Report to African Centre for Global Health and Social Transformation (ACHEST)

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"How are countries prepared to roll out and domesticate Health SDGs" – Zimbabwe Report

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List of Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
BRTI	Biomedical Research and Training Institute
CWGH	Community Working Group on Health
CZI	Confederation of Zimbabwe Industries
DA	District Administrator
DDC	District Development Committee
GDP	Gross Domestic Product
HIV	Human Immune Deficiency Virus
ICT	Information Communication Technology
MDGs	Millennium Development Goals
FBO	Faith Based Organization
NGO	Non-Governmental Organization
PPP	Public-Private Partnership
PA	Provincial Administrator
PDC	Provincial Development Committee
SDGs	Sustainable Development Goals
TARSC	Training and Research Support Centre
VIDCO	Village Development Committee
WADCO	Ward Development Committee
ZimASSET	Zimbabwe Agenda for Sustainable Social and Economic Transformation
ZiPHA	Zimbabwe Public Health Association
ZIMA	Zimbabwe Medical Association
ZINA	Zimbabwe Nurses Association
ZNCC	Zimbabwe National Chamber of Commerce

Executive Summary

1 Background

1.1 Purpose and Objectives of study

The purpose of the study is to undertake a scoping study of the various national-level institutional arrangements for SDG implementation and monitoring in Zimbabwe.

Objectives

- Establish to what extent have the SDGs been introduced, adopted in national and health and health related sector plans?
- Determine to what extent have the interdisciplinary nature of SDG been inclusive and cross cutting?
- Articulate to what extent are the common national and sectoral reporting frameworks been adopted?

2 Zimbabwe national context

2.1 Population

According to the 2012 census, Zimbabwe has total population of 13, 061,239 comprised of 6 280 539 males and 6 780 700 females. Annual Average Intercensus Growth Rate, (2002 – 2012) was 1.1%. The average household size was 4.2. The average population density is 33 persons per square kilometer. *(ZimStat National Report – Zimbabwe Population Census 2015)*

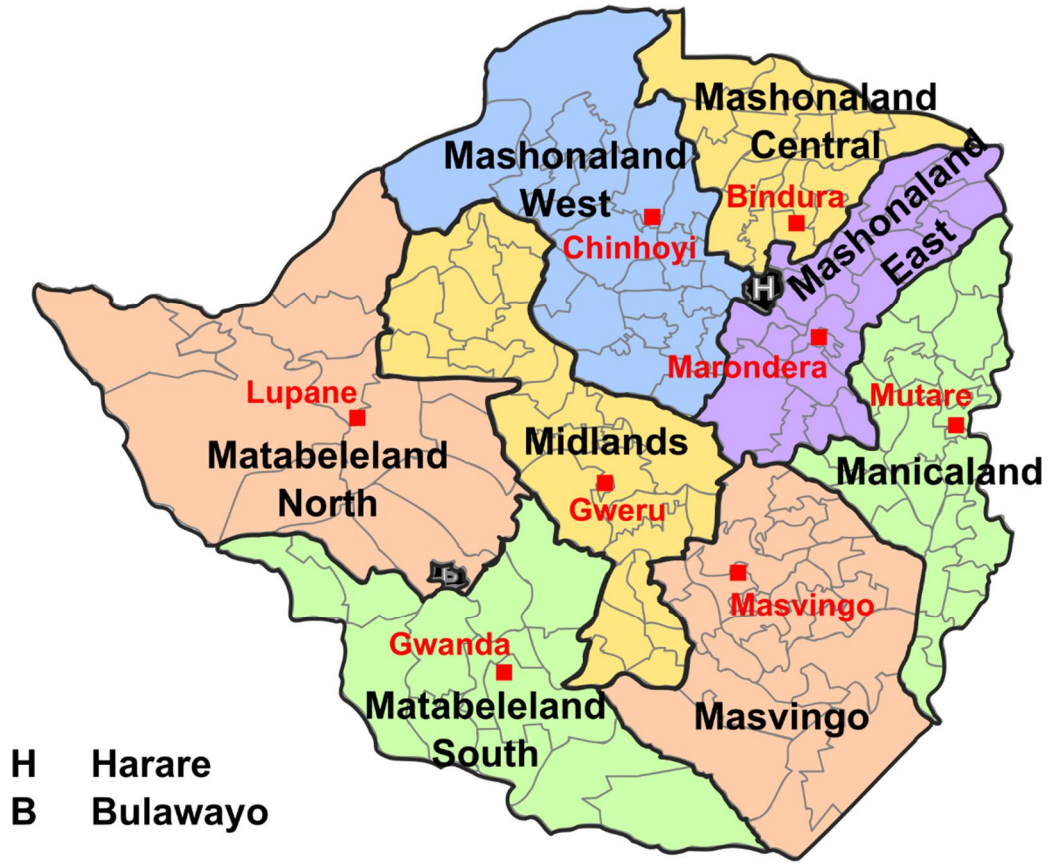
Total Population	13,061,239
Females	6,780,700
Males	6,280,539
Population Aged 15 – 24 %	20%
Intercensus population growth rate	1.1% (2002-2012)
Average Household size	4.2 persons
Average Population density	33 persons per sq. km

Distribution of population by province

Province	**Male**	**Female**	**Total**	**Percentage**
Mashonaland East	48.5%	51.5%	1,344,955	10.3
Mashonaland West	49.8%	50.2%	1,501,656	11.5
Mashonaland Central	49.2%	50.*%	1,152,520	8.8
Matebeleland North	48.2%	51.8%	749,017	5.7
Matebeleland South	47.8%	52.2%	683,893	5.2
Manicaland	47.4%	52.6%	1,752,698	13.4
Midlands	48.1%	51.9%	1,614,941	12.4
Masvingo	46.5%	53.5%	1,485,090	11.4
Harare	48.3%	51.7%	2123132	16.3
Bulawayo	46.4%	53.6%	653,337	5
TOTAL	48.1%	51.9%	**13,061,239**	**100**

At the time of the 2012 census, 33% of the population lived in rural areas and 67% in urban areas. Since the land reform and redistribution programme, there has been much movement

of people from previously overcrowded rural areas to new settlements in more agriculturally viable or productive land. In addition to the movement to new rural settlements, there has also been substantial rural-urban migration resulting in new urban and peri-urban settlements that have a bearing or effect on some of the SDGs.



2.2 Socio-political and governance structures and processes

2.2.1 Constitution -The Constitution guarantees political, civil, economic, social and cultural rights for all citizens. These rights are clearly articulated and provided for in the Bill of Rights and are justiciable. The Constitution of Zimbabwe explicitly provides for the right to health care in Section 76, sub-section 1 to 4 that: "(1) Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health (2) Every person living with a chronic illness has the right to have access to basic healthcare services for the illness (3) No person may be refused emergency medical treatment in any health-care institution, and (4) The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realization of the rights set out in this section" The Constitution further provides, that every person has a right to safe, clean and potable water, and sufficient food (Food Security, Quality and Safety).

2.2.2 *Legislature* - Parliament consists of the Senate (80 Senators) drawn from the different parties and representatives from the following groupings - regional governing councils, National Council of Chiefs, people with disabilities; the House of Assembly (270 members)

of whom 210 members are directly elected by popular vote and 60 seats reserved for women directly elected by proportional representation vote.

2.2.3 Executive – Composed of an Executive President, two Vice Presidents and a Cabinet. The President is elected through popular vote by registered voters. President serves a five-year term. The two Vice Presidents and cabinet are appointed by the President.

2.2.4 Judiciary –Composed of Supreme Court, Constitutional Court, High Court; Labor Court; Administrative Court; regional magistrate courts; customary law courts; special courts The Supreme Court consists of the chief justice and 4 judges and the Constitutional Court consists of the chief and deputy chief justices and 9 judges.

2.2.5 Electoral structures and processes -The Zimbabwe Electoral Commission (ZEC) was established in 2004. Its functions are to prepare for, conduct and supervise elections to the office of President and to Parliament, elections to provincial and metropolitan councils and the governing bodies of local authorities, elections of members of the National Council of Chiefs referendums and to ensure that those elections and referendums are conducted efficiently, freely, fairly, transparently and in accordance with the law

2.2.6 Local Government - Zimbabwe has ten administrative provinces - Bulawayo Metropolitan, Harare Metropolitan, Manicaland, Midlands, Masvingo, Mashonaland Central, East and West, Matebeleland North and Matebeleland South. There are 60 district administered by Rural District Councils. There are 6 city councils, 28 urban councils, 10 municipal councils, 8 town councils, 4 council boards. The political head of a province is the Provincial Minister who is supported by a Provincial Administrator (PA). Development activities and coordinated by the Provincial Development Committee. (PDC) At District Level the administration head is the District Administrator.

2.2.7 Community Level structures – At the sub-district level there are wards and villages in rural areas while in urban areas there are wards as well but there is no equivalent level of village. In rural areas Traditional Leaders (Chief, Headman and Kraal Heads) play a significant role in development-related activities including land allocation and mobilization of communities under their jurisdiction. In rural areas there are Ward Development Committees (WADCO) and Village Development Committees (VIDCO) that are the entry points of community level development activities. There is no equivalent of WADCO and VIDCO in urban areas. In some towns like Harare there are Residents Associations that work with councilors in development activities.

2.2.8 Civil Society - Civil society in Zimbabwe is relatively well-organised. Civil Society is composed of Non-Governmental Organizations (NGOs) and Faith-Based Organizations (FBOs). Under the leadership and coordination of the National Association of Non-Governmental Organizations (NANGO), the civil society in Zimbabwe participates in a variety development related activities including service provision, advocacy, policy formulation, community capacity building, peace building. So far, from 2015 to date, Civil Society has been an active player in the SDG processes.

2.2.9 Private Sector- Zimbabwe has a fairly well developed private sector with companies involved in mining, agriculture, manufacturing, tourism and hospitality, services (financial, electricity, transport, telecommunication and ICT). Through their umbrella bodies –

Zimbabwe National Chamber of Commerce (ZNNC) and the Confederation of Zimbabwe Industries (CZI), the private sector engages government and other stakeholders to contribute significantly to economic development through its involvement in policy formulation, job creation and financing of development projects. The government encourages Public-Private Partnerships (PPP) in development activities and has developed a Law / Guidelines for Joint Ventures between public entities and private entities.

2.3 Economy

Zimbabwe is endowed with significant natural resources. These include (a) Minerals (gold, diamonds, platinum, chrome, coal and other minerals found in smaller quantities; (b) fertile agricultural land and sizeable natural and man-made water bodies; (c) Several natural tourist attractions (Victoria Falls, Great Zimbabwe, Wildlife parks, good weather, a fairly well-developed hospitality industry). In addition there is a fairly well-developed manufacturing infrastructure including textile, agricultural chemicals, agricultural equipment and implements, food processing, car assembly to name a few. The services industry (power, water, transport, finance and Information and Communication Technology (ICT). The country has considerable human capital and it continues to spend more on education as a percentage of GDP than any other country in Sub-Saharan Africa. These factors augur well for rapid socio-economic development and job creation in Zimbabwe similar to what has been experienced in some Asian countries.

2.4 Zimbabwe's MDG achievements

- By the end of the MDG era in December 2015, out of the eight MDGs Zimbabwe had registered progress in three namely MDG 2: Universal Primary Education; MDG3 Promoting Gender Equality and Empowering Women; MDG 6.Combating HIV / AIDS, Malaria and other diseases.
- Key achievements in MDG 2 were (a) the net enrolment ratio (NER) remained high at 97.7 percent in 2009, before gradually declining to 92.2 percent in 2014, with gender parity; (b) literacy rates for those aged 15-24 years remained around 99 percent during the MDG period, with gender parity; (c) the Pupil to Text Book Ratio reached 1:1 for the 4 core primary school subjects (English, Mathematics, Shona / Ndebele, and Science).
- In MDG 3 key achievements were – (a) the country achieved gender parity in primary school enrolments and completion; (b) the share 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; (c) the share of women in Technical Colleges and ITCs enrolment increased from 17.6 percent in 2000 to 41.4 percent in 2012, against an MDG target of 50 percent by 2015; (d) women's share in National Parliament (Lower and Upper Houses combined) was 35 percent in 2013, up from 9 percent in 2000.
- Key achievements in MDG 6 were (a) the HIV prevalence among adults aged 15-49 years declined from a peak of 29.6 percent in 1998 to 14 percent in 2014 whilst the HIV incidence rate within the same age group declined from 2.6 percent in 2000 to 0.9 percent in 2014; (b) adult Anti-Retroviral Treatment (ART) coverage improved from 69 percent in 2011 to 77 percent in 2013, whilst Prevention of Mother to Child Transmission (PMTCT) coverage increased from 56 percent to 82 percent within the same period; (c) total AIDS related deaths declined from 122 282 in 2000 to 38 616 in 2014, which is a 68 percent reduction.

- ***Unfinished business from the MDG era includes (a)*** the need for inclusive economic growth and rural development to reduce poverty (b) Support to agriculture must be vigorously pursued to improve productivity in terms of ZIMASSET and the Ten Point Plan; (c) the need to continue efforts to further reduce maternal mortality and HIV incidence and prevalence; (d) effective Social Protection in assisting the vulnerable sections of our society; (e) Continuously improve the quality of the educational delivery system (f) the need to continue efforts in women economic empowerment.

2.5 Challenges facing Zimbabwe as it enters the SDG era

Zimbabwe is facing several challenges that will impact implementation of SDGs the SDGs. These include:

- Limited fiscal space, with the bulk of fiscal revenues going towards funding recurrent expenditures.
- High indebtedness to international financial institutions.
- Limited access to financial markets.
- An increase in the urban population and the rising informal economy which has led to several challenges including: rising incidence of urban poverty; inadequate housing; inadequate provision of services; and environmental degradation and pollution.
- The negative impact of relatively low per capita allocations on enablers such as health and education.
- Gaps in terms of policy implementation and coherence.
- Insufficient timely and disaggregated data for most indicators, making it difficult to track and monitor progress.
- Increasing levels of corruption in both public and private sectors.
- Unstable political environment.
- Inappropriate national policies on foreign investment.
- Uncertain property rights.

3 Methodology

4.1 Literature review

Several documents pertaining to SDG implementation in Zimbabwe were read. Appendix B lists the documents that were read.

4.2 Key informant's interviews

Key informants in government, development partners, civil society and private sector were interviewed. Appendix A lists the key informants that were interviewed.

4 Findings

4.1 Structures and Processes for multi-sectoral implementation of SDGs

- The Ministry of Macroeconomic Planning and Investment Promotion is responsible for coordinating implementation of the SDGs and supervised by the Office of the President and Cabinet.
- A Steering Committee, chaired by the Chief Secretary to the President and Cabinet and represented by all line ministry Permanent Secretaries and the heads of the UN agencies, to provide overall guidance and strategic leadership to the process.
- A Technical Committee, chaired by the Permanent Secretary in the Ministry of Macroeconomic Planning and Investment Promotion, and represented by SDG focal persons from line ministries and representatives from UN agencies, development partners, the private sector, civil society and the Office of the President and Cabinet, to spearhead the coordination, technical processes as well as providing technical back-stopping.
- Thematic clusters for mainstreaming and localising the SDGs.
- Extensive consultations with parliamentarians led to the establishment of a Parliamentary Thematic Committee on SDGs represented by all Chairs of portfolio committees.

4.2 SDG awareness raising and cascading of SDGs to subnational levels

- The Government has given a commitment to the effect that the SDGs are cascaded down to local level. Through support from the UNDP local government structures were sensitised on the SDGs to assist them in developing policies, which can assist in the attainment of the SDGs.
- Starting in October 2017, the Ministry of Macroeconomic Planning and Investment promotion will launch an SDG knowledge and skills building program for elected officials (parliamentarians).
- This launch will be followed by awareness SDG raising and information meetings in all the 10 provinces of Zimbabwe. In each of the provinces there will be 2-day workshops bringing together the Provincial Minister, Provincial Administrator, Parliamentarians, Provincial Heads of ministries, Civil Society organizations operating in that province, all District Administrators operating in the province.
- The Poverty Reduction Forum Trust (PRFT) spear-headed and is coordinating a CSOs Reference group on SDGs which is constituted by ten CSOs apex bodies each representing a different sector including PWD, children, youth, women, Media, Churches, the Elderly. The CSO-SDGs Reference Group at national level provides a meeting place for CSOs to meet and discuss SDGs issues in a bid to influence national processes to address the SDGs.
- Only last year at the national dialogue platform did we meet as broader stakeholders including private sector. However, after that there was no other attempt to continue with the broader stakeholders only when organised by government for workshop that when we have the other stakeholders.

4.3 Domestication of SDGs into National Strategic and Annual Planning

- The Government has developed a SDGs Position paper, which is aimed at setting up the institutional framework to aid the implementation of the SDGs.
- Zimbabwe has committed itself to implementing all the SDGs with an emphasis on SDGs 2, 3, 4, 5, 6, 7, 8, 9, 13 and 17.
- The government launched the Interim Poverty Reduction Strategy paper IPRSP inspired by the SDGs. The IPRSP is a two-year strategy developed as a vehicle to achieve the SDGs.
- We also have the Zimbabwe Agenda for Sustainable Socio-Economic Development, which has clusters around SDGs as well.
- Plans are in place to strengthen the capacities of sub-national authorities to align strategies and policies at that level to achieve the SDGs.
-

4.4 Monitoring of SDG implementation

- All ministries were asked to select indicators on their priority SDGs and targets have been agreed upon.
- A monitoring and evaluation policy including prioritised SDGs targets and indicators has been developed
- Appointed focal persons from each ministry are responsible for preparing and submitting quarterly reports on progress towards meeting set targets to the Technical Committee, chaired by the Permanent Secretary in the Ministry of Macroeconomic Planning and Investment Promotion, and represented by SDG focal persons from line ministries and representatives from UN agencies, development partners, the private sector, civil society and the Office of the President and Cabinet, to spearhead the coordination, technical processes as well as providing technical back-stopping. Data sources.
- There has been agreement to use 2015 as the baseline year.
- One of the challenges that the country is facing is insufficient timely and disaggregated data for most indicators, making it difficult to track and monitor progress.

4.5 Funding for SDG implementation

- Most of the funding of SDG promotion and dissemination activities is coming from the Ministry of Finance. However, fiscal resources are limited given that currently Zimbabwe currently facing significant budgetary constraints.
- The Treasury (Ministry of Finance) is now planning to use a performance-based financing approach using attainment of agreed upon targets on agreed SDG indicators.
- UNDP Zimbabwe also gives financial support for SDG promotion and information dissemination activities.
- Other development partners are interested in funding activities that are linked to specific SDGs. For example OXFAM UK is interested in SDG 2 “End Hunger”. Other development partners are also choosing specific SDGs that are in line with the development mandate or strategies in the country.
- The private sector companies have expressed interest in supporting SDG awareness and education activities. For example ECONET, the biggest cellphone service

provider has agreed to use its extensive network to disseminate SDG awareness raising messages.

5 Focus on SDG 3 and other health-related SDGs

5.1 *Health Statistics* – During the MDG era, Zimbabwe made significant progress in the health front including:

- Drop in HIV prevalence to 14 per cent in 2016 (Female at 16.6 per cent; Male at 11.2 per cent) from 18 per cent in 2005/06.
- Decline in under-5 mortality rate from 84 per 1,000 live births in 2010/11 to 69 per 1,000 live births in 2015. Infant mortality dropped from 57 per 1000 live births in 2010/11 to 50 per 1,000 live births in 2015.
- Coverage for all basic vaccinations among children age 12-23 months in Zimbabwe was 76 per cent in 2015 up from 65 per cent in 2010-11.
- A decline of maternal mortality ratio (MMR) estimated at 651 deaths per 100,000 live births during the 7-year period before the 2015 survey representing a decline from 960 deaths per 100,000 live births during the 7-year period preceding the 201011 survey.

5.2 Commitment to improving the health of citizens

There is a strong commitment to create an enabling policy environment to improve public health. This is evidenced by:

- Provision for the right to health under Section 76 of the Constitution.
- Development of the National Health Strategy 2016-2020 which seeks to achieve 'Equity and Quality in Health: Leaving no one behind.'
- The strategy lays out the health agenda for 2016- 2020 taking into account the broader policy context that is largely defined by the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim-Asset) and the Sustainable Development Goals.
- The priorities of the NHS are (a) Communicable diseases; (b) non-communicable diseases; (c) Reproductive, Maternal, Newborn, Child Health and Adolescents) and (d) Public health surveillance and disaster preparedness and response.
- Rehabilitation of water and sewerage infrastructure in several urban centres e.g. the Urgent Water Supply and Sanitation Rehabilitation Project Phase 1 in Mutare, Masvingo, Kwekwe, Chegutu, Harare, and Chitungwiza.
- Under SDG 2 (Zero Hunger) Zimbabwe has developed a strong policy environment for achieving food security and improved nutrition, and has prioritised ending hunger within its overall development agenda.
- Government is committed to the achievement of gender equality and women empowerment and the Constitution provides a robust legal framework for the promotion of SGD 5. Several policies and institutions have been put in place to actualise these provisions.

5.3 Health Financing

- Still heavy reliance on donor funding to the health sector through the Health Development Fund, Global Fund to fight AIDS TB and Malaria, bilateral and multilateral donors.
- Country has not been able to achieve the Abuja Declaration of 15% of government fiscal allocation to health.
- However significant progress and strides have been made to mobilization of domestic resources through the AIDS levy to ensure sustainability of the national response to HIV and AIDS.
- The introduction by Government in January 2017 Government of a 5 percent levy on all mobile phone airtime and mobile broadband which is going towards a Health Fund.
- The government has developed a National Health Financing Policy that provides an overarching framework to ensure that required resources needed to achieve Universal Health Coverage are raised sustainably, allocated according to need and efficiently utilized.
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5.4 Potential role of Health Think Tanks in supporting implementation and monitoring of SDGs in Zimbabwe.

- There are several entities in the country that work with, support or contracted by Ministry of Health and development partners to assist in policy development and / or conducting specific research. Examples of such institutions include Institute of Public Health and Research, University of Zimbabwe departments (Community Health Department etc.), BRTI, Training and Research Support Centre (TARSC), Community Working Group on Health (CWGH), Compre Health Services, Public Health Advisory Council, SAfAIDS, Professional Associations like ZIMA and ZINA.
- In Zimbabwe these organizations are not referred to as THINK TANKS.
- Some individuals have discussed need and the idea of establishing an "Informal Group" of interested individuals that can meet regularly to discuss topical issues on health.
- Some individuals interviewed during this consultation expressed the need for an umbrella entity that has no bureaucratic constraints but that has the ear and respect of MOHCC, government in general as well as the convening power for all interested actors or stakeholders and professional groupings.
- One potentially viable suggestion that has been put forward is to use the recently established Zimbabwe Public Health Association (ZiPHA). It was established with active support and encouragement of the Minister of Health and Permanent Secretary. Its membership cuts across all health professional associations and is open to non-health professional that may have an interest in national health issues.
- Challenges and issues - There are funding challenges. How can these be addressed. Seed capital. Resource mobilization strategies.

6. Discussion and recommendations

Below is a table that summarizes the key observations and issues and suggested recommendations:

Observation/Issue	Recommendations
Significant progress has been made in raising awareness about SDGs in Zimbabwe. At this stage this awareness is largely at national level of government. Awareness is still limited at subnational level (province, district, ward and village level)	1 Government Provincial and District level staff should be "educated" or informed about SDGs through various mechanisms including posters, fact sheets, presentations about SDGs at existing workshops, meetings, trainings. The planned 2-day workshops that are being launched in October will go some way in addressing this need. However 2-day workshops alone will not be enough. There is need for a continuous process of education and monitoring knowledge, skills and capacity. It should also be noted that there will a turnover of staff necessitating more trainings and refreshers. Implementation of MDGs is a 15 year undertaking that is a marathon and not a sprint. 2 Elected leaders (Parliamentarians and Councilors) should be equipped with the necessary knowledge and skills to speak to their constituencies during their visits or campaigns. 3 Mass media through radio and TV should organize SDG awareness raising programs. 4 There is need for much more attention to be given to educating and capacitating sub-district or community level structures (WADCOs, VIDCOs traditional chiefs, headman and kraal heads to speak confidently and knowledgeably about SDGs. 5 There should be a program for institutionalizing SDG understanding into the education system starting from pre-school to Tertiary institutions
To date most of the funding for SDG awareness, knowledge and skills building has been done by central government, UNDP and other development partners. The private sector should and can contribute to raising this awareness and education. The involvement and offer of ECONET confirms the wiliness of private companies (at least some) to assist government. This is a good way of enhancing the national ownership of SDG implementation.	1 The Ministry of Macroeconomic Planning should formally engage the private sector through their umbrella bodies (ZNCC and CZI) to discuss possible activities that companies could implement SDG awareness and promotion activities.
While the idea or concept of a Health Sector THINK TANK has been informally discussed by some individuals and there are entities that support government and developing partners in policy related health work, this consultation concluded that the is need for further exploration and discussion regarding the establishment of a Heath THINK TANK in Zimbabwe.	Further consultations should be health with MOHCC Leadership, professional Associations, health sector development partners, the Ministry of Macroeconomic Development in its capacity as coordinator of SDG implementation in the country. In this regard experiences from other countries in Africa and globally will be valuable.

Appendix A

List of persons contacted (Key Informants)

Name	Organization	Position/role	Email	Phone
1 Mr Nyaguse	Ministry of Macro-Economic Planning	Director		
2 Dr Christian Katsande	OPC	Deputy Chief Secretary	cmkatsande@opc.gov.zw	+263 4 707091-7
3 Ms. Ethel Bangwayo	UNDP Zim.	National Economist	Ethel.bangwayo@undp.org	+263 4 338 836-44
4 Dr Mudyiradima	Ministry of Health and Child Care	Principal Medical Director		
	Ministry of Gender			
5 Dr David Parirenyatwa	Ministry of Health	Minister of Health		
	Ministry of Local Government			
	Parliament of Zimbabwe	Chairman of Parliamentary Portfolio Committee on Health		
Dr Lovemore Mbengeranwa	Health Services Board	Chairman Health Services Board		
6 Dr David Okello	WHO	WHO Country Representative		
	UNICEF	UNICEF Country Representative		
	UNFPA	UNFPA Country Representative		
	UN Women			
	World Bank	World Bank Country Representative		
	NANGO			
	Parliament of Zimbabwe	Chairman of Parliamentary Portfolio Committee on Health		
	Women's NGO			
	Department of Community Medicine School of Health Sciences			
Dr Nyasha Masuka	Zimbabwe Public Health Ass.	Vice President		

Dr Rene Loewenson	TARC			
Mr. Itai Rusike	Community Working Group on Health	Executive Director		
Dr Agnes Mahomva	President ZIMA			
Dr Solomon Mukungunugwa	Secretary General College of Public Health Physicians			
	ZINA			
	ZIMSTAT			
	Zimbabwe Association of Local Authorities			

Appendix B

References

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