, the need for ART among children and mothers generally declined, though a small increase started again

<sup>2</sup> The global agreement for calculating coverage is based on the number of those who have been offered services over the number of those in need. Because this system has challenges, countries were allowed to adopt and adapt what is relevant to their situation. Zimbabwe calculates coverage based on those living with HIV, and those in need of ART.

Figure 6B.1 Proportional ART Coverage Estimates, by Programme, 2011 to 2014



Source: ZIMSTAT - ZDHS, MICS

in 2013. There is a gradual increase in the number of adults in need of ART because the number is cumulative, whereas pregnancy is not a permanent condition and so the programme deals with this group as they come and go. The estimated number of pregnant women needing PMTCT shows a gradual decline from 100 606 in 2000, to 77 780 in 2014. The estimated number of children aged 0 to 14 years needing ART decreased from 94 000 in 2000, to 86 128 in 2014. The number of children on ART also tends to decrease because children graduate into adulthood and the number of new infections has dropped as a result of successful PMTCT. The number of new child infections due to mother-to-child transmission declined from 16 868 infections in 2010, to 7 573 infections in 2014.

### Target 6C

Have halted, by 2015, and began to reverse the incidence of Malaria and other major diseases

## 8.5 THE SITUATION – TARGET 6C

There was a decline in clinical malaria incidence, from 113 cases per 1 000 people in 2010, to 40 cases per 1 000 people in 2014, surpassing the MDG target of 62 cases per 1 000 people. This decline was across all age groups and is attributed to recurring droughts, the reintroduction of the use of Dichloro-diphenyl-trichloroethane (DDT) in malaria vector control, and use of treated mosquito nets. According to the ZDHS and MICS, use of insecticide treated nets (ITNs) increased among children under 5 years in households with at least one ITN, from 2.9 percent in 2005/06 to 57.4 percent in 2014.

The proportion of children under 5 years who had fever in the two weeks prior to the survey increased between 2010/11 and 2014 in both urban and rural areas. Only 3 percent of the proportion of children under 5 years of age with fever in the two weeks preceding the survey in 2014

were given any anti-malarial drugs.

Children aged under 5 years having an episode of diarrhoea in the two weeks preceding the survey increased, while there was also an increase in the proportion of children aged 0 to 59 months having diarrhea for whom treatment or advice was sought from 32.1 percent in 1999, to 44 percent in 2014.

There was an overall decline in tuberculosis incidence from 2000 to 2014, reaching 552 cases per 100 000 people in 2013, not reaching the MDG target of 178 by 2015. The decline in TB incidence is attributed to introduction of ART in 2004 as HIV positive people on treatment rebuild immunity over time and are less vulnerable to TB infection and because their viral load is suppressed, less likely to spread HIV and render others

vulnerable to TB. Tuberculosis death rates generally increased, from 24 deaths per 100 000 people in 2000, to 40 deaths per 100 000 people in 2014, despite the fact that the TB treatment success rate under directly observed short course TB treatment strategy (DOTS) improved, increasing from 71 percent in 2001, to 82 percent in 2013.

## 8.6 STATUS OF TARGET 6C AND TRENDS

### Malaria

Zimbabwe's clinical malaria incidence was 40 cases per 1 000 people in 2014, surpassing the MDG target of 62 cases per 1 000 people. It rose from 113 cases per 1 000 people in 2000, to 155 cases per 1 000 people in 2003, before declining up to 2012, then with a gradual rise to the current figure, see Figure 6C.1. The increasing trend since 2012 can be attributed to the re-emergence of the drug-resistant malaria vector and climate change. However, the overall decline in clinical malaria incidence over the period is likely to have been caused by recurrent droughts, the reintroduction of the use of DDT and use of treated mosquito nets. Malaria incidence was highest between 2003 and 2005, when death rates for all ages were also highest. Malaria death rates were higher among children aged 0 to 4 years than among all other ages combined. Malaria deaths for all ages declined from 1 069 deaths and 1 916 deaths per 1 000 population in 2003 and 2004, respectively, to 406 per 1 000 population in 2014, Figure 6A.2. Similarly, malaria deaths for ages 0 to 4 years declined from 267 deaths and 350 deaths in 2003 and 2004, respectively, to 59 deaths in 2014, Figure 6C.2.

The decline in malaria deaths in ages 0 to 4 years could be due to an increase in use of ITNs. The proportion of children under 5 years in households with at least one ITN who slept under an ITN increased from 2.9 percent in 2006 to 57.4 percent in 2014. In 2014, the proportion of children in households with at least one ITN who slept under an ITN the previous night was higher in rural areas, at 59.1 percent, than in urban areas, at 50.6 percent. Also the proportion of children under 5 years with fever in

Figure 6C.1 Clinical Malaria Incidence, 2000 to 2014



Source: MOHCC

Figure 6C.2 Malaria death rate for All Ages and Ages 0 to 4 Years, 2003 to 2014



Source: MOHCC

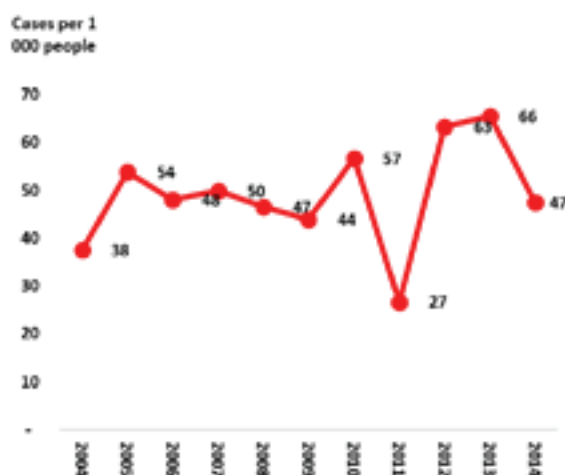
the two weeks preceding the survey who were given anti-malarial drugs was 3 percent in 2014, down from a high of 13.9 percent in 2009. Children in rural areas were more likely to be given anti-malarial drugs, at 3.7 percent, than urban children, at 0.9 percent, see Table 6C.1.

Table 6C.1 Malaria Protection and Treatment Status of Children Under 5 Years, 2005/06 to 2014

	2005/06	2009	2010/11	2014
Urban - Under-5s in household with at least 1 ITN who slept under an ITN the previous night	5.1%	17.1%	39.3%	50.6%
Rural - Under-5s in household with at least 1 ITN who slept under an ITN the previous night	2.1%	17.5%	27.3%	59.1%
Total	2.9%	17.3%	29.9%	57.4%
Urban - Under-5s with fever in the previous 2 weeks who were given anti-malarial drugs	0.7%	5.3%	3.6%	0.9%
Rural - Under-5s with fever in the previous 2 weeks who were given anti-malarial drugs	6.3%	16.9%	1.8%	3.7%
Total	4.7%	13.9%	2.3%	3.0%

Source: ZDHS, MICS

Figure 6C.3 Incidence of Diarrhoea/Dysentery, 2004 to 2014



Source: WHO Global TB Report

### Diarrhoea/Dysentery and Cholera

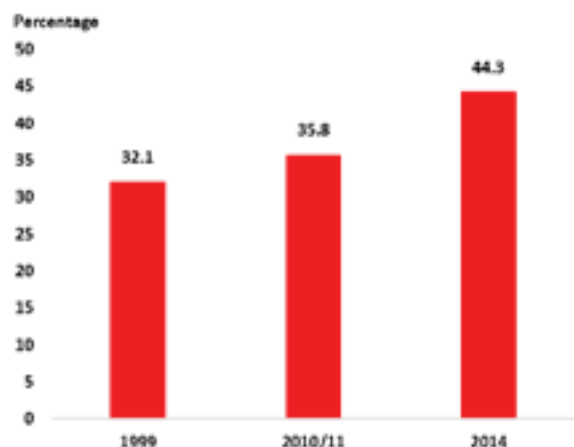
Generally, the incidence of diarrhoea/dysentery increased over the period 2004 to 2014, from 38 cases per 1 000 people in 2004, to 47 cases per 1 000 people in 2014, peaking at 66 cases per 1 000 people in 2013, Figure 6C.3. The 47 cases is much higher than the MDG target of 19 cases per 1 000 people. The highest numbers of diarrhoea/dysentery cases were recorded in 2012, with 805 833 cases, and 2013, with 850 105 cases. These higher numbers of cases were partly due to a typhoid outbreak in 2012. The proportion of children aged 0 to 59 months with diarrhoea for whom advice or treatment was sought increased from 32.1 percent in 1999 to 44.3 percent in 2014, Figure 6C.4.

Cholera outbreaks have become a common phenomenon in the country. In 2010, 706 976 cases of diarrhoea/dysentery were recorded and this was largely due to the cholera outbreak in that year. Previously, cholera was a condition of the rural areas but, since 1998, urban areas have reported cholera outbreaks in many years, with major cities like Harare and Chitungwiza being affected. The worst outbreak was reported in 2008/09 when the country reported close to 100 000 cases and more than 4 000 deaths. A total of 1 140 cholera cases and 45 deaths were reported in 2011, giving a crude fatality rate of 4 percent.

### Tuberculosis

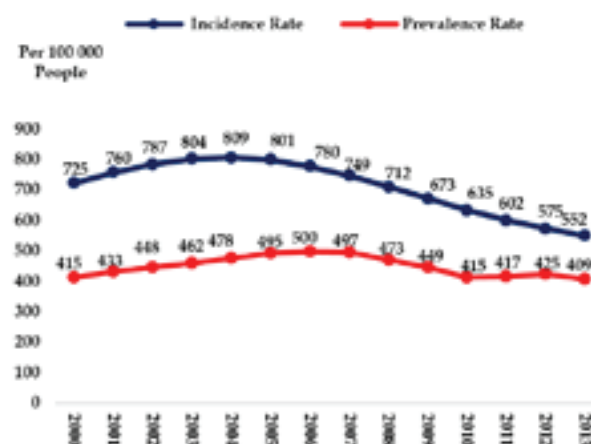
Tuberculosis remains a major cause of death among people living with HIV. Tuberculosis prevalence increased from 415 cases per 100 000 population in 2000 to 509 cases per 100 000 in 2006, before declining to 409 cases per 100 000 in 2013, Figure 6C.5. The same trend is observed in TB incidence, which increased from 725 cases per 100 000 population in 2000, to 809 cases per 100 000 population in 2004, before it declined to 552 cases per 100 000 population in 2013. The introduction of ART has brought about a continuous decline in TB prevalence and incidence. Although TB incidence has declined, it is far from reaching the MDG target of 178 by

Figure 6C.4 Children Aged 0 to 59 Months with Diarrhoea in the Two Weeks Preceding the Survey for whom Advice or Treatment was Sought, 1999, 2010/11 and 2014



Source: ZIMSTAT - ZDHS, MICS

Figure 6C.5 Tuberculosis Prevalence and Incidence, 2003 to 2013



Source: WHO Global TB Report

Figure 6C.6 Tuberculosis Death Rate, 2000 to 2013



Source: WHO Global TB Report

2015. Seventy percent of all TB patients are co-infected with HIV. As long as the incidence and prevalence of HIV remains high, the incidence of TB will also remain high. Tuberculosis death rates increased from 24 deaths

per 100 000 people in 2000, reaching a peak of 43 deaths per 100 000 in 2007, before declining to 40 deaths per 100 000 people in 2014, see Figure 6C.6. There was an overall slight decline in the TB detection rate under

DOTS, from 56 percent in 2000 to 42 percent in 2013. The TB treatment success rate under DOTS declined from 71 percent in 2001, to 48 percent in 2004, before increasing gradually, to 82 percent in 2013.

## 8.7 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF MDG6

### SUCCESSES

Some achievements recorded under MDG6 were:

- *HIV* – prevalence among adults aged 15 to 49 years declined by nearly half between 1998 and 2014 and incidence dropped to a third of its 1998 level over the same period, while prevalence among those aged 15 to 24 years declined at a slower rate. Both ART and PMTCT programmes were introduced and began to take effect, leading to a 68 percent decline in HIV related deaths and a 29 percent reduction in the number of AIDS orphans.
- *Malaria* – Clinical malaria incidence declined by nearly two-thirds between 2010 and 2014 to a low of 40 cases per 1 000 population, surpassing the MDG target of 62 cases, largely on the back of increased spraying and use of ITNs.
- *Tuberculosis* – TB incidence declined markedly, while there were also minor improvements in the TB treatment success rate between 2007 and 2013.

### Supportive Environment

The following policy frameworks are in place to support the realisation of the three targets under MDG6:

- *The National AIDS Policy*, to promote and guide present and future multi-sector responses to HIV in Zimbabwe, and mandated with administration and collection of the AIDS Levy.
- *The National AIDS Trust Fund*, commonly referred to as the ‘AIDS levy’ is a 3 percent tax introduced in 1999 to mobilise domestic resources for HIV prevention and care.
- *The Emergency Declaration on HIV and AIDS*, 2003, which has allowed public-private partnership in the local production of subsidised ARVs.
- *The Three Zeros*, a conceptual policy seeking zero new HIV infections, zero discrimination and zero AIDS-related deaths in response to the HIV epidemic.
- *National HIV and AIDS Strategic Frameworks*, developed to operationalise the National AIDS Policy, and generating two National Strategic Plans (ZNASPs) to improve the quality of life of people

living with HIV and contribute to prevention of new HIV infections.

- *The Behaviour Change and Communication Strategy*, to address the drivers of the epidemic and prevent sexual transmission of HIV through behavior change.
- *The 2004 Zimbabwe Human Development Report*, helped to link HIV with broader development and not only health, and thus became a resource for the region.
- *The National Orphan Care Policy, 1999*, identifies opportunities to provide care and support for vulnerable children that are inherent in the country’s legislative framework, the cultural tradition of caring and the collaborative approach, which exists between government and civil society.
- *The National Tuberculosis Programme Strategic Plan, 2009-2013*, sets out guidelines for co-management of TB and HIV.
- *The Sexual Offences Act*, criminalises willful transmission of HIV.

In addition, the following prevention, treatment, and care and support programmes are in place to operationalise the policies:

### Prevention programmes

- *Prevention of Mother-to-Child Transmission*, as part of a commitment to eliminating new HIV infections in children through prophylactic ART treatment, and keeping their mothers and families alive.
- *Condom Programming*, involving government promotion of both male and female condoms and free distribution by the government and through social marketing.
- *The ART Programme*, for treatment and management of people infected with HIV, including children, starting in 2004 and expanding with support from donor partners.
- *The HIV and AIDS in the Workplace Programme*, a government-private sector initiative to provide direction to the design, implementation and

coordination of workplace responses to HIV. Voluntary Voluntary Counselling and Testing (VCT), with sites throughout the country to enable individuals to get to know HIV status through pre- and post-test counseling and testing.

- *Provider-Initiated Testing and Counselling (PITC)*, permits healthcare providers to initiate discussion of HIV testing with any client and mandates offering HIV Counselling and testing to all clients.
- *The Voluntary Medical Male Circumcision (VMMC) Programme*, as part of the HIV prevention package given that male circumcision can reduce chances of HIV infection by 60 percent.
- *Water, Sanitation and Hygiene Linked Programmes*, provision of assistance by Government and international donors to fund essential supplies to prevent the spread of cholera.
- *The Roll Back Malaria Programme*, to ensure the prevention or reduction of morbidity and mortality due to malaria by preventing mosquito bites, through advocacy and promotion of ITNs.

#### **Treatment programmes**

- *Introduction of Primary Care Counselors and Primary Care Nurses*, towards enhanced awareness of and counseling on HIV.
- *The Provision of ART Programme*, for affordable and decentralised access to ARVs.
- *Participation in the Global Plan to Stop TB*, aiming to eliminate TB as a public health problem, with

a specific focus on managing and tackling cases of drug-resistant TB.

- *Introduction of Micro-scopists in Health Facilities*, to test for TB with the aim of better managing TB cases.
- *Task sharing*, allowing nurses (primary care cadres) to initiate treatment for both TB and HIV.
- *The Expanded Support Programme (ESP)*, to support scale up of the national HIV response.
- *Collaborative TB/HIV activities*, adopted since 2004 in line with WHO recommendations and scaled up since.
- Tax rebates for all companies that invest in health.

#### **Care and Support Programmes**

- *The NAP for OVC and National Secretariat on OVC*, to strengthen the existing coordination structures for OVC programmes and increase resource mobilisation.
- *Community-Based Care Programmes*, as a government-civil society partnership and an integral component of the continuum of care and support that includes palliative care, nursing care, counselling and psychosocial support, spiritual support, nutrition, referral services and newly emerging areas.
- *Increased participation of CSOs in supporting OVC*, in response to a dramatic increase in the number of orphans and other vulnerable children, and including strengthening of community level organisations providing care and protection.

## **8.8 CHALLENGES IN THE IMPLEMENTATION OF MDG6**

Some of the challenges in responding to the targets under MDG6 were:

- Sustaining health delivery in the face of concurrent crises in terms of the economy and the HIV epidemic;
- Sustaining behavioural change, as a key contributor to HIV prevention, given that the availability of ART has brought on more relaxed attitudes to HIV transmission;
- Improving and sustaining access to essential drugs and ARVs in terms of affordability and reliability of supply;
- Increasing the number and standard of diagnostic centres;
- Up-scaling PMTCT to provide universal coverage, ideally with enhanced involvement of men, and increasing paediatric ART coverage;
- Building the human resource base to respond to HIV, by arresting the brain drain of health professionals;
- Sustaining efforts to respond to TB-HIV co-infection in the context of combating both diseases;
- Increasing levels of care and Support for the remaining large number of orphans;
- Ensuring mainstreaming of gender in HIV policy, programming and practice;



## 8.9 LESSONS LEARNT FROM THE IMPLEMENTATION OF MDG6

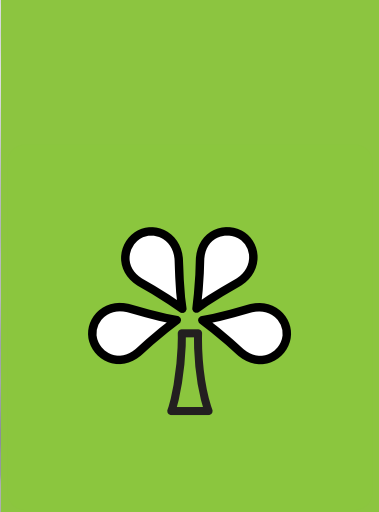
Zimbabwe's experience with MDG6 Targets 6A, 6B and 6C generated the following lessons:

1. Political commitment, including national prioritisation of this goal, helped in the mobilisation of government, private and donor resources, and ultimately in the reduction of HIV prevalence and incidence.
2. The NATF/AIDS Levy was successful as a home-grown, locally responsive strategy for resource mobilisation that received regional recognition.
3. Coordination through the NAC, within a single agreed HIV action framework led to substantial and demonstrable/reportable results.

## 8.11 THE WAY FORWARD – TOWARDS THE SDGS

Policies and interventions across all sectors contributed to the HIV response under the MDGs, suggesting that HIV should be mainstreamed in the implementation of the

SDGs although it only specifically mentioned as a single target under SDG3.



## Chapter 9

# MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

## SUMMARY OF PROGRESS

### Target 7A

Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

Deforestation has occurred at an estimated rate of up to 320 000 hectares per year, with the proportion of land area covered by forest declining from 48.8 percent in 2000 to 40.4 percent in 2010.

In 2012, 88.5 percent of rural households and 15.7 percent of urban households used wood as their main source of cooking energy.

Zimbabwe experienced a sharp decline in carbon dioxide (CO<sub>2</sub>) emissions from 13.887 million tonnes in 2000 to 9.861 million tonnes in 2011, attaining a 53.4 percent reduction by 2006.

Ozone-depleting substances were phased out ahead of the 2015 deadline, falling 836.7 tonnes in 2001 to 15.8 tonnes in 2013, with chlorofluorocarbons (CFCs) phased out by 2010 from 259.4 tonnes in 2001.

Zimbabwe has extensive dam infrastructure but many dams are poorly managed and maintained, although reservoirs have remained more than 50 percent full.

A large proportion of urban wetland areas has been lost to house construction in the past five years.

Groundwater and aquifers are under stress from pollution and a proliferation of boreholes, respectively.

### Target 7B

Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss.

About 14.9 percent of Zimbabwe is protected areas – national parks and wildlife areas (12.3 percent); state forests (2.6 per cent), and seven wildlife conservancies cover over a million hectares of land.

During 2010 and 2011, there was a 50 percent reduction in reported poaching crimes.

The area affected by veldt fires increased from 407 950 hectares in 2001, to 1 653 823 hectares in 2014.

Zimbabwe is involved in several transboundary natural resource management (TBNRM) initiatives, including the Kavango-Zambezi (KAZA) Transfrontier Conservation Area spanning approximately 520 000km<sup>2</sup>.

### SUCCESSSES

- Zimbabwe is doing well by regional standards, with 15 percent of land designated for conservation of biological diversity, ongoing reforestation efforts and near to complete reduction of ODSs ahead of the 2015 deadline.

### CHALLENGES

- Implementing land reform in a sustainable manner.
- Investing adequately in the energy sector, including renewable energy, and finding viable alternatives to the use of wood as the main source of energy for cooking.
- Addressing the negative impacts on biodiversity from frequent veldt fires and recurrent droughts.

- Planning strategically around Zimbabwe's long term declining rainfall trends.
- Adequately resourcing catchment and sub-catchment councils and ZINWA, and improving information and data collection, to strengthen water management and monitoring.
- Arresting the destruction of wetlands, particularly in urban areas.
- Addressing the solid waste management issues arising from rapid urbanisation, illegal settlements and changing consumption patterns.

#### LESSONS LEARNT

- Effective environmental management is a function of intersectoral collaboration, strategic partnership with regional and global actors, and consultative horizontal arrangements involving communities and traditional leaders.
- Poverty is major driver of environmental degradation and, therefore, sustained, inclusive and equitable economic growth underlies environmental protection.

#### Target 7C

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

During the economic recession of 2000 to 2008, both rural and urban water development and management deteriorated sharply with maintenance and repair works virtually seizing.

In 2014, 76 percent of the population had access to an improved drinking water source, unchanged since 2005/06, with greater access in urban areas, at 98.4 percent, than rural areas, at 67.5 percent.

The deterioration in water and sanitation facilities in both rural and urban areas, combined with a struggling healthcare system from 2000 to 2008, resulted in frequent diarrhoea and cholera outbreaks.

The proportion of the population with no toilet facility remained high and almost constant, at 31.9 percent in 2005/06 and 31.7 percent in 2014, 43.5 percent in rural areas and 1.1 percent in urban areas.

#### SUCCESSSES

- There were no explicit successes under WASH as measured by the indicators for this target.

#### CHALLENGES

- Coordinating or streamlining the currently fragmented management of and responsibility for water, sanitation and hygiene policy implementation.
- Prioritising and generating resources for infrastructure development, operation and maintenance, and assurance of water quality.
- Addressing the disparity between urban and rural areas in terms of access to water and sanitation.
- Providing sufficient and well dispersed facilities to obviate the need for open defecation.

#### LESSONS LEARNT

- The water, sanitation and hygiene (WASH) sector requires huge investment in order for it to recover and register notable progress in improved access by the population.
- There is likely to be greater sustainability in rural areas under demand led, rather than supply led models, supported by community based management of WASH infrastructure and environmental management.

#### Target 7D

By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers (globally).

Most poor Zimbabweans lack access to decent and secure housing, and many live in settlements that lack basic infrastructure and sustainable services, particularly in urban areas.

In some high density areas, stands are shared by as many

as 22 people instead of the recommended 6.

There was a housing backlog of around 1.25 million new units across all housing types in 2012, with an average of 10 000 to 15 000 units being constructed per year, against a target of 250 000 housing units.

In 2012, 47.2 percent of urban households lived in lodged accommodation, with Harare province having the highest proportion, 47.9 percent, followed by Bulawayo, at 38.5 percent.

The slum population as a percentage of urban population increased from 3.3 percent in 2000, to 25.1 percent in 2014.

#### SUCCESSSES

- There was no notable progress in the housing indicators being monitored under the MDGs.

#### CHALLENGES

- Provision of sufficient decent housing for a rising urban and peri-urban population.
- Ensuring adequate investment in housing by both the public and private sector, alongside rehabilitation of the construction and financial services sectors.

- Developing off-site infrastructure to reduce strain on existing infrastructure and enable housing development.
- Simplifying or streamlining the administrative process for obtaining land for housing, particularly to make them useable by the poor.

#### LESSONS LEARNT

- A reliable and sustainable housing finance system is critical to effective housing delivery and this requires sustained economic performance.
- Strengthening of public private partnership (PPPs) and strategic partnerships with non-state actors and development partners, is needed to complement government resources going to the housing sector.
- Some outdated housing legislation and by-laws will need to be reviewed in order to create a conducive environment for even individual households to provide themselves with decent accommodation.

#### Target 7A

Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

## 9.1 THE SITUATION – TARGET 7A

Zimbabwe has witnessed a reduction in the quantity and quality of its natural resources, mainly as a result of uncontrolled deforestation, siltation, various forms of pollution, and poaching of both flora and fauna.

#### *Deforestation and Reforestation*

Deforestation is increasing, mainly as a result of the conversion of forest land to agricultural purposes, and use of fuel wood by rural households, as the main source of energy, and for curing tobacco. A very high proportion of rural households and some urban households use wood as their main source of cooking energy. The number of smallholder farmers growing tobacco and curing it using fuel wood had increased from a few hundred, to over 111 000 in 2014. Less than a third of households nationally use electricity as their main source of cooking energy, with a higher proportion of urban households than rural households doing so. Deforestation is leading to a gradual reduction in biodiversity, as both habitat and species loss.

The reforestation initiatives being undertaken seek to increase provision and use of electricity, establish woodlots for use by tobacco farmers/curers, introduce more efficient tobacco curing systems, and discourage cutting of fuel wood through a deforestation levy.

#### *Carbon Dioxide (CO<sub>2</sub>) Emissions*

Zimbabwe experienced a 53.4 percent decline in CO<sub>2</sub> emissions by 2006, halfway through the MDG period. Although this is positive in terms of climate, it is possible that the decline in CO<sub>2</sub> emissions, could simply reflect the de-industrialisation taking place in the country over this period.

#### *Ozone-Depleting Substances (ODSs)*

The country has done well in phasing out ODSs ahead of the 2015 deadline set under the Montreal Protocol, with a 98 percent reduction in the consumption of all ODSs between 2001 and 2013. Ozone-depleting chlorofluorocarbons (CFCs) were phased out in 2010, halons, carbon tetrachloride and methyl chloroform were completely phased out in 2010.

#### *Water Resources Management*

Extensive water reforms since the 1990s culminated in a water management system based on the integrated water resources management (IWRM) approach, which made water a public good. Yet the country's water situation remains precarious in terms of both management and adequacy of water supply. There has been widespread pollution of water bodies, including through mining, agricultural activities and rapid urbanisation, which, among other things, resulted in increasing incidence of

waterborne diseases over the past fifteen years.

Although Zimbabwe has an impressive history of intensive dam development many of the dams are poorly managed and have silted up or are in danger of doing so. The rate of destruction of wetlands in Zimbabwe's urban area settlements has reached alarming proportions with significant hectareage being lost in the past five years to the construction of houses. This could cause a fall in water tables and underground water in urban settlements unsafe for drinking.

Zimbabwe has limited groundwater resources because of the weathered and fractured basement aquifers that underlie more than 60 percent of the country, but in recent years groundwater has become important in urban areas because of challenges in water supply.

## 9.2 STATUS OF TARGET 7A AND TRENDS

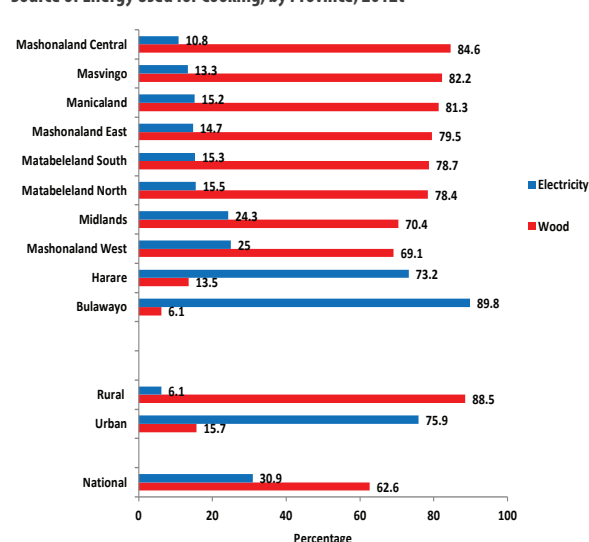
### *Land Area Covered by Forest, and Deforestation*

Woodlands and forests cover 21 million hectares, or 54 percent of Zimbabwe but loss of these has increased, leading to loss of biodiversity. Deforestation accounts for an estimated loss of 100 000 to 320 000 hectares of forest per year, that is, 0.5 to 1.5 percent of forest. According to the Forestry Commission report of 2009, 330 000 hectares of trees were being destroyed annually, mainly as a result of conversion of forest land into cultivated land.

Up to 60 percent of commercial farm land was unutilised before land redistribution (GoZ, 2001). Therefore, there was some clearance of indigenous woodland and forests as large farms were subdivided into many smaller farms and plots during the Fast Track Land Reform Programme (FTLRP). Trees were cut by the new farmers to open up land for agriculture and for residential purposes. However, this tree cutting was not continuous and in some cases, tree cover increased with time. An example is in Mazowe where studies showed an increase of up to 15 percent in tree canopy cover between 2003 and 2010, implying that A2 commercial farmers were not using all the arable land they had been allocated and trees were growing on the unused portion (Taruwanga, 2011).

Clearing of forests for fuel use, especially for curing tobacco, is causing biodiversity loss. The number of smallholder farmers growing tobacco had increased from a few hundred to over 85 000 by 2013, with a further 26 000 new growers registered for the 2014 season. Tobacco growing farmers use 84 cords (or 84 m<sup>3</sup>) of fuel wood to cure one hectare of tobacco. Up to 8.4 million cubic metres of fuel wood are needed for tobacco curing per season, assuming that, on average, each farmer only grows one hectare of tobacco. This implies that large forest areas of indigenous trees are going to be cleared on an ongoing yearly basis. At this rate of deforestation, it is projected that all indigenous trees will disappear in 50 years (EMA, 2010).

**Figure 7A.1 Households with Wood or Electricity as Main Source of Energy Used for Cooking, by Province, 2012t**



Source: ZIMSTAT, 2012 Population Census

In addition, in 2012, 62.6 percent of households nationally used wood as their main source of cooking energy, broken down as 88.5 percent of rural households, and 15.7 percent of urban households, particularly in Harare province, see Figure 7A.1. In rural areas, a higher proportion of female-headed households, at 91.5 percent, used wood as their main source of cooking energy than male-headed households, with 86.6 percent. On the other hand, in 2012, only 30.9 percent of households nationally used electricity as their main source of cooking energy, with a higher proportion of urban households, at 91.5 percent, doing so than rural households, with only 6.1 percent. In the predominantly rural provinces, higher proportions of male-headed households used electricity as their main source of cooking energy than female-headed households.

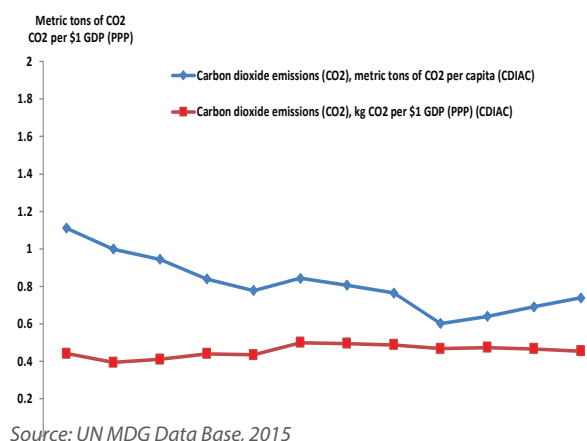
### *Carbon Dioxide (CO<sub>2</sub>) Emissions and Energy Use*

Zimbabwe experienced a 30 percent decline in CO<sub>2</sub> emissions, from 13.887 million tonnes (CDIAC) in 2000, to 9.861 million tonnes in 2011. Similarly, CO<sub>2</sub>, tonnes per capita (CDIAC) declined from 1.1106 in 2000 to 0.7381 in 2011. However, CO<sub>2</sub>, kg per \$1 GDP (PPP<sup>1</sup>) (CDIAC) remained relatively stable, at 0.441 in 2000, and 0.454 in 2011, see Figure 7A.2. It is possible that the decline in CO<sub>2</sub>, although positive in terms of climate, could reflect the deindustrialisation taking place in the country over this period, in addition to the stringent rules that are being applied on their import.

Energy use increased from 313 Kg Oil Equivalent per \$1 000 GDP (Constant 2005 PPP\$) in 2000, to 528 in 2008, before declining to 429 in 2011.

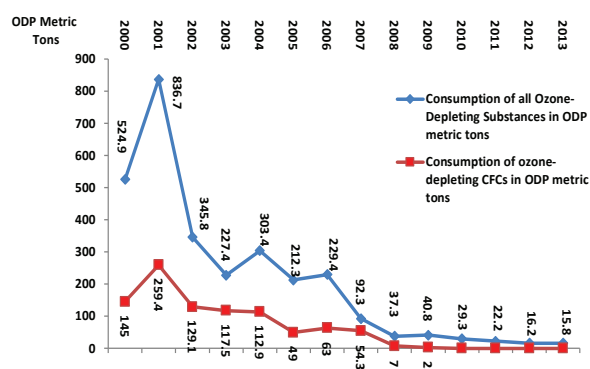
<sup>1</sup> Purchasing Power Parity.

Figure 7A.2 Carbon Dioxide Emissions (CDIAC), 2000 to 2011



Source: UN MDG Data Base, 2015

Figure 7A.3 Consumption of all ODSs and Ozone-Depleting CFCs, 2000 to 2013



Source: UN MDG Data Base, 2015

### Consumption of All Ozone-Depleting Substances

Zimbabwe has done commendably in phasing out ozone-depleting substances (ODSs) ahead of the 2015 deadline set under the Montreal Protocol. Consumption of all ODSs declined from 836.7 tonnes in 2001, to 92.3 tonnes in 2007, and then to 15.8 metric tons in 2013, which is a 98 percent reduction between 2001 and 2013, see Figure 7A.3. Ozone-depleting chlorofluorocarbons (CFCs) were phased out in 2010, from 259.4 tonnes in 2001. Halons, carbon tetrachloride and methyl chloroform were completely phased out in 2010 and only essential quantities of methyl bromide used in quarantine and pre-shipment activities, approximately 20.0 in 2010 and 1.0 in 2011, from a base line of 556.9, are now in use. The next focus is to phase out hydrochlorofluorocarbons (HCFCs) in the manufacturing and servicing industries through a series of procedures outlined in the HCFC Phase-Out Management Plan. These are to be reduced by 35 percent in 2020, 67.5 percent in 2025, and completely phased out by 2030.

### Fish Stocks Within Safe Biological Limits

The proportion of fish stocks within safe biological limits remained at 100 percent within the past 15 years, implying that there was no loss of any indigenous fish species (ZPWMA, 2015).

## TOTAL WATER RESOURCES USED

### Water Management

Zimbabwe undertook water reforms in the 1990s that culminated in a water management system based on the integrated water resources management (IWRM) approach. In order to improve water governance, all water resources in the country became a public good. Under this approach, management of water was organised according to hydrological boundaries instead of administrative boundaries, which led to the formation of popularly elected Catchment and Sub-catchment Councils.<sup>2</sup> Catchment Councils became the overall water management authorities and were mandated to prepare Catchment Outline Plans for the area under their jurisdiction, issue water permits, supervise sub-catchment areas, and resolve conflicts among water users in their catchments (Government of Zimbabwe, 2000a). Water allocation was to take into account that the environment is a legitimate water user.

Some of the responses covered by the water reforms occurred during the period 2008 to 2012 and included the approval of the River System Plans. Water resource planning was to be captured in the Catchment Outline Plans or River System Outline Plans (RSOPs) which were a legal requirement under Section 12 and 13 of the 1998 Water Act. This required catchments to develop detailed baseline studies that would inform Catchment Councils on resource availability, demands and demand points, as well as enabling them to project future demands, and to allocate water resources, based on stakeholder consultations. Catchment Councils were not allowed to issue substantive permits before approval of the River Systems Outline Plans. However, all catchments only presented their plans for approval in 2010 (over 10 years after the promulgation of the Water Act) and these were approved in 2011.

### Lakes and Dams

Zimbabwe has an impressive history of intensive dam development and is second to South Africa in terms of per capita storage within the Southern African Development Community (SADC) region. The total storage capacity in the country is estimated to be about 103 km<sup>3</sup>, of which Lake Kariba on the Zambezi River, which is jointly shared between Zambia and Zimbabwe, accounts for 94 km<sup>3</sup>. There are a good number of large, medium and small dams that were constructed for urban, agriculture, mining and industrial uses, whose total storage capacity amounts to 8.75 x 10<sup>6</sup> Ml with a 10 percent annual yield of 3.67 x 10<sup>6</sup> Ml (Government of Zimbabwe, 2013). In 2009, the total number of dams was 3 372, distributed as follows: Gwayi - 196; Sanyati - 558; Manyame - 896; Mazowe - 844; Save - 431; Runde - 226; and Mzingwane

<sup>2</sup> Zimbabwe is divided into seven catchment areas defined by the major river systems, the Gwayi, Sanyati, Manyame, Mazowe, Save, Runde and Mzingwane. The catchments are managed by Catchment Councils, which are divided into 47 Sub-catchment Councils, largely organised along tributaries of the major river systems.

- 221. It is estimated that there are over 10 000 small dams in the rural areas. Many, however, are poorly managed, and have silted up or are in danger of doing so. Generally Zimbabwe and other Southern African countries lag behind other regions in the world in per capita storage capacity.

### ***Reduced Agricultural Water Use***

Reservoirs in Zimbabwe have remained more than 50 percent full, without much variation in storage between seasons during the review period, even though trends in inflows were low. This was because of reduced use of available water by resettled farmers, the near collapse of the water permit system and disputes regarding the use and ownership of dams and irrigation infrastructure in the resettlement areas. Furthermore there was general reluctance to register commercial water use as well as pay the associated fees.

The low level of water utilisation had negative impacts on revenue collection for both ZINWA and Sub-catchment Councils, resulting in ZINWA depending more on revenue from selling clear than raw water. The reduced revenue base created operational challenges for monitoring and maintenance of water resources by the Catchment and Sub-catchment Councils as well as ZINWA (Manzungu et al., 2012).

### ***Wetlands***

Wetlands are also an important source of blue water, due to their ability to store large quantities of water. They can hold floodwaters or runoff reducing downstream peaks that could otherwise cause erosion and flood damage in the downstream catchment areas (Feresu, 2010). They store water during the wet season and slowly release it through the dry season to maintain the base flow of rivers and streams.

Infrastructural development in urban wetlands has emerged as a major threat in recent years as they lose out to other priorities, such as residential and industrial development, and recreational facilities. The construction of infrastructure in wetlands results in physical impacts on ecosystems, biodiversity loss, habitat loss and fragmentation, species movements and disturbance, increased run-off from surface areas affecting ground water recharge and discharge of water to urban river systems, visual impacts, and disturbance of cultural heritage (archaeological and historical remains). A large hectareage of wetlands has been lost in the past five years and this continues at the current rate, there is a risk of having to declare underground water in urban settlements unsafe for drinking.

### ***Groundwater***

Zimbabwe has limited groundwater resources because of the weathered and fractured basement aquifers that underlie more than 60 percent of the country (Davies and Burgess, n.d.). Groundwater constitutes the main source for domestic use and livestock watering in rural areas. Boreholes often dry up during the peak of the dry season,

forcing communities to walk longer distances to more reliable water points. Moreover, if not well protected, shallow wells expose users to waterborne diseases.

In recent years groundwater has become important in urban areas because of challenges in water supply. Boreholes have increased in urban areas because of shortage of municipal water. This development has raised fears of unsustainable exploitation of groundwater. Generally, there is poor groundwater monitoring in both rural and urban areas.

### ***Treated Wastewater and Water Quality Issues***

Treated wastewater can augment freshwater supplies and be used in industry and for irrigation. Before the breakdown of wastewater treatment facilities, the country recycled over 480 ML/day of treated wastewater, with Harare, Chitungwiza and Norton applying 240 ML/day of treated wastewater to irrigate food crops and pastures (GoZ, 2013). Currently it is estimated that some 0.365 x 106 ML/annum of treated wastewater is available from major urban areas (GoZ, 2013). Many studies have shown the dangers of wastewater to the environment through heavy metal accumulation, spread of pathogens and biological contaminants (see for example Masona et al., 2011). Continuous monitoring, alongside adequate investment in sewerage systems, sewage treatment plants and appropriate irrigation infrastructure, is crucial to counteract these environmental and health risks.

Water pollution is one of the most serious environmental threats that Zimbabwe faces today because it renders water unsuitable for its intended use and negatively affects the ecosystems. The main sources of water pollution in Zimbabwe are urban activity, mining and agricultural activities. Rapid urbanisation has become a major threat to the environment because of uncontrolled discharge of industrial waste and of poorly treated sewage effluent, sewer overflows, poor solid waste management, rapid land-use changes and stream bank cultivation.

Uncontrolled gold panning has led to the destruction of riverine and adjacent areas, and has been a major contributor to the very high turbidity and sedimentation in streams in most parts of Zimbabwe (Phiri, 2011). Panning causes changes in river flows. The holes dug in streambeds mean that more water needs to be released from upstream reservoirs to satisfy allocations downstream including environmental flows.

### ***Water Indicators***

Using the Falkenmark indicator, Zimbabwe was estimated to be water scarce in 1995 and is projected to be in the water stress category by 2025 (Hirji and Molapo, 2002). The International Water Management Institute indicator also shows that Zimbabwe suffers more from economic than physical water scarcity. Physical scarcity refers to the limited availability of water resources while economic water scarcity refers to the lack of financial and institutional capacity to develop water resources.



## Target 7B

Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss.

### 9.3 THE SITUATION – TARGET 7B

Zimbabwe has had among the highest achievements in biodiversity conservation within the SADC region, with about 14.9 percent of the country being protected area, comprising national parks and wildlife areas and state forests. In addition, there are wildlife conservancies under the Communal Areas Management Programme for Indigenous Resources (CAMPFIRE) and in private ownership, with the Save Valley Conservancy being the largest, at 351 000 ha. Two species, namely the black rhino and the white rhino are threatened with extinction in Zimbabwe but poaching crimes are reported to be on the decline and Zimbabwe is involved several transboundary natural resource management (TBNRM) initiatives.

There are competing interests between economic development and conservation of the environment, with veldt fires arising from poor land management practices seriously affecting biodiversity. Clearing of land for agriculture and conventional agricultural management practices of cotton and cattle farmers in Zimbabwe are major causes of veldt fires, although low intensity bush or

veldt fires are also part of the miombo ecology, keeping the undergrowth clear. The area affected by veldt fires more than quadrupled between 2001 and 2014. As well as increasing in frequency and intensity, veldt fires are becoming much more damaging due to increasing populations and farm density, and are causing massive damage to vegetation.

Solid waste management is one of the most pressing issues confronting urban authorities throughout Zimbabwe, being mainly a result of rapid urbanisation, including peri-urban and illegal settlements, as well as changing consumption patterns. This has occurred without a matching increase in the necessary infrastructure and services provision by urban local authorities. The bulk of Zimbabwe's urban solid waste is either reusable, recyclable or biodegradable, such that a reduction of the waste through resource recovery, recycling, energy generation and composting would reduce the final volume substantially.

### 9.4 STATUS OF TARGET 7B AND TRENDS

Zimbabwe's biodiversity conservation record compares well with the rest of the SADC region. About 14.9 percent of Zimbabwe is occupied by protected areas, comprising national parks and wildlife areas, at 12.3 percent, and state forests, at 2.6 percent. National parks and wildlife areas are state land set aside for preservation of wildlife and tourism activities, while state forests are gazetted forest reserves managed by the Forestry Commission. These include indigenous forests and forest plantations. A third of the country's forests are in protected areas (GoZ, 2013b).

About 1.9 percent of Zimbabwe's land is wildlife conservancies, while 11.2 per cent is under CAMPFIRE. There are seven wildlife conservancies in the country occupying about 1 096 543 ha of land, with the Save Valley Conservancy being the largest at 351 000 ha. Their establishment preceded the FTLRP, which explains the conflicts that sometimes arise over conservancies, especially with neighbouring communities (Shumba, 2004).

According to Zimbabwe Parks and Wildlife Management Authority (ZPWMA) records, the terrestrial areas protected remained constant, at 50 775, from 2000 to 2015, meaning that the terrestrial areas protected to total surface area also remained constant, at 13 percent over the same period.

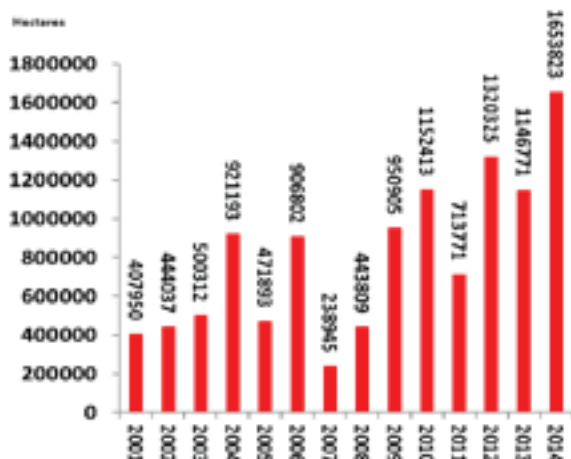
#### *Species Threatened with Extinction*

Two species, namely the black rhino and the white rhino are threatened with extinction in Zimbabwe. However, over the years, Zimbabwe has witnessed a reduction in the quantity and quality of its natural resources, mainly as a result of uncontrolled deforestation, siltation, veldt fires, various forms of pollution, and poaching of both flora and fauna. During the period 2010 to 2011, a 38 percent reduction in veldt fires was achieved, well below the government's target of 80 percent. However, there was also a 50 percent reduction in reported poaching crimes during the same period.

#### *Veldt Fires*

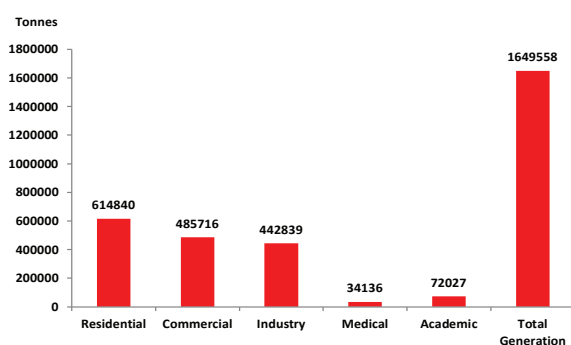
Veldt fires arising from poor land management practices seriously affect biodiversity. Clearing land for agricultural purposes is one of the main causes of uncontrolled fires, while other causes include: honey gathering, lighting a fire during the construction of a fire guard, small scale gold prospecting, hunting small mammals and cattle rustling. Fires are part of the conventional agricultural management practices in Zimbabwe, with cotton farmers being required by law to burn the plant remains in their fields by a certain date after harvest and cattle farmers burning the dry moribund grass to improve grazing land. Low intensity bush or veldt fires are also part of the miombo ecology, keeping the undergrowth clear.

Figure 7B.1 Area Burnt by Veldt Fires, 2001 to 2014



Source: EMA, 2015

Figure 7B.2 Solid Waste Generated in Urban Centres, by Source, 2011



Source: EMA, 2015

There has been an increase in the frequency and intensity of veldt fires in recent years, and they are becoming much more damaging due to increasing populations and farm density, and are causing massive damage to vegetation. The area affected by veldt fires increased from 407 950 hectares in 2001, to 1 653 823 hectares in 2014, an increase of 305 percent, see Figure 7B.1. From 2010 onwards, Mashonaland West and Matabeleland North faced higher risk of veldt fires than the other provinces.

### Solid Waste Management

Solid waste management is one of the most pressing issues now confronting urban authorities throughout Zimbabwe. This is being caused by rapid urbanisation, leading to high population densities and sprouting illegal settlements, as well as changing consumption patterns, and has not been matched by a similar increase in necessary infrastructure and services. In addition, indiscriminate dumping of solid waste, littering and poor management of waste pose environmental and health hazards, particularly to the urban population of Zimbabwe. It is now affecting the value of properties, creating an environment in which disease causing vectors can thrive, contributing to air, soil and water pollution, and emitting greenhouse gases that cause global warming. However, most of the waste generated in Zimbabwe is amenable to reuse, use as feed, composting or recycling.

In 2011, urban solid waste comprised 614 840 tonnes of residential, 485 716 tonnes of commercial, 442 839 tonnes of industrial, 34 136 tonnes of medical, and 72 027 tonnes of academic waste, giving total urban solid waste generated per annum of 1 649 558 tonnes, see Figure 7B.2. It is projected that, without some intervention, the national generation of solid waste for the whole population will be over 5 million tonnes per year, while that of urban centres will be about 2 million tonnes of solid waste by 2030. This level of solid waste generation is unsustainable.

In terms of composition, urban centres generated 530 746 tonnes of biodegradable solid waste in 2011, which made up the largest component, at 32 percent, of the total waste generated. This was followed by paper, at 407 207 tonnes (25 percent), plastic, at 303 040 tonnes (18 percent), metal, at 108 624 tonnes (7 percent), and textile, at 100 865 tonnes, (6 percent). The rest of the components (medical, glass, electronic, rubble and other) each contributed less than 5 percent. Thus 90 percent of the solid waste was either reusable, recyclable or biodegradable. Therefore, a reduction of the waste through resource recovery of reusable and recyclable waste and diversion of biodegradable waste to energy generation and composting would substantially reduce the final volumes that end up in landfills, to about 10 percent.

## 9.5 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGETS 7A AND 7B

### SUCCESSES

Zimbabwe retains a substantial portion of land area dedicated to conservation of biological diversity, in the form of indigenous forests, parks and wildlife estates. Significant reforestation efforts are underway.

The country has been successful in reducing all ODSs by

2010, ahead of the 2015 deadline under the Montreal Protocol.

### Supportive Environment

The Constitution of the Republic of Zimbabwe that was adopted in 2013 grants every Zimbabwean the right to an environment that is not harmful to their health and

well-being.

In terms of policy:

The Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) has a Food and Nutrition Cluster within which environment falls, with key outputs including strengthening and implementation of the climate and disaster management policy, formulation and implementation of a comprehensive veld fire management framework, and capacitation of local authorities and the Environmental Management Agency (EMA) to manage pollution and waste.

- The Integrated Conservation Plan for the Fast Track Land Reform Programme, addressed damage occurring during the FTLRP but has sidelined.
- The Wildlife-Based Land Reform Policy, sought to maximise livelihood options for resettled farmers by ensuring profitable, equitable and sustainable use of wildlife and other resources (GoZ, 2010).
- The Forest Based Land Reform Policy, aims to ensure that the forest development plans are integrated with the overall land use plans and supports the development of environmentally sustainable small scale forest based industries.
- The Energy Policy of 2008, combined with the formulation of the Renewable Energy and Bio-Fuel Policy, seek to combat deforestation by providing energy alternatives.
- The National Water Policy, 2013, aims to achieve sustainable utilisation of water resources in two phases – a recovery phase in response to immediate problems, and a longer term normalised phase.

Several regulatory and management structures and institutions are in place. Among these:

- The Ministry of Environment, Water and Climate, is the lead coordinating institution for the management of water and other natural resources in the country.
- The Environmental Management Authority, is responsible for ensuring protection of the environment, sustainable management of natural resources and the prevention of pollution and environmental degradation, including through the development of environmental management plans, and regular monitoring.
- The Zimbabwe Parks and Wildlife Management Authority (ZimParks), manages Zimbabwe's wildlife resources on private or communal lands, mandated by the Parks and Wildlife Act of 1975.
- The Zimbabwe National Water Authority (ZINWA), provides water services and products, and oversees

the seven Catchment Councils.

The legislation guiding environmental management and resource use includes:

- The Water Act, 1998, which vested custodianship of all forms of water in the state, replacing permanently held water rights with renewable water permits, as well as establishing water Catchment Councils and sub-Catchment Councils.
- The Public Health Act, 2002 (Chapter 15:09), stating that it is the duty of a local authority to furnish water supplies in line with health requirements.

Zimbabwe is linked to international environmental policy and advocacy processes and instruments, including:

- The 1992 Rio Conference on Environment and Development, which because of Zimbabwe's participation, was a milestone in raising national awareness on the need to integrate environment and development.
- The 2002 World Summit on Sustainable Development (WSSD), which resulted in the Johannesburg Plan of Action.
- The Hyogo Framework for Action (HFA), 2005, which is the key instrument for developing policies and implementing disaster risk reduction as a component of sustainable development.
- The Convention to Combat Drought and Desertification (CCDD).

Regionally, Zimbabwe is involved several transboundary natural resource management (TBNRM) initiatives, including:

- ZIMOZA, a collaborative framework for the management of natural resources in four districts of Zambia, Zimbabwe and Mozambique.
- The Great Limpopo Trans Frontier Park (GLTP), involving Mozambique, South Africa and Zimbabwe.
- Tulishashi TBNRM, involving Botswana, South Africa and Zimbabwe.
- The Four Corners, between Botswana, Namibia, Zimbabwe and Mozambique.
- The Kavango-Zambezi (KAZA) Transfrontier Conservation Area, the largest in the world, at 520 000km<sup>2</sup>, involving Zambia, Zimbabwe, Botswana, Angola and Namibia.

There are many local initiatives to address environmental degradation. Some of these are:

- Forestry Commission and private sector (including tobacco companies) projects supporting the establishment of woodlots for tobacco farmers, as well as use of coal as an alternative to fuel wood for tobacco curing;
- Formation of local-level, multi-stakeholder fire committees as a component of the National Fire Protection Strategy formulated in 2006;
- Celebration of World Water Day (22 March); and
- The introduction of environmental science in schools to 'catch them young' with sustainable environment messages.

The Government, through its various agencies, has taken

a number of steps to respond to the impacts of climate change. These include the development of the National Environmental Policy in 2009, the development of a National Climate Change Response Strategy, 2012-2014, followed by a Climate Change and Communication Strategy, and the commissioning of a World Bank Study on Climate Change and Water Resources Planning, Development and Management in Zimbabwe. International and non-governmental organisations are also involved in the response to climate change. For example the Food and Agriculture Organisation of the United Nations (FAO) and the Food, Agriculture and Natural Resources Policy Analysis Network (FARNPAN) are promoting climate smart agriculture, to increase productivity and resilience, reduce greenhouse gas emissions and enhance achievement of national food security.

## 9.6 CHALLENGES IN ACHIEVING TARGETS 7A AND 7B

The challenges that continue to exist relate to environmental protection generally, as well as specifically to water management and solid waste management. They are:

### *Environment*

- Implementing land reform in a sustainable manner, particularly given the increase in tobacco farming and clearing of indigenous woodland and forests as large farms were subdivided into many smaller farms and plots during the FTLRP.
- Provision of alternatives to fuel wood, as an energy source, particularly reliable and affordable electricity, to prevent further deforestation.
- Ensuring adequate new investment in the energy sector, including renewable energy.
- Improvement of land management practices, to limit the risk of environmentally damaging veldt fires.

### *Water Resources Management*

- Addressing the impacts of climate change and consequent drought on the environment, on water supply, and on the related impacts on food production methods and outputs;

- Securing adequate financial and human resources for the effective functioning of Catchment and Sub-catchment Councils, and ZINWA;
- Enhancing management and monitoring of land use and harvesting practices to arrest water catchment degradation;
- Examining the financing options for ZINWA outside of water sales, given weak demand and also limited supply in the medium term;
- Ensuring stakeholder participation in water management;
- Improving information and data collection throughout the water sector towards better monitoring and management of water resources;
- Halting the destruction of wetlands, particularly in urban areas to rescue ecosystems and preserve the supply of safe water.

### *Solid Waste Management*

- Reversing the deteriorating trend in solid waste management, particularly in urban areas and moving decisively towards resource recovery, recycling, energy generation and composting.

## 9.7 LESSONS LEARNT IN THE IMPLEMENTATION OF TARGETS 7A AND 7B

Zimbabwe's experience with MDG7 Targets 7A and 7B generated the following lessons:

1. Community involvement is critical in environmental management and it also enhances community livelihoods. In this regard, traditional leaders are key

in community conservation initiatives.

2. Inter-sectoral collaboration strengthens horizontal engagements and is a critical component, along with strategic partnerships with regional and global players, of effective environmental management and

sustainability.

3. Poverty is major driver of environmental degradation,

suggesting the need for sustained, inclusive and equitable economic growth to support and sustain environmental protection

## 9.8 THE WAY FORWARD – TOWARDS THE SDGS

Ideally working within a strengthened and sustainable economy and an adequately resourced set of environmental institutions and frameworks, Zimbabwe will need to target the pressing problems of environmental degradation, water supply and management, deforestation, pollution

and loss of biodiversity in the context of the SDGs. Additionally, attention will need to be directed to sustaining the commendable progress made in national and regional conservation of environmental resources.

### Target 7C

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

## 9.9 THE SITUATION – TARGET 7C

During the economic recession from 2000 to 2008, both rural and urban water development and management deteriorated sharply with maintenance and repair works virtually seizing as government could no longer provide the required resources and donors withdrew under general unilateral sanctions. The economic challenges experienced throughout the MDG period have created a situation in which the supply of water and sanitation, even to urban households in urban areas, has become unreliable. The collapse of water revenues that started in the late 1990s and continued in the next decade led to a precipitous deterioration in all water supply and sanitation infrastructure and services.

Despite significant efforts to develop rural WASH sector infrastructure, the imbalance between urban and rural services remains a distinctive feature of the sector. Access to an improved drinking water source<sup>3</sup> was higher in urban areas than in rural areas but the proportion of

urban dwellers who had access to an improved drinking water source did not increase between 2005/06 and 2014. Alongside this, the situation in rural areas became worse as large numbers of people moved to newly resettled areas, where there were no water and sanitation facilities or where infrastructure had been damaged. Open defecation remains high, particularly in rural areas, which is a major health hazard. This, in combination with the deterioration of water and sanitation facilities in both rural and urban areas, and an under-functioning healthcare system during the economic recession, resulted in frequent diarrhoea and cholera outbreaks.

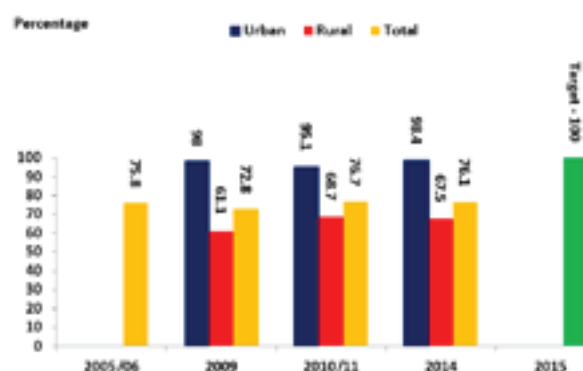
Water treatment is made difficult not only by dilapidated infrastructures, but by intermittent electricity supply for pumping and plant operations, as well as shortages of chemicals. Contamination of water resources occurs from improperly functioning sanitation systems, and inadequate management of industrial and household waste, thus pushing up the cost of purifying water.

<sup>3</sup> Improved water sources - piped water into dwelling/yard/plot, public tap/standpipe, tube well/borehole, protected dug well, protected spring, rainwater or bottled water.

## 9.10 STATUS OF TARGET 7C AND TRENDS

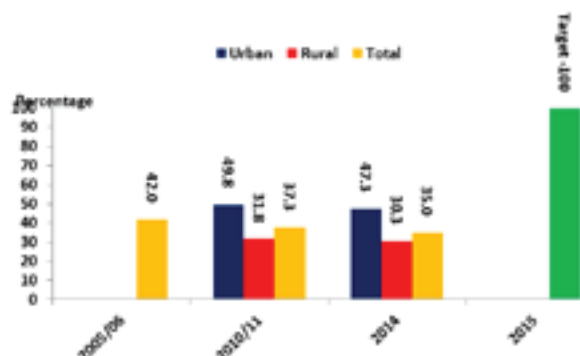
In 2014, 76 percent of the population had access to an improved drinking water source, but this had remained stagnant since 2005/06, see Figure 7C.1. Access to an improved drinking water source was higher in urban areas, at 98.4 percent, than in rural areas, at 67.5 percent, and this pattern persisted throughout the MDG period. In urban areas in particular, during the MDG period, access to safe water generally meant having piped water

Figure 7C.1 Proportion of the Population Using Improved Drinking Water Source, by Place of Residence, 2005/06, 2010/11 and 2014, and 2015 Target



Source: ZIMSTAT - ZDHS, MIMS/MICS

**Figure 7C.2 Proportion of the Population Using Improved (Unshared) Sanitation Facilities, by Place of Residence, 2005/06, 2010/11, 2014 and 2015 Target**



Source: ZIMSTAT - ZDHS, MIMS/MICS

sanitation (unshared)<sup>4</sup> was 35 percent in 2014, only just above one-third of the 2015 MDG target of 100 percent. In fact sanitation, has worsened, as the proportion of the population using improved sanitation facilities has declined from 42 percent in 2005/06, see Figure 7C.2. Access to improved sanitation was higher in urban areas, at 47.3 percent, than in rural areas, at 30 percent.

The proportion of the population with no toilet facility increased from 31.9 percent in 2005/06, to 32.9 percent in 2009, before declining to 28.3 percent in 2010/11, and increasing again to 31.7 percent in 2014, that is, there was an overall slight decline across the period. A hugely higher proportion of the rural population, at 43.5 percent, than of the urban population, at 1.1 percent, had no toilet facility in 2014.

infrastructure but often the taps did not run or had running water of poor quality.

The proportion of the population using improved

<sup>4</sup> Improved sanitation (not shared) facilities - toilets that flush or pour flush to a piped water system, septic tank, or pit latrine; ventilated improved pit (VIP) latrines or Blair toilets; and pit latrines with a slab.

## 9.11 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 7C

### SUCCESSES

There were no explicit successes as measured by the indicators under this target. However, given the near collapse of this sector in the past fifteen years, the fact that WASH provision did not become markedly worse and there was a reduction on the outbreak of water-borne diseases over the period are worth noting.

#### Supportive Environment

The African Union Summit of 2008 articulated a commitment for accelerating the achievement of Water and Sanitation Goals in Africa. This was further buttressed by the second Africa Conference on Sanitation and Hygiene, AfriSan +5, 2008 with a firm resolution to put sanitation and hygiene at the top of Africa's development agenda.

At the regional level, Zimbabwe shares trans-boundary water courses with neighbouring countries, whose utilization to augment Zimbabwe's internal water needs requires cooperation and coordination with its neighbours, through the SADC Revised Protocol on Shared Water Courses, and the SADC Regional Water Policy, 2005.

The supportive environment for broader water management has already been covered in earlier section, the discussion here concentrates on the household level issues of access to safe water and sanitation.

There are several entities involved in rural water and sanitation service provision, with some overlapping

responsibilities and sometimes lack of clarity of roles. Among these:

- *The National Action Committee on Water and Sanitation*, has overarching responsibility for coordination, including review and approval of all district level rural water and sanitation project proposals and plans, and setting policies and standards and implementation strategies for the rural sub-sectors.
- *Rural District Councils (RDCs)*, are responsible for development activities in their jurisdictions, including formulating development plans that integrate water and sanitation services.
- *The Ministry of Health and Child Care (MOHCC)*, is responsible for rural sanitation at the national level, and for promoting environmental health and hygiene nationally.
- *ZINWA*, is mandated with bulk water supply, and in the case of some smaller towns and settlements, with provision of sanitation as well.
- *Local authorities*, have responsibility for urban water distribution and billing, with the institutional arrangements for urban sanitation being similar to those for urban water.

The National Sanitation and Hygiene Strategy, 2011, provides a framework for improving and sustaining

sanitation and hygiene service delivery.

Some of the water and sanitation programmes in place are:

- *The UNICEF Emergency Rehabilitation and Risk Reduction Programme*, from 2009, is implemented in collaboration with GoZ and other partners to provide water treatment chemicals to 20 urban centres and seven catchment areas, rehabilitate water and sanitation systems and promote hygiene in urban and rural areas, as well as schools and clinics.
- *The ZIMWASH Project*, funded under the European Development Fund was made up of non-state (UN, national and community-based) actors and focused on the needs of rural women and children, especially those affected by HIV, to provide facilities, and training for locals to sustain maintenance and future development.
- *The Zimbabwe Multi-Donor Trust Fund*, administered by the African Development Bank, supports water supply and sanitation rehabilitation, particularly, for the six largest municipalities.
- *The Zimbabwe Rural WASH Sector Recovery Programme*, 2012-2015, aims, “To contribute to the reduction of morbidity and mortality due to WASH related diseases; to reduce the burden of water collection on women and girls and to improve dignity, basic education outcomes, gender equality toward achievement of the MDGs by 2015.”

## 9.12 CHALLENGES IN THE IMPLEMENTATION OF TARGET 7C

Challenges remain in terms of financing, institutional structures and programming to meet the WASH needs of Zimbabwe’s rural and urban population and arrest the deterioration of infrastructure and facilities:

- Streamlining the currently fragmented implementation and policy-making structure for WASH to ensure clarity of roles, responsibility and accountability.
- Finding alternative funding models for WASH infrastructure development, operation, and maintenance, given the collapse of water revenues that started in the late 1990s and continued for decade leading to a precipitous deterioration in sanitation infrastructure and services.
- Addressing the wide disparity between urban and rural areas in terms of access to water and sanitation, in the interests of equitable development and particularly to lessen the burden of sanitation and health related work for women and girls.
- Reversing the current deterioration in water and sanitation quality for both urban and rural populations in order to direct development towards meeting sanitation, health and safety targets in an equitable manner.

## 9.13 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGET 7C

Zimbabwe’s experience with MDG7 Target 7C generated the following lessons:

- The water, sanitation and hygiene (WASH) sector requires huge investment in order for it to recover and move on to making progress in improving access by the whole population.
- Development of WASH in rural areas is most likely to be sustainability if a demand led, rather than a supply led model, and community led management of infrastructure and environmental management are applied.

## 9.14 THE WAY FORWARD – TOWARDS THE SDGS

During the MDG period, in the face of severe economic crisis and consequent near collapse of water and sanitation, health delivery and other systems, as well as exogenous factors such as climate change, Zimbabwe struggled even to maintain existing levels of WASH infrastructure and provision. In the SDG period, Zimbabwe needs to move towards setting and achieving much higher targets for quantity, quality and equity of WASH provision.

## Target 7D

By 2020, to have achieved a significant improvement in the lives of at least 100 million slum<sup>5</sup> dwellers (globally).

### 9.15 THE SITUATION – TARGET 7D

*5 According to the 2015 UN MDG Database metadata, a slum household is defined as a group of individuals living under the same roof lacking one or more of the following conditions: access to improved water; access to improved sanitation; sufficient living area; durability of housing; security of tenure. However, since information on secure tenure is not available for most of the countries, only the first four indicators are used to define slum household, and then to estimate the proportion of urban population living in slums.*

There was no notable progress in the national level housing indicators being monitored under the MDGs, even though, some housing schemes are being implemented in Zimbabwe.

There is a comprehensive legal framework for housing in Zimbabwe and institutions with critical mandates for the development and management of housing in Zimbabwe exist at the levels of central and local government, in the private sector and in civil society. Nonetheless, most poor Zimbabweans lack access to decent and secure housing and many live in settlements that lack basic infrastructure and sustainable services, particularly in urban areas. Some neighbourhoods are overcrowded and the infrastructure in these sites fails frequently.

Investment in housing by the state and non-state sectors has been low. There was a huge housing backlog across all housing types in 2012, with the Ministry of Local Government, Public Works and National Housing (MLGPWNH) constructing only about 4 percent of the

required number of new units each year. Construction was even lower during the recession period from 2000 to 2008, largely because the hyperinflationary environment rendered medium term construction projects too risky and unviable, and led to the collapse of housing loan schemes.

Provision of urban accommodation is inadequate, with 47.2 percent of the urban households living in lodged accommodation in 2012, and close to half of these being in Harare province. Lodged accommodation, unlike tenancy, is usually characterised by indecency (overcrowding and lack of privacy) and insecurity of tenure.

The increase in slums, largely in the form of informal urban and peri-urban settlements is an issue of concern, with the slum population as a percentage of urban population having increased nearly eight-fold between 2000 and 2014.

### 9.16 STATUS OF TARGET 7D AND TRENDS

Secure, good quality housing and its associated infrastructure (water, sanitation, drainage, electricity and waste disposal) is vital to people's wellbeing. Relocation, forced eviction and the impact of natural disasters particularly threaten women's and children's welfare and development. When communities are forcibly evicted and moved to areas where they have no source of livelihood, men tend to migrate in search of work and leave women and children behind fendng for themselves.

According to the 2012 Zimbabwe National Housing Policy, most poor Zimbabweans lack access to decent and secure housing. Overcrowding is rife and studies show that some high density stands are shared by as many as 22 people, instead of the recommended six people. The housing backlog is thus seen in needs that are completely unmet as well as cases where needs are partially met. Evidence of partial meeting of needs is seen in informal settlements as well as existing formal settlements where services are strained – sewer bursts, water outages, bad road networks, and overcrowded health and education

facilities.

There is a huge housing backlog in terms of both the number of new housing units and facilities needed as well as old units and facilities needing refurbishment. Although no comprehensive assessment has been done, at least 1.25 million new units were estimated as the backlog across all housing types in 2012. The MLGPWNH has a target of building 250 000 housing units per year, but in the past ten years, has constructed, on average, only 10 000 to 15 000 units only. During the recession period, from 2000 to 2005, this was reduced to a meagre 5 000 units per year, with not much housing activity during 2006 and 2008, because of hyperinflation. Overall, during the MDG period, macroeconomic constraints and sector specific constraints slowed land delivery, dried up housing finance, made expansion of trunk services nearly impossible and drained capacity in key institutions. These combined to stall progress in supplying new units and maintaining existing ones. Investment levels by the state and non-state sectors have been low.



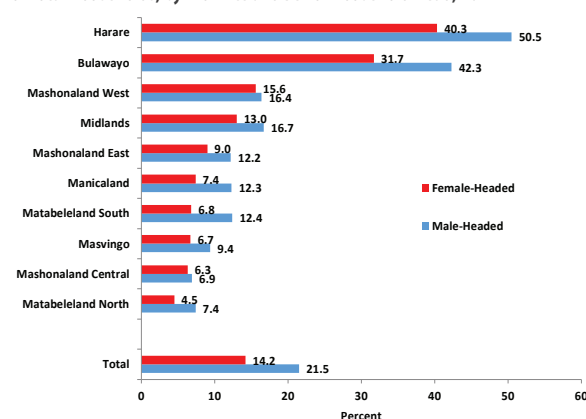
The sector vision of ‘a nation with sustainable housing’ is inspired by a quest for: orderly development; improvements to inadequate conditions including slum upgrading and urban renewal; improving building materials technology; and improving institutional performance and relations.

### Population in Slums, Lodging and in Shacks

Provision of adequate urban accommodation remains a major challenge in Zimbabwe, with 47.2 percent of urban households living in lodged accommodation in 2012, see Figure 7D.1. Harare had the highest proportion of households living in lodged accommodation, at 47.9 percent, followed by Bulawayo, with 38.5 percent. Unlike tenancy, lodged accommodation, is frequently characterised by indecency and insecurity of tenure. Nationally and in all the provinces, higher proportions of male-headed households were living in lodged accommodation than female-headed ones.

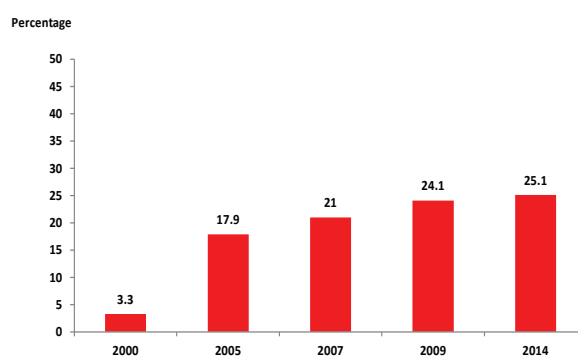
The increase in slums, largely in the form of informal urban and peri-urban settlements is concerning. The slum population as a percentage of urban population has steadily increased from 3.3 percent in 2000 to 25.1 percent in 2014. Nationally, in 2012, 0.9 percent of households lived in shacks. In all provinces, higher proportions of male-headed households than female-headed households were living in shack accommodation. Both the high levels of lodging and increasing level of slum dwelling are primarily a result of the slow speed of construction of new houses, amidst increasing rural-to-urban migration, leading to huge backlogs of even low cost housing units.

Figure 7D.1 Households with Tenure Status of Lodger as a Proportion of Total Households, by Province and Sex of Household Head, 2012



Source: ZIMSTAT - 2012 Population Census

Figure 7D.2 Slum Population as a Proportion of the Urban Population, 2000, 2005, 2007, 2009 and 2014



Source: UN MDG Database

## 9.17 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 7D

### SUCCESSES

Although, some housing schemes are being implemented in the country, there was no notable progress in the housing indicators being monitored under the MDGs nationally.

### Supportive Environment

The National Housing Delivery Programme (NHDP), 2004-2008, facilitated the revision of the housing policy which had been in place before 2000. The NHDP allowed the introduction of new appropriate building technology, participation of the informal sector in the building industry, and enhanced affordability of houses. In 2009, a National Housing Convention was held, culminating in the formulation of the Zimbabwe Housing Policy, 2012, to be operationalised within the context of the ZimAsset, 2014-2018, through the new NHDP, 2014-2018, with a target of 313 368 housing units and serviced stands.

Prior to this, there was already a comprehensive legal

framework for housing in Zimbabwe encompassing the 2013 Constitution of Zimbabwe, local government law, land law, and Acts governing environmental management, regional, town and country planning, lending institutions, professions (architecture, engineering, surveying), building, and housing standards.

Some of the institutions playing a critical role in the development and management of housing in Zimbabwe occur at the levels of central and local government; in the private sector; and in civil society as outlined below:

### Central Government

- The MLGPWNH is the lead Ministry responsible for sector policy formulation, implementation (including direct provision and maintenance), monitoring and review, as well as supervising local authorities, hosts the national spatial planning agency, and administering urban state land.

- The Ministry of Environment, Water, and Climate oversees environmental stewardship through, the EMA, which administers the Environmental Management Act.
- The Ministry of Health and Child Care administers the Public Health Act among other legislation with a bearing on human settlement standards and administration.
- The Ministry of Justice, Legal and Parliamentary Affairs, is the custodian of the deeds registry functions including administration of the property conveyancing system in the country.

#### **Local Authorities**

- The 92 local authorities are the land and planning authorities in rural and urban areas and participate in all steps of housing development and management, as direct providers of key services, regulators of the activities of private developers and as partners of state, private and civil society actors.

#### **National and International Development Organisations**

- Some leading non-state actors are Dialogue on Shelter for the Homeless People in Zimbabwe Trust (Dialogue), the Zimbabwe Homeless People's Federation (ZHPPF), the Zimbabwe National Association of Housing Cooperatives (ZINAHCO), Housing People of Zimbabwe (HPZ) Civic Forum on Housing, and several community-based organisations (CBOs).
- The Zimbabwe Human Settlements Programme (ZIMHABITAT) is a platform for stakeholder interaction on housing matters in Zimbabwe.
- A number of international development organisations have had a history of supporting housing development and management in Zimbabwe, including UN Habitat, bilateral agencies like Swedish International Development Cooperation Agency (SIDA), the Canadian International Development Agency (CIDA) and United States Agency for International Development (USAID), multilateral agencies like the World Bank and the African Development Bank (AfDB); and private foundations such as the Bill and Melinda Gates Foundation.

#### **The Private Sector**

- To date, these have been mainly Zimbabwean land development companies, Pension Funds and Building Societies, as well as private companies (especially in mining) involved in company-housing schemes for their employees, land owners in urban, peri-urban and rural areas; and the global private sector.

#### **Professional Institutes**

- Institutes of engineers, planners, surveyors, architects and realtors, are directly involved in housing development and management, bringing different perspectives which could make housing development and management responsive to people's different needs.

#### **Consumers of Human Settlement Services**

- Ultimately, housing goods and services are consumed by individual households in rural, peri-urban and urban areas, with different needs and resource levels.

There are several housing programmes underway in the country, including:

- The Urban Housing Expansion Programme, in which Central and Local Government, and the private sector provide serviced land on which home seekers build their own homes;
- The Poor Quality Housing Upgrading Programme, designed to provide decent housing for increasing numbers of urban dwellers by 2015;
- The National Housing Delivery Programme;
- The Housing Fund for Civil Servants;
- The National Housing Development Loan Facility; and
- Shelter Afrique.

The Government position is to see rural houses matching the minimum standards of urban houses, that is, a house must be constructed of material that is durable and non-combustible and meet other specifications in terms of ventilation, lighting and size of respective rooms.

## **9.18 CHALLENGES IN THE IMPLEMENTATION OF TARGET 7D**

The challenges in relation to urban and peri-urban populations and the economy are:

- Provision of adequate housing to meet the needs of a rising urban population, while improving the conditions of current urban dwellers in lodged and shack accommodation; and

- Ensuring sufficient national budgetary allocation in combination facilitation of private sector investment in conditions of economic stability and predictability.

The infrastructure and superstructure challenges include:

- Developing and maintaining off-site infrastructure

to support and make feasible new housing developments without further overloading existing infrastructure;

- Formulation of deliberate policy to provide adequate, affordable and functional housing and related infrastructure to Zimbabweans in farming communities, including those resettled under the FTLRP.

The following challenges exist in terms of land acquisition, land-use planning, surveying and registration:

- Simplifying and streamlining the administrative processes for availing land for housing, to reduce

land-related bottlenecks to housing delivery;

- Addressing urban land scarcity as a constraint to the provision of adequate housing, while discouraging construction of houses on wetlands because of the negative impacts this has on the environment.

In terms of housing policy and the legislative framework, the challenge is to:

- Ensure that the mix of policies and laws governing housing development and management is pro-poor in line with Zimbabwe's broader development objectives

## 9.19 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGET 7D

Zimbabwe's experience with MDG7 Target 7D generated the following lessons:

- A reliable and sustainable housing finance system is critical to effective housing delivery and this can only be assured through sustained good economic performance and appropriate budgetary allocations.
- Strengthening of public-private partnerships and

strategic partnerships with non-state actors and development partners, is needed to complement Government resources going to the housing sector.

- It is necessary to review outdated housing legislation including local authority by-laws in order to create a conducive environment for groups and individual households to provide themselves with decent accommodation.

## 9.20 THE WAY FORWARD – TOWARDS THE SDGS

In order to bridge the current housing backlog and meet the objective of appropriate housing for all Zimbabweans, it will be necessary to work on a number of fronts, including in terms of political will, strategic and innovative modes of financing, and a user friendly regulatory framework.

At the same time, housing needs will have to be balanced against environmental concerns, with the medium to long term objective of providing housing that is safe and sustainable, within a healthy and sustainable environment.



## Chapter 10

# MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

## SUMMARY OF PROGRESS

### Target 8A

Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

### Target 8C

Address the special needs of landlocked developing countries

### Target 8D

Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Zimbabwe was ranked 170 out of 189 economies in 2014 in terms of ease of doing business in 2014.

Zimbabwe is a regional leader in the use of computerised customs clearance systems but, at 15.4 percent, its average applied tariff rate is among the highest in the region.

Exports declined during the recession, from US\$2.5 billion in 2000, to US\$ 1.6 billion in 2009, before rising to US\$ 4.4 billion in 2011, and to US\$ 5.6 billion in 2014.

Imports increased from US\$1.9 billion in 2000, to US\$3.2 billion in 2009, and to US\$7.6 billion in 2011, before declining to US\$6.3 billion in 2014.

Total external trade as a percentage of GDP increased from 94 percent in 2009, to 106 percent in 2010, to 125 percent in 2011, showing increasing openness, mainly due to increasing imports.

The country's Balance of Payments (BOP) as a percentage of GDP was -1.4 percent in 2000, dropping to -21.1 percent in 2009, and recovering to -0.3 percent in 2014, against a background of no BoP support.

The introduction of toll gates in 2009 has facilitated the mobilisation of resources, and use of public-private partnerships (PPPs) for rehabilitation and maintenance of the road network is progressive.

Twelve new indigenous banking institutions have been formed since 2000 and have eclipsed traditional foreign owned institutions in terms of products, service, balance sheet and profitability.

The 2003 and 2004 banking sector crisis was characterised by liquidity and corporate governance challenges, leading to 17 financial institutions under liquidation or placed under curatorship.

Total banking sector deposits increased from US\$706 million in June 2009 to US\$5.6 billion in June 2015, signalling improving public confidence in the banking system, but these are mostly short-term deposits.

Financial sector inclusion has improved with the roll out of various mobile financial services valued at US\$60 million from January to October, 2014, and the introduction of the bond coins in December 2014.

External debt has risen in the past 15 years from a total of US\$ 3 422 million in 2000, of which US\$471 million was arrears, to US\$10 839 million in 2015, of which US\$5 556 million is arrears.

Debt as a percent of GDP rose from 28.8 percent in 2000, to peak at 81.5 percent in 2008, while debt as a percent of exports rose from 139.3 percent in 2000, to peak at 415 percent in 2009, before declining.

External debt service as a percent of GDP rose from 31.5 percent in 2000, peaking at 147.7 percent in 2007, before stabilising at between 60 percent to 70 percent between 2008 and 2014.

### SUCCESSSES

- No major economic success, but Zimbabwe introduced toll gates in 2009 which facilitate mobilisation of domestic resources, upgraded its computerised customs clearance systems, set

banking sector deposits on an upward trajectory, and increased financial sector inclusion.

### CHALLENGES

- Diversification of the economy to increase value addition and reduce the reliance on vulnerable and low value primary products.
- Continuing to build the performance of and confidence in the banking sector.

### LESSON LEARNT

The effective financing of the SDGs will involve, strengthened national economic performance, increased foreign inflows (both investment and development assistance) in the context of improved foreign relations, and the continuation and expansion of innovative domestic resource mobilisation strategies.

## Target 8E

In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Availability of selected medicines/health commodities improved from 2009 to 2013, from 8.3 percent to 82.6 percent of health facilities having at least 80 percent, with rural-urban parity.

Availability of selected essential medicines improved from 8.8 percent of the health facilities having at least 80 percent in 2009, to 82.5 percent in 2013, urban areas being best off with 86.8 percent.

Availability of selected antibiotics improved from 19.6 percent of the health facilities having at least 80 percent in 2009, to 94.6 percent in 2013, with parity across rural and urban areas, and health facility type.

The number of health facilities with at least 70 percent of listed vaccines increased from 55 percent in 2009 to 92.8 percent in 2013, with no rural-urban disparities.

Availability of selected paediatric medicines improved from 72.4 percent of the health facilities having at least 80 percent in 2011), to 90.4 percent in 2013, with rural facilities better off by a factor of around 1.1.

In 2013, 93.2 percent of health facilities had stocks of vitamin A available, with rural health facilities better off, at 94.3 percent, than urban ones, at 86.6 percent.

Recently there has been a general decline in medicines availability across all health facilities, from 94.8 percent of health facilities reporting improved medicines supplies in 2011, 55.5 percent in 2013. With central hospitals being the worst off.

Availability of ARVs was 59.1 percent in 2013, lower than 69.6 percent in 2011, with provincial hospitals had the highest ARV availability, at 88.1 percent, and urban hospitals the lowest, at 33.3 percent.

On average 66.2 percent of prescriptions surveyed were prescribed using full generic names as required by the national policy, an improvement from 41.6 percent in 2011.

### SUCCESSSES

- There was a marked improvement in the availability of selected medicines and health commodities, essential medicines, antibiotics, vaccines, paediatric medicines, vitamin A and ARVs in all health facilities, ranging from an increase of 8 percentage points in the case of paediatric medicines, to a ten-fold increase in the case of selected medicines and health commodities.
- Parity between rural and urban areas and across different types of health facility was achieved on many (although not all) of these indicators.

### CHALLENGES

Sustaining supply and availability of medicines in the face of recent declines, and the fragility of a system that is still totally reliant on multi-donor trust funds, by increasing the domestic/government contribution to medicines provision in the medium term and supporting the local drug manufacturing sector.

Reviewing and rationalising the dominance of NatPharm and central hospitals as suppliers of medicines, either to strengthen their performance, or to open up alternative supply sources.

### LESSONS LEARNT

Coordination of medicines provision has been beneficial in terms of efficiency in procurement and delivery, control of medicines quality, and harmonisation of treatment guidelines.

It will be necessary to provide an enabling policy environment for local manufacture of medicines to ensure sustainability into the future.

Target 8F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications technologies (ICTs)

Mobile-cellular technology reached 80.8 percent penetration by 2014, up from 2.1 percent in 2000.

Mobile-cellular subscriptions rose from 266 441 in 2000, to 11 798 652 in 2014, an increase of 4 328 percent or an average of 289 percent per annum, while fixed line subscriptions declined over this period.

In 2009 when mobile internet service was introduced there were 142 000 subscribers, increasing to over 2. 225 million by 2012, an increase of 1 460 percent, and an average annual growth of over 486 percent.

Internet users per 100 inhabitants rose from 0.4 in 2000, to 11.4 in 2009, and to 19.9 in 2014.

Fixed broadband users per 100 inhabitants rose from zero in 2000 to 1.0 in 2014, with 152 234 subscriptions in 2014, up from 771 in 2001, an increase of 10 645 percent.

In 2011, 36.3 percent of households had a television and 37.9 percent had a radio.

### MAJOR SUCCESSES

- There has been huge success in terms of the uptake of mobile-cellular technology, with around 4 000 percent increase in penetration and number of subscriptions and this technology has undergirded a similarly steep increase in use of mobile internet services.
- On the programming front: implementation of the E-Agriculture Application has supported newly resettled farmers; the E-Learning Model has enhanced ICT based learning in schools; government supported community information centres (CICs) have increased national Internet penetration rate and convenient availability of technical information (for example, agricultural and medical) away from main centres.

### CHALLENGES

- Achieving efficiencies to expand the existing backbone structure and access network while seeking to increase connection speeds and reduce costs to the consumer.
- Creation of a policy framework to include an explicit policy on infrastructure sharing, cyber security policy, and forward looking licencing policy.
- Overcoming the rural-urban digital divide, noting that rural electrification is essential to ICT rollout.

### LESSON LEARNT

Very rapid uptake of ICTs demonstrates their benefits to development in terms of speed of and access to information, creating information interlinkages between sectors, and providing private sector growth and job creation opportunities. Therefore, strategies aimed at broad based and equitable increases in ICT access and utilisation can be expected to yield exponential developmental impacts.

#### Target 8A

Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

#### Target 8C

Address the special needs of landlocked developing countries

#### Target 8D

Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

## 10.1 THE SITUATION – TARGETS 8A, 8C AND 8D

Zimbabwe began its efforts towards achieving the MDGs in the context of unfavourable international relations, marked by unilateral sanctions by: the European Union (EU), the United States of America (USA), Australia, and Canada; the suspension of financial support from the international financial institutions (IFIs); and general bilateral donor withdrawal. Throughout the MDG period, such ODA as was received was almost entirely limited to humanitarian assistance. Thus the country was reliant on domestic resources to meet its development goals, and these resources were near to non-existent in the context of the deep economic recession from 2000 to 2008, and even during the fragile recovery which has taken place since 2009. The prevailing environment was not conducive to either the domestic or the foreign investment that might have enabled the private sector to thrive and invest further.

Even after adopting a multi-currency system in 2009, which stabilised the macroeconomic environment, the 'new normal' in Zimbabwe was still characterised by liquidity crunch; low and fast declining economic growth; severely shrinking fiscal space; low inflation which quickly degenerated into disinflation and then into deflation, further undermining investment; depressed aggregate demand; continued deindustrialisation; high indebtedness; and high unemployment and

underemployment, particularly among the urban youth.

Savings as a proportion of GDP were negative, even in 2011, while gross fixed capital formation (GFCF) as a percent of GDP remained weak and well below target, and FDI flows recovered only slightly by 2014. A banking transformation since 2000 has seen the establishment of new indigenous banks, an ongoing rise in banking sector deposits and enhanced inclusion in the financial sector through a range of new instruments including mobile phone applications. Despite being a signatory to a number of bilateral, regional and multilateral trading arrangements, and pursuing a 'look east' policy in the face of disagreement with its traditional trading partners, the external sector position remained precarious up to 2008, and even since then, BoP and the trade balance both remain in deficit. Net ODA, both as a percentage of GNI and in terms of volume, has improved along with Zimbabwe's renewed international relations, although the inflows are still mostly for humanitarian assistance. Zimbabwe's total debt figure and the amount by which the country is in arrears ballooned over the MDG period, although not surpassing the recommended limit of 120 percent, but are now subject attempts to reign in debt through nationally designed management measures and internationally agreed informal monitoring.

## 10.2 STATUS OF TARGETS 8A, 8C AND 8D, AND TRENDS

Financing is critical to the development agenda, yet there was no clear mechanism for the UN to enforce funding commitments under the MDGs and these were far from being realised. Specifically, in the case of Zimbabwe, access to global development finances was always likely to be difficult because of unfavourable international relations which were marked by unilateral sanctions by the EU, the USA, Australia and Canada, the suspension of financial support from the IFIs; and general bilateral donor withdrawal. At the same time, the gap could not be plugged by domestic resources as these became increasingly scarce during the deep economic recession of 2000 to 2008, and still fragile recovery that has taken place since 2009.

### *Budget Deficit/Surplus*

The economy operated under budget deficits, throughout the period, 2000 to 2008. From 2009 onwards, the country adopted a cash budgeting system, resulting in a general balanced budget, although also creating severely limited fiscal space, which has undermined the country's development efforts.

### *Savings and Investment*

The economy has been in a severe dis-saving mode throughout the MDG period, with savings as a proportion of GDP being -25 percent in 2004 and -1

percent in 2011, against a recommended target of at least 20 percent per annum, to support investment, see Figure 8.5. Gross Fixed Capital Formation as a proportion of GDP remained weak and way below the recommended level of 25 percent per annum, throughout the MDG period, declining during the recession from 12.2 percent in 2000, to 2.9 percent in 2007, before recovering to 21.7 percent in 2010, and declining again to 11.2 percent in 2014.

Net foreign direct investment (FDI) flows were insignificant during the recession, recording levels of US\$23.2 million in 2000, and US\$51.6 million in 2008, before recovering to US\$105 million in 2009, US\$344.3 million in 2011, and US\$472.8 million in 2014. Although slowly recovering, the current levels are still very low in comparison to other countries in the SADC sub-region, with Zambia and Mozambique recording nearly US\$2 billion each in 2011, Madagascar, at US\$5 billion), South Africa, at US\$6 billion, Angola, at US\$14 billion, and Mauritius, at US\$38 billion.

In the World Bank report, Ease of Doing Business 2014, Zimbabwe was ranked 170 out of 189 economies in 2014 in terms of overall ease of doing business.



## Target 8A

Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

### 10.3 STATUS OF TARGET 8A AND TRENDS

#### *Zimbabwe's Trade Context*

The second World Trade Organisation (WTO) review of the trade policies and practices of Zimbabwe took place in October 2011. It acknowledged that, since the first review in 1994, Zimbabwe had experienced significant socioeconomic and political developments with impacts on both formulation and application of its trade policy. The imposition of sanctions by sections of the international community had a hugely negative effect on the Zimbabwean economy. Not only did the sanctions imply the suspension of the budgetary support previously provided by the EU and other donors, and the withdrawal of support by the IFIs, but also bilateral creditors and donors reduced or suspended disbursements on existing loans to the Government and parastatals. Except for humanitarian aid, Zimbabwe received very little development assistance during the MDG period. In response, Zimbabwe was forced to adopt an inward looking policy, the application of which may have been inconsistent with the central tenets of its commitments to the WTO.

On the trade front, this overarching global context contributed to persistent capital account deficits and reduced foreign currency capital inflows which led to pressures on foreign exchange reserves. Thus the government faced difficulty in raising resources to finance critical imports such as grain, drugs, raw materials, fuel and electricity. For a country that has to import 100 percent of its fuel and 40 percent of its electricity, the scarcity of these, along with limited capacity to import essential spare parts and raw materials, had a severe impact on industrial production, which fell to below 10 percent of capacity by 2008. Zimbabwe's renewed commitment to fiscal discipline and its de-facto adoption of the US dollar as legal tender under the implementation of its multi-currency system in February 2009 brought macroeconomic stability and improved its trade prospects.

Zimbabwe has lowered applied Most Favoured Nations (MFN) tariff rates unilaterally, with a view to reducing production costs. However, at 15.4 percent, its simple average applied MFN tariff is among the highest in the region. A range of other duties and charges may also be imposed on imports and/or exports. Internal taxes are applied to imports and locally produced goods. Export bans/suspensions or taxes may apply to selected products on value-addition or self-sufficiency grounds. Tariff suspensions are in place for a number of essential food items, and full rebates of the customs tariff and value added tax (VAT) may be granted for a variety of reasons. The particular focus on inputs under some rebate schemes

increases the effective protection of selected industries.

Zimbabwe is among the regional leaders in the deployment and upgrading of computerised customs clearance systems. It levies customs duties on the c.i.f. value of imports, computed as an aggregate of all costs up to the point of entry into its customs territory, giving preferential treatment of shipments from some of its neighbouring countries over those from any other African country. Permits/licences are maintained on security, health, sanitary and phyto-sanitary (SPS), moral, and environmental grounds. The documentation required for customs clearance often involves more than one competent authority, each of which may levy fees and charges independently.

The simple average tariff rates for Zimbabwe's preferential partners range from 0.2 percent (SADC excluding South Africa) to 11.4 percent (South Africa). Zimbabwe's Competition and Tariff Commission, which is responsible for investigating and correcting anti-competitive conduct on the domestic market, also plays an investigative role in trade remedies. Zimbabwe's procurement legislation provides for a 10 percent price preference to suppliers whose operations have local downstream and social benefits, as well as to 'previously economically disadvantaged' suppliers.

Efforts to bring Zimbabwe's intellectual property regime into line with the provisions of the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement of the WTO have translated into a number of legislative amendments, most of which entered into force from 2001 to 2004. Zimbabwe recognises patent, industrial design, and trade mark applications filed through the African Regional Intellectual Property Organisation (ARIPO) to which it is a party.

As the leading sector in Zimbabwe's poverty reduction strategy, agriculture remains heavily protected and supported, including through high tariffs and a price band system. Mining also has remained a preferred sector despite its marginal contribution to growth. Mining imports are subject to an average tariff rate of 5.9 percent for the extractive industries but the inclusion of various surcharges raises the average border charge to 31.3 percent. Imported manufactured goods face import duties and charges, while local manufacturing is supported through trade policy measures such as duty drawback and inward processing rebate schemes, import and export licensing, and tariff and tax concessions on various imported inputs and capital goods. The average tariff protection

for manufactured products is 15.4 percent, with tariff rates ranging up to 140 percent in industries including food products, beverages, wood and wood products, and tobacco.

Zimbabwe's specific commitments under the General Agreement on Trade in Services (GATS) are limited and cover only financial services (insurance and insurance related services; and banking and other financial services), tourism, and telecommunication services. Its Schedule includes some horizontal restrictions on market access.

### Trading Arrangements

Zimbabwe is signatory to a number of bilateral, regional and multilateral trading arrangements. These include:

Membership of the Common Market for Eastern and Southern Africa (COMESA) and Southern African Development Community (SADC) Free Trade Area (FTA) Protocols in support of the regional integration agenda, including participating in the preparations for the transformation of the SADC FTA into a Customs Union.

Being a party to the Tripartite FTA initiative among the three regional economic communities (RECs) namely COMESA, SADC and East African Community (EAC), which seeks to harmonise the trade regimes of the partners, enable movement of business persons, and facilitate joint implementation of regional infrastructure projects and programmes, and legal and institutional arrangements.

Being a signatory, as part of the Eastern and Southern Africa (ESA) group, to the African Caribbean Pacific (ACP)-European Union (EU) Cotonou Partnership Agreement that was governed by the Lome Conventions between 1975 and 2000, providing for WTO compliant

reciprocal trade arrangements between the ACP countries and the EU.

Membership, since its inauguration, of the WTO (having been a GATT Contracting Party), particularly working within this organisation in the ACP group, the WTO African Group, the G-90, and the G-33 and G-20 agricultural groupings of developing countries.

Membership of the Global System of Trade Preferences (GSTP) arrangement which provides for preferential tariff concessions and other forms of cooperation aimed at opening up and increasing trade among developing countries in the context of south-south cooperation.

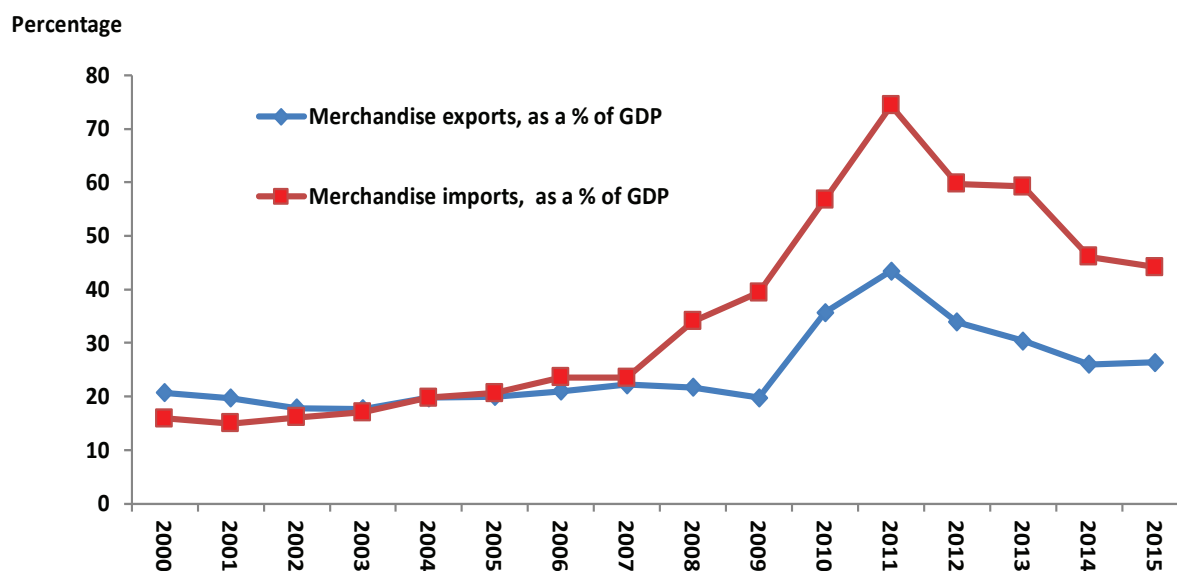
Zimbabwe has been penalised in its formal participation in aid for trade due to sanctions but was able to participate in this approach through regional institutions such as COMESA and SADC, in regional integration programmes in the areas of trade facilitation (Chirundu One-Stop Border Post), private sector participation in trade, ICT, technical assistance and product development.

### Trade and BoP

The country's external sector position remained precarious for the period 1997 to 2008, against the background of declining export performance, increased imports and declining capital inflows. The government responded to unfavourable relations with traditional trading partners by adopting a Look East Policy, targeting China, the Asian and Middle East markets. Thus, the SADC FTA, COMESA, EU, and the East, remain key free trading blocks for Zimbabwe.

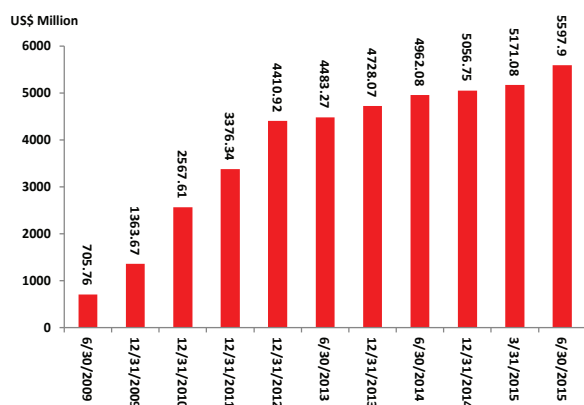
Zimbabwe remains a net importer of goods and services, with the gap widening since 2008, see Figure 8A.1. Exports declined during the recession period from US\$2.5

Figure 8A.1 Merchandise Exports and Imports as a Proportion of GDP, 2000 to 2015



Source: RBZ, 2015

Figure 8A.2 Total Banking Sector Deposits, \$US Million, June 2009 to June 2015



Source: RBZ, 2015

billion in 2000, to US\$1.6 billion in 2009, before rising to a peak of US\$4.4 billion in 2011 and declining again to US\$5.6 billion in 2014, in line with sluggish economic performance. Imports remained high, and rose as a result of reduced domestic production and shortage of basic commodities during the same period, increasing from US\$1.9 billion in 2000, to US\$3.2 billion in 2009, then to US\$7.6 billion in 2011, before declining to US\$6.3 billion in 2014. Merchandise exports as a percentage of GDP increased from 20.7 percent in 2000, to 43.4 percent in 2011, before declining to 26 percent in 2014, see Figure 8A.1. Merchandise imports increased from 15.9 percent of GDP in 2000, to a staggering 74.4 percent in 2011, before declining to 46.1 percent in 2014. Total external trade as a percentage of GDP increased from 94 percent in 2009, to 106 percent in 2010, to 125 percent in 2011, showing increasing openness, mainly due to increasing imports.

The current account remained in deficit throughout the MDG period, with the deficit increasing from negative US\$146.2 million in 2000, to negative US\$3 065.3 million in 2014. The capital account, which was at negative US\$315.2 million in 2000, remained negative until 2004, became positive by 2005, and reached US\$369.4 million in 2014.

The country's Balance of Payments (BOP) position has remained in deficit since 2000, with BOP as a percentage of GDP being -1.4 percent in 2000, deteriorating to -21.1 percent in 2009, before recovering to -0.3 percent in 2014, against a background of the country receiving no BoP support.

### Banking and Finance

Zimbabwe's banking and finance sector has been through a process of transformation since 2000, with twelve new banking institutions being

formed<sup>1</sup> and one existing institution closing<sup>2</sup> during the economic recession from 2000 to 2008.<sup>3</sup> During 2003 and 2004, the banking sector experienced a crisis which was characterised by liquidity and corporate governance challenges. Shortly before the crisis, newly established indigenous banks had successfully eclipsed traditional foreign owned institutions in several areas such as product offerings, customer service, balance sheet and profitability.<sup>4</sup>

However, the crisis culminated in several banks being placed under curatorship while others were summarily closed, following the Reserve Bank of Zimbabwe's (RBZ) tightening of liquidity in the market in December 2003.<sup>5</sup>

Consequently, seventeen financial institutions were put under liquidation or placed under curatorship.<sup>6</sup> This incident has left an indelible mark on the banking and finance sector.

The Zimbabwean economy dollarised informally during the last half of 2008, following the precipitous loss in value of the local currency.<sup>7</sup> Monetary authorities responded by formalising the use of foreign currency by the transacting public through issuing selected wholesalers and retailers with licenses to sell goods in foreign currency in September 2008, under the Foreign Currency Licensed Warehouses and Retail Shops (FOLIWARs). The country moved a step further and introduced a multiple-currency system in January 2009.

In its first monetary policy statement for 2014, the Reserve Bank of Zimbabwe (RBZ) announced that the Chinese Yuan Renminbi, Japanese Yen, Indian

1 Interfin Merchant Bank; Agricultural Bank of Zimbabwe (Agribank); TrustFin; Century Bank; Trust Banking Corporation; Renaissance Merchant Bank; Intermarket Banking Corporation; Royal Bank of Zimbabwe Limited; Premier Discount House; Barbican Bank Limited; Sunpol Finance; and Leasing Company of Zimbabwe.

2 Universal Merchant Bank (Unibank).

3 Reserve Bank of Zimbabwe Annual Report, Various Issues.

4 While the traditional banks such as Barclays, Standard Chartered and Stanbic chose to remain conservative, indigenously-owned banks such as Trust, Barbican and NMB aggressively rolled out new products and perfected customer services. The traditional foreign owned banks not only lost their clients, but also staff, to the new banks which had embraced modern banking technologies and competitive remuneration policies.

5 RBZ Annual Reports for 2001 to 2008.

6 Genesis Investment Bank; ENG Capital Investments (Pvt) Ltd (collapsed); First National Building Society; Barbican Bank Limited, Commercial Bank; Century Discount House (liquidation); CFX Bank Limited; CFX Merchant Bank; Intermarket Banking Corporation Limited; Intermarket Building Society; Royal Bank of Zimbabwe Limited; Time Bank Zimbabwe Limited; Trust Bank Corporation Limited; Barbican Asset Management (liquidation); Rapid Discount House (liquidation); Intermarket Discount House; CFX Asset Management; and Intermarket Discount House.

7 Consequently, economic agents conducted business transactions in secret, with basic goods disappearing from formal markets only to resurface in the thriving black market where they fetched foreign currency.

Rupee and Australian Dollar, would be accepted as legal tender alongside the US Dollar, South African Rand, Botswana Pula and British Pound.<sup>8</sup> Total banking sector deposits continued on an upward trajectory, from a low base of US\$706 million in June 2009, to US\$5.6 billion in June 2015, which is a 693 percent increase, see Figure 8A.2.

In addition, given high mobile phone penetration, financial sector inclusion has improved significantly with the roll out of various mobile financial services valued at US\$60 million from January to October 2014, such as Ecocash, One Wallet, and Telecash.

Zimbabwe has made significant progress in advancing financial sector reforms aimed at restoring confidence and enhancing financial stability, including through the recapitalisation of the RBZ and making critical amendments to the Reserve Bank and Banking Acts, aimed at further strengthening the legal and regulatory frameworks.

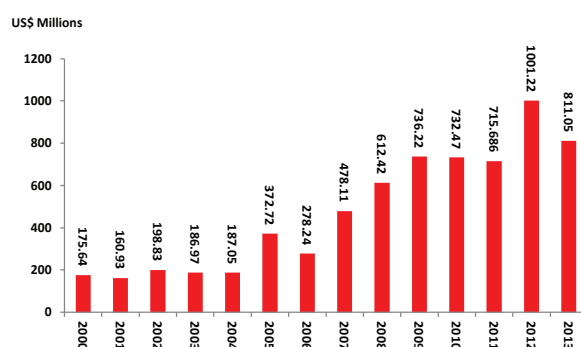
### Official Development Assistance

Net ODA as a proportion of GNI (mostly for humanitarian assistance) increased from 2.8 percent in 2000, peaking at 15.4 percent in 2008, before declining to 6.5 percent in 2013. In the SADC region, Malawi with 30.3 percent in 2013, had the highest net ODA as a proportion of GNI.

In terms of ODA volumes, net ODA rose from US\$175.64 million in 2000, to a peak of US\$1 billion in 2012, showing a significant improvement since 2008,

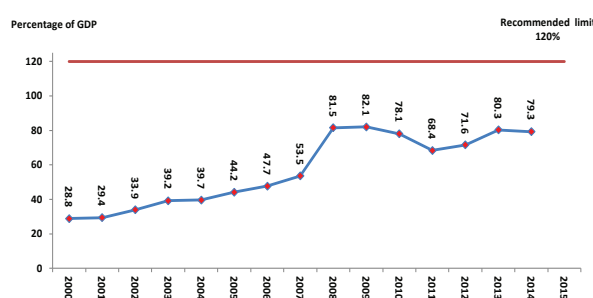
<sup>8</sup> An increase in trade and investment between Zimbabwe and Asia spurred this move, which is expected to reduce costs and boost trade between the partners.

Figure 8A.3 Net ODA, 2000 to 2013



Source: RBZ, 2015

Figure 8D.1 Total Debt as a Proportion of Real GDP, 2000 to 2015



Source: RBZ, 2015

see Figure 8A.3. In the SADC region, Tanzania recorded the highest ODA of US\$ 3.4 billion in 2013. Zimbabwe's net ODA per capita improved from US\$14 in 2000, to US\$48 in 2008, peaking at US\$73 in 2010. In 2013 in the SADC region, Seychelles recorded the highest per capita ODA of US\$283, with Zimbabwe at the lower end with US\$57 in the same year.

### Target 8D

Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

## 10.4 STATUS OF TARGET 8D AND TRENDS

The country's external debt ballooned during the past fifteen years, from a of US\$3.422 billion in 2000, of which US\$471 million was arrears, to US\$10.839 billion in 2015, of which US\$5.556 billion is arrears. Total debt as a proportion of GDP rose from 28.8 percent in 2000, to 81.5 percent in 2008, and to 79.3 percent in 2015, surging towards the recommended limit of 120 percent, see Figure 8D.1.

Total debt as a percentage of exports of goods and services rose from 139.3 percent in 2000, peaking at 415 percent in 2009, before declining to 169.8 percent in 2011, and rising to 303.4 percent in 2013, showing that current

weak export performance is not sufficient to service this debt. External debt service as a proportion of GDP rose from 31.5 percent in 2000, peaking at 147.7 percent in 2007, before stabilising between 60 and 70 percent between 2008 and 2014.

The accumulation of external payment arrears undermines the country's creditworthiness. In order to strengthen debt management, the government established the Zimbabwe Aid and Debt Management Office (ZADMO) within the Ministry of Finance, and adopted the Zimbabwe Accelerated Arrears Clearance, Debt and Development Strategy (ZAADDS) in December 2010. The ZAADDS

aims to accelerate reengagement with creditors, including the IFIs. In June 2013, the government adopted the International Monetary Fund (IMF) Staff Monitored

Programme (SMP), an informal agreement between country authorities and IMF staff to monitor the implementation of the authorities' economic programme.

## 10.5 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGETS 8A, 8C, 8D

### SUCCESSES

- The sole success was the introduction of the multi-currency system in 2009, which successfully stabilised the macroeconomic environment and all economic activity including domestic and international trade.
- However, notable progress was made on the following:
  - Sustained domestic resource mobilisation in support of MDG6 in the form of the National AIDS Trust Fund (NATF), which has been acknowledged as a good practice innovation;
  - Introduction of toll gates in 2009 as a means of mobilising domestic resources for rehabilitation and maintenance of the road network;
  - Deployment and upgrading of computerised customs clearance systems;
  - Improving public confidence in the banking system, as indicated by the upward trajectory in total banking sector deposits; and
  - Increasing the inclusiveness of the financial sector through the roll out of a range of mobile financial services.

### *Supportive Environment*

Zimbabwe's strong natural resource and human resource endowment, combined with relatively intact physical infrastructure remain the country's greatest comparative advantage in rebuilding and sustaining broad based, inclusive economic growth and development. This endowment includes one of the most comprehensive road and rail networks in Southern Africa, and several major tourist attractions. In this regard, despite the negative international reaction they engendered, the Fast Track Land Reform Programme (FTLRP) and the Indigenisation and Economic Empowerment (IEE) Programme addressed the historically enclaved nature of the economy and the former unjust distribution of the means of production.

Some of the frameworks, agreements and structures established in support of enhanced trade and improved financial management were:

- The Zimbabwe Aid and Debt Management Office

within the Ministry of Finance and Economic Development (MOFED) in December 2010, which assumed responsibility for debt management, via the Zimbabwe Accelerated Arrears Clearance Debt Development Strategy (ZAADS) and the Zimbabwe Accelerated Re-engagement Economic Programme (ZAREP).

- The COMESA Regional Regulations Governing Trade in Services, which Zimbabwe adopted in June 2009, having previously liberalised its priority services sectors tourism, financial, communication and transport in the context of the WTO.
- The Commodities Exchange of Zimbabwe (COMEZ), established to allow market based trading of agricultural commodities, in order to restore the viability of farmers and encourage diversification in the production of commodities, alongside the reintroduction of the Agricultural Marketing Authority (AMA) in February 2010.
- Merging of the Departments of Taxes, and Customs and Excise, to form the Zimbabwe Revenue Authority (ZIMRA) in January 2001 under the auspices of the Revenue Authority Act promulgated in 2000, in an effort to improve operational efficiency, create synergies and broaden service provision to the public.
- The Standards Association of Zimbabwe (SAZ), administered by the Ministry of Industry and Commerce, which is responsible for regulating standardisation of the quality of all products in Zimbabwe and among other functions, is the National Enquiry Point for Technical Barriers to Trade.
- The Open General Import License (OGIL), which exempts imports and exports from license requirements except where these are necessary to protect sensitive industries or to ensure compliance with sanitary and phytosanitary regulations.
- Various intellectual property rights protection laws, enacted in compliance with the TRIPS Agreement of the WTO, as well as the establishment of the Intellectual Property Tribunal in 2010 has jurisdiction to hear contentious matters under the Copyright and Neighbouring Rights Act, Geographical Indications Act, Industrial Designs Act, Integrated Circuit

Layout Designs Act, Patent Act, and Trade Marks Act.

Although ODA flows to Zimbabwe were minimal during the MDG period, the country gained some access to some international resources, for example, through the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the IMF Special Drawing Rights (SDR), which provided the equivalent of US\$510 million, the Zimbabwe Multi-Donor Trust Fund (ZIMFUND) set up to support early recovery and development efforts by mobilising donor resources and promoting donor coordination. Alongside this, were some successful domestic resource mobilisation initiatives, notably the NATF/AIDS levy, the introduction of toll gates in 2009 to generate resources for rehabilitation and maintenance of the road network, and PPPs for investment in road, rail and air infrastructure maintenance and rehabilitation.

Zimbabwe's Constitution guarantees legal protection for all investors irrespective of country of origin, including the right to private property, and a number of incentives are provided for investors, including:

The right to own private property;

- Remittances of up to 100 percent of after tax profit;

- A tax holiday for the first five years and a special tax rate of 25 percent thereafter in the mining and tourism sectors;
- Exemptions on VAT for the procurement of materials imported for use in development of infrastructure;
- Allocation of industrial land by Government on a thirty year renewal lease,
- Exemption of duty on imported capital goods; and
- A 10 percent corporate tax for a period of 15 years on income derived from infrastructure projects.

The Zimbabwe Investment Authority (ZIA), the successor to the Zimbabwe Investment Centre and the Export Processing Zones Authority, was established in 2007 to promote and facilitate both local and foreign direct investment, with an emphasis on sectors of the economy that are of strategic importance to the nation. Government also established the One Stop Shop Investment Centre in December 2010 to streamline the investment approval process and bring together the key departments involved in investment facilitation, thereby promoting both domestic and foreign investment.

## 10.6 CHALLENGES IN THE IMPLEMENTATION OF TARGETS 8A, 8C AND 8D

The contextual challenges are similar to those for the implementation of all of the MDGs. That is, to overcome Zimbabwe's continued poor economic performance by consolidating and building upon attempts to create a broad-based and inclusive economy. The international backlash to programmes such as the FTLRP saw the country deprived of foreign resource inflows, while internal economic instability, hyperinflation, deterioration of infrastructure and deindustrialisation meant that, despite some innovative programmes, domestic resources were also severely limited.

The challenges specific to trade revolve around the supply side and necessitate addressing:

Continued export of generally low priced primary products with little value addition;

Low and decreasing capacity in the sectors that would support strong export performance, particularly energy, and road, rail and air transport;

Deindustrialisation and poor capacity utilisation in most productive sectors;

A downward spiral of decreasing visitor numbers, falling incomes and falling standards in the tourism industry;

The need to import all liquid fuel requirements;

A backlog in terms of the country's WTO notification obligations due mainly to capacity constraints.

Challenges relating to the financial system include:

Facilitating greatly enhanced levels of investment in the country, including by speeding up and simplifying project approvals and residence permits;

Continuing to build public confidence in the banking sector, and ensuring that this is justified through regulations to ensure adequate capitalisation, availability of long term finance and affordable lending rates; and

Improving the performance of the insurance sector which, like the banking sector, is currently undercapitalised and suffers from a poor asset quality profile that compromises its ability to meet its liabilities.

Debt is one of the areas in which Zimbabwe has faced challenges arising from poor international relations throughout much of the MDG period. The specific challenges are to:

Improve the country's credit-worthiness by addressing the substantial debt overhang; and

Strengthen the economy generally to enhance the country's repayment capacity.

## 10.7 LESSONS LEARNT FROM THE IMPLEMENTATION OF TARGETS 8A, 8C AND 8D

Zimbabwe's experience with MDG8, Targets 8A, 8C and 8D generated the following lessons:

The development of infrastructure for key economic enablers, such as energy, roads, rail, water and ICT is a critical pre-condition for economic growth and development and therefore for the strengthening of the export sector (including through greater value addition), towards improved terms of trade and balance of payments,

thereby increasing debt repayment capacity.

Stable international relations are key for development, as a means of increasing confidence for investment in the productive sectors, boosting earnings from tourism and related sectors, and qualifying for both humanitarian assistance (when necessary) and development assistance to complement domestic resources.

## 10.8 THE WAY FORWARD – TOWARDS THE SDGS

To ensure the generation of domestic resources for the sustainable financing of the SDGs, success in all facets of economic performance is a must for Zimbabwe. As a key contributor to this, Zimbabwe's export trade will benefit from a move away from reliance on primary

commodity exports, towards value added exports, further simplification of the systems and mechanisms to facilitate trade, and access to trade-related technical assistance (TRTA) from international trade bodies such as the WTO.

### Target 8E

In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

## 10.9 THE SITUATION – TARGET 8E

There were marked improvements in the availability of selected medicines and health commodities, selected essential medicines, selected antibiotics, and listed vaccines, from Round 2 (May to August 2009), to Round 16 (May to July 2013), with rural-urban parity, except in the case of essential medicines, which were more readily available in rural than in urban areas. The availability of selected paediatric medicines also increased between Round 9 (July to September 2011) to Round 16, with rural facilities being better off than urban ones during Round 16, and rural health facilities also had the highest stocks of Vitamin A at this time.

Recently (2011 to 2013) there has been a general decline in medicines availability across all health facilities, mainly as a result of breaks in medicines supply from traditional suppliers and lack of alternative sources. It is of concern that, as well as overall availability falling by 2013, the availability of vital and essential medicines was lowest in central hospitals, while mission hospitals had the highest availability of essential drugs, and district hospitals had the highest availability of vital drugs. Central hospitals also had the least availability of basic vaccines (which were most readily available in provincial hospitals), while Availability of ARVs was lowest in urban hospitals, with only a third reporting holding 80 percent of necessary supplies, and highest in provincial hospitals.

The 2013 survey noted that most health facilities had adequate stocks of vital and essential medicines, which last for three to six months, and there had been an improvement in accounting for expiring or obsolete medicines, since the last survey in 2011. About two-thirds of prescriptions surveyed used full generic names as required by the national policy, as opposed to well below half in 2011. All of the surveyed health facilities were supported by trained medicine management supervisors in 2013.

The vital, essential, and necessary drug management environment in Zimbabwe is regulated by the National Medicines Policy, 2011, the Essential Medicines List, which is updated every four years, the Medicines Control of Zimbabwe responsible for quality control, and the Zimbabwe Informed Push (ZIP) system for distribution of essential medicines (including ARVs) through a network of six NatPharm branches.

Financial resources for essential drugs have also been available through the Vital Medicines Programme (2008), the Health Transition Fund (HTF) of 2011, the Global Fund, the STOP TB Global Drug Facility, and the National AIDS Trust Fund.

## 10.10 STATUS OF TARGET 8E AND TRENDS

The Zimbabwe National Medicines Policy (ZNMP) of 2011 aims to ensure the availability of safe, effective, affordable and cost-effective, vital, essential and necessary drugs for the population. The Essential Medicines List, from which the products to be procured are determined, is updated every four years. Estimates of commodity requirements are made through a multi-stakeholder quantification exercise conducted annually and updated semi-annually, and priorities are set according to whether a medicine is categorised as 'vital', 'essential' or 'necessary'.

In Zimbabwe, medicines used in the public sector are normally exclusively those on the Essential Medicines List. All medicines received in the country are tested for quality by the Medicines Control of Zimbabwe at receipt and throughout the supply chain, through a post marketing surveillance programme. While procurement is done through a multiple procurement mechanism, storage and distribution is harmonised through a network of six NatPharm branches. Distribution is conducted at predetermined periods for essential medicines, including ARVs, directly from central level to all health institutions.

Zimbabwe, like other countries in the region, is faced with managing the public health impact of HIV, Malaria and TB, and has relied for this on global financing mechanisms such as the Global Fund and the STOP TB Global Drug Facility for medicines supplies. However, on the global level, the TRIPS Agreement of the WTO that has a significant impact on the health sector by introducing global minimum standards for the protection and enforcement of intellectual property rights (IPRs), including for pharmaceutical products and processes. This can affect access to medicines and public health as governments are required to bring their legislation on IPRs into conformity with the TRIPS agreement which may limit their access to the most affordable medicines. In addition, Zimbabwe is a member of regional economic blocs that also have IPR regulations with the potential to constrain local pharmaceutical production, and have impacts on the pricing and thus availability of medicines.

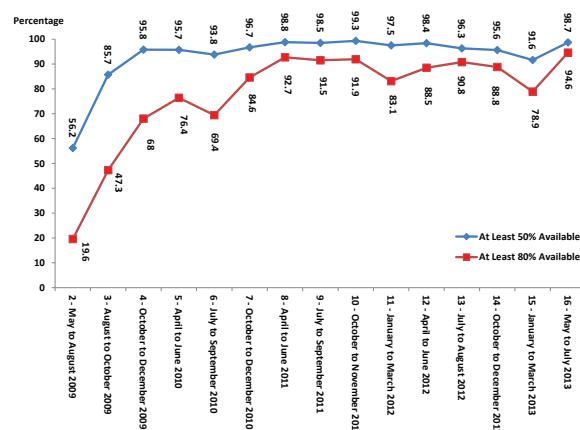
### *Trends in Availability, 2009 to 2013*

The Ministry of Health and Child Care (MOHCC) and the HTF have monitored the availability of vital medicines and health commodities every three months since 2009 under the Vital Medicines Availability and Health Services (VMAHS), in more than 1 300 health facilities countrywide. Round 16 (May to July 2013) covered 1 389 facilities. This survey tracks the availability of 28 selected medicines and health commodities. These medicines are further subdivided into four categories – essential medicines, antibiotics, paediatric medicines, and medical sundries. Some of the findings are highlighted below.

### *Availability of Selected Medicines and Health Commodities*

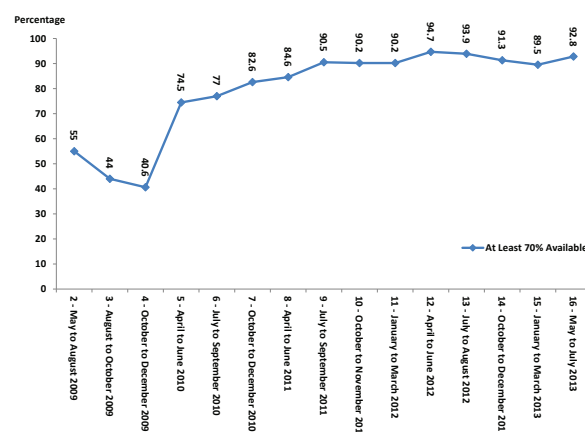
Availability of selected medicines and health commodities

Figure 8E.3 Proportional Availability of Selected Antibiotics, Round 2 to Round 16



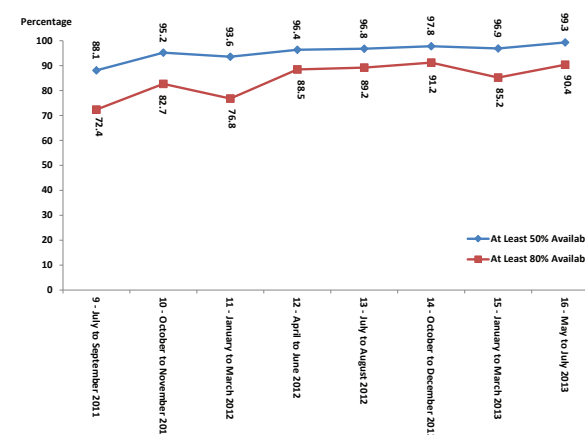
Source: MOHCC and the HTF, VMAHS, 2013

Figure 8E.4 Proportional Availability of Vaccines, Round 2 to Round 16



Source: MOHCC and the HTF, VMAHS, 2013

Figure 8E.5 Proportional Availability of Selected Paediatric Medicines, Round 9 to Round 16



Source: MOHCC and the HTF, VMAHS, 2013

improved markedly from Round 2 (May to August 2009), to Round 16 (May to July 2013), from 8.3 percent to 82.6 percent of health facilities having at least 80 percent of the selected medicines and health commodities, see Figure 8E.1. Generally, all the health facilities surveyed have had at least 50 percent of the selected medicines and



health commodities since Round 5 (April to June 2010). There were no rural-urban, or clinic-hospital disparities in the availability of at least 80 percent of the selected medicines and health commodities.

#### **Availability of Selected Essential Medicines**

The selected essential medicines monitored were Coartem Tablets for both adults and children, Oxytocin, Hydrochlorothiazide (HCT), Magnesium Sulphate, Oxygen, Dextrose (50 percent), and Rifampicin Isoniazid (RH). There was a marked improvement in the availability of these essential medicines, from 8.8 percent of the health facilities having at least 80 percent of them in Round 2, to 82.5 percent in Round 16, see Figure 8E.2. Generally, all the health facilities surveyed have had at least 50 percent of the selected essential medicines since Round 5. In Round 16, 81.8 percent of rural and 86.8 percent of urban health facilities were observed to have at least 80 percent of these essential medicines.

#### **Availability of Selected Antibiotics**

The antibiotics reviewed under this category were Amoxicillin tablets, Amoxicillin paediatric suspension, Benzylpenicillin, Co-trimoxazole paediatric tablets, and Co-trimoxazole tablets for adults. There was a marked improvement in the availability of these antibiotics, from 19.6 percent of the health facilities having at least 80 percent in Round 2, to 94.6 percent in Round 16, see Figure 8E.3. Generally, very high proportions, of 95 percent and above, of the health facilities surveyed have had at least 50 percent of the selected antibiotics since Round 4 (October to December 2009). There were no rural-urban disparities among health facilities with at least 80 percent of the selected antibiotics.

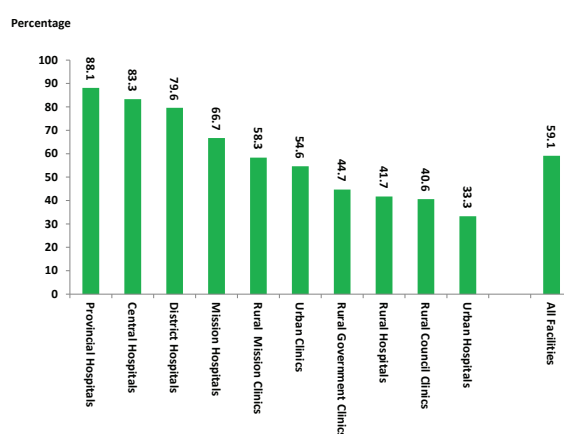
#### **Availability of Vaccines**

The vaccines assessed during Round 16 were Bacille Calmette Guérin (BCG) vaccine, Diphtheria-Tetanus (DT) vaccine, Pentavalent Vaccine, Measles Vaccine, Oral Polio Vaccine, Diphtheria, Tetanus Toxoids and Pertussis (DPT) vaccine, Pneumococcal Conjugate Vaccine (PCV), Tetanus Toxoids Vaccine (TTV), and Rabies Vaccine. Overall there has been an improvement in the number of health facilities with at least 70 percent of the listed vaccines, from 55 percent in Round 2, to 92.8 percent in Round 16, see Figure 8E.4. There were no rural-urban disparities in the proportion of facilities with all listed vaccines and 98.5 percent of the health facilities that had stocks of any one of the listed vaccines had refrigerators that were exclusively for vaccine storage, with 98.0 percent of the health facilities with refrigerators, reporting that the refrigerators were working.

#### **Availability of Selected Paediatric Medicines**

The selected paediatric medicines were Co-trimoxazole suspension/tablets, Coartem tablets for children, Amoxicillin suspension, Paracetamol suspension, Zinc tablets, and Oral Rehydration Salts (ORS). There was a marked improvement in the availability of these, from 72.4 percent of the health facilities having at least 80 percent of the selected paediatric medicines in Round 9

**Figure 8E.6 Proportional Availability of ARVs, by Type of Health Facility, 2013**



Source: MOHCC, NMS, Zimbabwe Public Sector Report, 2013

(July to September 2011), to 90.4 percent in Round 16, see Figure 8E.5. Generally, a very high proportion, of 95 percent and above, of the health facilities surveyed have had at least 50 percent of the selected paediatric medicines since Round 10 (October to November 2011). During Round 16, rural facilities were more likely to have at least 80 percent of the selected paediatric medicines, at 91.8 percent, than were urban ones, with 81.6 percent.

#### **Availability of Vitamin A Supplements**

Overall, during Round 16, 93.2 percent of health facilities had stocks of Vitamin A available. This was consistent with findings from previous survey rounds. Rural health facilities were significantly more likely, at 94.3 percent, to have Vitamin A supplements in stock than urban health facilities, with 86.6 percent.

#### **Availability Status from 2013**

According to the National Medicines Survey (NMS), 2013, there has been a general decline in medicines availability across all health facilities since 2011. In 2011, 94.8 percent of health facilities reported improved medicines supplies, which declined to 55.5 percent in 2013. This is mainly a result of breaks in medicines supply from traditional suppliers and a lack of alternative sources.

In 2013, the majority, 83.2 percent of the 137 surveyed facilities relied on the National Pharmaceutical Company of Zimbabwe (NatPharm) for their medicine supply and overall availability of vital and essential medicines was 66 percent, with vital medicines at 65.7 percent, and essential medicines at 75.3 percent, see Figure 8E.1. However, these availability levels were lower than those in 2011, when vital medicines were at 76.6 percent, and essential medicines availability was 81.0 percent. It is of concern that, in 2013, the availability of vital and essential medicines was lowest in central hospitals, with 48.7 percent and 56.7 percent, respectively. Mission hospitals had the highest availability of essential drugs, at 87 percent, while district hospitals, had the highest availability of vital drugs, at 70.7 percent. The average number of days out of stock is 69 days for vital medicines and 64 days for essential medicines.

### ***Availability of Vaccines***

In 2013, nationally, the availability of basic vaccines was generally high, at 81.9 percent. The range was 77.8 percent availability each for DT and DTP, to 83.7 percent each for Polio and DTP-HepN-Hib. Provincial hospitals had the highest availability, at 98 percent of vaccines, followed by urban clinics, with 91.3 percent, while central hospitals had the lowest availability, at 57.1 percent.

### ***Availability of ARVs***

The overall availability of ARV medicines was 59.1 percent in 2013, lower than 69.6 percent in 2011. Nevirapine 200mg was the most readily available ARV, at 81 percent, followed by Tenofovir/Lamivudine 300/300mg, at 73.5 percent, and Zidovudine/Lamivudine/Nevirapine 60/30/50mg, at 71.5 percent, while Stavudine/ Lamivudine/ Nevirapine 6/30/50mg was the least readily available, at 37.1 percent. In terms of overall availability of ARVs, provincial hospitals were best off, with 88.1 percent, followed by central hospitals, with 83.3 percent, while urban hospitals were worst off, with 33.3 percent, see Figure 8E.6.

In 2013, the average days out of stock for ARVs were 86.4 days. Zidovudine/ Lamivudine/Nevirapine 300/150/200mg tablets (Bottle of 60) and Stavudine/ Lamivudine/ Nevirapine 6/30/50mg tablets (Bottle of 60) were the ARV products that more than 90 days out of stock.

### ***Availability of TB Medicines***

In 2013, overall, TB medicines availability was 69.9 percent on average. The most readily available TB medicine was Rifampicin/Isoniazid/Pyrazinamide/Ethambutol 150/75/400/275mg, at 90.9 percent, followed by RH 150/75mg, at 90 percent, with the least available being RHZ 60/30/150mg, at 22.5 percent. The average number of stock out days was 67, and Rifampicin/ Isoniazid 60/30mg tablet had the highest number of days out of stock, at 101 days.

The 2013 survey noted that most health facilities had adequate stocks of vital and essential medicines, which last for three to six months. There was generally an improvement in accounting for expiring or obsolete medicines, since the previous survey in 2011. On average, 66.2 percent of prescriptions surveyed used full generic names<sup>9</sup> as required by the national policy. This was an improvement on 41.6 percent in 2011. In addition, Zimbabwe has made a significant improvement in supervision of medicines management, with 100 percent of the surveyed health facilities in 2013 being supported by trained medicine management supervisors, in comparison to only 29 percent in 2004, and 90 percent in 2011.

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<sup>9</sup> The generic name is the official name of a medicine, regardless of the manufacturer. The generic or medical name is generally the International Non-proprietary Name (INN) established by the World Health Organisation and relates to its chemical structure or therapeutic use. Generic medicines are not covered by patent protection.

## **10.11 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 8E**

### **SUCCESSSES**

The successes made need to be defended carefully as there has been some deterioration in medicines supply recently. As Zimbabwe moved from deep economic recession into economic and social recovery, there was considerable improvement in the availability of all types of medicines and supplies – medicines and health commodities, essential medicines, antibiotics, paediatric medicines, vaccines, ARVs, TB medicines and Vitamin A – with the most notable improvements being in the availability of selected medicines and health commodities, which increased from 8.3 percent in mid-2009, to at least 80 percent in mid-2013.

### ***Supportive Environment***

The drug management environment in Zimbabwe regulated by the National Medicines Policy, 201, and monitored via an Essential Medicines List updated every is years, while the Medicines Control of Zimbabwe carries out quality control and periodic distribution is handled through NatPharm's network of six branches.

Very early in the MDG period, Government supported initiatives for the local production of ARV drugs in conjunction with the pharmaceutical industry. This improved availability and reduced the cost of drugs to make them affordable to the majority of the people living with HIV. Although most manufacturing companies in Zimbabwe are operating below capacity and facing common challenges for recapitalisation, some pharmaceutical companies are doing well and even exporting.

The Vital Medicines Programme, a pooled donor fund was established in February 2008 to address non-availability of essential medicines and medical supplies at public health facilities, especially at primary healthcare (PHC) level. The programme, coordinated by UNICEF, provides funding for procurement, storage and distribution of essential medicines and medical supplies and supported the bulk of supplies at PHC level up to 2011. The Health Transition Fund (HTF) was put in place by the MOHCC at the end of 2011, with several donors including the

EU, the UK Department for International development (DfID) contributing. The HTF continues to support the procurement, storage and distribution of essential medicines, with funds still being managed by UNICEF.

Medicines for chronic and life threatening conditions are exempted from custom duties and taxes through a statutory instrument and raw materials for the manufacture of medicines are exempted from customs duties. All donated medicines are distributed free of charge to health facilities, and onward to patients. Some medicines, such as ARVs, TB and malaria drugs, are supported through programme grants, such as the Global Fund and the NATF/AIDS Levy and with funding from the HTF for a primary healthcare package (PHCP) of medicines. Some medicines have been re-categorised to allow them to be dispensed by trained community health workers, thereby increasing access.

In 2008, the MoHCW met with partners to find a better method for the distribution of TB and malaria medicines. This resulted in a shift from the former 'pull' system of health facilities monitoring medicines supplies and ordering as needed, to the ZIP system, based on the country's well-functioning contraceptives distribution system, and ensuring regular top-up of supplies to an optimum level. Commodities are distributed from a regional warehouse and delivered to service delivery points (SDPs), where they are joined by trained district pharmacy managers from the district hospitals who count the commodities, calculate losses and adjustments, analyse consumption since last delivery, and determines the average monthly consumption using AutoDRV software. These calculations determine the level of supplies needed in each facility, at minimum and maximum stock levels of two and four months of stock, respectively.

## 10.12 CHALLENGES IN THE IMPLEMENTATION OF TARGET 8E

As Zimbabwe has moved into a situation of vastly improved medicines supply following its recovery from economic recession, the leading challenge is to ensure that the same supply levels are maintained and improved over time: Specific challenges are to:

Ensure sustainability of supply by moving as soon as practicable from reliance on partner support and funding, to a mix of local production and procurement of imported medicines using domestic resources.

Improving capacity utilisation among local manufacturers to enable them to contribute to enhancing sustainability

of medicines supply.

Building human resources for effective inventory management of essential medicines.

Continuing to explore options for distribution, including building upon the successful system adopted in 2008, with a focus on ensuring supplies across rural and urban settings and across health facility type.

Opening up options health facilities to procure medicines from private suppliers.

## 10.13 LESSONS LEARNT IN THE IMPLEMENTATION OF TARGET 8E

In achieving at least 80 percent availability of all categories of medicines and health commodities in health facilities, it has been learnt that:

While Zimbabwe is still reliant on external funding and procurement, coordination of partners supporting the procurement of medicines removes duplication of effort.

Local manufacture of medicines in combination with availability of domestically obtained resources will ensure sustainable availability of medicines in the medium and long term.

Regulation and efficient systems are vital to strategic and equitable distribution of medicines, as well as to assuring product quality.

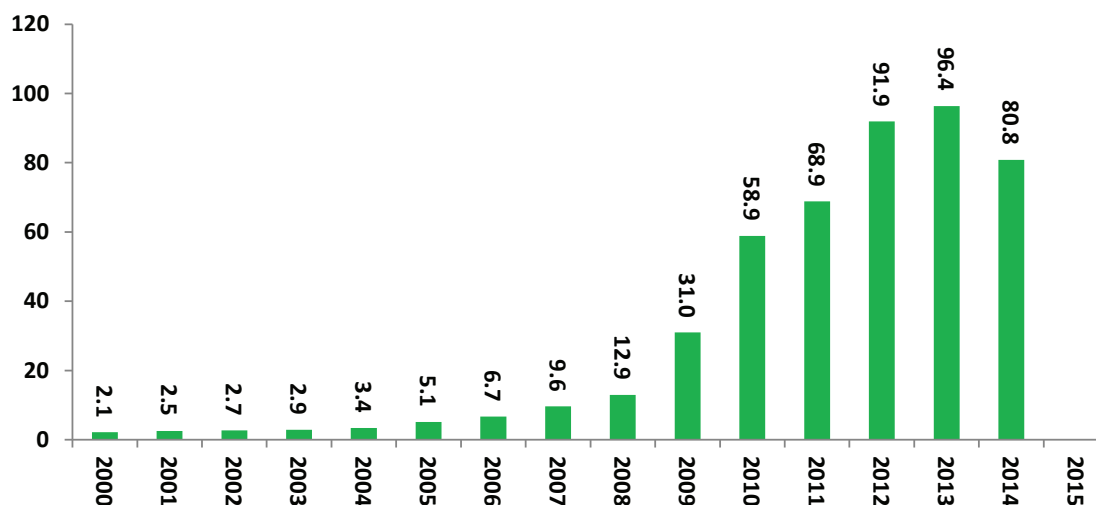
## 10.14 THE WAY FORWARD – TOWARDS THE SDGS

Moving into the SDG era, Zimbabwe needs to build upon current strong performance in improving medicines availability, seeking to ensure close to 100 availability of all vital, essential and necessary medicines, across all settings and all types and levels of healthcare. Targets

related to this achievement will focus on ensuring adequate resource and supplies and inflows in the short to medium term, increased domestic resource mobilisation for the procurement of medicines, and strengthened local production capacity and efficiency.

## 8F.1 Mobile-Cellular Subscriptions, per 100 Inhabitants, 2000 to 2015

### Subscriptions per 100 inhabitants



Source: ITU Database, 2015

### Target 8F

In cooperation with the private sector, make available the benefits of new technologies, especially information and communications (ICTs)

## 10.15 THE SITUATION – TARGET 8F

Mobile-cellular technology has been a huge success, with penetration reaching 40 times 2000 levels by 2014, while the proportion of Internet users in the population increased by around 50 times over the same period. Within this context of modern ICTs taking over, fixed-line telephone subscriptions rose only slowly up to 2009 and declined by 2014. In 2011, only about one-third of households had a television and/or radio.

The increased use of modern ICTs is changing the development terrain in terms of speed of and access to information, and deregulation of the ICT sector has

helped to unleash the private sector to play a central role in development through PPPs and joint ventures which complement government resources. In addition, the sector has significant employment creation potential.

However, at this stage: the backbone structure and access network is not adequate; the cost of connectivity is still high; because there is no explicit policy on infrastructure sharing, infrastructure is not being utilised fully; the absence of cyber security laws allows cyber crime to go unchecked; and there is still a digital divide between the urban and rural areas.

## 10.16 STATUS OF TARGET 8F AND TRENDS

Before the deregulation of the Zimbabwe telecommunications sector, the Post and Telecommunications Corporations (PTC) was the only player. The Postal and Telecommunications Act of 2000 unbundled the PTC, creating three different public entities – Zimpost, Tel One and Net One – to operate postal, telecommunication and cellular telecommunication licenses, respectively. Econet Wireless was the first private entity to enter into the cellular telecommunications sector, marking its deregulation, and was followed by two other players which created competition.

### *Mobile Cellular Penetration and Subscription*

Phenomenal growth has been realised by the two private mobile cellular companies, while the two public entities (one mobile and the other fixed) have had only limited growth and face funding, corporate governance and commercialisation challenges as a result. The overall picture is that, mobile-cellular technology has been a huge success, at 80.8 percent penetration in 2014, up from 2.1 percent in 2000, 12.9 percent in 2008, 31 percent in 2009, and a peak of 96.4 percent in 2013, see Figure 8F.1. Correspondingly, mobile-cellular subscriptions rose from 266 441 in 2000 to 11 798 652 in 2014, an increase

of 4 328 percent or an average of 289 percent per annum. In 2012, Econet wireless dominated the mobile cellular market with 65 percent of market share, followed by Telecel with 19 percent, and Net One with 16 percent (POTRAZ, 2012). By comparison, mobile-cellular penetration rates are 71.2 percent in Africa, 90.6 percent in Asia and Pacific, 108.2 percent in the Americas, and 120.5 percent in Europe.

### Mobile Internet Subscription

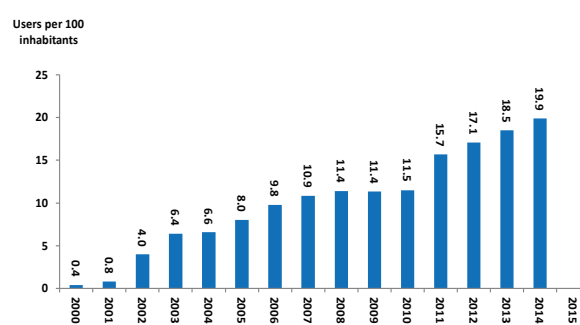
Further developments have been realised in the mobile-cellular sector through the introduction of mobile Internet subscription in 2009 by Econet Wireless, followed by Telecel in 2010, and Net One in 2011. In 2009 when mobile Internet service was introduced, there were 142 000 subscribers, increasing to over 2 225 895 by August 2012, an increase of over 1 460 percent, giving an average growth of over 486 percent per annum (POTRAZ, 2012).

### Internet Subscription

Another development that was realised after deregulation was the introduction and growth of Internet use in the country. Nine Internet service providers<sup>10</sup> were registered with POTRAZ in 2012. Internet users per 100 inhabitants rose from 0.4 in 2000, to 11.4 in 2009, then to 19.9 in 2014, see Figure 8F.2. A more recent development in the ICT sector is the use of fixed broadband, with users per 100 inhabitants rising from zero in 2000, to 0.1 in 2008, 0.4 in 2009, and 1.0 in 2014, with 152 234 subscriptions in 2014, up from 771 in 2001, an increase of 10 645 percent. In comparison, fixed broadband users in 2011 were 0.4 in Africa, 8.3

<sup>10</sup> These were Telco, Bluesat, Aptics, Powertel, Liquid, Spiritage, Tel One, Dandemutande and Africom.

Figure 8F.2 Internet Users, per 100 Inhabitants, 2000 to 2015



Source: ITU Database, 2015

in Asia and Pacific, 17.4 in the Americas, and 28.6 in Europe. Thusimbabwe is doing fairly well in this new ICT development as well. The total incoming and outgoing bandwidth in Zimbabwe in 2011 was 6 208 mega bits per second.

### Fixed-Telephone Subscription, Radio and Television Coverage

In the context of increasing use of modern ICTs, fixed-telephone subscriptions per 100 inhabitants remained low, at 2.0 in 2000, slowly rising to 3.0 in 2009, and declining to 2.3 in 2014, with 329 475 subscriptions in 2014, up from 249 400 in 2000, which is an increase of 32 percent over fifteen years. By comparison, fixed-telephone subscriptions in 2011 were 1.3 in Africa; 11.9 in Asia and Pacific; 26.2 in the Americas; and 38.8 in Europe.

In 2011, 36.3 percent of households had a TV, while 37.9 percent had a radio, which is quite low.

## 10.17 SUCCESSES AND THE SUPPORTIVE ENVIRONMENT FOR THE ATTAINMENT OF TARGET 8F

### SUCCESSES

Mobile-cellular technology has been a huge success, achieving over 80 percent penetration from 2012 onwards. In the wake of this success, mobile internet service increased by over 1 460 percent from its introduction in 2009, up to 2014. Over the same period, fixed broadband use increased by 10 645 percent.

Some practical development successes have been:

- The implementation of an E-Agriculture Application to support the newly resettled farmers;
- Introduction of an E-Learning Model to enhance learning in schools by establishing one ICT lab per school in rural areas;
- A government supported initiative to establish Community Information Centres (CICs) as a one-stop ICT point to increase the national Internet penetration rate.
- Launching of ICT awareness campaigns including ICT exhibitions to attract international and regional ICT players to network and foster relationships with local ICT players;
- The AU Indo Project stationed at Parirenyatwa Hospital in Harare, enabling consultation with doctors in India in which they view patients remotely and then prescribe medicines.
- Introduction of teleconferencing for research and other functions.

### ***Supportive Environment***

The telecommunications sector witnessed the emergence of new players in the mobile telephone sub-sector following the deregulation of the telecommunications industry in 2000 but new regulatory bodies were also established across the ICT sector. The major one is POTRAZ, which has create a conducive environment for licensed operators to develop their networks and extend their services.

Other positive environmental factors include:

- The formulation of the ICT Policy in 2005, and its subsequent revisions over the years;
- Creation of the Ministry responsible for ICT;
- Establishment of the Cabinet Committee on Scientific Research, Technology Development and Applications;
- Computerisation of government ministries in the main centres of the country;

- Enactment of the Criminal Law Amendment (Protection of Power, Communications and Water Infrastructure) Act, No. 1 of 2011 to deal with the problem of vandalism of existing power, communications and water infrastructure;
- A draft ICT Bill; and
- The removal of duty on ICT hardware and software.

Resource mobilisation for the ICT sector has taken place via the Universal Services Fund (USEF), under which operators pay a levy that goes towards enhancing services in under-serviced areas, as well as more general engagement of the private sector, including in the establishment of computer labs in schools, and community ICT centres.

Infrastructural support has been in the form of introduction of 3G and 4G from 2009, as well as optic fibre, VSAT, wireless communication, pay per view services, such as DSTV, and linking to both the Seacom and the EASSy undersea fibre optic cables.

## **10.18 CHALLENGES IN THE IMPLEMENTATION OF TARGET 8F**

The following challenges exist if Zimbabwe is to maintain the current positive trends in availability and utilisation of modern ICTs:

Further enhancement of the backbone structure and access network, including up-scaling the roll-out of optic fibre and base station expansion to enable enhanced wireless infrastructure.

Achieving economies of scale and opening up to greater competition to facilitate greater affordability of ICT services.

Formulation of a policy on infrastructure sharing to optimise utilisation of existing and future infrastructure,

and increase efficiency.

Overcoming the digital divide between urban and rural areas through the location of more base stations and the continuation of the Rural Electrification Programme.

Increasing speed of connectivity and national bandwidth to enable the transformation to an e-economy in all sectors.

Developing the skills for effective use of ICTs in education to create an ICT literate population.

Putting in place data management systems, including cyber security laws.

## **10.19 LESSONS LEARNT IN THE IMPLEMENTATION OF TARGET 8F**

Zimbabwe's experience with MDG8, Target 8F generated the following lesson:

- Given that modern ICTs are fast taking over and changing the development terrain in terms of speed

of and access to information, all sectors need to be enabled to embrace the benefits of ICTs, so that Zimbabwe can transform to an e-economy within the next fifteen years.

## **10.20 THE WAY FORWARD – TOWARDS THE SDGS**

Increasingly, ICTs are at the centre of all development processes, and therefore, Zimbabwe needs to sustain the current positive trends during the SDG era and optimise the potential impacts of modern ICT in achieving targets in all areas of development.

The recent stabilisation of Zimbabwe's economy opens opportunities for enhancing ICT access and quality, and moving into the SDG era, the synergies between economic growth, ICT expansion and positive development incomes need to be explored and exploited.





## Chapter 11

# CONCLUSIONS AND RECOMMENDATIONS FOR THE POST-2015 SUSTAINABLE DEVELOPMENT GOALS

The Millennium Development Goals (MDGs) era coincided with one of the most difficult periods in Zimbabwe's economic history, reflected by severe economic challenges, which saw GDP halving over the decade to 2008, and hyperinflation reaching 231 million percent at its peak in July 2008, amidst low agricultural productivity. Company closures, high urban unemployment of 30 percent, and urban youth unemployment of 38 percent in 2014, high informalisation of employment, at 95 percent, and a large informal sector employing 14 percent of all employed persons, all put a strain on the fiscal space. This in turn, led to a reduction in social services provision and an increase in poverty. The majority (53 percent) of those in the informal sector are women, and the unemployment rate of urban young women aged 15 to 34 years is the highest at 47 percent, compared to 26 percent for urban young men.

Sanctions and negative perceptions of the country, arising largely from the Fast Track Land Reform of 2000 onwards, limited both FDI, and Government's ability to obtain international funds. This compounded the country's debt overhang. In addition, the global financial and economic crisis reduced ODA commitments and export demand, and with most of the remaining ODA being channelled outside government systems, it was difficult to align available funds with national priorities. A major exogenous challenge came in the form of the HIV epidemic which affected all sectors of the economy, exerting great strain particularly on the country's health delivery system. Pervasive gender inequality particularly

in the economy, continued to marginalise women.

Despite these challenges, Zimbabwe has made significant progress on some MDGs, particularly in reducing the prevalence of HIV, gender equality, primary school enrolment and provision of books, tertiary enrolment, literacy, maternal health, child immunisation, ICTs, and ceasing the use of ozone depleting substances. The SDGs are being introduced at a time when the MDGs have not been achieved fully and in an era of new (local and global) challenges which have emerged since the introduction of the MDGs. The unfinished agenda of the MDGs necessitates addressing: weak economic performance,

high income poverty, agrarian reform following the land reform, high maternal mortality, high HIV prevalence, sustainability of essential drug provision, food insecurity,

gender inequality, particularly in the economy and in decision making, water and sanitation, and environmental management.

## 11.1 AREAS OF PROGRESS AND CHALLENGES IN ACHIEVING THE MDGS

The MDG period in Zimbabwe can be divided into two distinct periods: 2000 to 2008, characterised by deep economic recession, largely undermining development efforts; and 2009 to 2015, characterised by fragile economic and social recovery, and therefore, greater potential for reaching development targets. The achievements made within this scenario as well as the challenges it presented are summarised below:

### ***MDG1 – Eradicate Extreme Poverty and Hunger:***

The proportion of the population below the FPL was nearly halved, from 42 percent in 2001, to 23 percent in 2011/12. However, poverty generally was exacerbated by exogenous factors such as the HIV epidemic and the impacts of climate change (particularly on agriculture), while internal initiatives around land reform and indigenisation of the economy invoked international sanctions which undercut any poverty reduction and food security efforts that were reliant on external funding. Income poverty remained high at 72.3 percent at the national level, while rural areas continued to register very high levels of income poverty of 84.3 percent, compared to 46.5 percent in urban areas.

***MDG2 – Achieve Universal Primary Education:*** The NER remained high, at 97.7 percent in 2009, before gradually declining to 92.2 percent in 2014, with gender parity. Literacy rates for those aged 15 to 24 years remained universal around 99 percent during the MDG period, with gender parity. The pupil-text book ratio reached 1:1 for the four core primary school subjects. The proportion of trained primary school teachers remained high, at 89 percent in 2014. Grade 7 Pass Rates of 56 percent for girls and 47 percent for boys in 2012 were in the normal range. Primary school dropout rates declined from 7.9 percent in 2011, to 4.8 percent in 2012. Finally, 98 percent of all primary schools had ECD classes by 2014. The challenges for education are largely financial, noting that, despite the education sector consistently receiving the highest share of the national budget, education is inadequately financed, with knock-on effects in terms of the quality of education, and high staff attrition.

***MDG 3 – Promote Gender Equality and Empower Women:*** Zimbabwe made considerable progress in promoting gender equality, particularly, in relation to education at all levels. There is near universal literacy (97 percent) among adults aged 15 years and above, and gender parity in primary school enrolment and completion.

Alongside overall increases, gender parity or near gender parity was achieved across all secondary school indicators

– Form 1 to 4 enrolment, Form 1 to 4 completion, transition from Form 4 to Form 5, Form 5 and 6, and O' and A' level pass rates. There was tremendous improvement in tertiary enrolment in all types of institution, with the GPI increasing from 60 percent in 2000, to 95 percent in 2012. Women's enrolment in tertiary education rose from 10 103 to 50 958 over the MDG period, a 404 percent increase.

In terms of women's participation in decision making the greatest success was achieved in the Upper House of Parliament/Senate, with the zebra-list system ensuring a 45 percent share of women in 2013, up from 23.2 percent in 2008, against an MDG target of 50 percent. In the Lower House of Parliament, the women's share increased from 9 percent in 2000, to 32 percent in 2013. In the civil service and judiciary, 54 percent of Commissioners and 30 percent of Permanent Secretaries were women during 2013-2015, with some progress also in the share of women in the judiciary, notably a woman Judge President and women making up 58 percent of Labour Court Presidents, 35 percent of High and Supreme Court Judges, and 38 percent of Magistrates, in 2009.

However, political will to follow through on the gender requirements in policies and the Constitution, or to domesticate regional and international gender instruments is limited, and women's equality at all levels continues to be compromised by a lack of gender mainstreaming, a dearth of gender disaggregated data, and negative cultural factors.

***MDG4 – Reduce Child Mortality:*** Progress was registered in all the indicators of child mortality, with declines in under-5 mortality from 120 deaths per 1 000 live births to 75 deaths, and infant mortality from 65 deaths per 1 000 live births to 55 deaths, between 1999 and 2014. Vaccination against measles, increased from 71 percent in 1999 to 83 percent in 2014. Stunting among children under 5 years of age declined from 36 percent in 2005/06 to 28 percent in 2014, whilst underweight remained moderate at 11 percent in 2014. Exclusive breast feeding for children for the first six months increased from 26 percent in 2009 to 41 percent in 2014.

For both this Goal and the maternal health Goal (MDG5, below), HIV remains the major challenge because of its contribution to continuing high child and maternal mortality, a weakened health delivery system, inadequacy of safe water and sanitation leading to disease outbreaks, and high levels of vulnerability among orphaned children.

***MDG5 – Improve Maternal Health:*** Despite the

challenges of HIV just mentioned, the MMR declined significantly, from 1 069 deaths per 100 000 live births in 2002 to 526 deaths in 2012. The proportion of births attended to by skilled health personnel increased from 69 percent in 2005/06 to 80 percent in 2014, while home deliveries in rural areas were reduced from 41 percent to 22 percent over the same period.

**MDG 6 – Combat HIV and AIDS, Malaria and Other Diseases:** The HIV epidemic coincided with the time when the country's health delivery system was at its weakest, so that the challenges in attaining this Goal are linked to those of health system recovery, as well as sustaining progress in terms of behavioural change, access to ART, PMTCT and other essential medicines, and fighting stigma and discrimination. Both prevalence and incidence of HIV saw significant declines, with prevalence among adults aged 15 to 49 falling from a peak of 29.6 percent in 1998 to 16.7 percent by 2014, and incidence among adults declined from 2.6 percent in 2000 to 0.9 percent in 2014. Among young people aged 15 to 24 years, HIV prevalence declined from 7.8 percent in 2005/06 to 5.5 percent in 2010/11. Adult ART coverage improved from 69 percent in 2011 to 77 percent in 2013, while PMTCT coverage increased from 56 percent to 82 percent over the same period, with resultant declines in the numbers of HIV related deaths and AIDS orphans.

Clinical malaria incidence declined from 113 cases per 1 000 population in 2010, to 40 cases in 2014, surpassing the MDG target of 62 cases. Increased spraying coverage and usage of insecticide-treated bed nets are associated with this decline. Tuberculosis incidence declined from 809 cases per 100 000 population in 2004, to 552 in 2013, with improvements in the TB treatment success rate also increasing from 78 percent in 2007, to 82 percent in 2013.

**MDG7 – Ensure Environmental Sustainability:** Zimbabwe has done well in reducing ozone depleting substances ahead of the 2015 deadline under the Montreal Protocol, and is also among the best in the region in terms of biodiversity conservation. About 15 percent of land is designated to conservation of biological

diversity, and significant reforestation efforts are ongoing. Carbon dioxide emissions (CDIAC) decreased from 13 000 tonnes in 2000, to 9 861 tonnes in 2011. The challenges in environmental management revolve around halting the destruction of wetlands, implementing land reform in a sustainable manner, and addressing climate change impacts and issues of solid waste management, particularly in urban areas.

As no significant progress was made in terms of water, sanitation and hygiene, or the provision of safe and secure housing, these remain major challenges.

**MDG8 – Develop a Global Partnership for Development:** Notable progress was made in the ICT sector and in supply of essential drugs. In terms of ICTs, mobile-cellular penetration increased from 2 percent in 2000, to 81 percent in 2014, while Internet penetration increased from 0.4 percent in 2000 to 20 percent in 2014 over the same period. Thus modern ICTs are fast taking over and changing the development terrain in terms of speed of and access to information. The most marked improvement in the availability of selected essential medicines was noted from 2009 to 2013, a shift from 9 percent to 83 percent of health facilities having at least 80 percent of the selected medicines

In terms of trading and financial systems, the challenges include addressing the export of generally low priced primary products and increasing value addition, as well as continuing to improve Zimbabwe's international relations to ensure adequate foreign financial inflows to sustain development in combination with domestic resource mobilisation initiatives. Zimbabwe is already among the regional leaders in the deployment and upgrading of computerised customs clearance systems. In addition total banking sector deposits continued on an upward trajectory, from a low base of US\$706 million in June 2009, to US\$5.6 billion in June 2015, signalling improving public confidence in the banking system. In the context of high mobile-cellular penetration, financial sector inclusion has improved significantly with the roll out of a range of mobile financial services.

## 11.2 LESSONS LEARNT AND PRIORITIES IDENTIFIED

General lessons were learnt around the following areas during the implementation of the MDGs:

- **Political Will and National Ownership** Political will at the highest level is a critical success factor, as evidenced by achievements in HIV including orphan care, education and gender under the MDGs. This includes broad consultation of all stakeholders, from national to grassroots levels, domestic prioritisation of goals to direct concrete development efforts, particularly in the context of limited resources, and inter-sectoral collaboration. Modern ICTs may be

facilitators of this.

- **Prioritising the Economy** The development of key economic enablers, such as energy, roads, rail, water, and ICT infrastructure, is a critical pre-condition for economic growth, and equitable, inclusive, pro-poor economic growth underpins development. An effective framework would incorporate all the key facets of development, including enlarging the economic cake, redistribution of the key means of production such as land and minerals to ensure inclusive economic transformation and economic

empowerment of the indigenous people, governance and other human rights issues.

- **Comprehensive Agrarian Reform to Support High Agricultural Productivity** In addition to the land reform, a comprehensive agrarian reform package needs to be made available to farmers to ensure high productivity, make agriculture viable and enhance household and national food security. This would include improved access to agricultural inputs, credit, tillage, extension services, research and development innovation and markets, as well as rehabilitation of irrigation systems, roads, dip tanks and communication infrastructure. Good access to basic social services is also necessary in the newly resettled areas.
- **Sustainable Financing** As highlighted in the Addis Ababa Financing for Development Conference of July 2015, domestic financing is central to the achievement of development goals because it is the most sustainable source of funding. Innovative approaches have proven effective in the mobilisation of domestic resources in Zimbabwe, while there are still opportunities to explore PPPs and joint ventures with the local and international private sector. Domestic resources complemented by development partner resources should be directed to supporting the nationally determined development priorities.
- **Environment, Water and Sanitation and Housing Demand led, rather than supply led approaches, supported by community based management, are** effective and sustainable, particularly in the delivery of water and sanitation services, while community involvement is also critical in innovative and efficient environmental management, including wetlands and solid waste management.
- **Monitoring and Evaluation** Baselines should be established as nearly as possible to the time a programme is started to ensure relevance in setting the targets and avoid the problem of shifting targets during implementation. Furthermore, more nuanced monitoring and evaluation measures than the MDGS' 'on-track' and 'off-track' are needed to register significant progress being made by countries with low initial levels of human development and/or other complicating factors. At national level, support may be needed to the capacitation and updating of national statistical systems to ensure efficient monitoring and evaluation of the implementation of the agreed goals framework. Indicators need to be customised to ensure local relevance, and reflect people's lived experiences and voice, through a range of qualitative measures.
- **Gender and Women's Empowerment** In addition to having its own goal, gender should be mainstreamed in all development goal. Quota systems and affirmative action remain relevant in moving forward the gender equality and women's empowerment agenda in education, politics and the economy. Alongside this, it is necessary to address the negative sociocultural and religious factors that hinder gender equitable development in all sectors and at all levels.

## PRIORITY AREAS FOR THE POST-2015 SDG AGENDA

As Zimbabwe moves into the implementation of the Post-2015 Sustainable Development Goals in 2016, Government has decided that it will implement all the 17 SDGs as they are deemed to be important to the country. However, taking into account the successes and challenges of the MDGs and the lessons that their implementation generated, Government has decided to focus upon and prioritise the following ten SDGs:

### **SDG8**

Promote sustained, inclusive and sustainable economic growth, full and productive employment – A growing economy is necessary if the country is to create wealth to be channelled to the social sectors, and create economic opportunities for citizens to go into business or to become gainfully employed.

### **SDG7**

Ensure access to affordable, reliable, sustainable, and modern energy for all – Modern energy provision is critical in order for the economy to be fully functional and productive, in the least environmentally detrimental manner possible.

### **SDG2**

End hunger, achieve food security and improved nutrition, and promote sustainable agriculture – As well as being vital to food security and nutrition, sustainable agriculture is the bedrock of Zimbabwe's economy and the bulk of the population derive their livelihood from this sector.

### **SDG9**

Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation – Resilient infrastructure, industrialisation and innovation are key to the promotion of sustainable economic growth.

### **SDG6**

Ensure availability and sustainable management of water and sanitation for all – Availability and sustainable management of water and sanitation support all economic and social sectors.

### **SDG13**

Take urgent action to combat climate change and its impacts – The negative impacts of climate change have

also become evident in Zimbabwe's strategically vital agriculture sector, with knock-on impacts across many other development outcomes, including those around nutrition, health and poverty reduction.

### ***SDG17***

Strengthen the means of implementation and revitalise the global partnership for sustainable development – Despite the relative sustainability of domestic financing, it is acknowledged that domestically mobilised resources will not be enough to finance the SDG Agenda, and that both FDI and development partner funding will be needed.

### ***SDG3***

Ensure healthy lives and promote well-being for all at all ages – The relationship between a healthy nation and economic growth is a two-way one as good health reduces health system costs, while healthy citizens are more productive and better contributors to economic growth.

### ***SDG4***

Ensure inclusive and equitable quality education and promote life-long learning opportunities for all – Better educated people are better able to contribute to economic growth and productivity, as well as innovation.

### ***SDG5***

Achieve gender equality and empower all women and girls – The achievement of full human potential and sustainable development is not possible if half of population is denied the opportunity to participate effectively in society and all sectors of the economy.

It should be noted that implementation of policies, projects, and programmes in relation to all of the prioritised SDGs is already underway in Zimbabwe with Government working in collaboration with development partners and the private sector.

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