Zimbabwe

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ZIMBABWE 2012

Millennium Development Goals Progress Report

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CONTENTS

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Honourable T. Mashakada, MP
Minister of Economic Planning and Investment Promotion

ACRONYMS

AAP	Accelerated Action Plan
ACP	African, Caribbean and Pacific Group of Countries
AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral Drug
BCG	Bacillus-Calmette-Guerin
BEAM	Basic Education Assistance Module
BMI	Body Mass Index
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality
CBO	Community-Based Organisation
CCPR	Convention on Civil and Political Rights
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CFCs	Chlorofluorocarbons
CFS	Child-Friendly School
CIDA	Canadian International Development Agency
COMESA	Common Market foe Eastern and Southern Africa
DAC	Development Assistance Committee
DfID	Department for International Development
ECD	Early Childhood Development
EFA	Education for All
EMA	Environment Management Agency
EPA	Economic Partnership Agreement
ETF	Education Trust Fund
EU	European Union
FDI	Foreign Direct Investment
FPL	Food Poverty Line
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GNP	Gross National Profit
GPA	Global Political Agreement
HCFC	Hydrochlorofluorocarbons
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
HTF	Health Transition Fund
ICT	Information and Communications Technology
IES	Incomes and Expenditure Survey
IFI	International Financial Institutions
ILO	International Labour Organisation
IMF	International Monetary Fund
ITN	Insecticide-Treated Net
LFS	Labour Force Survey
MCH	Maternal and Child Health

MDG	Millennium Development Goal
MIMS	Multiple Indicator Monitoring Survey
MIS	Malaria Indicator Survey
MoAMID	Ministry of Agriculture, Mechanisation and Irrigation Development
MoESAC	Ministry of Education Sports and Culture
MoEPIP	Ministry of Economic Planning and Investment Promotion
MoLSS	Ministry of Labour and Social Services
MMR	Maternal Mortality Rate
MoHCW	Ministry of Health and Child Welfare
MoHTE	Ministry of Higher and Tertiary Education
MoLSW	Ministry of Labour and Social Welfare
MSME	Micro, Small and Medium Enterprises
MTP	Medium-Term Plan
NAC	National Aids Council
NATF	National AIDS Trust Fund
NER	Net Enrolment Ratio
NMCP	National Malaria Control Plan
ODA	Official Development Assistance
ODS	Ozone Depleting Substance
OECD	Organisation for Economic Co-operation and Development
OVC	Orphans and Vulnerable Children
PASS	Poverty Assessment Study Survey
PICES	Poverty, Income Consumption and Expenditure Survey
PMTCT	Prevention of Mother-To-Child Transmission
QDS	Quarterly Digest of Statistics
SADC	Southern African Development Community
STERP	Short-Term Emergency Recovery Programme
STI	Sexually Transmitted Infection
STPF	Social Transfer Policy Framework
TB	Tuberculosis
TCPL	Total Consumption Poverty Line
TRIPS	Trade Related Intellectual Property Rights
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
VMAHS	Vital Medicines Availability and Health Services
WFFC	World Fit For Children
ZAADDS	Zimbabwe Accelerated Arrears Debt and Development Strategy
ZAREP	Zimbabwe Accelerated Re-engagement Programme
ZDHS	Zimbabwe Demographic Health Survey
ZIMFUND	Zimbabwe Multi-Donor Trust Fund
ZIMSTAT	Zimbabwe Statistical Agency
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZUNDAF	Zimbabwe United Nations Development Assistance Framework

EXECUTIVE SUMMARY

Based on the latest data available and through an analysis of the trends of the eight MDGs, as well as the current supportive environment, this report assesses the likelihood for the achievement of each MDG target. In sum, out of a total of 21 targets, four targets are likely to be achieved by the 2015 deadline; six targets can potentially be achieved; while eleven targets are unlikely to be achieved.

Positive trends are mainly found in MDG2 on universal primary education, MDG3 concerning gender equality in schools and MDG6 on HIV and AIDS. Some of the largest MDG challenges that the country faces are in MDG1: eradicating extreme poverty and hunger, and MDG5: improve maternal mortality, where all the targets under these goals are unlikely to be met by the 2015 deadline.

Below is a summary of the country performance on each of the MDGs.

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

The economy is growing, but poverty is not declining proportionately.

Although Zimbabwe has experienced improved economic growth rates in the past three years, rising from a negative GDP of 5.7% between 2001–2006 to 5.4% in 2009 and 9.3% in 2011, this has not translated to growth in productive employment and hence poverty reduction. This is likely due to weak connections between the growth sectors and other sectors of the economy. In 2011, 72.3 per cent of all Zimbabweans were considered poor, whilst 62.6% of the households in Zimbabwe are deemed poor. Poverty is more prevalent in rural areas compared to urban areas with about 76% of the rural households considered poor compared to 38.2% of urban households.. Individual poverty prevalence is 84.3% in rural areas compared to 46.5% in urban areas, while extreme poverty is 30.3% in rural areas compared to only 5.6% in urban areas. The decline in formal employment, with many workers engaged in poorly remunerated informal jobs, has a direct bearing on both poverty and hunger. Ninety-four per cent of paid employees in 2011 received an income equal to or below the total consumption poverty line (TCPL) for an average family of five, while three out of every four employed persons in Zimbabwe are classified as 'vulnerable employment'[1].

The percentage of food-insecure rural households at peak (January to March) declined steadily following the onset of economic recovery from 15% in 2010–2011 to 12% in 2011–2012. However, due to this year's poor rainy season, the percentage of food-insecure rural households is projected to rise sharply, up to 19% for the period in 2012–2013, reflecting Zimbabwe's reliance on rain-fed agriculture. The prevalence of underweight children under five years of age fell from 11.8% in 2009 to 10% in 2011, although this figure may be affected by the projected increase in food-insecure households.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Primary school net enrolment is high, but greater effort is needed to improve completion rates.

Although there have been fluctuations in net enrolment ratios (NER), these rates have traditionally been very high. In 2011, NER declined to 87% from a high of 91% in 2009. Very little gender or geographic disparity is found at primary school level. Completion rates have not been as high as NER, although they have risen from 68% in 2005 to 82% in 2009. Students in urban areas and female students have been shown to demonstrate higher completion rates. Zimbabwe has in 2012 developed a focused Accelerated Action Plan to address the specific issue of primary school completion rates. Financial constraints remain one of the key factors preventing higher quality of education.

Literacy rates have also traditionally been high in Zimbabwe, rising from 85% in 1994 to 99% in 2011 amongst 15-24 year olds.

1 *Vulnerable employment is defined as the sum of own-account workers and contributing family workers. They are less likely to have formal work arrangements, and are therefore more likely to lack decent working conditions, adequate social security and 'voice' through effective representation by trade unions and similar organizations.*

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Zimbabwe has achieved gender parity at primary and secondary school levels, but the proportion of women in decision-making positions is still very low.

Zimbabwe has achieved gender parity at primary and secondary school levels with respect to enrolment, attendance and completion rates. There is also gender parity in literacy rates. However, enrolment gender disparities still exist at tertiary level, although this is gradually being improved, especially considering that cohorts with gender parity in high schools are proceeding to the tertiary level.

There is need for greater effort to increase the participation of women in decision-making in all sectors. Although the legislative framework for the empowerment of women has led to some progress, more affirmative action to promote gender equality in higher positions is required. The percentage of women managers in the private sector was only 21% in 2011, and the percentage of female Parliamentarians has remained as it was after the 2008 elections, at 14% for the Lower House and 24% for the Upper House. The percentage of female urban and female rural councillors is 19%.

GOAL 4: REDUCE CHILD MORTALITY

Although infant and child mortality rates have gradually declined, better immunisation and water and sanitation programmes are pivotal to achieving the necessary dramatic reductions.

Both under-five and infant mortality rates are improving but very slowly. The under-five mortality rate declined from 102 deaths per 1,000 live births in 1999 to 84 per 1,000 in 2010/2011. The infant mortality rate declined from 65 deaths per 1,000 live births in 1999 to 57 deaths per 1,000 live births in 2010/2011. Even so, this decline is not fast enough to achieve the MDG 4 target.

Rural children have a higher mortality rate than their urban counterparts; findings indicate that socioeconomic status and the education level of the mother lead to lower mortality rates for children. Four preventable conditions have led to the vast majority of under-five deaths: AIDS, neonatal problems, pneumonia and diarrhoea. Immunisation coverage has improved in general, but the high cost of obtaining treatment and the lack of easy access to safe drinking water and improved sanitation are major obstacles to reducing under-five and infant mortality rates.

GOAL 5: IMPROVE MATERNAL HEALTH

The number of mothers dying has increased in recent years due to lower rates of attended births and the higher costs of healthcare.

The current maternal mortality rate of 960 deaths per 100,000 live births is significantly higher than the rate of 612 deaths per 100,000 live births recorded for 2005–2006. Maternal health-related issues are responsible for the death of 12% of women aged 15-49 as of 2010–2011. There has been a decrease in the proportion of births attended by skilled health personnel, especially in rural areas.

Major challenges remain, including unaffordable maternity fees, reduced attendance of expectant mothers at antenatal clinics due to associated costs or distances to clinics and the inability of some women to make choices on reproductive health issues due to social or cultural pressures.

It is hoped that this situation will be greatly improved by 2015, given that the Government of Zimbabwe and the donor community have assembled a health transition fund aimed at improving maternal, new-born and child health and nutrition; increasing the availability of medical products, vaccines and technologies; increasing human resources for health; and improving health policy, planning and financing.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

HIV/AIDS remains a serious public health problem, but Zimbabwe is making good progress in the fight against HIV and AIDS, with rates of infection falling.

According to the 2011 Zimbabwe Demographic Health Survey (ZDHS) 2011, 15% of Zimbabwean adults aged 15-49 years are infected with HIV, which is a three-point decline from 18% in 2007. In Zimbabwe, HIV and AIDS is a feminised epidemic, with HIV prevalence among women at 18% and men at 12%. The prevalence rate for 15 to 24 year olds is 5.5% (2011), again much higher in women (7.8%) than in men (3.6%).In general, people with better education and socioeconomic status have lower HIV prevalence.

There is geographical heterogeneity with HIV prevalence, which in urban areas is 17% and rural areas 15%. There were an estimated 1,214,126 people, including 162,889 children, who were living with HIV/AIDS in 2011. An estimated population of 476,321, including 40,140 children, was enrolled on antiretroviral therapy by the end of 2011, of which 60% are women. The prevention of mother-to-child transmission (PMTCT) coverage is at 86%, with 18% of babies currently being infected.

Zimbabwe is one of 34 African countries that has stabilised the spread of HIV/AIDS, with a 49% reduction in new cases, especially among young people. In addition, blood transfusions are now 100% safe; there is 60.9% correct condom use at last high-risk sex; the incidence of multiple sexual partners is reduced; fewer young people engage in sexual activity before age of 15 years; and 33% of the population know their HIV status.

The country's successful domestic resource mobilisation through the AIDS levy and strong partnerships remains undaunted. The AIDS levy alone generated $26 million during 2011.

Malaria was a leading cause of hospital admissions in 2009, but 2010 statistics show that incidences of this disease declined by 64%, based on 2000 levels. The number of reported cases of tuberculosis has also decreased, dropping from a peak of 782 per 100,000 people in 2007 to 633 per 100,000 people in 2010. Cholera cases have been reported annually in Zimbabwe since 1998, but these have remained fairly consistent since the large outbreak of 2008. The 2010 typhoid outbreak in Harare was the first to occur for more than 40 years; two further outbreaks occurred in 2011 and late-2012. Preventing these and other diarrhoeal diseases requires exposure to safe drinking water, sound sanitation and good personal hygiene practices.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

While Zimbabwe remains a net carbon sink and has developed robust legislation, most Zimbabweans still rely on illegally extracted natural resources such as firewood, thereby increasing deforestation.

Progress on environmental sustainability in Zimbabwe has been variable. Positive results include phasing out ozone-depleting substances, minimising carbon dioxide emissions as well as gradual improvements in access to safe sources of water, increasing from 61% of 2009 to 79% by 2010. However, there are indications that the water situation in Zimbabwe may have since worsened.

Deforestation remains a problem, as the majority of Zimbabweans continue to harvest natural resources such as firewood without the enforcement of any prohibitive regulations. This highlights the fact that poverty, which can lead individuals to rely on resources such as firewood to sustain themselves, is intimately connected with environmental sustainability. Additionally, while there was a reduction of 50% in reported poaching during 2010–2011, there are at least three endangered species of animals in Zimbabwe which still require support.

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Zimbabwe has made gains in stabilising international relations and increasing telecommunications, although there is still work to be done in managing the debt burden.

Zimbabwe is making progress in addressing the debt overhang (including debt arrears estimated at US$7.1 billion owed to bilateral and multilateral partners), which is key for unlocking development assistance. Although relations with the international community have largely stabilised, these remain crucial to engaging more effectively with donor countries in order to encourage the return of investment and aid.

The overall availability of critical medicines at public health institutions has improved significantly in the past four years, but access to affordable important medicines on a sustainable basis remains a challenge and the country relies heavily on donor supplies.

Tele-density in Zimbabwe continues to improve and is currently estimated at 90%, up from 68% in 2011. Internet penetration rate was 15% in 2011, and is now 20%, well above the regional average of 11%.

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INTRODUCTION

The 2012 Millennium Development Goals (MDGs) Progress Report is the fourth national report on the status of the MDGs in Zimbabwe, the trends in MDG attainment and the associated challenges. MDG Progress Reports were also produced in 2004, 2007 and 2010. Another national report will be produced in 2014, one year prior to the 2015 deadline. Based on a trend analysis of each MDG, evaluated against the target of each goal, this report assesses whether the country is on- or off-track to achieving the MDGs by 2015. The 2012 MDG progress report is fact-based and accounts for the most recent data available for each of the MDG targets, using the latest official data sources. To the extent possible, Zimbabwe specific trends are shown on each MDG from the baseline year of 2000, when the MDGs were adopted. A particular focus has, however, been placed on developments since the last national MDG report in 2010.

The report identifies the legislative framework and the national policies and programmes that constitute a supportive environment for achieving the MDG in question. It also highlights the challenges faced. Furthermore, the report provides concrete recommendations as to how off-track MDGs can be attained.

This report lays out the status of each MDG and the trends in progress toward each MDG in a table. The overall progress towards each goal is highlighted in the 'Status' column, which lists each goal as red, amber, or green. A red coding indicates that the MDG target is unlikely to be achieved by 2015, while an amber coding indicates that the MDG target can potentially be achieved by 2015. A green coding indicates that the MDG target is likely to be achieved by 2015 if efforts continue.

Given the growing attention to the post-2015 development agenda, as the MDG deadline grows closer, the report closes with a chapter discussing ideas for the evolution of the MDGs. In this regard, it presents the views of a variety of development stakeholders in Zimbabwe on the post-2015 agenda, based on the country's experiences with the MDGs since 2000 and taking into account global and regional dynamics.

THE MILLENNIUM DEVELOPMENT GOALS

GOAL 1
Eradicate Extreme Poverty and Hunger

GOAL 2
Achieve Universal Primary Education

GOAL 3
Promote Gender Equality and Empower Women

GOAL 4
Reduce Child Mortality

GOAL 5
Improve Maternal Health

GOAL 6
Combat HIV and AIDS, Malaria, and Other Diseases

GOAL 7
Ensure Environmental Sustainability

GOAL 8
Develop a Global Partnership for Development

ZIMBABWE DEVELOPMENT CONTEXT

Zimbabwe is recovering from a decade of economic decline that led to rising levels of poverty, unemployment and underemployment. The country is confronted with major developmental challenges, manifested by high unemployment, rising poverty levels and inequality, low savings and investment rates and a decaying infrastructure. Basic infrastructure in Zimbabwe deteriorated significantly during this period, thus constraining the pace of economic recovery. There is also a high infrastructural deficit in energy, transport and water, which requires huge resources to rehabilitate and expand.

Tackling these challenges and ensuring economic growth and sustainable development required a multifaceted approach that combined macro and micro-economic interventions that focused on the quantity and quality of employment and economic growth. As a result, in 2009, the Government of Zimbabwe formulated the Short-Term Emergency Recovery Programmes (STERP I and II) to halt the economic decline and thereafter launched the 2011–2015 Medium Term Plan (MTP) as a strategic response to address the challenges it faced. The MTP is the national economic blueprint that guides the national development agenda and contains a set of policy targets and objectives that respond to development challenges across various sectors. Being a pro-poor national development framework, the MTP seeks to achieve transformational change for improved economic performance, underpinned by the philosophy of growth with equity and sustainable development.

MACRO-ECONOMIC ENVIRONMENT

Since 2009, the country has experienced a stable macro-economic environment with strong GDP growth rates of 5.4% in 2009, 8.1% in 2010 and 9.3% in 2011. Generally, GDP growth rate indicators have been above the MTP's annual average target of 7.1%. The inflation rate has remained below 5%, largely a result of the multi-currency regime introduced in 2009. Nevertheless, this economic recovery has not been accompanied by commensurate rise in employment and job creation, or by a decline in poverty. The MTP will continue to address this, as will the recently enacted Employment Policy.

Despite recent positive economic performances, the economy remains fragile. This is mainly due to political challenges, poor social and economic infrastructure, very low ODA (approximately US$725 million in 2010 and mostly in humanitarian aid) and low Foreign Direct Investment (FDI) flows (approximately $387 million in 2011), which are amongst the lowest in Southern Africa. Levels of investment are low, in particular FDI, which is below 3% of GDP. Domestic investment levels of around 19% of GDP remain well below thresholds consistent with rapid and sustainable rates of economic growth (30-40%). The country's external debt of roughly US$10.7 billion (about 114% of GDP), of which US$7.1 billion is in arrears, presents an impediment to the capital flows and poses serious difficulties to Zimbabwe attaining its own development objectives, as reflected in MTP and its MDG targets. On the positive side, efforts are being made through the Cabinet-approved Zimbabwe Accelerated Arrears, Debt and Development Strategy (ZAADDS) to deal with the debt issue and to access new financing for broad-based economic development. Further consolidation of the macro-economic environment is underway to strengthen fiscal management, address vulnerabilities in the financial sector and ensure policy consistency in order to build confidence in the economy. Zimbabwe is also taking advantage of its membership of regional bodies such as SADC and COMESA to expand on trade, tourism and investment linkages as part of its diversification strategy.

GOVERNANCE AND SUSTAINABLE DEVELOPMENT

Zimbabwe is a signatory to the Millennium Declaration, which recognises the central importance of good governance to creating an environment that is conducive to development and to the elimination of poverty. The social, economic and political context of the past decade has necessitated considerable outlay

towards strengthening the national architecture for public service and justice delivery, rule of law and fundamental freedoms and participatory approaches for the population. The ongoing national consultative process to promulgate a new constitution and efforts directed at strengthening institutions of governance will thus contribute to the promotion of democracy, strengthening the rule of law and contributing to sustainable development vital for poverty reduction and the achievement of the MDGs.

HUMAN DEVELOPMENT

Some good progress has been observed in the delivery of social services over the last three years. For example, Zimbabwe has been able to make significant progress on a number of MDGs such as MDG 6 and MDG 2. With regard to MDG 6, the government, in partnership with development partners has enacted strong policies and programmes to tackle the challenge of HIV and AIDS. As a result, the infection rate among adults aged 15-49 dropped from a high of 23.6% in 2001 to 15% in 2010–2011. The prevalence rate is currently 5.5% for 15 to 24 year olds compared to 13.7% in 2009. While this drop is quite significant, it still remains a major development challenge that needs to be addressed.

The Human Development Index (HDI) remains low but is on the rebound. It had dropped to 0.338 by 2008, from a high of 0.425 in the years 1985 and 1990, started to rise steadily from 0.349 in 2009, and rebound to 0.376 by 2011, even though well below the sub-Saharan Africa average HDI of 0.463.

The rising inequity remains a challenge and this is affected by environmental risk and gender disparities in power, which both disproportionately affect the most vulnerable. To ensure inclusivity and equity, the country is moving towards incorporating gender issues in all national development processes. This will be further strengthened through the introduction of gender-sensitive budgeting; legislative reforms; and increasing gender awareness that focuses both on women's rights and women economic empowerment.

NATURAL RESOURCES AND ENVIRONMENTAL MANAGEMENT

Zimbabwe is endowed with both renewable (water, land, forest, fisheries) and non-renewable natural resources in form of minerals (platinum, gold, diamonds, cobalt and nickel). Given that the majority of the citizens depend on natural resources as sources of livelihoods, the country has witnessed a reduction in the quantity and quality of its natural resources. This is mainly arising from rapid deforestation, siltation, pollution, poaching of both flora and fauna and general degradation of the natural environment arising from economic activities such as mining. Whilst regulation pertaining to the management of natural resources is robust, there is a consistent challenge in the interpretation and enforcement of regulations. Effective and efficient harnessing of the country's extractive sector could further contribute to the country's economic growth and human development through creation of employment opportunities and generation of fiscal revenues.

In conclusion, fostering equity and inclusivity for sustainable development remains a medium- and long-term objective of the Government of Zimbabwe. The MTP, which is a pro-poor national development strategy, clearly identifies investments and policy regimes that are critical for the transformation of the economy. If fully implemented, the plan will contribute to poverty reduction and to the achievement of the MDG targets as part of the overall national development agenda.

Photo courtesy Sven Schermer © www.123rf.com

GOAL 1:

Eradicate extreme poverty and hunger

TABLE 1.1 • STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 1A Halve, between 2000 and 2015, the proportion of people whose income is less than the Total Consumption Poverty Line (TCPL).	***1.1:*** *Percentage of people below the TCPL*	The percentage of the population living below the TCPL was 55% in 1995, 72% in 2003 and 72.3% in 2011.	*MDG target is unlikely to be achieved by 2015.*
	1.2: *Human Poverty Index (HPI)*	The HPI was 40.3% in 2005 and dropped to 34% in 2009.	
Target 1B Achieve full and productive employment and decent work for all, including women and young people.	***1.3:*** *Employment-to-population ratio*	The employment to population ratio fell from 79.3% in 2004 to 78% in 2011.	
	1.4: *Proportion of employed people living below TCPL*	As of May 2011, 94% of paid employees received an income below or equal to TCPL for an average household of five persons. In May 2012, 90% of employed persons earned an income below the TCPL for an average household of five.	
	1.5: *Proportion of own-account and contributing family workers in total employment*	This increased from 70.88% in 2004 to 74.6% in 2011.	
Target 1C Halve, between 1990 and 2015, the proportion of people suffering from hunger.	***1.6:*** *Prevalence of underweight children under five years of age*	The prevalence of underweight children declined from 11.8% in 2009 to 10% in 2012 from a previous high of 17% in 2005.	
Reduce by two-thirds, between 2002–2015, the proportion of malnourished children under five	***1.7:*** *Proportion of population below minimum level of dietary energy consumption*	7.1% females and 15.2% males had a body mass index (BMI) below 18.5.*	

**BMI is taken as proxy for dietary energy consumption.*
Sources: 2010/11 ZDHS, MIMS, 2009, LFS 2011, PASS II, 2003, Global HDR 2009.

STATUS AND TRENDS

Target 1A: *Halve, between 2002 and 2015, the proportion of people whose income is less than the Total Consumption Poverty Line (TCPL)*

Poverty

The current level of poverty in Zimbabwe has its roots in the cumulative effects of the protracted economic decline that the country experienced prior to the formation of the Government of National Unity in 2009. Per capita GDP, which peaked at US$574 in 1998, had shrunk to US$284 by 2008. Hyperinflation, which reached 231 million per cent per annum in July 2008, had significant negative effects on income poverty. The quality of public service delivery was also eroded by the government's inability to pay for materials, maintenance and workers' salaries. Due to the increasing cost of goods and the corresponding decrease in the value of salaries, households liquidated assets, including savings, in order to provide for their families. As a result, many households struggled to make the investments in education and health to help their families succeed and increase their incomes during the period of post-crisis recovery.

According to the 2003 Poverty Assessment Study (PASS II), the percentage of people living below the Total Consumption Poverty Line (TCPL) was 55% in 1995 and rose to 72% by 2003. According to the 2011/12 Poverty and Poverty Datum Line Analysis in Zimbabwe2, in 2011, 72.3% of all Zimbabweans were poor and had per capita expenditures below the TCPL and 22.5% of the people were considered to be extremely poor, living below the Food Poverty Line (FPL)3.


Photo courtesy WFP ©

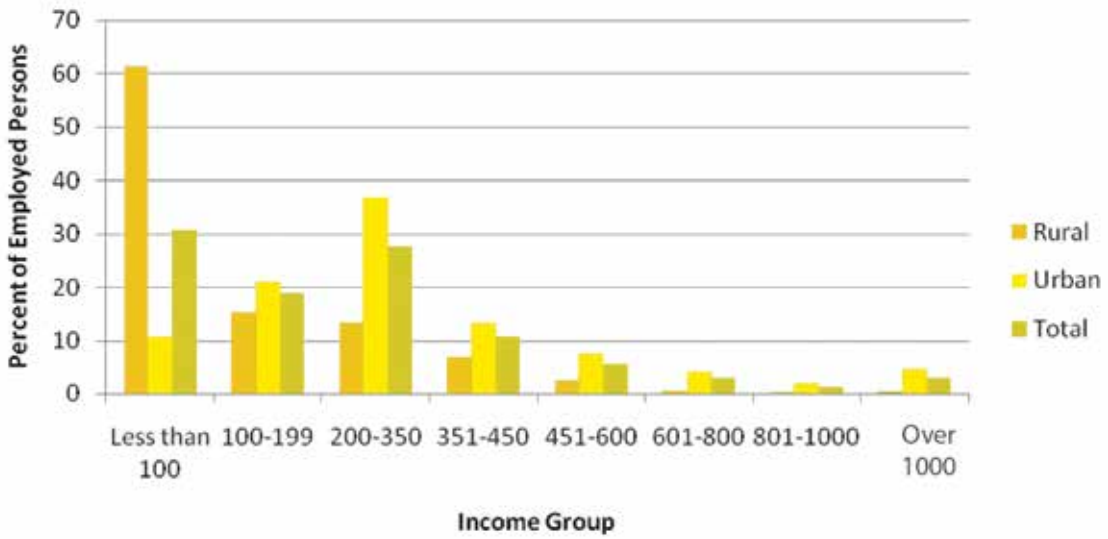
The 2011/2012 analysis also observed that 62.6% of households In Zimbabwe are deemed poor and 16.2% considered extremely poor. The analysis shows that poverty is more prevalent in rural areas compared to urban areas with about 76% of the rural households considered poor compared to 38.2% in urban areas. Individual poverty prevalence is 84.3% in rural areas compared to 46.5% in urban areas, while extreme poverty is 30.3% in rural areas compared to only 5.6% in urban areas.

In terms of geographical distribution, Matabeleland North province has the highest poverty prevalence at 89.9% whilst 49% are deemed to be living in extreme poverty. Other provinces with high prevalence of households in poverty include Mashonaland Central, Matabeleland South, Manicaland and Mashonaland West with prevalence levels of about 70%.

2 *Poverty and Poverty Datum Line Analysis in Zimbabwe 2011/12, April 2013, ZIMSTAT*

3 *The Food Poverty Line (FPL) represents the minimum consumption expenditure necessary to ensure that each household members can (if all expenditures were devoted to food) consume a minimum food basket representing 2100 calories. The Total Consumption Poverty Line (TCPL) includes an allowance for non-food minimum need requirements, such as housing clothing, transportation, health care etc. The TCPL naturally exceeds the FPL, and households or people whose per capita consumption expenditure is below the TCPL are deemed to be poor.*

Figure 1.1 Percentage of employed persons, rural and urban, and gross primary income



Source: Poverty, Income, Consumption and Expenditure Survey (PICES) 2011/12

Although the prevalence of poverty among male- and female-headed households is almost the same at 62.9 percent and 62 percent respectively, huge differences are observed in those households headed by divorced or widowed individuals. The highest prevalence of poverty of 69% is observed in female-headed widowed households compared to 55% percent for male-headed widowed households. Further, households headed by a permanent paid employee or by an employer have the lowest likelihood of being poor compared to those headed by casual, temporary employees or own account workers.

Proportion of employed people living below TCPL

With the average household in Zimbabwe estimated to consist of five people, the TCPL in May 2011 was US$497.84; according to the 2011 Labour Force Survey, 94% of paid employees received an income equal to or below the TPCL.4 In May 2011, 58% of these paid employees received an income equal to or below the Food Poverty Line (FPL) and were thus categorised as very poor.

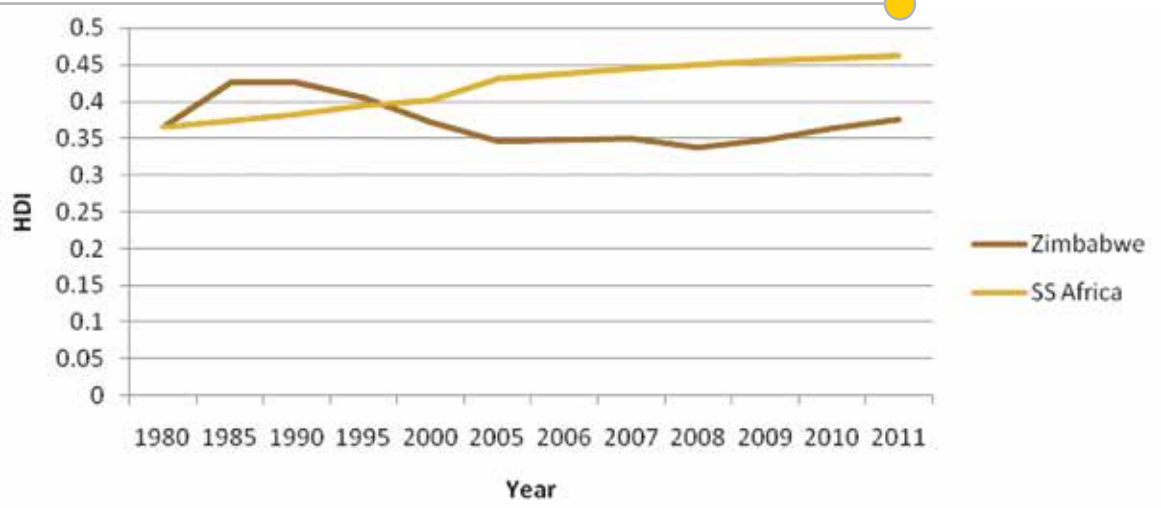
Data from the 2011/12 Poverty, Income, Consumption and Expenditure Survey (PICES) shows that 90% of employed persons' gross primary incomes are below the TCPL – a four percentage-point improvement from the previous year.[5] Zimbabwe's Human Poverty Index (HPI), which was 24% in 1995 and 40.3% in 2005, dropped to 34% in 2009, reflecting the country's improvement in economic performance post-2008. The Human Development Index (HDI), which had fallen from a high of 0.425 in 1990 to 0.338 by 2008, started to rise steadily from 0.349 in 2009, and with the recovery of the economy, to 0.376 by 2011. This gives the country a ranking of 173 out of 187 countries with comparable data. Zimbabwe is still well below the sub-Saharan Africa average HDI of 0.463.

Whilst Zimbabwe has registered positive economic growth rates since 2009, the number of Zimbabweans employed in the formal sector is still declining. Even though GDP was growing between March 2010 and March 2011, total formal sector employment declined from 1.327 million to 1.201 million.[6] Similarly, in the agricultural sector, the total number of both formal and informal employees declined by 5% from 2010 to 2011. The mining sector has been a key driver of the economic recovery process, growing by 25% in 2011.[7] However, the capacity of the mining sector to generate employment is limited by the fact that most minerals are exported in raw or semi-processed form with little value addition, hence the sector generates little downstream industry or employment. At the same time, most of the machinery and equipment used in mining is imported, rather than locally made or assembled. There is a weak connection between the various sectors of the economy that are growing rapidly, such as mining and those sectors of the economy in which low-income Zimbabweans work, primarily agriculture. Furthermore, the areas in which the majority of Zimbabwe's low-income individuals live are not the geographical locations in which rapid economic growth is occurring.

Since the majority of people living in poverty live in rural areas and largely depend on agriculture to meet their household requirements, sustained growth in the agricultural sector would greatly contribute to poverty reduction. In turn, this would have a positive effect on the manufacturing sector, since it sources

4 *2011 Labour Force Survey (LFS), ZIMSTAT.*
5 *Poverty, Income, Consumption and Expenditure Survey (PICES) 2011/12, ZIMSTAT.*
6 *Quarterly Digest of Statistics, 2nd Quarter, 2012, ZIMSTAT.*
7 *Ministry of Finance Budget statement 2013.*

Figure 1.2 Human Development Index: Trends, 1980–2011



Source: International Human Development Indicators – UNDP: http://hdrstats.undp.org/en/countries/profiles/ZWE.html.

60% of its raw materials from agriculture. In addition, an increase in rural incomes stimulates manufacturing by increasing demand for manufactured goods and services. Agriculture grew by an impressive 34% in 2010, but only by 7.4% in 2011 and is projected to have a negative 6% growth rate in 2012.[8]

***Target 1B**: Achieve full and productive employment and decent work for all, including women and young people*

Employment to population ratio

Although there are no official figures for the employment to population ratio for 2010, trends in formal sector employment and in agriculture indicate that it has decreased between 2010 and 2012, despite positive economic growth over this period.

According to the 2011 Labour Force Survey (LFS), total employment to population ratio for the year 2011 was 78% (83.9% male/72.8% female), reflecting a marginal decline from the situation in 2004 when the ratio was 79.3% (84.4% male/74% female). The 2011 ratio is higher in rural (87.9%) than urban areas (59.4%). Agriculture is still the dominant sector, with 66% of currently employed persons in this sector.

Own-Account and Contributing Family Workers in Total Employment

In 2011, 73.7% of all employed persons were self-employed workers (60.5% communal, resettlement and peri-urban and 13.2% other), and 0.9% were contributing family workers. This represents an increase from the figure of 70.88% in 2004. This category of workers is classified as 'vulnerable employment', in that such work arrangements usually lack social protection and the pay is normally too low to generate savings. This means three out of every four employed persons in Zimbabwe are in vulnerable employment, with a disproportionate number of females (83%) compared to males (66%).[9]

8 *Ministry of Finance Mid-Year Fiscal Policy Review, 2012.*
9 *LFS 2011, ZIMSTAT.*

***Target 1C:** Reduce by two-thirds, between 2002 and 2015, the proportion of malnourished children under five*

Progress in eradicating extreme poverty and hunger largely depends on the country's performance in agriculture. Zimbabwe continues to rely heavily on rain-fed agriculture but, due to climate change, the country is experiencing more frequent droughts and late onset and erratic rainfall. As a result, agricultural output for 2012/13 is projected to decline by 6%. The introduction of effective and low-cost irrigation systems has immense potential to reduce poverty, hunger and food insecurity by enabling predictable and efficient agricultural production.

The percentage of food-insecure rural households at peak season (January to March), which had been steadily declining since 2009/10 to a low of 12% in 2011/12, is projected to rise sharply to 19% during 2012/13.[10] This represents 1.6 million people who are likely to need food aid. The provinces of Matabeleland South, followed by Masvingo and Matabeleland North, are projected to have the highest proportion of food-insecure households in the 2012/13 consumption year.

Weight-for-age is an overall indicator of a population's nutritional health. A child can be underweight for his/her age because he/she is stunted, wasted, or both. Overall, 10% of all children in Zimbabwe are underweight, and 2% of children are severely underweight. This represents an improvement from the 2003 and 2005 levels of 17% underweight children. A higher percentage of males are underweight compared to females (11% and 8% respectively). Ten per cent of rural children are underweight compared with 8% of urban children. Matabeleland North has the greatest percentage of children who are underweight (14%). The percentage of children who are underweight born to uneducated mothers is more than five times as high as the percentage underweight among children whose mothers have tertiary education. Although the National Nutrition Survey[11] report was pessimistic about attaining the target of reducing malnutrition to 7% by 2015, the decrease from 2010 to 2011 indicates that by scaling up interventions that address child nutrition the 2015 target can be achieved. The recently approved Food and Nutrition Security Policy is a step in the right direction.

10 *Zimbabwe Vulnerability Assessment Committee (ZimVac), 2012.*
11 *Government of Zimbabwe, United Nations and the Food and Nutrition Council, National Nutrition Survey 2010.*

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SUPPORTIVE ENVIRONMENT

There are numerous national policy frameworks which support issues related to poverty and employment, principally the MTP, the National Employment Policy Framework and the National Budget 2012. Zimbabwe also has an extensive range of formal social protection measures. Specific funds have been created to benefit disadvantaged groups such as women, youth and people with disabilities. However, while the Poverty Alleviation Action Programme includes a range of social protection measures such as the Community Action Project and the Enhanced Social Protection Strategy, it has remained limited in scope. A comprehensive Social Transfer Policy Framework (STPF) has been put in place with the intention of harmonising the broad array of ongoing social transfer initiatives implemented through a range of funding mechanisms into a coherent and consolidated system.

The STPF also includes the following initiatives to enhance food security: agricultural input support for the non-labour-constrained rural poor (households with able-bodied members who are fit for work), a public works programme, and social cash transfers for households without able-bodied members fit for work (labour-constrained households).

The Ministry of Economic Planning and Investment Promotion (MoEPIP) has increased its commitment to support Provincial Development Plans, while the Ministry of Agriculture, Mechanisation and Irrigation Development (MoAMID) is supporting input schemes for vulnerable populations and is developing a strategic plan that focuses on increasing agricultural productivity and expanding irrigation coverage. The efforts of MoAMID in this regard are complemented by the Food and Nutrition Security Policy for Zimbabwe in the Context of Economic Growth and Development, which was recently approved by Cabinet. This policy aims to promote and ensure adequate food and nutrition security for all people at all times in Zimbabwe, particularly for the most vulnerable.

In recognition of the key role of agriculture in the economy and in fighting poverty, the government directed greater resources to agricultural activities. Budgetary allocations to MoAMID increased from less than 3% of the total budget in 2010 to almost 6% in 2012.

CHALLENGES

Zimbabwe's national irrigation infrastructure requires rehabilitation to reduce its reliance on rain-fed agriculture. The 2012 ZIMVAC reported that out of the sampled wards with irrigation schemes 32% had non-functional irrigation schemes and 30% had partially functional schemes. Only 38% had fully functional schemes. The unreliability of electricity supplies is also a strong disincentive to farmers to grow winter wheat, which depends on irrigation.

Not only is the disbursement of agricultural inputs late but they are also unaffordable for most smallholder farmers. In addition, there are limited credit facilities to support farming.

Zimbabwe continues to face persistent levels of chronic malnutrition, which are exacerbated by food insecurity and deepening poverty.

There are weak institutional arrangements and poor co-ordination of social protection programmes, resulting in fragmentation of responsibilities and duplication of efforts among government ministries and other agencies. This renders such programmes costly and minimises impact on the intended beneficiaries. This problem is exacerbated by the lack of up-to-date data relevant for planning purposes.

A major challenge relating to the structure of the national economy is the size of the informal sector, which is characterised by a high decent work deficit, that is, low productivity, exclusion from social protection, no compliance with safety and health standards and non-environmentally friendly activities.

Micro, small and medium enterprises (MSMEs) can play an important role in employment and income-generation and contribute to national development and poverty reduction. However, they face a number of challenges ranging from limited access to capital, skills shortage, a challenging regulatory environment and lack of proper infrastructure.

RECOMMENDATIONS

A number of measures need to be taken to accelerate achievement of the goal of eradicating extreme poverty and hunger by 2015. These include:

- Expanding irrigation development to smallholder and communal farmers, specifically targeting women and youth as well as rehabilitating non-functional irrigation schemes to reduce reliance on rain-fed agriculture.
- Supporting small-scale farmers to access key agricultural inputs by facilitating their access to credit, specifically targeting women and youth.
- Finalising and implementing the National Food and Nutrition Security Strategy.
- Supporting MoEPIP's strategy of decentralised decent and high-productivity job creation to fight poverty.
- Promoting the development of MSMEs for poverty reduction and employment and wealth creation.
- Putting in place policies and institutional mechanisms for the effective co-ordination of social protection programmes at all levels.
- Aligning the MTP policy framework with pro-poor, inclusive growth and women empowerment strategies.
- Strengthening the national statistical system for poverty data collection.

Photo courtesy Nolre Lourens © www.123rf.com

GOAL 2:
Achieve Universal Primary Education

TABLE 2 • STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 2A Ensure that by 2015 all Zimbabwean children, boys and girls alike, will be able to complete a full programme of primary education.	***2.1:*** *Net enrolment ratio (NER) in primary education.*	NER was 96.9% in 2005 and in 2009 had increased slightly to 97.7%. Thereafter it fell to 81.4% by 2011.	*MDG target is likely to be achieved by 2015 if current efforts continue.*
	2.2: *Proportion of pupils starting Grade 1 who reach the last grade of primary school.*	After a dramatic decrease from 1996 (82.6%) to 68.2% completion rates by 2006. Rates rose to 82.4% by 2009.	
	2.3: *Literacy rate of 15- to 24-year-olds, male and female.*	Literacy rates have remained high amongst this age group, rising from 91% in 2009 to 99% in 2011. Literacy rates are 99.6% for both males and females.	

Source: MoESAC, ZDHS 2010/11, MIMS 2009, LFS 2011.

STATUS AND TRENDS

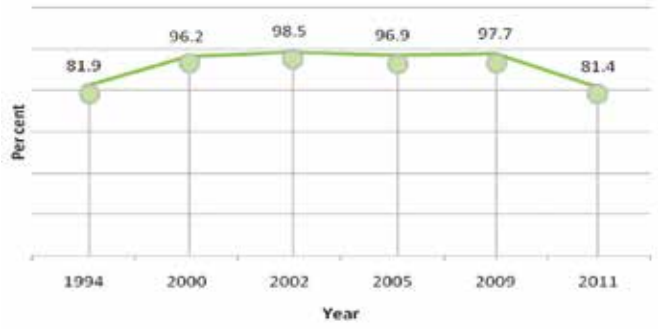
Education is recognised the world over as a fundamental and universal human right and is a prerequisite for economic growth, human development and poverty reduction. Education is important in protecting children from exploitative labour practices and is the most empowering tool for gender equality and equity. In addition to being MDG 2, universal access to basic education for children is one of the 2015 Education for All (EFA) and 2010 A World Fit for Children (WFFC) goals.

Target 2A: *Ensure that by 2015 all Zimbabwean children, boys and girls alike, will be able to complete a full programme of primary education*

Net Enrolment Ratio in Primary Education

Zimbabwe's primary school Net Enrolment Ratio (NER) had risen to well above 95% by the year 2000. In 2005, it was 96.9% and in 2009, at the onset of economic recovery, it rose slightly to 97.7%.[12] However, by 2011, the primary school NER had fallen down to 81.4%.[13] Primary school NER was higher in rural areas (84.1%) than in urban areas (73.4%).

Figure 2.1: Primary School Enrolment Ratio, 1994 to 2011



Source: MoESAC; PICES, 2011/12

12 *There is no data on primary school NER for the years 2006 to 2008 because of the prevailing economic challenges of this period.*

13 *Poverty, Income, Consumption and Expenditure Survey (PICES) 2011/12.*

According to the 2011 LFS, 59% cited financial constraints as the reason for children between ages of five and nine years being out of school. Other reasons for children dropping out of school included not being interested in school (7.4%), the distance to school (3.1%) and child illness (2.1%). The proportion of children aged between ten and 14 who had dropped out because of financial reasons is even higher (72.9%).[14]

Completion Rates

There is no official published data for primary school completion rates beyond 2009, but indications are that it may not be possible to meet the MDG target of 100% completion rates by 2015, unless the implementation of the recently developed MDGs Accelerated Action Plan (AAP) for Target 2A is successful.

In 2009, completion rates were 82.4%, possibly because of the improved economic situation that enabled children to stay in school. The rate for females (85%) rose to beyond that of males (80%),[15] which should reflect the success of the national campaign to sensitise parents throughout the country on the need to educate the girls. Urban areas had a higher completion rate (88.3%) than rural areas (80.4%).

Literacy Rates

Literacy rates in Zimbabwe are very high. Among 15- to 24-year-olds, they increased from 91% in 2009 to slightly above 99% in 2011.[16] This indicates a strong recovery from the decline that occurred during the years 2000 to 2008, when many children were not attending school due to economic hardship. Moreover, variations in literacy across sub-groups of the population are low, with no significant difference between males and females.

Photo courtesy UNCG (UN Communications Group) ©

14 *LFS 2011.*
15 *Multiple Indicator Monitoring Survey (MIMS), 2009.*
16 *LFS 2011.*

SUPPORTIVE ENVIRONMENT

There has been progress in improving access to quality education in the past few years, with numerous interventions able to continue through the support of government line ministries, UN agencies and international donors.

The Basic Education Assistance Module (BEAM) is one of the largest of these interventions and aims to reduce the number of orphans and vulnerable children (OVC) dropping out of primary school by covering their tuition fees and other levies. The Ministry of Education, Sport, Arts, and Culture (MoESAC) has also implemented other interventions targeting children who have dropped out of school, among them being the School Feeding Programme and a Second Chance Education Programme. The implementation of the Accelerated Action Plan (AAP) on MDG 2 intends to eliminate bottlenecks affecting the effective implementation of these programmes, thereby accelerating progress toward achieving MDG 2.

The pupil:textbook ratio for the four major primary school subjects: mathematics, English, a local language and Environmental Science has reached the target of 1:1 as result of the support of the Educational Transition Fund (ETF), a multi-donor funding mechanism designed to mobilise resources for the education sector to ensure equitable access to quality education. The ETF also invested in the training of School Development Committees to improve management of schools at community level. It also provided technical assistance to strengthen MoESAC's ability to monitor educational services.

The national School Improvement Grants Programme that is still in the making is intended to strengthen education by providing financing directly to schools. It will identify the poorest and neediest schools and enable them to participate in a grants initiative aimed at eliminating the costs of schooling for parents and children and ensuring quality education for the most vulnerable.

Through the policy circular P77 of 2006, MoESAC adopted a two-pathway education structure which will help ensure that children leave school with education with at least one skills pathway: general/academic, business/commercial or technical/vocational. This will lay a foundation for further training in tertiary institutions.

The ministry has also embraced the philosophy of Child-Friendly Schools (CFS) and child-centred learning. 250 schools have been identified in which the CFS programme will be implemented. The objective is to mainstream the concept into all schools. The CFS programme is aimed at schools that do not currently cater for the needs of vulnerable children and enabling them to provide a safe, child-friendly environment.

The Early Childhood Development (ECD) programme is progressing well. About 98% of all primary schools have established ECD 'B' centres catering for children between the ages of four and five and 60% have ECD 'A' centres for children aged three to four, all with teachers trained by the Ministry of Higher and Tertiary Education. The government is endeavouring to democratise access to ECD centres, mainstreaming them so that they receive the same benefits as those of primary schools.

CHALLENGES

Zimbabwe still faces challenges with respect to primary school education. These are largely in terms of budgetary constraints as a result of inadequate government revenue inflows. UNESCO recommends that 6% of gross national product (GNP) be allocated to education, a target that was met in 2012[17]. However, the majority of the expenditure goes to salaries (which still remain inadequate) and overheads, rather than implementing policies that could improve the quality of education.

According to the Rapid Assessment of Primary and Secondary Education conducted by the Education Advisory Board (2009), teacher morale was very low in all the schools visited. Teachers were under-motivated due to low salaries, lack of accommodation and shortages of teaching and learning resources such as textbooks and stationery.

17 *CONFINTEA V, Fifth International Conference on Adult Education, UNESCO, July 1997.*

School fees, coupled with other educational costs such as travel, exam fees and levies for various school programmes pose challenges for many parents. BEAM, which assists OVCs, does not have adequate resources to cover all children qualifying for this assistance. The number of children benefiting from BEAM dropped to 403,398 in 2011 from 537,594 in 2010,[18] even though more than one million children qualified for BEAM assistance.

Satellite schools in newly settled areas often lack basic infrastructure, including housing for teachers. Many schools in rural areas have no electricity, which inhibits the penetration of information and communication technologies and e-learning.

Early Childhood Development (ECD) is an important component of primary education. It is critical to ensuring that children start school at the right age. Late entry is associated with increased risk of dropout.[19] However, the ECD programme has several disadvantages compared to mainstream primary schools. The salaries of temporary teachers in the ECD programme are paid by parents, imposing a large financial burden which could prevent them from enrolling their children.

Another challenge that has implications for planning purposes is the lack of current data, which results in planning based on outdated facts and figures.

RECOMMENDATIONS

A number of measures need to be taken to accelerate achievement of the goal of achieving universal primary education by 2015. These include:

- Undertaking timely disbursements of budgetary allocations to MoESAC.
- Improving conditions of service for teachers and increasing their opportunities for professional development.
- Government and development partners intensifying efforts to increase resources for programmes such as BEAM to ensure universal access to primary education for both boys and girls.
- All government ministries taking ownership of, and fully implementing, the MDG AAP.
- Providing government grants for ECD centres.
- Strengthening MoESAC's capacity for data processing and analysis.

18 *MoLSS, Process and Impact Evaluation of the Basic Education Assistance Module (BEAM) in Zimbabwe, 2012.*
19 *UNESCO, Education for All Global Monitoring Report, 2011.*

Photo courtesy Lisa Orrenius ©

Photo courtesy Mikkel Rytter Poulsen ©

GOAL 3:

Promote Gender Equality and Empower Women

TABLE 3.1 • STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 3A Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	***3.1:*** *Ratio of girls to boys in primary, secondary and tertiary education.*	Gender parity remains strong, with an index of 1 in primary and secondary school (Form 1 to 4) and 0.7 in university education.	*MDG target is likely to be achieved by 2015 if current efforts continue.*
	a) Net enrolment ratios (NER) by gender at primary school level.	NER has remained fairly high for both genders, with 97.9% females/97.5% males (97.7% total) in 2009.	
	b) NER by gender at secondary school level (Forms 1-4).	NER at secondary school level is 45.9% female/43.1% males (44.5% total) as of 2009, with a gender parity index of 1.06.	
	c) Literacy rates of 15- to 24-year-olds by gender.	Literacy rates are high at 99.6% females/99.6% males in 2011, increasing from 91% in 2009.	
	d) Completion rates by gender for primary education.	Completion rates have improved from 69% females/68% males in 2006 to 85% females/79.8% males in 2009.	
	e) Percentage share of female enrolment rate in universities.	The percentage female enrolment rate at universities has increased from 23% in 2006 to 43% by 2011.	
	3.2: *Share of women in wage employment in the non-agricultural sector.*	Share of women in wage employment in the non-agricultural sector was 34% in 2011.	
Target 3B Increase the participation of women in decision-making in all sectors and at all levels (to 40% for women in senior civil service positions and to 30% for parliament) by 2005 and to a 50:50 balance by 2015.	***3.3:*** *Proportion of seats held by women in Parliament.*	The proportion of seats held by women has not changed since 2008, remaining at 14% in the Lower House and 24% in the Upper House.	*MDG target is unlikely to be achieved by 2015.*
	3.4: *Percentage share of women in the civil service who are at under-secretary level and above.*	The percentage of women at levels of Permanent Secretary, Principal Director, Director, Deputy Director, Ambassadors and Heads of Missions is above 25% but less than 35%. (2012).	
	3.5: *Percentage share of women in the private sector at managerial level.*	The percentage of women managers was 21% in 2011. In 2004, female directors, managers and company secretaries were 17% of this occupational category.	
	3.6: *Percentage share of women in local government decision-making bodies.*	The percentage share of female councillors as of 2011 has remained more or less consistent with 2010 figures, with 19% female representation in all local government positions.	

Sources: MoESAC, ZDHS 2010/11, MIMS 2009, LFS 2011, Gender Links, 2011.

STATUS AND TRENDS

Improving gender equality and empowering women and girls both promote equitable economic growth and long-term stability as well as contributing to the achievement of other MDG targets, such as improving maternal health, reducing child mortality and reducing poverty and hunger.

Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015

Ratio of girls to boys in primary, secondary and tertiary education

Zimbabwe has achieved gender parity at primary and secondary school levels in terms of enrolment and completion rates. There is also gender parity in literacy rates.[20] The NER at primary school level in 2009 was 97.9% for females and 97.5% for males – a gender parity index of 1. Although declining completion rates for male students between 2000 and 2006 resulted in gender parity in completion rates by 2006, by 2009 the primary school completion rate for females was 85%, five percentage points higher than that of males, indicating a change in attitude by parents towards education of girls. At secondary school level, the NER in 2009 was 45.9% for females and 43.1% for males, giving a gender disparity index of 1.06,[21] an improvement over the gender parity index of 0.95 for 2000.

Gender disparities remain at the tertiary level, as 57% of university students in Zimbabwe are male. Efforts are underway to achieve gender parity at universities, as affirmative action has been introduced to facilitate increasing enrolments of women in institutions of higher learning, making the 2015 target of 50% enrolment of women achievable. Moreover, as the cohorts in high schools that achieved gender parity proceed to tertiary education, the 2015 target of 50% enrolment of women at universities seems even more achievable.[22]

Share of women in wage employment in the non-agricultural sector

The share of women in wage or paid employment in the non-agricultural sector in relation to the total wage employment in the non-agricultural sector was 34% in 2011.[23] This indicator measures the degree to which women have equal access to decent jobs. The sectors with the highest proportion of women

20 *Labour Force Survey (LFS), 2011.*

21 *MoESAC.*

22 *MoHTE.*

23 *LFS 2011.*

Figure 3.1: Proportion of Female and Male Students at Zimbabwean Universities

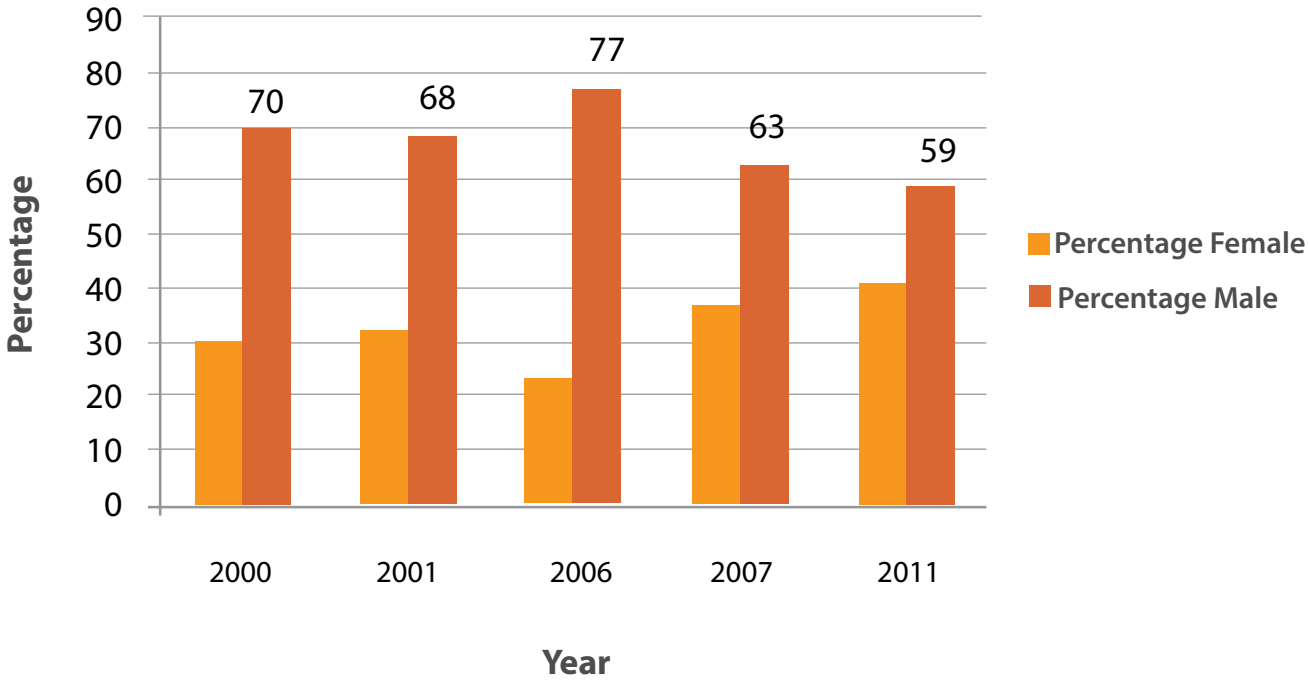



Photo courtesy Mikkel Rytter Poulsen ©

in wage employment include employment in households (87%), health and social work (64%), hospitality and food services (59%) and education (55%).[24] The majority of this employment is concentrated in the micro, small and medium enterprises sector, and is largely informal.[25] Being self-employed in the informal sector can make women vulnerable to unemployment, underemployment, difficulties incurred by lack of formal regulation of the sector and low wages.

Target 3B: *Increase the participation of women in decision-making in all sectors and at all levels by 2005 and to a 50:50 balance by 2015*

Women in decision-making positions

Irrespective of the regulatory framework established by several gender-responsive laws and policies, womens participation and representation in decision-making remains low. The key challenge in this area lies in implementation of existing regulations. As of 2011, only 21% of all private sector managers were women.[26] By 2012, only 20% of Cabinet Ministers, 9% of Deputy Ministers, 14% of members of Parliament's Lower House and 24% of members of the Upper House of Parliament were women.[27]

Women occupied about 19% of local government positions in 2011. There are now three key high positions filled by women, namely, First Vice President, President of Senate and Deputy Prime Minister. The four independent commissions – the Zimbabwean Electoral Commission, the Zimbabwe Human Rights Commission, the Zimbabwe Anti-Corruption Commission and the Media Commission – are each made up of four women, four men and a Chairperson. However, all 16 women are at deputy levels.

In Public Service the percentage of women employed at various levels for 2010/12 was as follows:

Permanent Secretaries (26%)
Principal Directors (26%)
Directors (33%)
Deputy Directors (28%)
Ambassadors and in Missions (30%)
Supreme and High Court Judges (29%)
Magistrates (41%)
ZDF – None at highest levels
ZRP – Deputy Commissioners (25%)
Public Service Commission (67%)


Photo courtesy RCO ©

24 *Ibid.*
25 *Ministry of Small and Medium Enterprises Development, 2012.*
26 *LFS 2011.*
27 *CEDAW Report and Barometer, Gender Link 2011.*

SUPPORTIVE ENVIRONMENT

Zimbabwe has put in place up to 17 pieces of legislation to promote gender equality and protect women's rights, among them being the Legal Age of Majority Act, the Labour Act, the Matrimonial Causes Act, the Administration of Deceased Estates Act, the Maintenance Act, the Marriages Act and the Domestic Violence Act.

Zimbabwe is also a signatory to various regional and international conventions, treaties, declarations and protocols that seek to promote and create an enabling environment for attaining gender equality and women's empowerment. These include:

- The Convention on the Elimination of All forms of Violence Against Women (CEDAW) (1991) The Convention on Civil and Political Rights (CCPR)The Global Platform for Action and the Beijing Declaration (1995)The SADC Protocol on Gender and Development (2008)
- Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (AU Women's Protocol)
- ILO Convention No. 111 – Prohibition of Discrimination in Occupations.

The government is reviewing the National Gender Policy in order to align it with MDGs, MTP objectives, CEDAW, SADC protocol on Gender and Development and the African Union Protocol on Women's rights. The draft National Gender Policy is currently undergoing validation with stakeholders in provinces.

The Gender Budgeting Programme intended to facilitate the implementation of the national gender policy through targeted resource allocation has been initiated and, in the 2012 Budget Statement, six ministries were allocated specific budgets for internally mainstreaming gender.

Government also introduced the Gender-Responsive Economic Policy Management initiative in September 2011. This programme is aimed at strengthening the capacity of economic planners in government and other policy-makers to formulate and implement economic policies and strategies that are gender-sensitive.

The government also has a Bill in place that seeks to establish a National Women's Council to specifically improve women's social, economic and political status. In addition, the Broad-Based Women's Economic Empowerment Framework of 2012 aims at promoting the participation of women in the country's three key economic sectors as articulated in the MTP: agriculture, tourism, and mining.

The National Gender-Based Violence (GBV) Strategy (2010–2015) has been designed to improve the efforts of the Government of Zimbabwe, civil society and donors to prevent and respond to violence against women through an effective multi-sectoral coordinated response. The strategy addresses all major forms of GBV and covers national response, including at provincial and district levels. As a complement to this, the Standard Operational Manual on Shelter for GBV Survivors aims to engage communities on the promotion of gender equality by outlining the steps needed to reduce GBV.

CHALLENGES

Most international treaties on gender equality are still to be domesticated, institutionalised and operationalised in national policy frameworks.

Whilst prohibiting workplace discrimination, the Labour Act and the Public Service Act do not have specific affirmative action in employment provisions. This needs to be addressed.

Likewise, although there are ongoing reforms to the Electoral Act, these do not articulate specific quotas to increase the number of women members in Parliament and local government. The implementation of quota systems articulated in the three main political parties also varies and is inconsistent.

Despite the existence of national legislation for reducing gender inequality by providing a legal framework to deal with issues such as domestic violence, inheritance and child marriage, their implementation has been less effective than hoped. Several factors may have affected this, among them being negative cultural norms,

women's fear of being isolated from their families for reporting domestic violence, religious proscriptions, limited knowledge of the law, delays in the legal system and economic dependence on male partners. Only 37% of women who experience physical or sexual violence seek help.[28] In Zimbabwe, more than 50% of domestic violence cases reported to the police are withdrawn due to the victim's economic dependence on her spouse and limited access to legal aid.[29] The existence of two marriage laws for customary and formal legal marriage have contradicting sections, and while the Customary Marriages Act [Chapter 5:07] sets no age restrictions, the Marriage Act [Chapter 5:11] does.

The higher rate of dropouts for girls at secondary school level is, among other things, due to early pregnancy, marriage and financial constraints. In 2011, 1% of children aged between 10 and 14 and 4% of children aged 15 to 17 left school for reasons related to pregnancy[30]. The existence of a policy entitling pregnant girls to attend school is alone insufficient; there must be positive actions taken to mitigate factors such as stigma and bullying in order to encourage the attendance of pregnant girls.

The limited availability of sex-disaggregated data remains a significant challenge in terms of assessing where gender equality is furthest behind.

RECOMMENDATIONS

A number of measures need to be taken to accelerate achievement of the goal of gender equality and empowerment of women by 2015. These include:

- Scaling up support to tertiary education, with targeted interventions for girls through scholarships, and encouraging girls to study sciences and technology.
- Putting in place legislative quotas that guarantee women's participation and representation in politics and decision-making.
- Strengthening the Women's Parliamentary Caucus and the Women in Local Government Forum as well as relevant Parliament Portfolio Committees.
- Finalising the review of the National Gender Policy and putting in place a results-based Implementing Strategy with adequate resources.
- Enacting and immediately implementing the National Women's Council.
- Adopting and implementing sustainable measures to curb early marriages.
- Promoting gender-responsive policies and budgeting in all sectors of the economy, including specific measures on alternative financing for women's economic empowerment.
- Strengthening capacity for the collection and dissemination of sex-disaggregated data in all sectors of the economy.
- Intensifying the sensitisation and education of the public, including traditional and religious leaders, on existing laws against GBV.
- Strengthening the capacity of national machineries, particularly the Ministry of Women Affairs, Gender and Community Development, to effectively co-ordinate gender equality and women's empowerment measures across sectors.
- Equipping women entrepreneurs with enterprise education skills and management training and enabling them to have access to credit, financial resources and markets.

28 *ZDHS 2010/11*
29 *Zimbabwe Women Lawyers' Association, 2008*
30 *LFS, 2011*

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GOAL 4:

Reduce Child Mortality-

TABLE 4 • STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 4A : Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	***4.1*** *Under-five mortality rate*	The under-five mortality rate has improved from 102/1000 in 1999 to 84/1000 in 2010-11. This is far off the desired target of 34/1000 by year 2015.	*An amber coding indicates that the MDG target can potentially be achieved by 2015.*
	4.2 *Infant mortality rate*	The infant mortality rate of 57/1000 in 2010-11 shows an improvement over the 2005-06 and 1999 rates of 60/1000 and 65/1000 respectively. This is off the 2015 target of 22/1000.	
	4.3 *Proportion of one-year-olds immunised against measles*	Vaccination coverage for measles is 69.3% in 2010-11, up from 55.9% in 2005-6 but a decline from 71.4% 1999.	

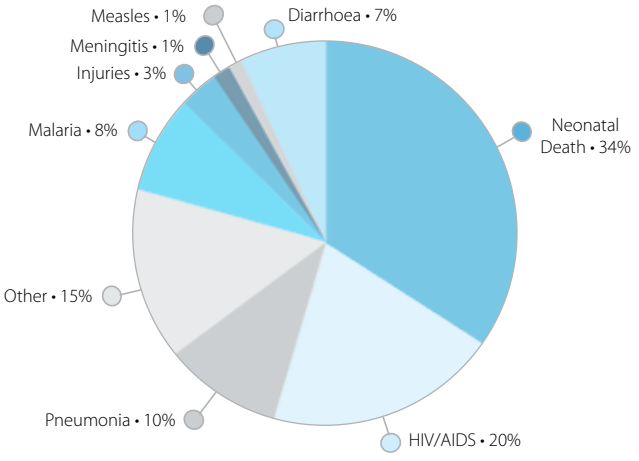
Source: ZDHS 2010/11 (Note: Mortality figures are based on five years preceding the survey)

STATUS AND TRENDS

Both infant and under-five mortality rates have seen slight improvements over the past 12 years, but they are far from the 2015 target. The infant mortality rate stands at 57 per 1,000 live births, which is a minor improvement over the 1999 rate of 65 per 1,000. The target for infant mortality by 2015 is 22/1000. The current under-five mortality rate is 84 children per 1,000, also distant from the 2015 target of 34 per 1,000. Whilst the current number is a stark improvement from the 102 per 1,000 of 1999, it is only a slight increase from 2005/06 when 82 per 1,000 children died before reaching the age of five. Both infant and under-five mortality rates are higher for males than for females.

Neonatal causes, mainly pre-term birth complications (13%), birth asphyxia (9%) and sepsis (6%), as well as HIV and AIDS, remain the major causes of all under-fives' deaths in Zimbabwe, accounting for 54%. Malnutrition is an underlying factor in most of these deaths. Globally, more than one-third of child deaths are attributable to under-nutrition.

Figure 4.1•
Causes of Under-five Deaths in Zimbabwe



Source: WHO/CHERG 2012

The level of education of the mother has a correlation with both infant and child mortality; the more educated the mother, the lower the infant or child mortality rate. ZDHS 2010/11 statistics show that infants from mothers with no access to maternal and child health (MCH) services such as

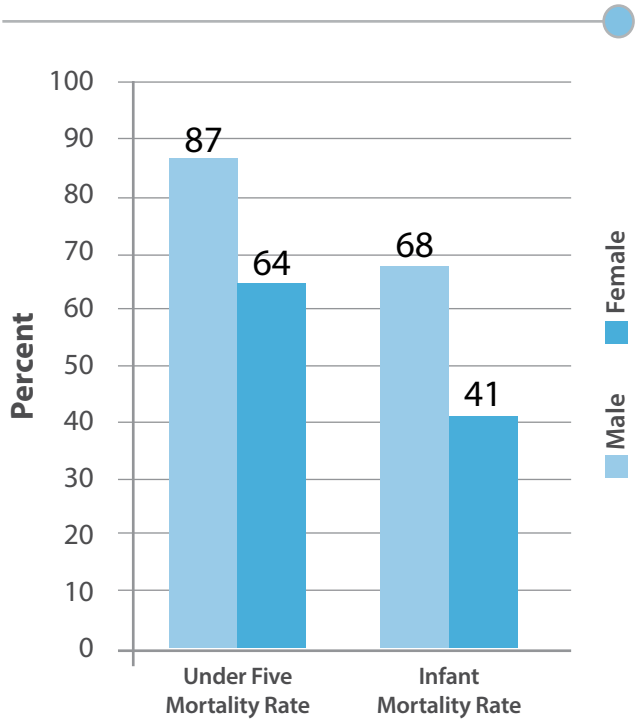

Photo courtesy Anesu Freddy ©

antenatal care (ANC) or delivery care from a skilled health worker (doctor, nurse or midwife) are about three times more likely to die compared to those who had both antenatal and delivery care from a skilled health worker.

With about 20% of Zimbabwean households lacking access to safe drinking water and 35% having no access to improved sanitation, children are regularly exposed to water-borne diseases. The situation is particularly bad for rural households (30% and 50% without access to safe drinking water and improved sanitation respectively) and poor households (45% and 89% without access to safe drinking water and improved sanitation respectively) compared to their urban and wealthier counterparts.[31] The disparities in access to water and sanitation facilities can, among other factors, translate into observed health outcomes, as households in the higher wealth quintiles experience relatively lower infant and child mortality rates.

The depressed socioeconomic environment that prevails in rural areas sees both infant and child mortality rates being relatively higher than in urban areas. Poverty and HIV/AIDS-related ailments are also associated with reduced household disposable incomes and the inability to pay hospital expenses.

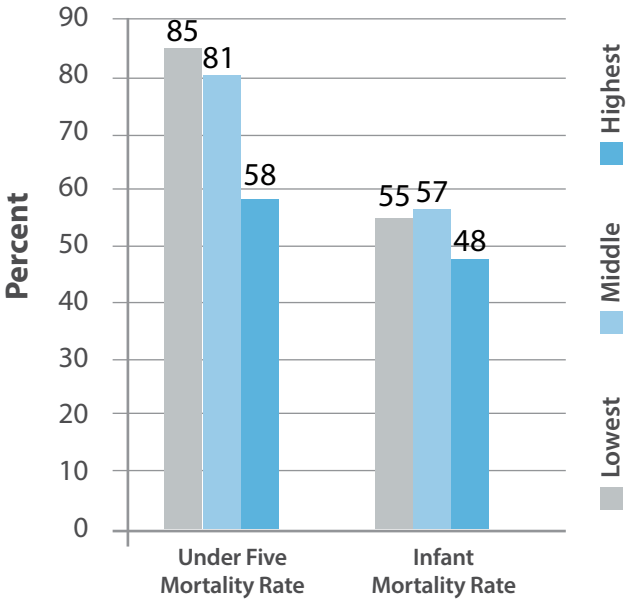
Figure 4.2: Child Mortality by Gender



Source: ZDHS 2010/11.

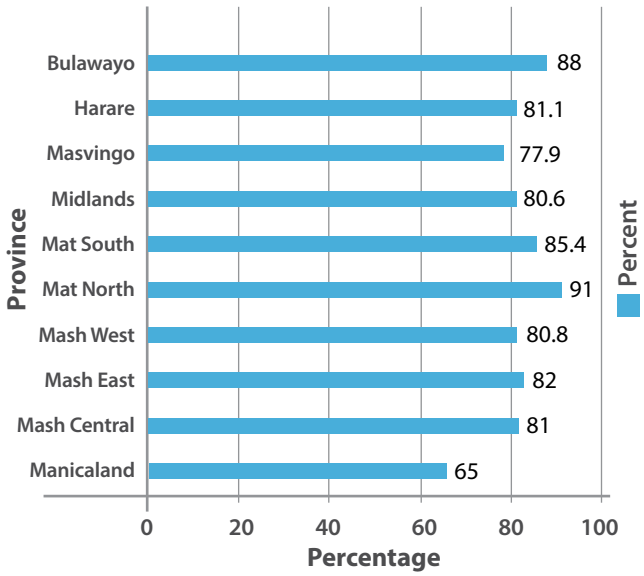
31 ZDHS 2010/11.

Figure 4.3 Infant and Child Mortality per 1,000 live births by Mother's Wealth Quintile



Source: ZDHS 2010/11 (Note: mortality estimates based on ten years preceding survey)

Figure 4.6: Percentage of children vaccinated against measles by province



Source: ZDHS 2010/11.

Vaccination

In terms of vaccination by 12 months of age, measles inoculation and basic coverage for the 12-23-month age group steadily decreased between 1994 (74% and 67% respectively) and 2005/06 (56% and 41% respectively). However, both rates increased to 69% and 56% respectively in 2010/11.

The number of infants in the 12-23-month age group who were vaccinated against measles by 12 months of age (69.3%) is relatively lower than that for other major vaccines (BCG 87%, DPT1 85%, DPT2 80%, Polio1 87%, Polio2 80%).[32] Full immunisation coverage for the 12-23-month age group at the time of the survey showed that urban areas had a higher coverage (70%) than rural areas (62%). Vaccination against measles also increases with the mother's/caretaker's level of education and family wealth. Provincial trends list Matabeleland North (91%) as having the highest vaccination rate, followed by Bulawayo (88.0%) and Matabeleland South (85.4%). Manicaland has the lowest coverage (65%), while Harare and Mashonaland West both had 81% vaccination rates. Vaccination coverage has begun to rebound, rising from 53% (2005-06) to 65% in 2010-11.

Photo courtesy Nikolay Suslov © www.123rf.com

32

SUPPORTIVE ENVIRONMENT

The Prevention of Mother-To-Child Transmission (PMTCT) programme, including its more efficacious regimens, is being significantly scaled up in an effort to reduce new HIV infections among children by 90% by 2015 through the use of more effective antiretroviral medicines. Increased funding from government and donors for this programme and other initiatives, coupled with free treatment of the under-fives, has generated positive results. The introduction of new vaccines against other life-threatening illnesses such as the pneumococcal and rotavirus are complementing the free expanded programme on immunisation (EPI). Other supportive national initiatives include the Nutrition/Child Supplementary Feeding Programmes and the promotion of exclusive breast-feeding within the first six months of the infant's life.

The government has further enacted the Health Service Skills Retention Fund, which includes the Health Transition Fund and other incentives, with the objective of motivating and retaining professional staff in the health sector. The sector is paying special attention to addressing infections common to newborns and infants through Integrated Management of Child Illness. Lastly, the Government of Zimbabwe and the donor community have assembled a new health transition fund aimed at improving maternal, newborn and child health and nutrition, the availability of medical products, vaccines and technologies, human resources for health, as well as health policy, planning and financing.

CHALLENGES

Hospital user fees continue to be a barrier to accessing healthcare for children and infants, despite existing proactive policies. Furthermore, inadequate funding for the many health initiatives and limited resources for outreach areas, coupled with challenges of reaching out to remote locations and communities, are inhibiting the expansion of child immunisation programmes. The challenge of limited safe water and poor sanitation needs to be addressed.

Access to quality maternal and child healthcare is inadequate due to staff shortages and the unavailability of essential drugs. The lack of public feeding systems through which to address poverty, hunger and malnutrition further complicates the situation. Moreover, a persisting challenge to children's health and wellbeing is their exposure to HIV through mother-to-child transmission.

RECOMMENDATIONS

Most under-five deaths can be prevented through simple, cost-effective interventions. These include:

- Improving access to quality maternal, child and neonatal health services.
- Addressing infections common to newborns and infants by increasing coverage and access to high-impact maternal and child health interventions.
- Addressing the underlying causes linked to poor households' socioeconomic status.
- Strengthening the infant/child health system by scaling up the integrated management of neonatal and childhood illness approach.
- Strengthening logistics and supply systems for maternal, neonatal and child health services.
- Strengthening multisectoral collaboration in healthcare, improving living environments and alleviating of the plight of children living in difficult circumstances.
- Increasing water and sanitation programmes.

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Photo courtesy © Jacqui Taylor

GOAL 5:
Improve Maternal Health

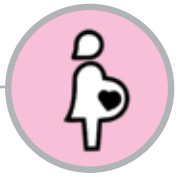


TABLE 5.1 • STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 5A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	***5.1:*** *Maternal mortality ratio (MMR)*	The MMR has increased from 612/100,000 in 2005-06 to 960/100,000 in 2010-11. The median age at maternal death is 28 years.	*MDG target is unlikely to be achieved by 2015.*
	5.2: *Proportion of births attended by skilled health personnel*	The number of births attended by a skilled health worker shows a negative trend, dropping from 69% in 2009 to 66.2% in 2010-11.	
Target 5B: Achieve, by 2015, universal access to reproductive health	***5.3:*** *Contraceptive prevalence rate*	There has been a marginal decline since 2005-06 when the rate was 60.2% to 58.5% in 2010-11.	
	5.4: *Adolescent birth rate (per 1,000 females aged 15-19)*	The adolescent birth rate has increased from 96/1,000 in 2009 to 114.6/1,000 in 2010-11. The rate is higher in rural areas (120/1,000 girls) than in urban areas (70/1,000).	
	5.6 *Unmet need for family planning*	The unmet need stands at 12.8% in 2010-11, virtually no change from 13% in 2006	

Source: ZDHS 2010/11, MIMS 2009

STATUS AND TRENDS

Target 5A: *Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio*

A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. The ZDHS 2010/11 survey showed that the mortality rate associated with pregnancy and childbearing was 1.3 maternal deaths per 1,000 women, a considerable and rather worrying increase from 0.8 in the 2005/06 ZDHS survey. The trend for the maternal mortality ratio (MMR) has worsened, rising to 960 per 100,000 live births in 2010-2011 compared to 612 in 2005/06. This translates to about 12 women dying every day and 374 every month from pregnancy related complications.

Results of a Ministry of Health and Child Welfare (MoHCW) study revealed that the median age at maternal death was 28 years, with a maximum of 47 years and a minimum of 14 years.[33] About a quarter (24%) of the deceased were between 15 and 19 years of age. Most were affiliated to an apostolic group (38% in 2011) and in domestic service (83% in 2011). 82% of those women who died of pregnancy related complications were married.[34] Findings further showed that the majority were also HIV-positive (34% in 2011) and that only 9% had made

33 *MoHCW, An Analysis of Notified Institutional Maternal Deaths: January 2010-December 2011.*
34 *Maternal Deaths Audit Report 2010/11.*

use of maternity waiting homes, which are run by the Ministry of Health and Child Welfare.

The four main causes of death for 2010-11 were post-partum haemorrhage, sepsis, eclampsia and malaria.

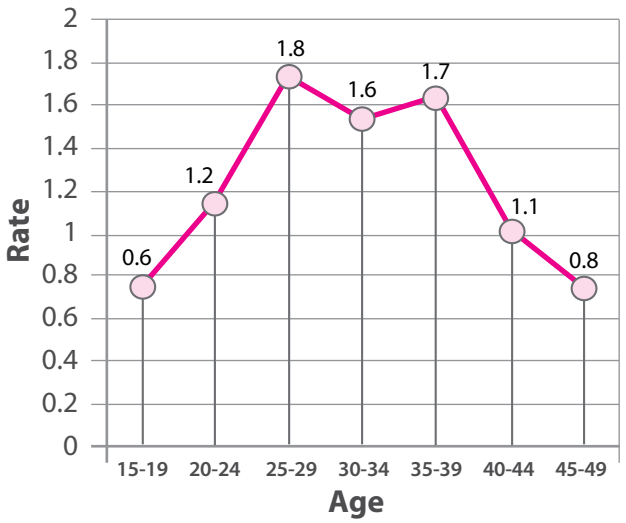
TABLE 5.1: Maternal Death Audit Report 2010/11 MOHCW

CAUSE	2010	2011
Post-partum haemorrhage	23%	24%
Sepsis	20%	21%
Eclampsia	9%	11%
Malaria	10%	7%

Three-quarters of maternal deaths can be attributed to three types of delay: i) time taken to seek healthcare; ii) time needed to reach a healthcare facility; and iii) time taken to access care at the health facility.[35]

The majority of deaths were attributed to the first and third delays, being 52% and 31% respectively. Of the deaths notified in 2010 and 2011, 70% were perceived as avoidable.

FIGURE 5.1:
Maternal Mortality Rate by Age Group



Source: ZDHS 2010/11

Figure 5.1 shows that most women die at the height of their productive years, that is, before the age of 30.

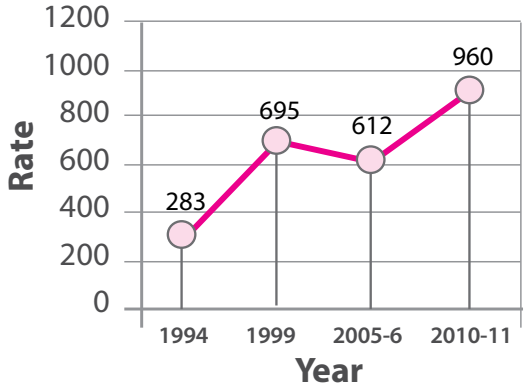
The mother's level of education is highly correlated with the uptake of healthcare services. Births to mothers with secondary education are likely to take place in a formal health facility, unlike mothers who have little or no education. The MMR for women

35 *Zimbabwe Maternal and Perinatal Mortality Study 2007.*

Photo courtesy Monika Adamczyk © www.123rf.com

with tertiary education was lower than for those who had no higher learning.[36] With regard to women's occupational status, it was shown that pregnant women in domestic service are more likely to die from complications than women in professional positions.

Figure 5.2:
Maternal Mortality Ratio Time Trend



Source: ZDHS 2010/11. (Note: MMRs for 1994 and 1999 refer to ten years preceding survey and MMRs for 2005/06 and 2010/11 refer to the seven years preceding survey and hencemay not be directly comparable. The graph is nevertheless indicative of the overall trend.)

The proportion of births attended by skilled personnel decreased from 69% in 2009 to 66.2% in 2010-11, directly contributing to the increasing MMR. With respect to place of birth, the 2010/11 survey revealed that, nationally, 65% of all births were institutional deliveries and had a strong rural–urban discrepancy: in urban areas, 81.1% took place in a health facility compared to 43.3% in rural areas. Key problems for women aged 15-49 in accessing healthcare included the cost of treatment (50%) and the distance to a healthcare facility (34%).

36 *ZDHS 2010/11.*

Target 5B: *Achieve, by 2015, universal access to reproductive health*

Even though almost all men and women have knowledge of a contraceptive method .[37] , the contraception prevalence rate showed a marginal decline in 2010-11 from the 2005-06 figures, falling to 58.5% from 60.2%. The adolescent birth rate increased from 96 per 1,000 girls in 2009 to 114.6 per 1,000 in 2010-11. The rate is higher in rural areas (120 per 1,000 girls) than in urban areas (70 per 1,000).

The unmet need for family planning among married women remains static at 13% since 1999.

37 (ZDHS 2010/11).

SUPPORTIVE ENVIRONMENT

Several supportive initiatives and programmes are in place, such as antenatal care, postnatal care and prevention of mother-to-child transmission (PMTCT) programmes. government and supporting partners have revised and distributed maternal death notification forms to facilitate data capture on cases for submission to head office within 30 days of the death. This is a crucial component of the maternal mortality database.

Through the Health Transition Fund (HTF) and the adoption of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), government is highly committed to improving maternal health in Zimbabwe. However, with the statistics showing a worsening trend, it is apparent that efforts to reduce maternal mortality need to intensify.

Photo courtesy RCO©

CHALLENGES

The deteriorating condition of maternal mortality in Zimbabwe is caused by a number of interlinked factors, of which the following are key:

- The reduced proportion of births attended by skilled health personnel
- Fewer women attending at least four antenatal care visits
- Unavailability of critical drugs
- Maternity fees
- Socio-cultural/religious issues
- Weak national Health Management Information Systems
- Inaccessibility and/or long distances to clinics
- Lack of communication and information.

RECOMMENDATIONS

The following recommendations to upscale maternal health require the strengthening of the health delivery system, and with a focus on the six pillars:[38]

- Resolving the barrier of user fees.
- Minimising the three delays: decision to seek healthcare; reach a healthcare facility; access care at the health facility.
- Addressing cultural and religious objectors.
- Developing and disseminating targeted information, education and communication materials to address misinformation and misunderstanding on health issues.
- Developing innovative strategies to engage adolescents on sexual and reproductive health issues in order to reduce teenage pregnancies.
- Ensuring adequate supplies of critical maternal and newborn health and medical equipment and commodities such as blood products.
- Extending health education on maternal and newborn issues to all women, particularly those in the domestic services sector, and those with little or no education.

38 *These are human resources, transport, financial resources, governance, drugs and equipment.*

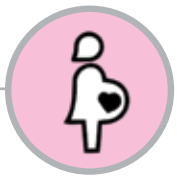


Photo courtesy RCO ©

Photo courtesy Rick Scavetta, U.S. Army Africa Public Affairs ©

GOAL 6:

Combat HIV/AIDS, Malaria and Other Diseases

TABLE 6.1: STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.	***6.1:*** *HIV prevalence among population aged 15-24 year.s*	5.5% – prevalence in women is much higher (7.8%) than in men (3.6%).	*MDG target is likely to be achieved by 2015 if current efforts continue.*
	6.2: *Condom use at last high-risk sex.*	60.9 – 73.7% men, 48% women Less than half of adults support teaching children aged 12-14 on the use of condoms.	
	6.3: *Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS.*	49.5% – 47% of men and 52% of women have comprehensive knowledge of HIV and AIDS.	
Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.	***6.4:*** *Proportion of population with advanced HIV infection with access to ARV drugs (ART).*	79.5% ART coverage in 2011 compared to 53% in 2009. 80% adults, 46% children.	*MDG target can potentially be achieved by 2015.*
Target 6C: Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases.	***6.5:*** *Incidence and death rates associated with malaria.*	Incidence 2009 – 5.8%; 2010 – 4.9% 2011 –2.5% Deaths (case fatality rate): 2009 –3.0% 2010 – 4.6% 2011 – 4.5%	
	6.6: *Proportion of children under five sleeping under insecticide-treated bed-nets (ITNs).*	9.7 % – 9.2% boys, 10.2% girls (Data for 2010-11).	
	6.7: *Proportion of children under five with fever who are treated with appropriate anti-malarial drugs.*	2.3% – 2.1% boys, 2.5% girls.	
	6.8: *Incidence rates associated with tuberculosis.*	Incidence: 9.6% – 10.0% boys, 9.1% girls.	
	6.9: *Proportion of tuberculosis cases detected and successfully treated.*	50% detection rate in 2011, up from 40% in 2007. 81% treatment success rate in 2010, up from 78% of 2007.	

Sources: ZDHS 2010/11; MoHCW, Mortality Report 2011, ZIMSTAT, NMCP Annual Reports, MIS 2008 and 2012, Global TB report 2012

STATUS AND TRENDS

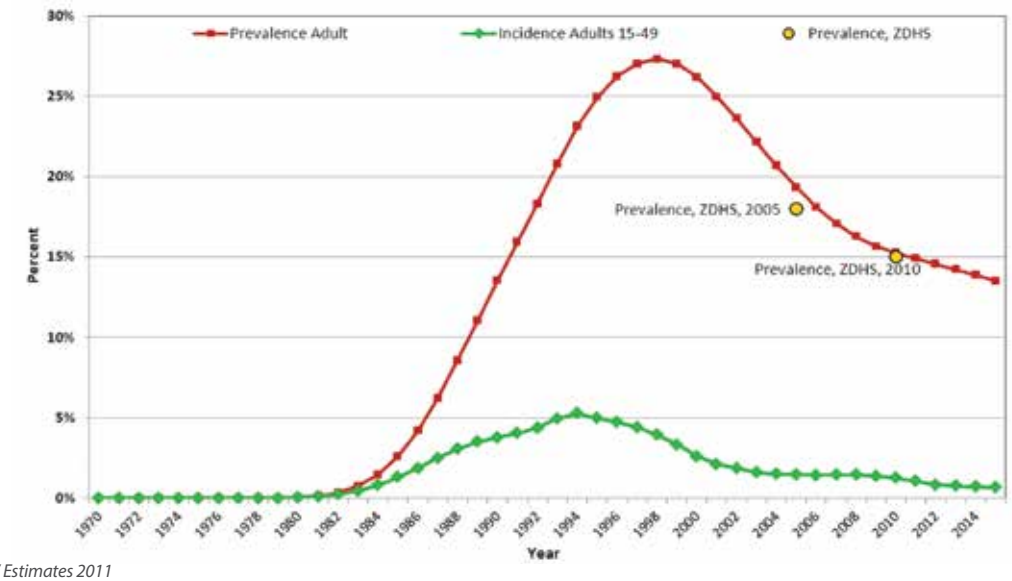
TABLE 6.2: HIV and AIDS Fact Sheet

HIV prevalence	15%
Type of epidemic	Generalised
Estimated number of people living with HIV	1,214,126 (including 162,889 children)
Number of PLHIV under ARV treatment	476,321 (including 40,140 children)
ARV coverage (%)	80% adults, 46% children
Estimated number of new infections	57,678 – downward trend
Estimated number of new infections among children	9,886 – downward trend
PMTCT coverage (%)	86% (2010)
Maternal mortality ratio	960
Estimated number of HIV-related deaths	49,760 (including 9,326 among children)
Estimated number of HIV-related orphans	1,003,689
How the epidemic compares to other countries in the region	The fifth most HIV-burdened country in the Eastern and Southern Africa Region (after, Botswana, Lesotho, South Africa and Swaziland)
Percentage of care and treatment expenditures from international sources	74.2%

Target 6A: *Have halted by 2015 and begun to reverse the spread of HIV/AIDS*

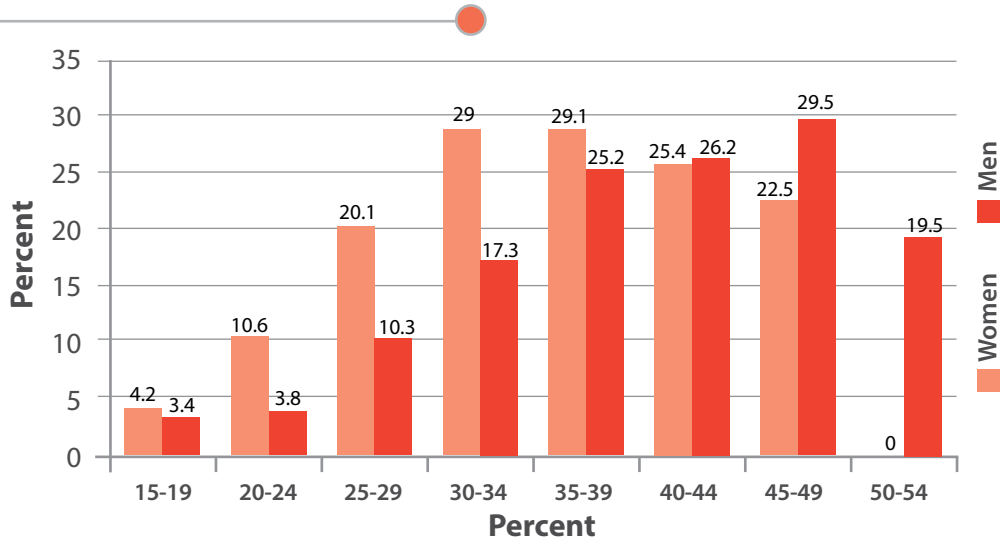
According to the ZDHS 2010/11, 15% of adults aged 15-49 are HIV-positive; three percentage points lower than the figures for 2005-06. This drop is attributed to programme intervention success. Women have a higher prevalence (18%) than that of men (12%). The peak age group affected in women (29%) is 30-39 and in men is 45-49 (30%). HIV prevalence for the 15 to 24 year age group was 5.5% in 2011.Other key findings of the study revealed that 77% of women and 79% of men knew the risks of HIV/AIDS and benefits of the use of condoms. Furthermore, 34% of women and 21% of men had been tested for HIV and received their results. An average of 50% of young people had a comprehensive knowledge of HIV and preventive methods. Almost 80% knew that the use of condoms reduces the risk of HIV infection. Of concern, however, is that 12% of couples are sero-discordant, that is, one partner is HIV-negative and the other HIV- positive.

Figure 6.1: Trends in Adult (15-49 years) HIV Prevalence and HIV Incidence, Zimbabwe 1970–2015



Source: MOHCW HIV Estimates 2011

Figure 6.2: HIV Prevalence



Source: ZDHS 2010/11

Globally, Zimbabwe is among countries most affected by HIV. An estimated 1,168,263 were living with HIV at the end of 2010, with 52% (608,700) being women, 35% (414,338) being men and 13% (145,224) being children. Sexual transmission of HIV prevails, with low-risk heterosexual sex contributing to a majority of new infections (55.9%).[39] Mother-to-child transmission is the second highest source of new infections.

Zimbabwe has developed a strong policy and strategic framework for responding to HIV/AIDS. The response is guided by the Zimbabwe National HIV/AIDS Strategic Plan I & II. The current national strategy for 2011–2015 is evidence-informed and fully aligned with the vision of the Three Zeros [40] and 2011 Political Declaration targets. ZNASP I & II are people-centred, focussing on promotion of access to and utilisation of services, with full participation of communities and pronounced emphasis on strengthening systems.

In line with the Three Ones[41], different partners contribute towards the overall national targets. Funding for the national AIDS response comes from national and international sources. The bulk of the national investment is supplied by the National AIDS Trust Fund (NATF) via the AIDS levy, a 3% tax on individual and institutional income in the formal sector. The Global Fund, the United States Government, DfID, CIDA, Irish Aid, Norway and SIDA, through a pooled funding mechanism of an Expanded Support Programme, have provided crucial support to sustain and expand the national AIDS programme. Since the economy was dollarized, the size of the NATF has grown significantly, with collections expected to top US$30 million by the end of 2012, a massive increase from the US$7 million of 2009.

Target 6B: *Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it*

Achieving national targets is on track. Zimbabwe has recorded a consistent decline in HIV incidence, seeing it fall from 1.14% in 2006 to 0.85% by 2009.[42] A total of 476,000 people living with HIV were receiving ART at the end of May 2012,[43] a significant achievement given that only 8,000 people were on treatment in 2004.

As a result of high adult ART coverage, combined with improved nutrition support and enhanced TB/HIV management, the number of AIDS-related deaths has almost halved since 2006, falling from 123,000 (2006) to 71,299 (2010). Even so, HIV is still one of the leading causes of death through disease in Zimbabwe. The levels of HIV/TB co-infection remain high, with 80% of TB cases estimated to be co-infected with HIV (ZNASP 2011-2015). Increasing the coverage of paediatric ART has been slow; it is currently estimated at only 40%.

The decline in both prevalence and incidence from 2009 to 2011 has been underpinned by a major expansion of access to HIV prevention and treatment services. This, coupled with other initiatives such as behaviour change and communication, PMTCT, the

39 *ZNASP II.*

40 *Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths*

41 *One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners, one National AIDS Coordinating Authority, with a broad-based multisectoral mandate, and one agreed country-level Monitoring and Evaluation System*

42 *Ibid.*

43 *NAC 2012.*

promotion of use of both male and female condoms and HIV testing and counselling have generated good results. In 2010, the government has also introduced voluntary medical male circumcision as part of the HIV prevention package. Although HIV prevalence has declined, the rate is not sufficient to reach the goals of reducing the number of people acquiring HIV infection by 50% by 2015.

There is a strong co-relationship between sexually transmitted infections (STI) and HIV. The ZDHS 2010/11 noted that adults aged between 15 and 49 who have had one or more STIs had higher rates of HIV infection (31%) compared to those with no STI history (17%).

The majority of persons on ART are aged 15 years and above, of whom 85% are receiving the necessary drugs. However, less than 50% of those under the age of 15 years who are HIV-positive are receiving ART. Of those with advanced HIV infection, more females than males are receiving ART. More support for PMTCT is needed, as only 86% of HIV-positive pregnant women needing ARVs have received the drugs. Overall however, the number of adults and children on ART rose from 476,321 (2011) to 517,000 (June 2012), which is a positive result.[44]

44 *NAC data sources 2012.*

TABLE 6.3: HIV TREATMENT – ART Data as at 31 December 2011

	All persons	Males	Females	Individuals under 15 years of age	Individuals aged 15 years and above
Percentage currently receiving ART	79.5			46.13	85.48
Number of persons with advanced HIV receiving ART	476,321	173,004	303,317	40,140	436,181
Number of persons with advanced HIV infection	597,293			87,015	510,278

Source: NAC data sources 2012

Photo courtesy Joaquim Viera Carlos © UN Photo Library

Target 6C: *Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases*

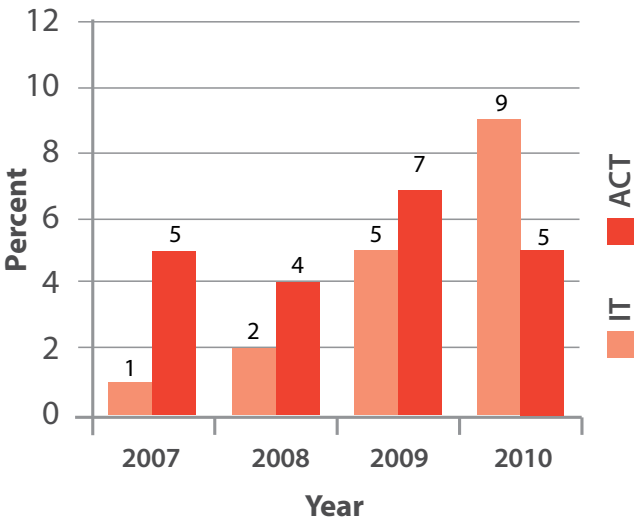
Malaria

The most recent surveys on malaria were carried out in 2009[45] and 2010-11.[46] In December 2010, the malaria incidence rate was 49 cases per 1,000, a decline of 64% from the 2000 level. This further decreased to 25 cases in 2011. The trend in malaria deaths revealed a marked decline: 1,200 (2006) to 451 (2011). The decline in the malaria mortality rate may be attributed to increased spraying coverage (90% in 2009), ownership of Insecticide-treated bed nets, (ITNs), (29% in 2010/11) and increased ITN utilisation (10% in 2010-11).

ITN ownership averaged 29% in 2010-11 as against 9% in 2005, with rural households owning more ITNs than those in urban areas. Of households with children owning at least one ITN, about one third were in urban areas and about one quarter in rural areas. Household spraying with insecticide for rural households was six-fold to that of urban households.

45 MIMS 2009.
46 ZDHS 2010/11.

FIGURE 6.3:
Malaria Indicator Estimates, Zimbabwe 2007–2010



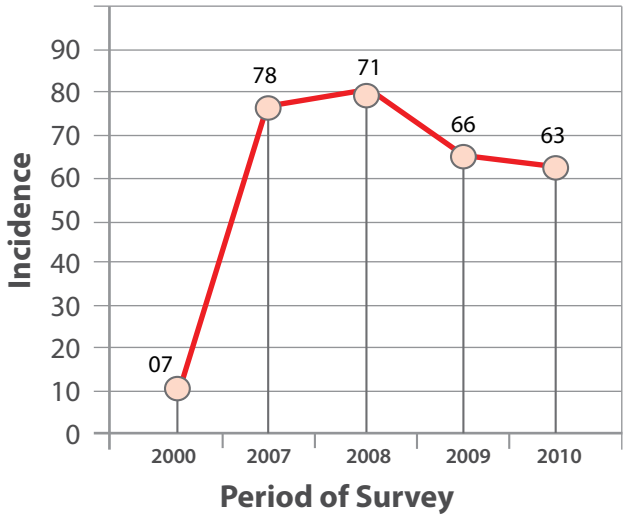
Source: ZDHS 2010/11
ITN = Proportion of households with one or more ITN
ACT = Proportion of children under five who received treatment with ACT

Photo courtesy MShep2 © www.istockphoto.com

Tuberculosis (TB)

TB continues to be one of the leading causes of morbidity and mortality in Zimbabwe. Incidence rates increased to a peak of 782 per 100,000 people in 2007, most likely due to HIV co-infection. However, by 2010, incidence rates had decreased to 633 per 100,000 persons as various interventions, such as rehabilitation of diagnostic centres, were scaled up.

FIGURE 6.4: Incidence of Tuberculosis per 100,000 people



Source: World Bank online database on incidence of tuberculosis

National TB control efforts have demonstrated improvements based on results achieved on the two main global indicators of TB control. The case detection of all types of TB increased from 37% in 2007 to 50% in 2010, while the treatment success rate increased from 64% in 2006 to 81% in 2010.[47]

The government has also scaled up provision of collaborative TB/HIV activities. About 86% of TB patients were tested for HIV in 2011. Seventy-nine per cent of TB patients who were co-infected with HIV were put on cotrimoxazole and 44% commenced ART. Supportive and affirmative responses to the TB challenges include the Ministry of Health and Child Welfare's efforts to rehabilitate diagnostic centres and strengthening collaboration with the ART programme.

47 *WHO Global TB Report 2012.*

Cholera

Zimbabwe suffers from recurrent cholera outbreaks, with the last severe outbreak taking nine months to eradicate (August 2008 to June 2009). The government declared the outbreak a state of emergency on 4 December 2008. The WHO estimated that there had been 60,000 cases by the end of January 2009, with a case fatality rate of 10%. The outbreak was eventually declared over in July 2009. Nationally, by 10 January 2010, 98,741 reported cases and 4,293 deaths had been reported, making it the worst outbreak in Africa for 15 years.

The four most severely affected provinces were Harare and Mashonaland West, Manicaland and Masvingo, with the incidence highest in Beitbridge, Chegutu, Mudzi and Zvimba Districts (over 1,000 cases per 100,000 people). According to the Red Cross, the extent of the outbreak may have been underestimated, as many affected people failed to reach clinics in time.

Typhoid

The first cases of typhoid were reported Harare's eastern high-density suburbs of Tafara and Mabvuku in February 2012. By mid-2012, Harare and Chitungwiza reported 112 new cases of water-borne typhoid as a consequence of contaminated water supply. Ministry officials attributed this to water shortages and excessive contamination of Lake Manyame.

SUPPORTIVE ENVIRONMENT

Government has adopted the Three Ones concept for co-ordinating AIDS programmes. Resources for these and the fight against HIV/AIDS have been mobilised from the Global Fund, government and local and multi-lateral donors. Policies have been enacted on decentralising antiretroviral treatment, PMTCT and HIV testing and counselling in an attempt to address the issues of access and equity. Efforts are also being made to increase the availability of strategic documents such as National HIV and AIDS Strategic Plan.

Supportive responses to TB-related challenges include government's initiative to rehabilitate diagnostic centres in collaboration with ART programmes and the procurement of vehicles and motorcycles to support TB programmes. The government has also established a programme to manage the WHO-recommended 'STOP TB STRATEGY' and to tackle cases of drug-resistant TB.

Assistance to prevent the spread of cholera has been provided by government and international donors to fund WASH-linked programmes and essential drugs.

CHALLENGES

Of the 2011 and 2012 national budgets only 8.4% and 9.6% were allocated to the health sector respectively. This remains significantly below the Abuja Declaration target of 15%. Human resources for health in Zimbabwe remains a key challenge, as do weak health information systems for data collection, analysis and interpretation. Specific to the area of HIV and AIDS, low paediatric ART coverage as a result of unmet need is another cause for major concern.

Inadequate funding for long-lasting ITNs to ensure universal coverage against malaria is a problem, while challenges hampering progress in the fight against TB include limited access to diagnostic centres, lack of quick accurate tests and emergence of drug-resistant strains. Clinic-user fees and shortage of essential drugs are further recurring setbacks.

With regard to cholera, collapsed water and sanitation systems and shortage of water purification chemicals have led to several severe outbreaks. Many households are unable to afford fuel for pre-boiling drinking water, while housing shortages, overcrowded settlements and poor waste management are additional negative contributory factors.

RECOMMENDATIONS

A number of measures need to be taken to accelerate achievement of goal 6 by 2015. These include:

- Strengthening and scaling-up private–public-partnerships in the fight against HIV and AIDS.
- Prioritising the scaling-up of early infant diagnosis and access to paediatric antiretroviral treatment.
- Strengthening the involvement of communities in HIV programming.
- Improving ownership of ITNs and household spraying for malaria prevention.
- Scaling-up collaborative TB/HIV activities.
- Increasing internal and external partner support to sustain coverage of malaria interventions.
- Collaborating with neighbouring countries to ensure the pre-elimination of malaria in the sub-region.
- Educating households and communities on exemplary sanitation and hygiene practices to prevent cholera and typhoid recurrence.

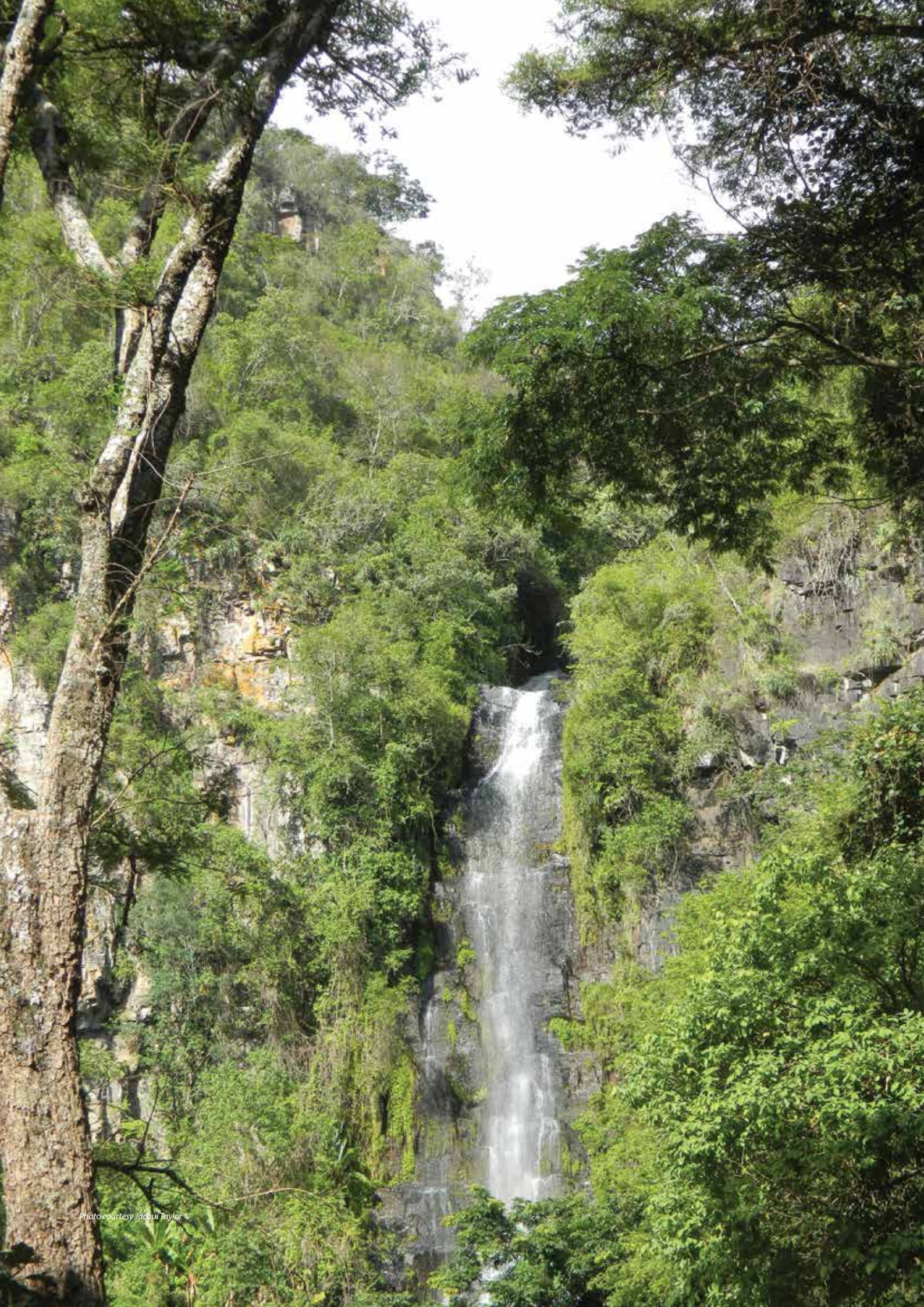


Photo courtesy Jacqui Taylor ©

GOAL 7:

Ensure Environmental Sustainability

TABLE 7.1: STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 7A: Integrate sustainable development principles into country policies and reverse the loss of environmental resources.	***7.1:*** *Proportion of land area covered by forest.*	About 54% (21 million ha), with an estimated rate of deforestation of 1.5% per year (100,000-320,000 ha per year).	*MDG target can potentially be achieved by 2015.*
	7.2: *CO^2 emissions, total, per capita and per GDP.*	By 2000 Zimbabwe was a net emitter of greenhouse gases.	
	7.3: *Consumption of ozone-depleting substances (ODS).*	By 2010 all ODS were phased out, with the exception of HCFCs and methyl bromide. Phasing out of these is in progress.	
	7.4: *Proportion of fish stocks within safe biological limits.*	Of the 132 fish species in Zimbabwe, only a few commercially and biologically important types have been monitored. However, it seems that their diversity is on the decline.	
Target 7B: Reduce biodiversity loss, achieving by 2010 a significant reduction in the rate of loss.	***7.5:*** *Proportion of total water resources used.*	Major dam catchments over 80% full.	
	7.6: *Proportion of terrestrial and marine areas protected.*	15% of Zimbabwe is under Statutory Protection: 12.3% under Parks and Wildlife Estate and 2.6% (800 258ha) under Gazetted forests.	
	7.7: *Proportion of species threatened with extinction.*	672 bird species supported, seven vulnerable, one endangered; 175 mammalian supported, one critically endangered, one endangered and nine vulnerable.	
Target 7C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.	***7.8:*** *Proportion of population using an improved drinking water source.*	95.1% urban 68.7% rural 76.7% total	*MDG target is likely to be achieved by 2015 if current efforts continue.*
	7.9: *Proportion of population using an improved sanitation facility.*	49.8% urban 31.8% rural	
Target 7D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers.	***7.10:*** *Proportion of urban housing backlog.*	There is a backlog of over two million low-cost housing units.	*MDG target is unlikely to be achieved by 2015.*

STATUS AND TRENDS

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, all forms of pollution and poaching of both flora and fauna.[48] Although regulations pertaining to the management of natural resources are robust, there is a consistent challenge in their interpretation and enforcement. The majority of people in Zimbabwe, both rural and urban, live off natural resources, clearing land for agricultural purposes, fuel wood and wildlife, leading to increasing deforestation and land degradation.[49] However, during the period 2010–2011, a 38% reduction in veld fires was achieved against the government's target of 80%.[50] There was also a 50% reduction in reported poaching crimes during this same period.

The country has also done commendably well in phasing out ozone-depleting substances (ODS) ahead of the 2015 deadline set under the Montreal Protocol.[51] Chlorofluorocarbons (CFCs) were phased out in 2010 from a base of 451 ozone-depleting potential tonnes,[52] again in line with the Montreal Protocol schedule. Halons, carbon tetrachloride, 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. HCFCs are to be reduced by 15% in 2012, 35% in 2020, 67.5% in 2025 and completely phased out by 2030.[53]

The period 2000 to 2008 saw a significant deterioration in the quality of water and sanitation facilities.[54] Thereafter, a lack of funds dedicated to maintenance and rehabilitation hindered meaningful improvements in waste management and water supply systems. However, gradual improvements in average access to improved sources of water (71% by 2012) have been observed,[55] an improvement from 61% in 2010. A minor deterioration in the percentage of urban households with access to safe water may be attributed to under-serviced informal settlements and frequent water disconnections.

Due to financial constraints, the government and local authorities have been unable to provide the requisite on- and off-site infrastructure for housing development since 2000. Instead, this role has been left to individual co-operatives and other community-based organisations (CBOs). This situation has negatively affected housing delivery. Although the government and local authorities have reviewed housing delivery standards by allowing both parallel and incremental developments, the high cost of building materials and lack of finance from traditional sources, such as banks and building societies, have negatively affected delivery.

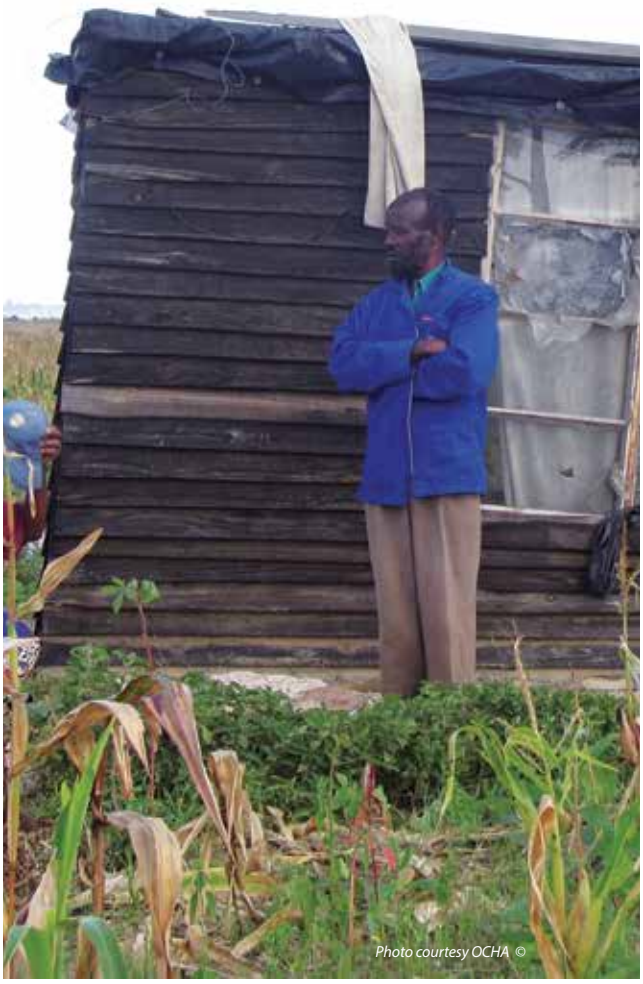


Photo courtesy OCHA ©

48 *Environment Statistics 2010.*

49 *Here, it is instructive to note that the impact of this environmental degradation is differently experienced by women and men, given their traditional roles in most community settings in Zimbabwe. For example, deforestation may require women to travel farther for fuel wood*

50 *MTP 2011–2015 guidelines.*

51 *National Ozone Office Reports.*

52 *The exceptions to this protocol are critical and essential uses in the medical field such as metered dose inhalers.*

53 *MTP 2011–2015.*

54 *Zimbabwe Environment Outlook 2010.*

55 *ZDHS 2010/11.*

Photo courtesy OCHA ©

SUPPORTIVE ENVIRONMENT

The government is engaging a variety of stakeholders, through the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) process, in implementing policies relating to environmental management, energy, climate change and water and sanitation.[56] The MTP is being re-aligned in order to incorporate the guiding principles of Agenda 21 and the outcome of the Rio+20 summit. In addition, the government has in place a variety of energy and draft climate change policies and housing strategies. The new national housing policy, for example, allows parallel housing development and incremental development, thereby accelerating the process of housing estate development to ensure housing for all. The energy policy will encourage energy sector decentralisation, rural electrification and the adoption of renewable energy resources. The climate change strategy will, once approved, provide a framework for reducing greenhouse gas emissions and managing climate change-related issues.[57]

CHALLENGES

The main challenge for the Government of Zimbabwe in terms of ensuring environmental sustainability is the effective and timely implementation of environmental policy and legislation. For example, enforcing the Environmental Management Act (Chapter 20:27) is problematic as there is a lack of both human and financial resources. Furthermore, there are differences in interpretation of the statutes that govern the use and management of natural resources, which poses further implementation challenges. In other words, different government institutions have different pieces of legislation relating the management of natural resources, resulting in scenarios such as local licensing authorities issuing permits for development on sensitive ecosystems when this ought to be the sole preserve of the Environment Management Agency (EMA).[58]

The low levels of environmental awareness amongst the judiciary and police further hinder the successful implementation and enforcement of environmental statutes. There is also lack of buy-in from the social and economic sectors, another indication of low awareness and prevalence of negative attitudes toward environmental issues. Whilst adverse environmental impacts can be regulated to some extent by setting minimum environmental standards, the emphasis needs to shift from regulation and enforcement to self-regulation.

Widespread denuded institutional and community capacity in terms of financial, material and human resources together with a weak monitoring system weighed down by an equally weak policy framework and information management system impact negatively on the water and sanitation sub-sector as whole.

The housing sector is riddled with liquidity challenges; traditional sources of housing finance have not provided the required support. Government and individual efforts need to be complemented by lending institutions.

RECOMMENDATIONS

An accelerated achievement of goal 7 by 2015 would be facilitated by a number of measures. These include:

- Strengthening the environmental capacity of key law enforcement agencies such as the police, the judiciary and the EMA.
- Leveraging sustainable financial and human resources through the development of public–private partnerships, including housing delivery schemes.
- Informing key government institutions on various climate change/environmental issues.
- Promoting renewable energy technologies to address deforestation and global warming challenges, thereby creating 'green jobs'.
- Making concerted efforts to scale up public awareness campaigns on environmental cross-cutting issues.
- Strengthening information management systems for environment and natural resources as part of the national statistics database.

56 *Zimbabwe Second National Communication to the UN Framework Convention on Climate Change, 2012.*
57 *Zimbabwe National Sustainable Development Strategies 2010.*
58 *Environment Sustainability Status Report 2012.*

- Increasing the participation of government agencies and partners in international environment gatherings to leverage funding opportunities.
- Increasing support to strengthen micro-finance institutions to augment sources of housing finance.
- Strengthening housing-delivery initiatives by local authorities and CBOs.

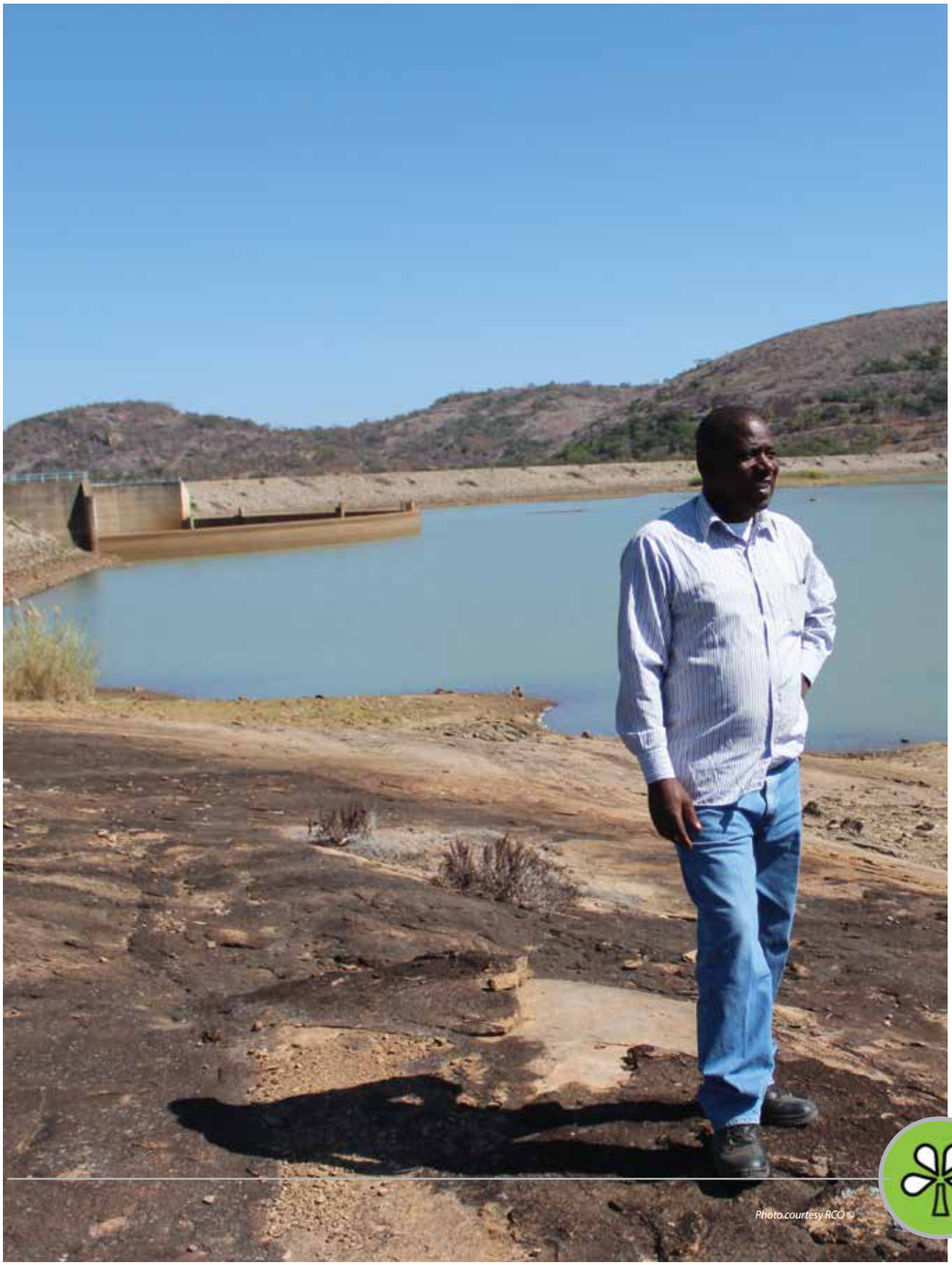


Photo courtesy RCO ©

Photo courtesy David Acosta Allely © www.123rf.com

GOAL 8:

Develop A Global Partnership for Development

TABLE 8.1: STATUS AT A GLANCE

TARGET	INDICATORS	TRENDS	STATUS
Target 8A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	***8.1:*** *Total trade-to-GDP ratio.*	Trade to GDP ratio increased from 94% in 2009 to 106% in 2010 and to 125% in 2011.	*MDG target is unlikely to be achieved by 2015.*
Target 8C: Address the special needs of landlocked developing countries.	***8.2:*** *Cost of transport per kilometre by rail, road and air.*	(2010 estimates) Rail – $0.01 Road – $0.02 Air – $0.03	
Target 8D: Deal comprehensively with the debt problem.	***8.3:*** *Total debt as a percentage of GDP.*	Increased as follows: 2010 –103% 2011 – 111% 2012 – 113%	
Target 8E: In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.	***8.4:*** *Proportion of population with access to affordable essential drugs on a sustainable basis.*	Overall availability of vital medicines at public health institutions has improved, with all health institutions having at least 50% of the selected vital medicine.	
Target 8F: In co-operation with the private sector, make available the benefits of new technologies, especially information and communications.	***8.5:*** *Telephone lines per 100 people.*	These have been on a steady decline as follows: 2010 – 5% 2011 – 4% 2012 – 3%	*MDG target can potentially be achieved by 2015.*
	8.6: *Cellular subscribers per 100 people.*	These have been increasing sharply: 2006 – 14% 2011 – 76% 2012 – 86%	
	8.7: *Internet users per 100 people.*	Internet use has increased steadily over the past three years: 2010 – 12% 2011 – 15% 2012 – 20%	
	8.8: *Personal computers per 1,000 people.*	65/1000 persons in 2010.	

Sources: QDS 2nd Quarter 2012, UNICEF, VAHMS Survey 2012, POTRAZ 2012 Internal data, 2010 MDG Report, MTP Annual Progress Report 2012

STATUS AND TRENDS

The signing of the Global Political Agreement (GPA) in September 2008 provided an opportunity for Zimbabwe to re-engage with the international community. Both STERP II (2009) and the MTP 2011–2015 were underpinned by robust macro-economic and governance reforms that are credited for the stabilisation and economic recovery that led to the average GDP growth rate of 7.1% between 2009 and 2012. However, economic recovery remains fragile, partly due to domestic policy challenges but also as a result of weak engagement with the international community. The country is still experiencing low foreign direct investment flows, limited access to development financing due to the escalating debt arrears owed to international financial institutions (IFIs), widening current account deficits and low commodity prices. The situation is further aggravated by the global economic shocks such as the Euro Zone crisis, which is having a negative impact on commodity markets and remittances from the diaspora. However, despite these challenges, there has been progress in the area of technology, particularly information and communication technology (ICT).The signing of new bilateral investment promotion and protection agreements (BIPPAs) also provide a confidence measure for new investors.

Total Trade to GDP Ratio

The total external trade to GDP ratio is a measure used to reflect the openness of an economy. Zimbabwe's trade to GDP ratio increased from 94% in 2009 to 106% in 2010 and rose to 125% in 2011. This reflects the upsurge in imports, which increased by 146% between 2009 and 2011, although exports increased by only 11% during the same period.

Finished consumption goods continue to account for the largest share of imports, implying the need for greater support for investment in domestic manufacturing value-addition.[59] Given the unsustainable current account deficit, a deliberate policy is necessary to manage the imports of finished manufactured goods, financed through short-term capital inflows and arrears accumulation. Improving the country's competitiveness is key to improving the current account balance, but this might prove difficult as Zimbabwe is ranked 171 out of 183 in the 2012 World Bank index relating to ease of doing business.

Debt Overhang

Zimbabwe is still struggling to recover from the economic challenges of the last decade and is still under sanctions from some Western nations. The situation regarding the non-payment of debt that led to International Financial Institutions (IFIs) withdrawing funding is still to be resolved. The external debt burden is currently estimated at US$10.7 billion (113.5% of GDP), of which approximately US$7.1 billion (66%) represents accumulated arrears. With penalties and arrears to creditors continuing to accumulate, Zimbabwe is unlikely to reach debt sustainability, even if increased receipts from the country's mineral resources are taken into account.

This debt overhang continues to undermine the country's creditworthiness and its resolution is extremely important for consolidating progress and further boosting the economy.[60] Sustainable debt resolution and a strategy to unlock external credit lines, particularly from the country's traditional financiers, is vital to enabling the achievement of the MDGs.[61]

Official Development Assistance

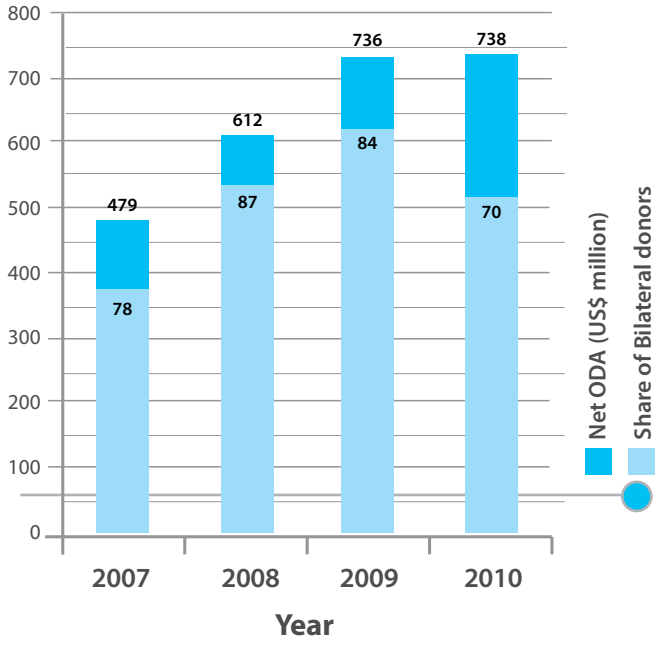
Globally, aid is predicated to grow at a much slower rate than in previous years. Allocations to low-income countries are estimated to lessen, putting overall achievement of the MDGs at risk. Donors' consolidated financial reports indicate that official development assistance (ODA) expenditure in Zimbabwe in 2010 amounted to US$617.5 million but was only US$205.7 million in 2011. With many of the major donors who withdrew ODA in 2000 awaiting further progress on implementation of the Global Political Agreement (GPA) before they decide to re-engage with government, direct ODA has not yet resumed. In its place, many bilateral donors have opted to fund activities in development sectors through the UN and non-governmental organisations.

59 *2012 Budget statement on external sector performance.*

60 *See UNDP Economic Outlook for 2012.*

61 *Monetary Policy Statement July 2011; ZADCP.*

FIGURE 8.1:
Share of Bilateral Donors in Total ODA



Source: OECD-DAC

Bilateral donors, mainly OECD-DAC countries, contributed the bulk of ODA in past years, with about 40% of aid inflows into the country for the period 2007 to 2010 intended for humanitarian assistance. Health and other social sectors received 38% over the same period.

Access to Essential Drugs

Although most companies in Zimbabwe are operating below capacity and facing common challenges for recapitalisation, some pharmaceutical companies are doing well and even exporting. Overall availability of vital medicines at public health institutions has improved significantly from the 2008–2010 situation. Almost all health institutions have at least 50% of selected vital medicines and about 79% have at least 80% of the listed medicines and health commodities. No health institution recorded a complete stockout during 2011 or 2012,[62] but the overall availability of essential medicines was only 17.6% by June 2012, against the MTP target of 80%.[63]

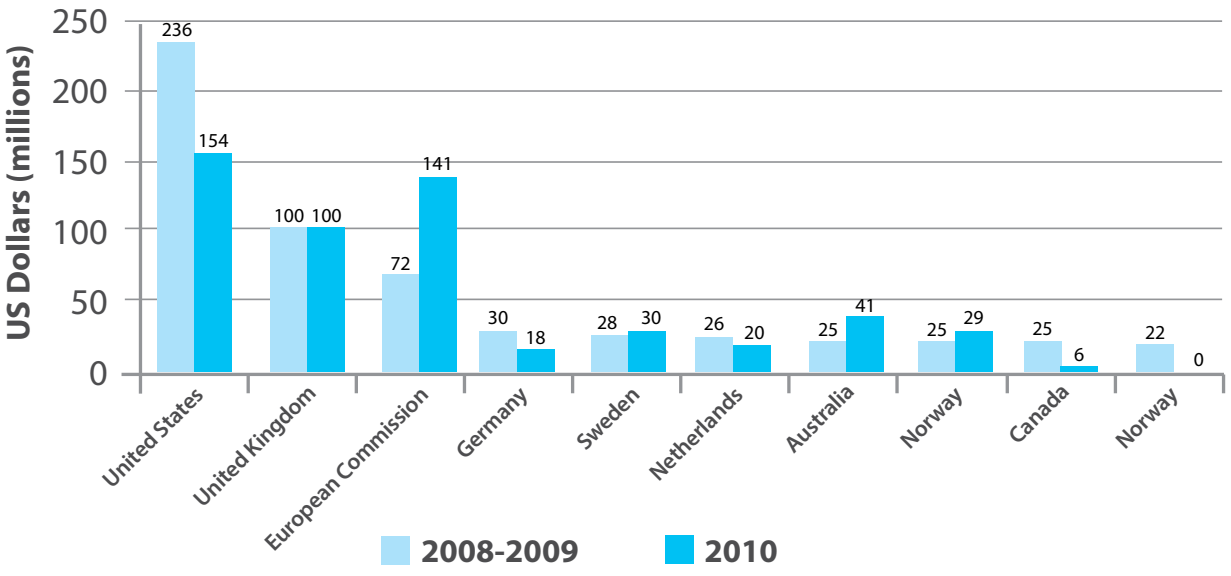
The health sector relies heavily on donor support. Many drugs come as donations and are thus procured externally. Zimbabwean-based pharmaceutical companies are missing out on an opportunity to supply the local market.

Regional Strategic Partnership

In order to gain greater market access, Zimbabwe is signatory to SADC, COMESA, African Union, ACP EU and World Trade Organisation protocols. Together with other African countries, Zimbabwe is actively involved in negotiating Economic Partnership Agreements (EPAs) with the European

62 *UNICEF 2012.*
63 *MTP Annual Progress Report 2012.*

FIGURE 8.2: ODA to Zimbabwe by Donor Country, 2008/09–2010



Source: Ministry of Finance, OECD statistics

Photo courtesy Biswarup Ganguly © http://commons.wikimedia.org

Commission under the East and Southern Africa configuration. The objective of the EPAs is to reduce poverty by supporting sustainable development and the gradual integration of ACP countries into the world economy.

Information and Communication Technology

The benefits of new technologies, especially information and communications technologies (ICT), for economic growth and development are incontestable. ICT is essential for creating an integrated economic and social space, for building and harnessing social capital, for accessing knowledge and for economic growth. There is need to continue narrowing the digital divide that exists between Africa and the rest of the world as well as among countries in Africa's sub-regions in order to strategically harness the full potential of the digital age.

The tele-density or voice penetration rate of Zimbabwe continues to improve; in 2011 it was 68% but is now 90% (POTRAZ). The Internet penetration rate has increased from 15% in 2011 to 20% in October 2012. Even though this is still below the international level of 26.6%, it is well above the regional average of 11%.

The mobile Internet penetration rate is 54% and, according to the 2010 Information Telecommunication Union ICT Index Report, Zimbabwe moved up four places on the ICT world ranking of 128 in 2008 to 124 in 2010. Within Africa, it is now ranked number 12 in terms of ICT development.

TABLE 8.2:
Trends in the growth of ICT sector, 2010–2012

YEAR	MOBILE	FIXED NETWORK	INTERNET USERS PER 100
2010	7.7 million	386,000	12
2011	9,2 million	356,000	15
2012	10.9 million	346,000	20

Source: POTRAZ 2012

SUPPORTIVE ENVIRONMENT

The Existence of an Aid and Development Results Co-ordination Mechanism

The Government of Zimbabwe has put in place an aid coordination policy (ACP) to provide a framework for enhanced aid effectiveness and accountability. The ACP, which is designed in line with the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, contains guidelines, structures and objectives to support coherent interactions between government and partners by building an institutional framework which will improve the effectiveness of aid in Zimbabwe. The shift from the humanitarian to recovery phase coupled with the launch of MTP lays a strong basis for reviewing current aid co-ordination mechanisms and structures in Zimbabwe.

The Launch of the Medium Term Plan 2011–2015

The launch of the MTP in 2011 provided a coherent framework for supporting the restoration of economic stability and growth in Zimbabwe, driven by a common development agenda. It is expected to pave the way for various policies and programmes that address the macro-economic fundamentals critical for the growth of the economy.

The Zimbabwe United Nations Development Assistance Framework (ZUNDAF)

The 2012–2015 ZUNDAF is the UN's strategic programme framework to support national development priorities for the four-year period, as well as the achievement of the MDGs. The ZUNDAF was designed at a strategic level to provide the government and the United Nations in Zimbabwe with a flexible framework that can respond and adapt to the evolving national context.

Zimbabwe Accelerated Re-engagement Programme (ZAREP)

Government has, in consultation with key stakeholders, formulated a Zimbabwe: Accelerated Re-engagement Economic Programme (ZAREP) for the next 18-24 months. This should facilitate faster re-engagement with development partners on policy issues. ZAREP will be a stepping-stone towards arrears clearance, debt relief and new financing from the international community, including IFIs.

In addition, it has also launched the Zimbabwe Accelerated Arrears Clearance, Debt and Development Strategy (ZAADDS) and is making strides in implementing this via accelerated re-engagement with creditors, including multilateral financial institutions – the IMF, World Bank and the African Development Bank.

The Zimbabwe Aid and Debt Management Office was established within the Ministry of Finance in December 2010 to assume responsibility over debt management, presenting another opportunity for strengthening debt management in Zimbabwe.

ICT Initiatives in Zimbabwe

With Zimbabwe now linked to both the Seacom and the EASSy undersea fibre optic cables, the country's Internet connectivity has greatly improved. The government is supporting an initiative to establish community information centres and one ICT lab per school in rural areas in order to increase the national Internet penetration rate. ICT awareness campaign programmes, which include ICT exhibitions, have also been launched with the intention of attracting international and regional ICT players to network and foster relationships with local ICT players.

Establishment of Trust Funds

The purpose of the Zimbabwe Multi-Donor Trust Fund (ZIMFUND) is to contribute to early recovery and development efforts in Zimbabwe by mobilising donor resources and promoting donor co-ordination so as to channel financial assistance to such efforts.

ZIMFUND has been an effective platform for donor co-ordination and has been established in line with the OECD–DAC Principles of Good International Engagement in Fragile Situations. The Project Oversight Committee of the ZIMFUND, which is made up of representatives of the contributing donors, the government and the two observers (the World Bank and UN Resident Coordinator), meet regularly to assess the performance of the ZIMFUND projects and ensure that there is no duplication of effort.[64]

The Education Transition Fund and the Health Transition Fund are also important platforms for donor resource mobilisation to support the health and education sectors. However, there is much room for improvement in the area of co-ordination.

Private Sector as Catalyst for Global Partnership

The private sector, through the Confederation of Zimbabwean Industries has contributed towards global partnerships by directly engaging and hosting delegates from various countries in the region and beyond with regard to forming business associations for joint ventures, capacity building and related activities. The government has also signed BIPPAs with Botswana, South Africa and Russia.

CHALLENGES

Zimbabwe has not taken full advantage of its membership to regional integration initiatives such as COMESA, SADC and EU-ACP. Now that SADC is a Free Trade Area it represents a large market that Zimbabwe must aim to take advantage of. Doing so may, however, be difficult as Zimbabwe's manufacturing sector continues to face supply side challenges due to low capacity utilisation and high cost of utilities and electricity load shedding.

Zimbabwe has signed the interim Economic Partnership Agreement (EPA) to comply with the World Trade Organisation guidelines and will sign the full EPA, which will facilitate duty-free access to EU markets. However, to access EU markets, Zimbabwe must address the challenge of limited capacity to meet high EU standards. Most companies in the manufacturing sector are still operating with equipment that is outdated or not up to standard, for which spare parts are difficult or impossible to source.

Limited Access to Essential Drugs

High prices remain a major barrier to accessing essential medicines. Prohibitive drug prices are often the result of strong intellectual property protection. The World Trade Organisation's Trade-Related Aspects of Intellectual Property Rights Agreement (TRIPS) sets out the minimum standards for the protection of intellectual property, including patents for pharmaceuticals. While TRIPS does offer safeguards to remedy the negative effects of patent protection or patent abuse, in practice it is unclear whether or how countries can make use of these safeguards.

Lack of ICT Policy and Legislation

The growth of the ICT sector in Zimbabwe is impeded by a lack of a robust policy and legislation. The current ICT policy, which was launched in 2007, is currently under review and the draft Bill is with the Cabinet, awaiting approval.

Aid and Development Results Co-ordination Mechanism

The aid co-ordination policy is yet to be fully operationalised. Government, with support from the United Nations Country Team, commissioned a study in 2011 to look at ways to strengthen the aid and development results co-ordination mechanism in the country. The study is expected to assist the government in devising a partnership mechanism that is driven by the implementation of the MTP and where the prioritisation of activities, as well as the mobilisation of resources to implement those activities, is conducted in a co-ordinated and effective manner. The resulting co-ordination mechanism would meet global best practice, define the role of the government in leading and managing aid co-ordination architecture, determine

64 *AfDB Country Brief 2011-13.*

the role of development partners and assess the type and level of capacity needed to enhance aid and development effectiveness in Zimbabwe.

Global Shocks

The 2009 global financial crisis and the 2011 Euro Zone crisis have had the general effect of slowing down ODA flows to Zimbabwe from global development partners. Many development partners are scaling down operations and levels of funding. This is not peculiar to Zimbabwe; but a global phenomenon, as traditional donor countries face their own economic challenges due to the global recession.

The global economic crisis has also depressed the prices of Zimbabwean exports, undermining export revenue-generating capacity and the viability of exporting industries such as mining. The Euro Zone sovereign debt crisis could further affect Zimbabwe through financial contagion, tighter credit markets, reduced capital inflows and dampened demand for commodities.

RECOMMENDATIONS

Accelerated progress on MDG 8 on global partnerships by 2015 would be facilitated by a number of measures. These include:

- The ongoing processes of re-engaging the international community to secure comprehensive external arrears clearance and debt relief from creditors, as well as restoring Zimbabwe's credibility with international development partners, should continue to receive high priority and support. This could be fast-tracked through the implementation of ZAADDS.
- There is need to implement strong measures to correct Zimbabwe's trade deficit. These should be directed at addressing the supply-side bottlenecks in the manufacturing sector within the context of regional and international integration, including the EPAs.
- There is need to review and implement Zimbabwe's aid and development results co-ordination mechanism, anchored on the MTP, to address the country's changing context, all the while leveraging post-Busan commitments towards a global co-operation agenda for development effectiveness.
- There is need to expedite the review of the ICT policy and fast track Cabinet's approval of the ICT Bill and its passage by Parliament.
- There is need to improve the country's competitiveness by leveraging ongoing macro-economic reforms, building investor confidence through policy consistency and reducing the cost of doing business.

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The Post-2015 Global Development Agenda

The Millennium Development Goals, adopted in 2000, set out a shared global framework of development priorities for the next 15 years. At that time, they were unique amongst other development commitments, in that they had a unanimous global adoption and an integrated, ambitious, time-bound and quantifiable nature. Although the MDGs will expire on 31 December 2015, even with the majority of global targets unmet, there has been substantial progress in many areas. Thus, there is global consensus that the momentum towards sustainable development created by the MDGs needs to be preserved.

The establishment of a post-2015 development agenda will need to capitalise on the strengths of the MDGs, while at the same time ensuring that the gaps are addressed and that the new development context is considered. The world has changed considerably since the year 2000, as have individual countries. The twelve years since the start of the millennium have seen new crises affecting development, such as the global financial and economic crisis and an acute food crisis. The impact of climate change is also affecting our planet to a much higher degree. A new set of goals or development framework will need to reflect these realities.

As this report has noted, Zimbabwe has made progress on some MDGs, but it has also suffered setbacks, particularly during the decade of protracted economic decline and the political disturbances of 2008. Despite the generally positive trends associated with the economic recovery that began in 2009, which was characterised by positive economic growth rates and a relatively stable political environment, there is no room for complacency. As such, it is certain that Zimbabwe will achieve only a few MDG targets by 2015. With barely three years to the 2015 deadline, it is imperative not only to accelerate progress but, based on assessments of the successes and failures to date, also begin to discuss what should come after 2015 and what implications a global post-2015 development agenda will have on Zimbabwe.

The global discussion on these issues has already begun and Zimbabwe should not miss out on the opportunity to contribute to that global discussion and help to shape the post-2015 development agenda.

Positive Contributions of the MDGs

Despite some shortcomings, the MDGs are generally considered a success. The eight goals have focused attention on the poor and have made significant contributions to the socio-economic development of countries across the globe. Their framework has also helped to raise global consciousness about the multiple dimensions of poverty. As a result, developing countries have given priority to poverty reduction and streamlined the MDGs within their development plans.

The goals have had unprecedented success in galvanising international support from governments and international bodies, as well as from civil society, the private sector, charity foundations, the media and academia, on the need to focus on a common set of goals that seek to enhance human capabilities.[65]

The MDGs have also created a greater focus on results. With specified targets, they allow countries to track and report on specific indicators, emphasising the importance of data collection and analysis to cater for evidence-based reporting and planning. This has not only encouraged countries to improve on data monitoring, evaluation and reporting systems, but has also allowed governments to create social and economic development policies that better reflect the realities of their countries.

65

Challenges and Shortcomings of the MDGs

The MDGs have been criticised for being too general and sometimes viewed as a global, one-size-fits-all, development framework, overlooking differences in the context and capacities of different countries. It has also been argued that the goals lack clear ownership at national and international levels. This is because they were conceived as a top-down approach and the involvement of developing countries in the initial framework was minimal, leading to weak national ownership. Furthermore, the goals were also not aligned with existing continental programmes.

The MDGs have also been criticised for being disproportionately focused on social indicators, at the expense of employment creation and the productive sectors, thereby creating a tension between desired outcomes and sustainable economic development. For example, in Zimbabwe, the health sector as a whole remains heavily dependent on donor assistance, such that the improved performance of HIV/AIDS indicators has been largely due to donor support. If such aid ceases, gains made are likely to reverse. Without the requisite positive rates of economic growth and strengthened productive capacities, the observed positive social outcomes are unlikely to be fiscally sustainable.

Furthermore, it is often noted that the MDGs miss the fundamental development dimension of governance issues, including human rights. While the contra-argument is that governance underpins all MDGs, it is a fact that no concrete targets were set for these issues.

An obstacle to adequately monitoring MDG performance in many countries is the lack of timely and reliable quality data. This challenge is evident in Zimbabwe, where up-to-date information for policy-making is often lacking.

Shaping the National Discussion on the Post-2015 Agenda

Central questions that will form the discussions on a post-2015 agenda are: i) whether the MDGs should be retained in their current configuration with an extended deadline; ii) whether they should be reformulated; or iii) whether they should be replaced by a new framework or a new set of goals. Another question is whether a greater emphasis on intermediate rather than final outcomes and a focus on 'enablers' of development would generate more development impact? Or is an MDG+ option the best way forward?

There are also suggestions that the post-2015 development agenda could be built around sustainable development goals emanating from the Rio+20 process. The issue thus far has been that global development has included only limited attention to the natural environment. The new approach therefore will seek to include critical problems that affect all communities, such as the plight of the poor, political, social and economic stability, as well as peace and security. As such, the post-2015 development agenda will combine sustainable development and poverty reduction themes.

A bottom-up approach will add enormous value to, and influence, the global post-2015 discussions. In the case of Zimbabwe, at national level, discussions could ask the following set of questions: Do the MDGs adequately address the key development challenges in Zimbabwe? If not, what has been left out and how can it be formulated into concrete and measurable goals for the next 15 to 20 years? How can a new set of goals best address the changing context and development challenges in Zimbabwe?"

The findings of this report, together with previous MDG and development reports and assessments, will inform the post-2015 discussions in Zimbabwe. As a key finding, this 2012 MDG progress report observes that even though the country posted positive economic growth rate since 2009 that growth did not translate into proportionate productive employment creation and poverty reduction. This observation is consistent with the findings of the 2012 Africa MDGs progress report, which underscores the poor capacity of Africa's recent rapid growth to commensurately boost jobs and reduce poverty. The report attributes this pattern to the dependency of many African countries on primary commodity exports and capital-intensive extractive industries that have limited other sectors of the economy. Expecting that a new framework for the post-2015 period will continue to have poverty reduction as a cornerstone, this is one of the issues that will need discussion, debate and increased attention. Other issues that the current MDGs do not address, as identified in Zimbabwe MDG reports and national discussions around the goals, include:

- The quality of education and a focus on secondary education
- Job creation and informal employment
- Issues of discrimination and inequality
- Gender-based violence
- Non-communicable diseases and mental health issues
- Rural–urban migration
- Trade
- Governance issues, including human rights and community accountability.
- Access to sustainable, clean energy.

There are many suggestions for the post-2015 agenda, and it will be necessary to ensure that it is not overloaded. The simplified and concise nature of the MDGs helped to 'brand' them and the subsequent efforts at implementation. The following guiding principles have been suggested:

- Goals and targets post-2015 should be kept to a minimum
- Overlaps should be minimised
- MDG areas that are likely to have the greatest multiplier effect in advancing developing countries socioeconomically should receive priority consideration
- It is important to maintain a balance between development outcomes and enablers
- Common and binding constraints to achieving the MDGs should be highlighted, thereby creating a global platform for advocacy and support for addressing such constraints
- Poverty eradication should be the guiding and overarching framework for the post-2015 MDGs
- National governments need to have primary ownership and accountability of the MDGs
- International institutions must pay due respect to national development frameworks
- The process of formulating the post-2015 development agenda should be participatory, inclusive and responsive to those affected by poverty and injustice.
- Investments in data collection, analysis and dissemination will need to be scaled-up post-2015, given that the lack of timely and reliable quality data is an important obstacle to monitoring MDG performance in Africa.

As discussions intensify for the post-2015 development agenda, it will be very important to not lose focus on the achievements of the current eight MDGs. In this regard, countries must collectively and individually remain committed and accountable to the targets they have set for themselves.

ANNEX A • COUNTRY FACTSHEET

		SOURCE
Population, 2012	12.6 million (Est.)	ZIMSTAT
Population, percentage female, 2011	52%	ZIMSTAT
Area	390,757km^2	ZIMSTAT
Gross domestic product, 2011	US$8.865 billion	ZIMSTAT
External debt, by end of 2012 (Est.)	US$8 billion	MoF
External debt as percentage of GDP	118%	MoF
Population growth	1% (Est.)	ZIMSTAT
Urban population	31%	ZIMSTAT
Infant mortality rate per 1,000 live births, 2010–2011	57	ZDHS 2010/11
Under-five mortality rate per 1,000 live births	84	ZDHS 2010/11
Orphanhood rate among those under 18 years of age, 2009	25%	MIMS 2009
Maternal mortality rate per 100,000 births, 2010–2011	960	ZDHS 2010/11
Births with skilled assistance, 2010–2011	66.2	ZDHS 2010/11
HIV infection among 15- to 24-year-olds	5.5%	ZDHS 2010/11
Net enrolment ratio, primary school, 2010–2011	87%	ZDHS 2010/11
Ratio of girls to boys in primary education, 2010–2011	1.0	ZDHS 2010/11
Ratio of girls to boys in secondary education, 2010–2011	1.0	ZDHS 2010/11
Ratio of boys to girls in tertiary education, 2010–2011	0.7	ZDHS 2010/11
Female Parliamentarians – Lower House	14%	Parliament
Female Parliamentarians – Upper House	33%	Parliament

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