2010
MILLENNIUM DEVELOPMENT GOALS STATUS REPORT
ZIMBABWE








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FOREWORD

This 2010 MDG Status Report is the third in a series of national MDG reports produced by my Government. It provides the current implementation status on each of the MDGs in Zimbabwe and indicates trends over the last decade in terms of the progress attained in socio-economic development. Significant strides have been made in a number of key areas of development such as attaining universal primary education, halting and reversing the spread of HIV and AIDS, and attaining gender parity in primary school enrolment. The 2010 status report also highlights challenges in the attainment of the MDGs and provides intervention strategies that will be instituted by Government to move towards the realisation of set targets.

Zimbabwe is convinced that the MDGs are achievable as we continue to consolidate our independence through social, political and economic empowerment of our people, by crafting and implementing pro-poor development policies and programmes.

I would like to take this opportunity to thank Zimbabweans for the patriotism, dedication and perseverance they have shown under the weight of illegal sanctions imposed on our country by those opposed to our pro-poor programmes. Our people have dug deep into their resourcefulness in achieving the success we have so far registered in our development programmes.

With unity of purpose and assistance from our bilateral and multilateral partners, my Government will continue to implement policies for economic recovery and growth, remaining always determined to realise the Millennium Development Goals by fiscal year 2015.

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

ACKNOWLEDGMENTS

The 2010 Zimbabwe Millennium Development Goals Status Report was made possible through the active engagement and participation of Government ministries and departments, the United Nations agencies, international organisations, partners from the private sector, local academic and research institutions, and civil society organisations.

The Government of Zimbabwe would like to acknowledge the tireless efforts of all its officers and external partners in the development of this report.

The following sector Ministries facilitated the consultative process through the coordination and chairing of various thematic groups:

- Ministry of Labour and Social Services
- Ministry of Agriculture, Mechanisation and Irrigation Development
- Ministry of Health and Child Welfare
- Ministry of Education, Sports, Art and Culture
- Ministry of Women Affairs, Gender and Community Development
- Ministry of Environment and Natural Resources
- Ministry of Finance

Special commendation is also extended to the United Nations Development Programme (UNDP) and the UN country team (UNCT) for backstopping the thematic groups. This support included the provision of relevant literature, technical direction, costing the goals, and financial resources to facilitate the report production process, as well as the recruitment of a team of local consultants.

Hon. Paurina Mpariwa
Minister of Labour and Social Services
Chairperson of the National MDGs Taskforce

LIST OF ACRONYMS

ANC	Antenatal Care
ART	Anti-Retroviral Therapy
AIDS	Acquired Immune Deficiency Syndrome
BEAM	Basic Education Assistance Module
COMESA	Common Market for Eastern and Southern Africa
CSO	Central Statistics Office
DPT	Diptheria, pertussis, and tetanus
EDCs	Economic Development Corridors
EMA	Environmental Management Agency
EMIS	Education Management Information Systems
ESAP	Economic Structural Adjustment Programme
FNC	Food and Nutrition Council
FPL	Food Poverty Line
GDP	Gross Domestic Product
GHG	Greenhouse Gas
GNU	Government of National Unity
GPA	Global Political Agreement
HDI	Human Development Index
HIV	Human Immune Virus
HPI	Human Poverty Index
ICT	Information and Communication Technology
IGME	Inter-agency Group for Child Mortality Estimation
IMF	International Monetary Fund
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MIMS	Multiple Indicator Monitoring Survey
MMR	Maternal Mortality Rate
MoEASC	Ministry of Education, Arts, Sports, and Culture
MoENRM	Ministry of Environment and Natural Resources Management
MoHCW	Ministry of Health and Child Welfare
MoLSS	Ministry of Labour and Social Services
MoPSLSW	Ministry of Public Service, Labour and Social Welfare
MoWAGCD	Ministry of Women Affairs, Gender and Community Development
MTP	Medium-Term Plan
NCHS	National Centre for Health Statistics
NER	Net Enrolment Ratio
NGP	National Gender Policy
OCHA	Office of the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
ODS	Ozone Depletion Substances
OVCs	Orphaned and Vulnerable Children
PASS	Poverty Assessment Study Survey
PMTCT	Prevention of Mother to Child Transmission
PPP	Purchasing Power Parity
RBZ	Reserve Bank of Zimbabwe
SADC	Southern Africa Development Community
SDIs	Spatial Development Initiatives
SDR	Special Drawing Rights
STERP	Short-Term Emergency Recovery Plan
TCPL	Total Consumption Poverty Line
TRs	Transport Routes
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNESCO	United Nations Education and Scientific Organisation
WASH	Health, Water, Sanitation, and Hygiene
WDTF	World Bank's Multi-Donor Trust Fund
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZIMPREST	Zimbabwe Programme for Economic and Social Transformation
ZiNEPF	Zimbabwe National Employment Framework
ZMPMS	Zimbabwe Maternal and Perinatal Mortality Study

PREFACE TO THE REPORT

Of the eight Millennium Development Goals (MDGs), the Government of Zimbabwe has identified Goals 1, 3, and 6 as the national priority. The sections for these three goals in this report are thus slightly more comprehensive.

As the title indicates, this is a status report that aims at providing the current standing of each of the MDGs in Zimbabwe as of June 2010, and, where possible, to show trend patterns of the last decade. Reliable and new data is, however, a major problem in Zimbabwe. In some areas the data available was outdated and in others none existed, which is why this report may not provide a comprehensive picture of the current situation and trends, or use the same baseline, as would otherwise be desirable. The findings of the report build on the MDG Mid-Term Report of 2007 and do not aim at providing a deeper analysis behind the current status of the MDGs, nor to provide extensive proposals for solutions or policy changes. It is, however, the intention that such a national 'MDG Action Plan' will be developed as a subsequent step towards accelerating MDG-related achievements in Zimbabwe.

The MDG Status Report for Zimbabwe was facilitated by a team of four Zimbabwean consultants, namely, an economist, an educationist, a gender specialist and a health specialist. Numerous consultation meetings coordinated by the Ministry of Labour and Social Services were held with relevant government ministries, as well as with other stakeholders including state institutions, civil society organisations, academic institutions, research institutes, bilateral partners, and UN system organisations. A consultation workshop was held to discuss the first draft of the report with the various stakeholders, and a peer review group was formed and used for additional comments and input and for refining the report.

Zimbabwe – The Development Context

ZIMBABWE: THE DEVELOPMENT CONTEXT

The country's economic performance since independence in 1980 can be broken down into three periods: the post-independent era of 1980–90, the economic liberalisation and ESAP period of 1990–2000, and the crisis period of 2000–2008.

At Independence in 1980, Zimbabwe inherited a dual and diversified modern economy operating alongside a large subsistence peasant agricultural sector that was skewed in favour of the racial minority.

During the first decade of independence, 1980–1990, real GDP growth rate averaged 3-4% per annum and reached a peak of 7% in 1990. During this period, public expenditure was geared towards the social sector and the expansion of the rural infrastructure, with the aim of reducing social and economic inequalities. Such spending led to strong positive indicators in education and health.

The period of economic liberalisation, 1990–2000, saw the implementation of the Economic Structural Adjustment Programme (ESAP) that was introduced in response to poor macro-economic indicators. The key elements of the reforms were an emphasis on export-led policies, monetary policy reforms in the form of liberalised interest regimes and exchange rate policies, government divestiture from public enterprises, and the liberalisation of labour markets.

However, recurrent droughts, coupled with shortcomings in terms of implementation of the necessary fiscal adjustments, led to a decline in real GDP growth. Between 1991 and 1995 growth averaged only 1.5% per annum.

The introduction of cost-sharing measures in the health and education sectors under ESAP reversed the gains achieved in these areas, with severe consequences for the poor and vulnerable groups who could not afford the user fees. By 1997, the economic crisis had deepened such that the government replaced ESAP with the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST), 1996–2001.

Notwithstanding the introduction of ZIMPREST, the onset of the land reform programme and the decline in the output of the commercial farming sector, in exports, and in inputs for the manufacturing sector, together with a growing budget deficit and severe foreign exchange shortages, contributed to further declines in GDP from 0.0% in 1998 to -7.4% in 2000 and subsequently -10.4% in 2003. From 2000 to 2008, Zimbabwe's economy suffered a further decline, with GDP shrinking by an estimated 40% between 2000 and 2007. Extremely high levels of inflation ensued, with profoundly negative consequences for development and the eradication of poverty.

During this same eight-year period, Zimbabwe faced serious economic challenges that eroded its capacity to remain competitive in regional and international markets. Following the land reform programme the country faced sanctions from some western countries and the withdrawal of funding by the Bretton Woods institutions.

By 2003, the population living below the total consumption poverty line (TCPL) stood at 72% and this may have further increased with the prolonged crisis. In the same year, structural unemployment was recorded at 63%. Current estimates suggest a figure of up to 80%.

Another consequence of the declining economy has been the out-migration of large numbers of both skilled and unskilled labour. A significant percentage of the population now resides outside the country, mainly in South Africa and in the United Kingdom. This brain drain has severely compromised the capacity of both the private and public sector.

The economy has also faced daunting challenges in the face of global crises, shocks and vulnerabilities, especially during the period 2007–2008. The rise in price of imported food and fuel, the global recession, and the impact of climate change have all impacted on the country's development prospects generally, and progress on the MDGs specifically.

Notwithstanding the poor performance of the economy, Zimbabwe has been able to make significant progress in a number of key areas of the MDGs, such as universal primary education, where enrolments in primary schools have consistently been relatively high, with net enrolment ratio (NER) of 91% in 2009. (The NER is, however, down from 98.5% in 2002.) The country is also on course to attain gender parity in both secondary and primary education.

Zimbabwe has also experienced a gradual decline in HIV and AIDS, as demonstrated by the trend in prevalence rates for the past decade. The estimated rate for HIV and AIDS in adults (people aged 15 and above) declined from 23.7% in 2001 to 18.4% in 2005. The national HIV and AIDS 2010 Report shows the adult prevalence rates to have been 16.1% in 2007, 15.1% in 2008, and 13.7% in 2009. This consistent reduction is a significant achievement.

With the formation of the Government of National Unity (GNU) in February 2009, the future outlook of the country looks promising, and the subsequent launch of the Short-Term Emergency Recovery Programme (STERP) has contributed significantly to the stabilisation of the political and economic situation. Positive economic trends began to show in the first quarter of 2009 following the adoption of the multi-currency system, which eliminated hyperinflation. Capacity utilisation figures in both manufacturing and services have also shown some encouraging improvements, although infrastructural deficits, particularly in terms of power generation and distribution, still constitute constraints on this nascent economic turnaround. These positive economic developments are still to translate into significantly improved levels of employment.

STRATEGIES FOR ECONOMIC RECOVERY

The government recognises the need to redress this decade-long crisis period and get the economy onto a path of recovery and growth. The formulation of the Medium-Term Plan (MTP) 2010–2015 is a direct response to fundamental development challenges. Based on the mandate espoused in Article III of the Global Political Agreement (GPA) of the Inclusive Government to support the restoration of economic stability and growth in Zimbabwe, such growth will be inclusive and pro-poor in order to simultaneously address the country's high poverty and inequality levels. The MTP thus establishes a platform for consolidating the macroeconomic stability achieved under STERP, its predecessor, and for steering the economy towards a sustainable growth path that addresses the need to ensure multi-sectoral growth, rebuild the country's human capital base, revive employment, and reverse the decline in its social indicators.

1

Eradicate Extreme Poverty and Hunger

ERADICATE EXTREME POVERTY AND HUNGER

1

TARGET	INDICATORS	TRENDS
Target 1A Halve, between 2002 and 2015, the proportion of people whose income is less than the Total Consumption Poverty Line (TCPL)	1 *Percentage of people below the TCPL* 2 *Human Poverty Index (HPI)*	1 *Population living below the TCPL stood at 72% in 2003 and may have increased due to the economic crisis.* 2 *The HPI was 24% in 1995. It had risen to 40.3% by 2005, but dropped to 34% in 2009 (Global Human Development Report, 2009)*
Target 1B Achieve full and productive employment and decent work for all, including women and young people	1 *Growth rate of GDP per person employed* 2 *Employment-to-population ratio* 3 *Proportion of employed people living below US$1 (PPP) per day* 4 *Proportion of own-account and contributing family workers in total employment*	*Not available*
Target 2 Halve, between 1990 and 2015, the proportion of people suffering from hunger. Reduce by two-thirds, between 2002–2015, the proportion of malnourished children under five	1 *The prevalence of underweight children under five years of age* 2 *Proportion of population below minimum level of dietary energy consumption*	*The percentage of underweight children under the age of five increased from 13% in 1999 to 18% in 2003, but dropped to 17% in 2005 and 15% in 2010*

STATUS AND TRENDS

According to the 2003 Poverty Assessment Study Survey (PASS II), the population living below the Total Consumption Poverty Line (TCPL) rose from 55% of the total population in 1995 to 72%in 2003 (Figure 1.1). This situation is likely to have worsened due to the sharp economic decline between 2000 and 2008, which saw the GDP shrink by 40%. Additional factors such as the significant decline

in agricultural production during the same period, droughts, and inadequate availability of agricultural inputs have combined and accentuated the impact of a declining economy on human welfare.

POVERTY

In relation to poverty trends, the 2007 MDG Mid-Term Progress Report showed that poor urban households increased from 45% in 1995 to about 61% in 2003, with the number of poor rural households increasing from 57% to 71% during the same period. Again, this was mainly due to the worsened macro-economic situation of that period, which was epitomised by a hyperinflationary environment, no development spending, unemployment, and declining economic output. Urban poverty was also directly affected by a rapidly shrinking manufacturing sector.

The feminisation of poverty in Zimbabwe manifests itself through a higher prevalence rate of poverty among female-headed households, with 68% of all female-headed households living under the TCPL in 2003. The economic crisis in the last decade disproportionally affected women through the informalisation of employment sectors such as food processing and the textile industry. These sectors, which were dominated by women, all but collapsed during this period.

People with disabilities experience a slightly higher prevalence of extreme poverty (61%) than people without disabilities (58%).[1] This highlights the need for a targeted approach in addressing the poverty dimensions affecting people with disabilities.

MALNUTRITION

The high level of malnutrition attributed to food insecurity is largely responsible for mortality and ill-health among children under five years of age. The percentage of underweight under-fives rose from 13% in 1999 to 18% in 2003, but dropped to 15% in 2010 (Figure 1.2). According to the National Centre for Health Statistics (NCHS) references, these percentages of affected children in Zimbabwe are mostly determined by the effects of stunting (27.1%) (Figure 1.3) and not by acute malnutrition/ wasting (2.1%).

The fluctuation between 12% and 18% indicates that malnutrition remains a serious problem in Zimbabwe, affecting a substantial number of children under the age of five.

Since nutrition plays such an important role in preventing young children from falling victim to diseases, a resumption of nutrition provision for pregnant women in antenatal clinics and for the under-fives would play an important part in lowering child mortality rates.

HUMAN DEVELOPMENT AND THE POVERTY INDEX

The Human Development Indicator (HDI) and Human Poverty Index (HPI) for Zimbabwe show significant declines. The indicators worsened between 1995 and 2009: the HPI fell from 24% in 1995 to 40.3% in 2005, but rose to 34% in 2009. The HDI fell from 0.654 in 1990 to 0.613 in 1995, to 0.541 in 2000, and to 0.513 in 2005.[2]

UNEMPLOYMENT

In Zimbabwe, Target 1B – achieving full and productive employment and decent work for all, including women and young people – is unlikely to be met by 2015. Unemployment and under-employment remains a persistent challenge. According to PASS II, the rate of structural unemployment in Zimbabwe was 63% in 2003. The survey also observed that structural unemployment that same year was higher amongst females (70%) than males (56%) because of the latter's dominance in the agriculture sector and the informal economy. Rural areas had a higher structural unemployment rate (62%) than urban areas (35%).

The Zimbabwe National Employment Framework's (ZiNEPF) Report of December 2007 showed a direct correlation between economic growth, job creation,

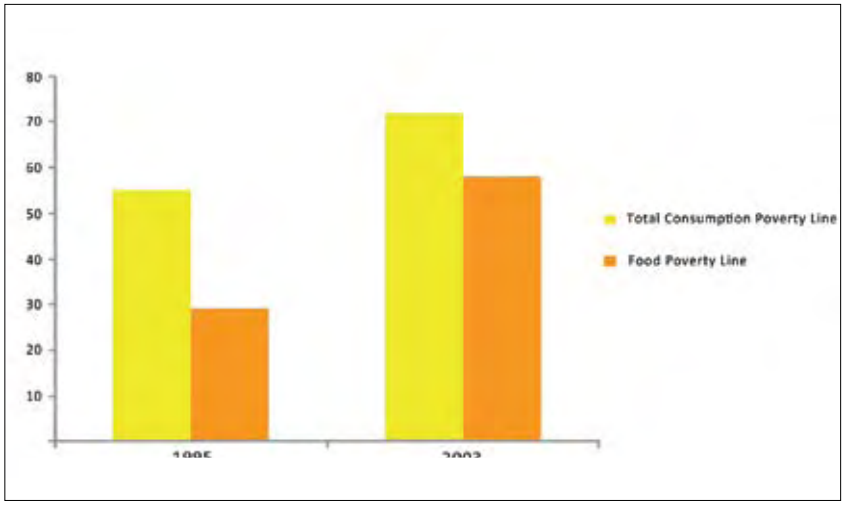

Figure 1.1 Percentage of the population living below the Total Consumption Poverty Line (TCPL) and the Food Poverty Line (FPL)

Source: PASS II, 2003

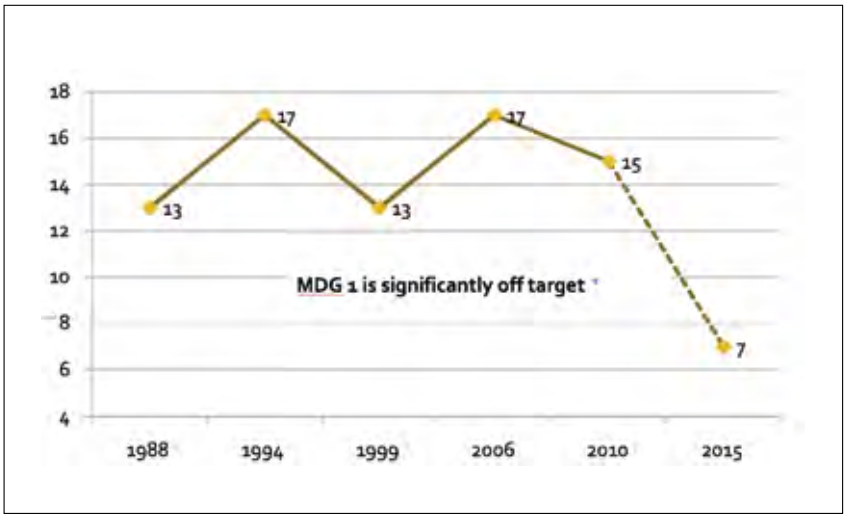

Figure 1.2 Percentage of underweight children by year of survey, including MDG 1 target

Source: MDG Mid-Term Review, Government of Zimbabwe, 2008; National Nutrition Survey, MoHCW, 2010. All rates use the NCHS reference population

and poverty reduction. Previous policy focusing on macro-economic stabilisation emphasised fiscal and inflation indicators, but overlooked employment creation and poverty reduction.

The government of Zimbabwe has signed a number of international commitments to provide decent and full employment for youths and women. These include the Millennium Declaration, the UN Resolution on Promoting Youth, the Ouagadougou Declaration of the Heads of State and Government of Africa, the Resolution of the 93rd International Labour Conference concerning youth employment, Resolutions of the Tripartite Meeting on Youth Employment, and the Conclusions of Southern Africa Sub-Regional Conference on Youth Employment.

FOOD SECURITY

Zimbabwe, once the food basket for southern African region, is now a net importer of food. The proportion of people living below the Food Poverty Line (FPL) increased from 29% in 1995 to 58% in 2003; this percentage has probably increased since then.

In terms of the 2010 ZIMVAC Report, an estimated 1.3 million people will be food insecure at the the peak of food insecurity (February and March 2011). This is the result of the drought situation that prevailed in the southern African region during the previous agricultural period.

Urban agriculture continues to be one of the most important sources of livelihoods for the majority of households in peri-urban and high-

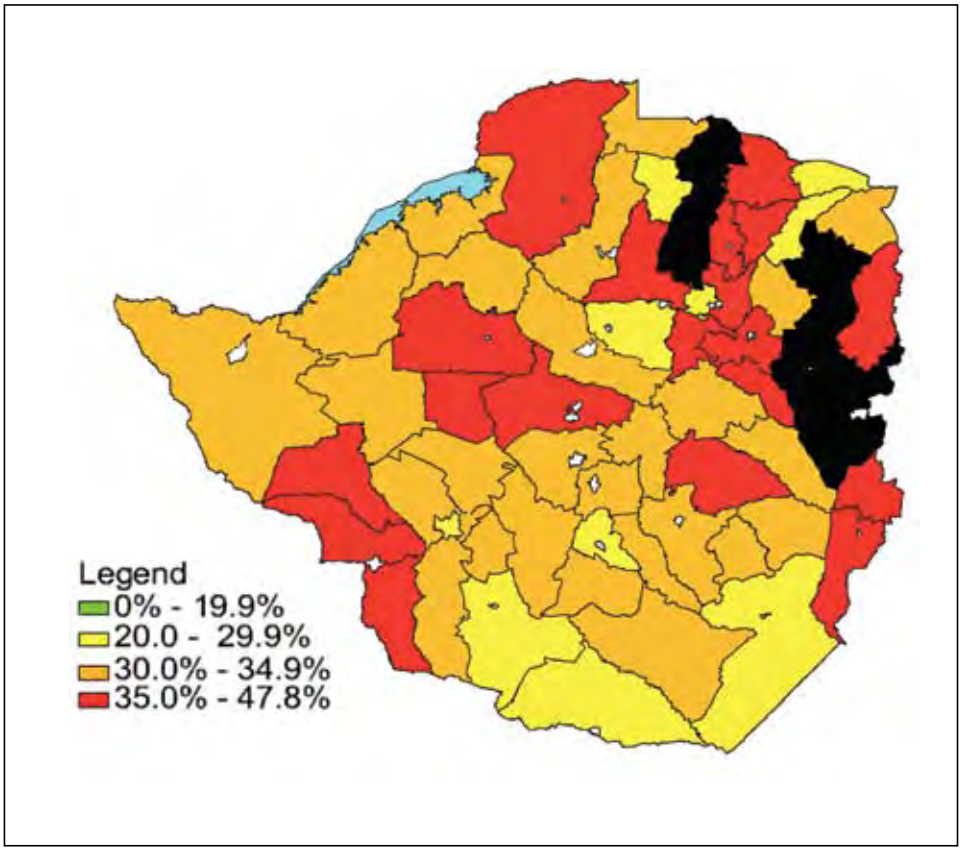

Figure 1.3 Percentage of children less than 5 years of age below average height, by district

Source: National Nutrition Survey 2010, Food and Nutrition Council, Zimbabwe

density areas. On average, in 2006, household maize production for those growing the crop in urban areas contributed up to eight months of household cereal requirements. Three years later, 56% of these households grew maize during the 2008–09 agricultural season; the highest proportion of these households was in Mashonaland Central (82%) and the lowest in Matabeleland South (30%).

The decline witnessed in overall national agricultural production after 2000 can be attributed to adverse weather conditions and land disputes, and to smallholder farmers being unable to access inputs and credit.

MAJOR CHALLENGES TO ACHIEVING GOAL 1

A number of key constraints are impeding progress towards the realisation of MDG 1 in Zimbabwe. From the policy perspective, there is a need to address the land reform issue as one of the drivers for national agricultural revitalisation, given the large numbers of people who are economically dependant on agriculture. Central to this is addressing the land tenure system for both communal and commercial farms, including property rights that would facilitate investment and accessibility to credit. So doing would optimise productivity and transform smallholder agriculture for the majority populace and also enhance food security.

The precipitous decline in agriculture had a knock-on effect in terms of the de-industrialisation experienced during the crisis period, principally because of Zimbabwe's strong inter-sectoral linkages between manufacturing and agriculture. The capacity utilisation in industry had declined to 10% by 2008, resulting in massive unemployment and a critical lack of basic goods and services. This situation contributed to the increasing levels of urban poverty as the manufacturing sector could not generate jobs.

Falling investments in agriculture, particularly in infrastructure and extension services, directly added to the decline in food production and the rise in poverty levels, especially in rural areas. There

is consensus that public expenditure in agriculture should be directed towards productive investment in infrastructure programmes that are key enablers in the agriculture value chain. Smallholder farmers would greatly benefit from investment in extension services and research, rural feeder roads, and water supplies.

The rising incidence of poverty in Zimbabwe is also directly linked to the contraction in the government's fiscal space. Severe budget constraints have had a debilitating effect on public expenditure on health and education and other social infrastructure. The national economy has lost its competitive edge and the ongoing investment climate has not been conducive to attracting new capital and investment. Additional external shocks and other vulnerabilities in the form of the food and fuel crises experienced during 2007 and 2008, as well as the 2009 financial and economic crisis and the impact of periodic droughts and floods, further increased this economic vulnerability.

REQUIREMENTS FOR ACHIEVING GOAL 1

Zimbabwe is unlikely to meet the MDG 1 target on eradicating extreme poverty and hunger by 2015. However, although the status and trends for MDG 1 have not been positive, the country can halt and reverse the increasing levels of poverty, hunger and malnutrition by, inter alia, undertaking the following measures:

- Supporting the land reform policy
- Pursuing economic transformation by deepening the economic reforms in the medium and long term through pro-poor and inclusive growth. The Medium-Term Plan 2010–2015 provides a good policy framework for this
- Pursuing governance reforms to create an environment conducive to sustainable development
- Strengthening the social protection system
- Strengthening bilateral and multilateral partnerships as a strategy towards resource mobilisation to support economic recovery and development
- Promoting job creation and decent jobs for all as a strategic policy thrust for mainstreaming employment.

Notes

1 MDG Mid-Term Report, 2007.
2 *Global Human Development Report*, 2008, 2009.

2

Achieve Universal Primary Education

ACHIEVE UNIVERSAL PRIMARY EDUCATION

2

TARGET	INDICATORS	TREND
Target 2A Ensure that by 2015 all Zimbabwean children, boys and girls alike, will be able to complete a full programme of primary education	1 *Net enrolment ratio (NER) in primary education* 2 *Proportion of pupils starting Grade 1 who reach the last grade of primary school* 3 *Literacy rate of 15- to 24-year-olds, male and female*	1 *The NER decreased from 98.5% in 2002 to 91% in 2009* 2 *Primary school completion rates went down from 82.6% in 1996 to 68.2% in 2006* 3 *99% in 2009, compared to 85% in 1994*

STATUS AND TRENDS

Zimbabwe has consistently maintained relatively high levels of primary school enrolments. The net enrolment ratio (NER) increased from 81.9% in 1994, peaking at 98.5% in 2002 (Figure 2.1). Since 2003, however, there has been a gradual decrease, with the 2009 Multiple Indicator Monitoring Survey (MIMS) recording an NER of 91%. In urban areas the NER is 94% compared to 90% in rural areas. Gender equality at primary school level is good; in fact, 2009 saw a pro-female enrolment rate of 50.5%.[1]

Although enrolments have remained high, completion rates deteriorated between 1996 and 2006, falling from 82.6% in 1996 to 68.2% in 2006.[2] In 2009, the dropout rate was around 30% and slightly higher for boys than it was for girls.

MAJOR CHALLENGES TO ACHIEVING GOAL 2

The economic situation for the average Zimbabwean family has worsened during the past decade. This has had a direct negative impact on their ability to send their children to school and pay for school fees and uniforms. In this worsened economy, there is greater pressure on children to contribute to the family economy in order to make ends meet.

A key reason behind the high dropout rates of the last ten years may be related to poor nutrition; many children seldom have enough to eat in order to be able to manage school. Fewer children in rural areas attend school than do children in urban areas. The primary school dropout rate is also much higher in rural areas, which account for 78.9% of the total number of dropouts.[4] One possible reason for this could be families' increasing need to use their

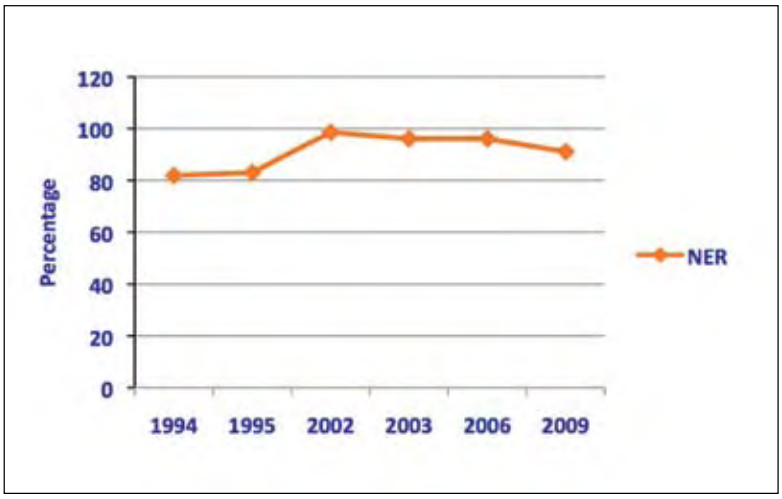

Figure 2.1 Net primary school enrolments, 1994–2009

Sources: Central Statistics Office (CSO); Ministry of Education, Sports and Culture (MoEASAC)

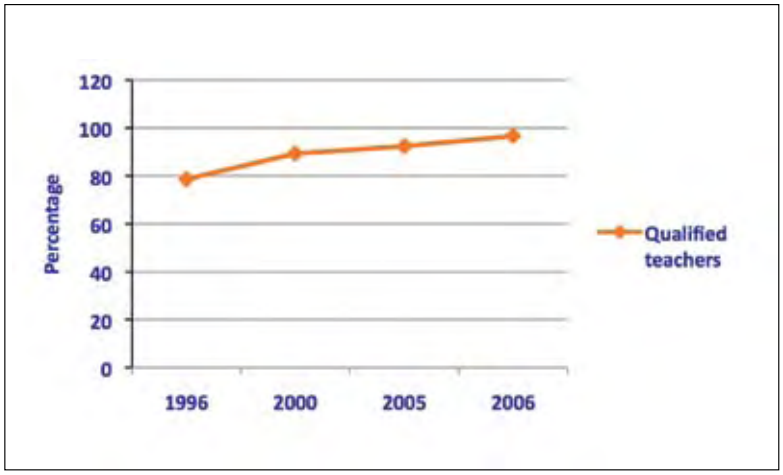

Figure 2.2 Percentage of qualified primary school teachers

Sources: CSO 1996, 2000; MoESAC 2005, 2006

children as free labour in the fields. Many of the out-of-school are teenagers, who find returning to primary school challenging. At present, there is very limited non-formal education on offer that could enable children out of school to obtain a quality and relevant basic education.

The government has budgeted for social assistance with education for vulnerable groups through a Basic Education Assistance Module (BEAM). This was established in 2000 and targeted poor and vulnerable children in both primary and secondary schools. However, BEAM assistance to pupils has been erratic and financially inadequate. BEAM catered for about 600,000 children in 2009.

HIV and AIDS have also had an enormous impact in this area. In Zimbabwe, the pandemic has created a huge number of orphans and vulnerable children (OVCs). It is estimated that HIV and AIDS are responsible for close to 70% of the current number of orphans.[5] Although the estimated number of OVCs has dropped slightly, falling to 975,956 in 2009, from 1,008,540 in 2006,[6] this decrease has been attributed to the introduction of anti-retroviral therapy (ART) and the subsequent reduction in mortality. Despite many positive results from the National Action Plan for OVCs, launched in 2005 to care for the orphan population in Zimbabwe, many of these children are still unable to go to and stay in school because of their inability to afford the tuition fees, the uniform, and other associated costs.

Another obstacle towards achieving MDG 2 is the long distances (more than five kilometres in each direction) many children must travel to and from school. This is a problem for 14% of the country's children, particularly so for a number of rural provinces, such as Mashonaland Central,

Matabeleland North and Matabeleland South, where over 20% of all children live more than five kilometres from their school.[7]

THE QUALITY AND RELEVANCE OF EDUCATION

Despite the relative stability of the enrolment figures, quality indicators show a sharp deterioration in the period 1990–2009. Indicators of quality include, inter alia, examination results, the relevance and quality of the curriculum and textbooks, teacher morale and their commitment and qualifications, and professional leadership and supervision of schools.

At the end of Grade 7 – the last year of the end of primary education – pupils' achievements in four subjects are tested by a series of examinations. Between 2003 and 2009 results from these examinations indicate a marked deterioration in the percentage of pupils attaining a pass level of 6 or better in the four subjects.[8] Only 20% of children managed to pass four subjects in 2009, compared to 46% in 2003.[9] This grave situation reflects the number of problems primary schools faced during this period, particularly in 2008, when many school were closed. A lack of learning materials, lack of appointments of school heads, and low teacher motivation also played a part.

Another challenge is the long lack of curriculum renewal, which has resulted in an outdated syllabus that is not responsive to the country's significant situational changes.

Pupil-to-textbook ratios also deteriorated between 2003 and 2009. In 2003, the ratio at primary schools was 8:1 nationally, with 6:1 in urban areas and 10:1 in rural areas.[10] In 2009, studies showed that 20% of urban primary schools had a pupil-textbook ratio of 9:1 or above, while 11% had no textbooks at all. In rural primary schools, 37% had a pupil-textbook ratio of 9:1, while 8% had no textbooks at all.[11]

However, 2010 has seen considerable progress towards improving this situation. Through the Education Transitional Fund, which was established

by international partners together with the Ministry of Education, Sport, Arts, and Culture (MoESAC), a total of 13 million primary school textbooks have been obtained, enough to provide about five textbooks per child.

TEACHER MORALE, COMMITMENT AND QUALIFICATIONS

Overall, teacher-to-pupil ratios remained stable at between 1:38 and 1:39 over the period 2000–2010. However, these ratios vary according to the type and location of schools, ranging from 1:36 in privileged private schools to 1:52 in some poor and/or remote districts.[12]

Low teacher morale poses a serious challenge to the education system. Although children continue to go to school, they often receive irregular education.[13] In a study on school financing, pupils at primary schools reported a 16% absentee rate of teachers in the previous week, with 32% of teachers being absent at least once during the same period.[14]

In a 2009 sample survey, 90% of teachers indicated that they were demoralised and dissatisfied with the conditions of service.[15] Poor salaries (presently at about US$176 per month) are the main contributing factor. Parents are encouraged to pay salary supplements or provide basic food for teachers, but while these contributions benefit urban teachers and teachers in wealthier communities, the majority of parents, particularly in rural areas, are unable to afford such supplements. Frequent teachers' strikes and so-called 'go slow' strategies have led to a serious deterioration of the quality of education. Additional challenges include housing problems for teachers and the lack of in-service teacher training.

One of the major achievements of the Zimbabwe system of teacher education is the marked improvement in the qualifications of primary school teachers over the period 1990–2009 (Figure 2.2).

THE SUPERVISION AND QUALITY OF SCHOOLS

A noticeable change in this area is the feminisation of the teaching service, with women comprising 54% of primary teachers in 2009, a significant rise from 44% in 1996.[16]

The supervision of schools has shown marked deterioration, mainly due to shortages of staff, transport, and funds. One indicator of the lack of supervision was the large number of Acting School Heads in schools in 2009, although 2010 has seen major effort being made to redress this problem. School infrastructure has also deteriorated due to lack of maintenance. A recent study shows that only a third of existing primary school classrooms are in good condition.[17]

PUBLIC INVESTMENT IN EDUCATION

Public investment in primary and secondary education was fairly predictable in the 1980s and early 1990s, but has since become less so due to budget constraints indicative of varying commitment and poor forward planning.

Guidelines from UNESCO suggest that 20% of the state budget and 6% of GDP should be allocated to education. In 2010, the state allocated 12.3% of its budget to MoESAC, donor funds excluded.[18] The present state budget for education mainly funds salaries; there is little investment into areas which contribute to the qualitative aspects of education.

REQUIREMENTS FOR ACHIEVING GOAL 2

Despite the negative trends of the last decade, it is possible for Zimbabwe to attain universal primary education by 2015. In order to do so, and to bridge the challenges impeding full attainment of Goal 2, the following key interventions need to be prioritised:

- Reintroducing free primary education
- Improving the quality and relevance of primary education

- Providing school lunches to mitigate problems caused by chronic malnutrition
- Improving the conditions for teachers through increased salaries as well as training and other conditions for service
- Ensuring a predictable and adequate state budget for education.

Notes

1 Multiple Indicator Monitoring Survey (MIMS), 2009.
2 CSO, 1997, 2000, 2001; MoESAC, 2000, 2006.
3 CSO, *Inter-Censal Demographic Survey 2008 Report,* Harare, 2009, p. 56.
4 PASS II, 2003, p. 162.
5 MIMS, 2009.
6 MIMS, 2009.
7 PASS II.
8 The four subject papers are English, Shona or Ndebele, Mathematics, and the General Paper, which covers environmental science, religious and moral education, and social studies.
9 Zimbabwe Schools Examination Council (ZIMSEC).
10 PASS II 2003, p. 173.
11 National Education Advisory Board, *The Rapid Assessment of Primary and Secondary Schools*, 2009, pp. 42-3.
12 MoESAC, 2009.
13 National Education Advisory Board, *The Rapid Assessment of Primary and Secondary Schools*, 2009.
14 National Education Advisory Board, *Cost and Financing of the Education Sector in Zimbabwe*, 2009.
15 National Education Advisory Board, *Cost and Financing of Education in Zimbabwe*, 2010.
16 CSO, 1997; MoESAC, 2009.
17 National Education Advisory Board, *The Rapid Assessment of Primary and Secondary Schools*, 2009.
18 Only 0.08% of this amount was allocated to sports, arts and culture.

3

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Promote Gender Equality and Empower Women

PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

3

TARGET	INDICATORS	TRENDS
Target 1 Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015	1 *Net enrolment ratios (NER) by gender at primary school level* 2 *NER by gender at secondary school level* 3 *Literacy rates of 15-24 year-olds by gender* 4 *Completion rates by gender for primary and secondary education* 5 *Percentage share of female enrolment and completion rate in universities*	1 *The NER increased from 81.9% in 1994 and peaked at 98.5% in 2002. Since 2003, there has been a decrease: 96% in 2006 and a low of 91% in 2009* 2 *There is near equality in enrolment in lower secondary school by gender. However, girls comprise only 35% of the pupils in upper secondary schools and the secondary school completion rate is higher for boys* 3 *99% in 2003 for both men and women in this age group* 4 *Completion rates at primary level declined from 73% in 2001 to 68% in 2006 for males and 71% in 2001 to 69% for in 2006 for females* 5 *Female university enrolment increased from 23% in 2006 to 37% in 2007*
Target 2 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	1 *Percentage share of women in parliament* 2 *Percentage share of women in the civil service who are at under-secretary level and above* 3 *Percentage share of women in the private sector at managerial level* 4 *Percentage share of women in local government decision-making bodies*	1 *Increased from 14% in 1990–1995 to 16% in 2005 and to 18.55% in the 2008 elections (14% in the Lower House of Assembly and 33% in the Upper House)* 2 *In 2009, the Public Service Commission had 67% women commissioners. In 2010 women comprise 20% of cabinet ministers and 26% of permanent secretaries. In government, 26% of principal directors are women, as are 33% of directors and 28% of deputy directors. Women constitute 30% of ambassadors and heads of mission, 29% of Supreme and High Court judges, 41% of magistrates. The Defence Forces have no women at the highest levels and very few at lower levels. In the police force 25% of deputy commissioners are women* 3 *Not available* 4 *In the 2005 elections, women comprised 28% of councillors in rural district councils and 10.5% in urban councils. Now, women comprise 18% of urban councillors and 19% of rural councillors*

STATUS AND TRENDS

Although approxiamtely 52% of the population in Zimbabwe is female, women are disproportionately represented in politics and in other decision-making positions.

While there is gender parity in primary school level, and near gender parity at lower secondary level, particularly in the lower forms (Forms 1 to 4), the gender parity decreases in upper levels, where there is low representation and completion rates amongst girls. Although both girls and boys have dropped out of school as a result of a decade of economic crisis, the percentage share is higher for girls.[1] There is also a low enrolment of women in universities, particularly in the fields of mathematics and science. Yet despite some of these negative trends, Zimbabwe will most likely reach the gender parity target in secondary and primary education.

The target of increasing the participation of women in decision-making in all sectors, and at all levels, to 50:50 by 2015 is seriously off-track and may be difficult to achieve (Figure 3.1).

The trend in increasing women's participation in decision making in all sectors shows a slight increase in the number of women representation in parliament from 14% in 1990 to 19% in 2008. This is below the 2005 target of 30%. Zimbabwe has had a female Vice President since 2005 and a female Deputy Prime Minister, President of the Senate, Deputy Speaker of the House of Assembly, and Judge President of the High Court between 2006 and 2010. At other levels of decision-making, 67% of Public Service Commissioners are women, 29% are Supreme Court and High Court Judges, 41% Magistrates, 42% Administrative Court Judges.

In the police force, 25% of deputy commissioners are women, 36% Senior Assistant Commissioners and 17% Chief Superintendents. In the defence forces, while there are no women at brigadier general level and above, there are 7% women Colonel, 6% Lieutenant Colonel, 5% Group Captain, 13% Wing Commanders and 16% Flight Lieutenant. In the prison services, there are 50% women Assistant Commissioners and 19% Superintendents.

However, with the exception of a co-minister at the Ministry of Home Affairs, women ministers are found in what might be termed 'soft' ministries, such as those dealing with gender, social services, and small and medium enterprises. There is also a need for greater qualitative and quantitative representation in decision-making positions in the public and private sectors.

Figure 3.2 shows the low representation of women in the public sector, which in turn influences their participation in all development sectors. While some commendable attempts have been made to increase women's participation in some key positions in the civil service, statistically, women are still largely under-represented and far below the Goal 3 target. In the absence of any data, it can only be assumed that the private sector mirrors this trend.

MAJOR CHALLENGES TO ACHIEVING MDG 3

While it is likely that Zimbabwe reach gender parity in both secondary and primary education, big challenges remain in terms of completion rates, particularly for the girl child. The limited scholarships for girls and inadequate social safety nets further affect their equal participation in education and resulting in gender imbalances that are even more pronounced at university level.

Although there are at least 17 pieces of legislation in place that enhance the status of women (Annex D), the lack of specific legislative provisions on quotas is a barrier to the increased representation of women in elective positions. The Constitution and electoral laws of the country are silent on quotas to advance the representation of women in elective public positions. In addition, there are gaps between government and political parties' policies and practice.[3] Moreover, the constituency-based electoral system is viewed as highly competitive and does not easily allow for holding of seats in parliament by women. Politics is an expensive

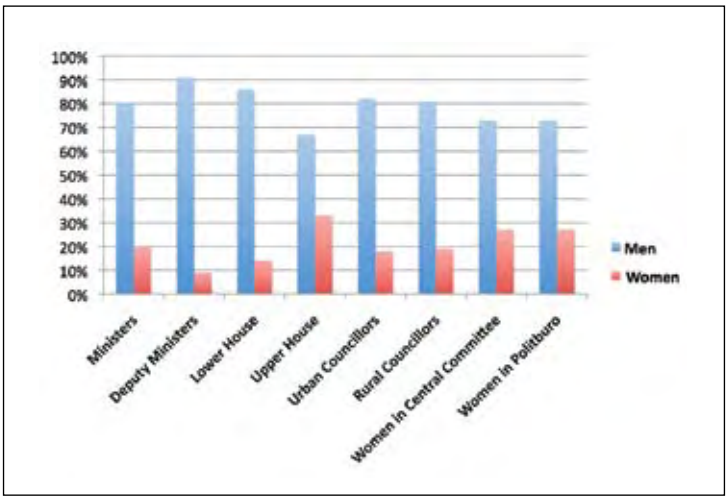


Figure 3.1 Political positions by gender

Source: Ministry of Women Affairs, Gender and Community Development (MoWAGCD), 2010

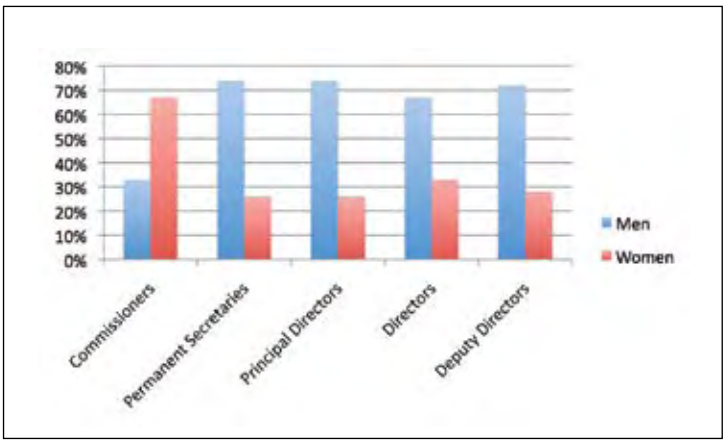


Figure 3.2 Public services sector composition by gender

Source: MoWAGCD, 2010

business and women in Zimbabwe seldom have access to resources to fund their election campaigns.

The low representation of women at secondary school and university level has also affected their holding decision-making positions in both the public and private sectors. The absence of clear affirmative action provisions in the Constitution is also a problem, as is the lack in adherence to those affirmative action policies that actually are in place. While there is some significant increase in the representation of women in public sector decision-making, this still falls below the 50% gender parity target.

Sex-disaggregated data is not readily available. Line ministries do not provide ZIMSTAT with administrative data and there is no clear mechanism to ensure the regular supply of such data from the private sector. Further, there are difficulties in using such data in the development of clear gender equality indicators, which has led to difficulties in tracking progress in order to inform policy reforms.

Zimbabwe has a good track record in ratifying key international and regional instruments, such as the Convention on the Elimination of All Forms of Discrimination Against Women and the SADC Protocol on Gender and Development, and there is partial domestication and implementation of these instruments. The 2008 SADC Gender and Development Protocol that advocates for, inter alia, 50:50 gender parity in decision-making positions at all levels of development, and which Zimbabwe's Parliament ratified in 2009, requires domestication through constitutional reforms. However, the National Gender Policy (NGP), and related policies and legislation all fall short on enforcement. For example, the NGP provides for redressing numerical gender imbalances in decision-making and politics

by increasing the numerical representation of women to 52%,[4] but, in practice, and as reflected in Figure 3.2, this provision is far from enforced.

The NGP strategy was developed in 2004 but requires updating in order to align it to international instruments such as the Millennium Declaration, the MDGs, and the SADC Gender and Development Protocol of 2008. Without a clearly defined gender monitoring mechanism, the Ministry of Women Affairs, Gender and Community Development (MoWAGCD) cannot effectively track progress on the implementation of the NGP or MDG 3. Nevertheless, it has been able to timeously submit gender reports, including the CEDAW Report 2009, despite ongoing financial and human resource constraints. Additionally, the Gender Management System, comprising the MoWAGCD, gender focal points in ministries, the Parliamentary Portfolio Committee on Gender, the Parliamentary Women's Caucus, the Inter-Ministerial Committee on Gender, and the Women's Movement, is characterised by weak coordination, resulting in a fragmented approach to promoting, accelerating and sustaining gender equality and the empowerment of women. A bill to address these challenges is on the current legislative agenda.

Zimbabwe's society is strongly patriarchal and is thus scaling-socialised and conditioned to the subordination of women to men and to their confinement to traditional and multiple gender roles that are inclusive of care work. If women are to have time to explore opportunities in politics and other sectors that are traditionally considered 'male', they must be relieved of some of the many roles they play in Zimbabwean society. Indeed, the current Constitution-making outreach process is showing signs that attitudes are changing. This has been evident in the public expression of both men and women demanding 50:50 representation in decision-making, education, and employment opportunities.

REQUIREMENTS FOR ACHIEVING MDG 3

Zimbabwe is partially on track as regards achieving the first target under MDG 3, but it may only achieve gender parity in primary and secondary

school education. The country is not on track for achieving the second target on the participation of women in decision-making positions. Unless radical constitutional and policy reforms are developed and implemented, Zimbabwe may not meet this target. Some of the requirements that could contribute to the achievement of Goal 3 are:

- Scaling-up support to secondary and tertiary education, with targeted interventions for the girl child through scholarships and other social safety nets
- Incorporating provisions for gender equality and empowerment of women in the Constitution, focusing on quotas for women in elective positions or appointed bodies
- Electoral reform, for example, introducing a combination of quotas, proportional representation, and first-past-the-post systems to pave way for increased representation of women in parliament, local government bodies, and other decision-making positions
- Finding innovative ways to increase resources for women to campaign in elections
- Supporting initiatives under government's national healing and reconciliation programme to build social cohesion to reduce polarisation and thereby create an enabling environment for women to freely participate in politics
- Reviewing and updating the National Gender Policy through an inclusive process and establishing a Gender Observatory to monitor its implementation
- Scaling-up initiatives on confidence- and capacity-building of women members of parliament and councillors to retain their seats and inspire other women to participate in the forthcoming elections.

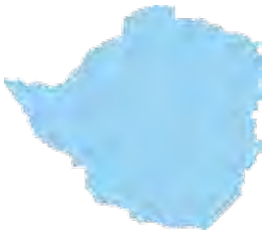
Notes

1 Zimbabwe Women's Resource Centre Network, 2009 Gender Analysis of the Education Sector.
2 Zimbabwe, Human Development Report, 2009, p. 19.
3 Women in Politics Support Unit, *Are Political Parties Serious About Gender Equality and Women's Rights: A Gender Audit of Political Parties*, 2009, p. 28.
4 Government of Zimbabwe, National Gender Policy, 2004.

4

Reduce Child Mortality

REDUCE CHILD MORTALITY



4

TARGET	INDICATORS	TRENDS
Target 4A Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	*4.1 Under-five mortality rate (The probability of dying between birth and the fifth birthday per 1,000 live births)* *4.2 Infant mortality rate (The probability of dying between birth and the first birth day per 1,000 live births)* *4.3 Proportion of one-year-olds vaccinated against measles*	*1-2 The under-five mortality rate rose from 77 per 1,000 live births in 1994 to 102 per 1,000 live births in 1999. It thereafter decreased to 82 per 1,000 live births in 2005, but rose to 86 per 1,000 live births in 2009 according to MIMS (2009)* *3 Not available*

STATUS AND TRENDS

The child mortality rate is a sensitive indicator of the level of a country's socioeconomic development. In Zimbabwe, infant and under-five mortality rates decreased substantially after Independence in 1980, but began to increase in 1996, possibly in response to the start of economic challenges and the introduction of cost-recovery policies The under-five mortality rate rose from 77 per 1,000 live births in 1994 to 102 per 1,000 live births in 1999, but thereafter decreased to 82 per 1,000 live births in 2005. The infant mortality rate (IMR) followed the same trend. Neonatal mortality decreased from 29 per 1,000 live births in 1999 to 24 live births per 1000 in 2006. According to the Zimbabwe Demographic and Health Survey Report of 2006, peri-natal mortality was 25 per 1,000 live births. The Multiple Indicator Monitoring Survey (MIMS) of 2009 reported a small increase in the under-five mortality rate of 86 per 1,000 live births compared to 82 in 2005 while the 2009 estimates by the Inter-agency Group for Child Mortality Estimation (IGME) (which includes technical experts from WHO, UNICEF, the United Nations Population Division, the World Bank, and independent experts), using a method adjusting for HIV- and AIDS-related mortality for each data observation, showed an under-five mortality of 96 per 1,000 live births. This rise is mainly attributed to the direct and indirect impacts of the HIV and AIDS epidemic and the concomitant rise in poverty levels due to economic challenges.

Although the trend has been an increase in mortality since the mid-1990s, the fact that Zimbabwe was, at one stage, able to lower these rates points towards the possibility of achieving the MDG of reducing the child mortality rates by two-thirds by 2015 (Figure 4.1). However, this will require concerted effort by all, including the state, health professionals, the private sector, parents, and the international community in implementing evidence-

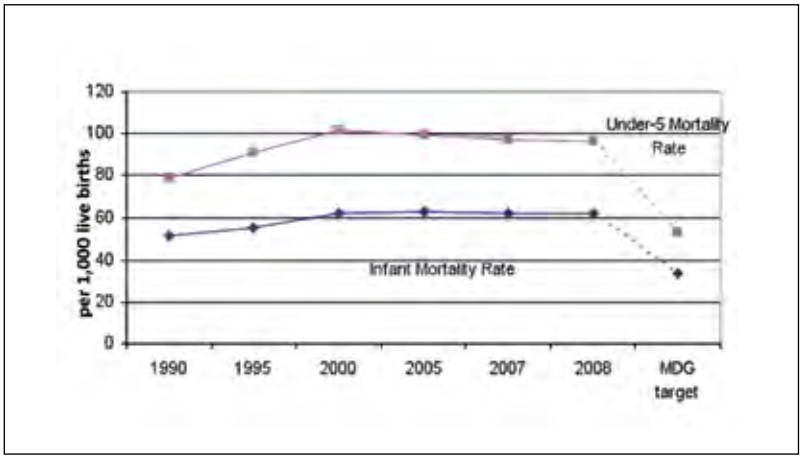


Figure 4.1 Infant and under-five mortality rates per 1,000 live births and the MDG target, 1990–2015

Source: IGME 2009

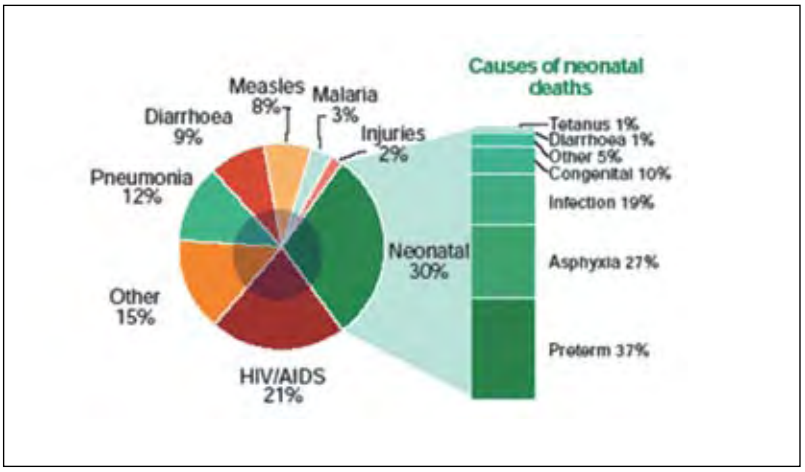


Figure 4.2 Causes of death in the under-five age group in Zimbabwe

Source: 'Countdown to 2015 Decade Report (2000–2010): Taking Stock of Maternal, Newborn and Child Survival', WHO and UNICEF, 2010

based, high-impact, child survival interventions. It is clear that without the full commitment of all, it will be virtually impossible to follow such an ambitious trajectory over the course of the next five years.

HIV- AND AIDS-RELATED CONDITIONS

HIV and AIDS is one of the leading causes of under-five mortality in Zimbabwe, accounting for 21% of the deaths (Figure 4.2). Over 95% of the paediatric cases of HIV in children less than five years of age are vertically transmitted from mother to child during pregnancy, childbirth and/or breastfeeding. At the end of 2009, of the 387,649 who needed ART, 53% (215,123) of all HIV-positive patients (public and private) were receiving it. Of these, about 21,000 (9.5%) were children below 15 years of age, with only about 700 of them younger than 18 months, thus implying that most of the children on treatment are long-term 'survivors', since it is known that over 50% of infants infected with HIV die before two years of age unless they receive medical treatment. Thus, preventing mother-to-child transmission and screening infants for HIV after delivery and throughout breastfeeding are critical to reducing the numbers of children dying from HIV-related conditions.

VACCINATION/IMMUNISATION

Generally speaking, a child is said to be fully immunised if he/she has had a BCG vaccine; three inoculations against diphtheria, pertussis (whooping cough) and tetanus (DPT); three doses against polio; three doses against haemophilus influenzae type b and Hepatitis-B, as per immunisation schedule; and one inoculation against measles at the age of nine months.

Figure 4.3 shows the performance of the routine immunisation programme between 2000 and 2009.

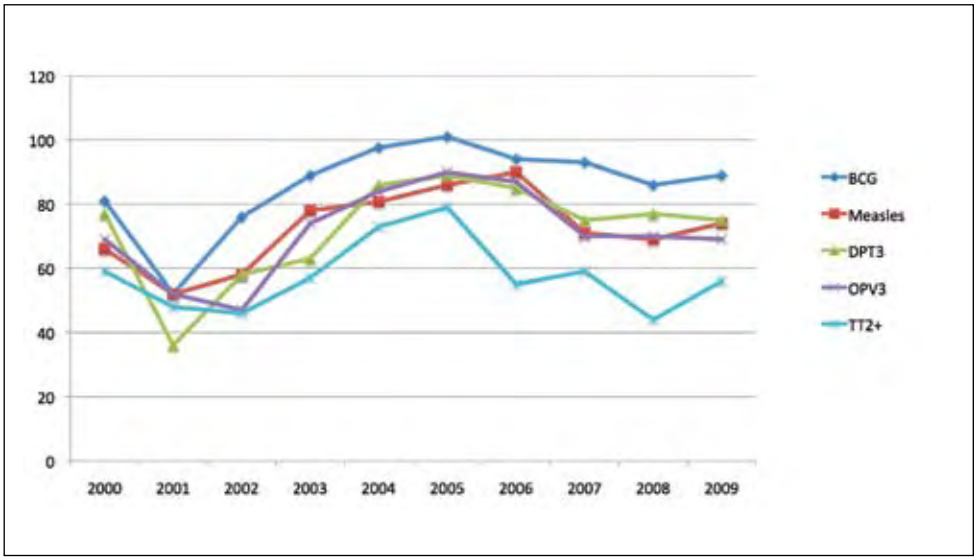


Figure 4.3 Trends in the percentage of EPI coverage during the last decade by antigen, 2000–2009

Source: Ministry of Health and Child Welfare

If Zimbabwe is to meet regional and global targets, coverage by *all* antigens needs to increase to 95%.

MAJOR CHALLENGES TO ACHIEVING GOAL 4

Challenges in the health system and disease outbreaks

Zimbabwe's unprecedented economic decline saw spiralling inflation, deteriorating physical structures and, in 2008, the inability of the public sector to deliver basic social services. The country has been facing severe human resources capacity constraints in the public sector, the health sector in particular. Filling vacant posts and responding to the needs of the doctors, nurses that have remained in work has been difficult. This grave situation reached breaking point in 2008 when the health workers took prolonged industrial action, which resulted in very few services being offered in health facilities and in communities. Drugs and medical supplies were largely unavailable. The retention scheme introduced in 2009 partially resolved the human resources issue, but only for the lower level staff; there is still a shortage of highly technical staff. The consequences of these challenges were further reflected in a major outbreak of cholera in 2008–2009, which saw 98,591 documented cases and 4288 deaths, and an outbreak of measles in 2009–2010.

Socio-cultural issues

Those who refuse medical treatment or advice, whether on religious or traditional grounds, are an important factor in relation to the shaping of the population's health-seeking behaviours. For example, both tradition and indigenous religions have a strong bearing on the child mortality rate in Zimbabwe. Some religious groups do not allow their children to be immunised or their sick to be treated using modern drugs.

Environmental factors

The provision of a safe water supply and good sanitation are major contributory factors to positive childcare. At present, Zimbabwe is unable to provide clean water for all rural and urban areas. Of the total population, 33% still rely on the bush toilet for sanitation, and it is widely understood that diarrhoeal diseases can be exacerbated in environments where sanitation is poor.

Health services user fees

It is also evident that the rise in child mortality is directly linked to the introduction of user fees to access health services. Although the government does have an existing user fee policy which should provide free of charge health services for pregnant and lactating mothers, children under five and the elderly (60 or more years of age), it has proved

extremely difficult to implement. At present, user fees provide the main income for a very large number of facilities to provide at least the minimum service in the absence of substantial government support.

State budget for health

During the decade 2000–2010, state investment in health varied from 4.2% of the state budget in 2001 to 15.3% in 2009. An important commitment would be to keep to the Abuja Recommendation of 15% of the state budget for health. However, this proportion of the national budget falls significantly short of the per capita health cost allowance, which, according to the Ouagadougou Declaration, should be US$34-US$40. Currently, Zimbabwe's annual budgetary allowance only stretches to US$9 per capita.

REQUIREMENTS FOR ACHIEVING GOAL 4

Trends in infant, neonatal, and under-five mortality rates for the last twenty years have not been very encouraging. Nevertheless, Zimbabwe can still build on the heavy investments of the early 1980s in health and education. Though Zimbabwe still has a population that places high demands on its health services, it is clear that it can, as a very minimum, achieve the lower level of child mortality of the 1980s (59 per 1,000 for under-five mortality and 40 per 1,000 for infant mortality). There is also potential to achieve MDG 4 of 27 per 1,000 Live birth for under-fives and 22 per 1,000 for infant mortality, respectively, given the available health infrastructure and training facilities.

In order to make further progress for meeting MDG 4, there is a need to:

- Focus on the most vulnerable age groups and young infants
- Focus on filling health services gaps within the continuum of care
- Implement interventions that address major newborn-related problems, namely, prematurity, birth asphyxia, and infections
- Address the major causes of mortality in the under-fives using the continuum of

care principle that follows the life cycle approach, linking the facility with the community health services delivery system

- Strengthen the primary care approach including institutionalisation of the community health service delivery system
- Follow a comprehensive approach to address both maternal and neonatal problems in an integrated fashion, with particular focus given to providing standard postnatal care
- Address the issue of user fees
- Enable a task-sharing policy to scale up child survival intervention.

With adequate resources supporting the recently developed health sector investment case and the national child survival strategy for the country, Zimbabwe should be able to make considerable progress towards achieving MDG 4 by 2015.

5

Improve Maternal Health

IMPROVE MATERNAL HEALTH

5

TARGET	INDICATORS	TRENDS
Target 5A Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	1 *Maternal mortality ratio (MMR)* 2 *Proportion of births attended by skilled health personnel*	1 *283 per 100,000 live births in 1994; 725 per 100,000 live births in 2007* 2 *69% of all births attended by health personnel*
Target 5B Achieve, by 2015, universal access to reproductive health	1 *Contraceptive prevalence rate* 2 *Adolescent birth rate* 3 *Antenatal care (ANC) coverage of at least one visit and at least four visits* 4 *Unmet need for family planning*	1 *60% in 2006, 64% in 2009* 2 *99 births per 1,000 females aged between 15 and 19* 3 *94% in 2009 for at least one visit and 71% in 2009 for at least four visits* 4 *13% in 2006*

STATUS AND TRENDS

The maternal mortality ratio (MMR) has worsened significantly over the past 20 years. In 1994 the MMR was 283 per 100,000 live births, rising to 695 in 1999, before declining to 555 in 2005–2006. In 2007 the MMR was estimated at 725 per 100,000 live births.[1] This is much higher than the MDG target for MMR for Zimbabwe which is 174 per 100,000 live births.

The proportion of births attended by skilled health personnel has fallen over the past 20 years. In 2009, the proportion stood at only 69%.[2] The target is universal access to skilled attendance at delivery by 2015.

Given the positive gains in family planning programmes over the last two decades, events and risks during pregnancy and delivery have taken a more significant role as key determinants of maternal health outcomes. The high levels of at least one antenatal care (ANC) visit (94%) are followed by fewer women completing at least four ANC visits (71%). Even fewer women return to deliver in the institutions where skilled attendance at birth can be accessed. The 2009 Multiple Indicator Monitoring Survey (MIMS) estimated that 39% of women who gave birth in the two years prior to the survey delivered without the assistance of a skilled birth attendant (Figure 5.1).

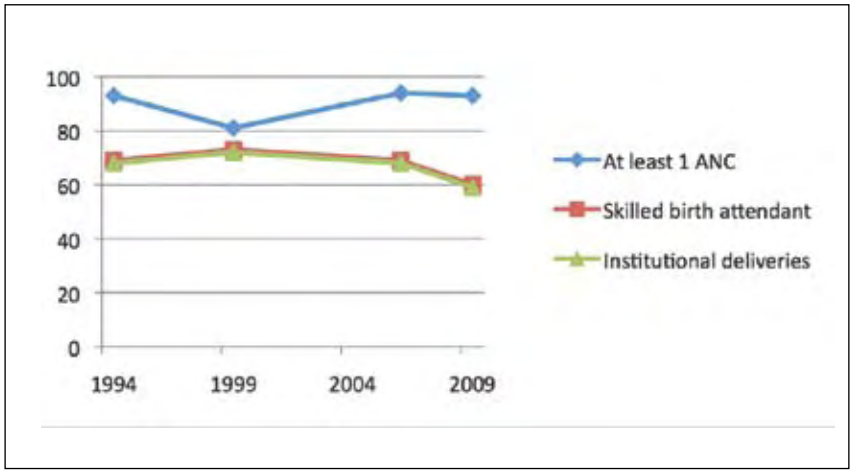


Figure 5.1 Trends in utilisation of maternal health services, 1994-2009

Source: ZDHS 1994, 1999, 2006; MIMS 2009

Significant progress has been recorded in addressing the targets for universal access to reproductive health. Demand for modern methods of contraception has increased, rising from 63% in 1994 to 71% in 2006. The contraceptive prevalence rate also increased further, rising from 48% in 1994 to 60% in 2006, and increasing to 65% in 2009. The method mix is mainly pill-dominated and public health facilities remain the most common source of the contraceptive products. However, the contribution of the community-based distribution network as a source of contraceptive commodities, a key driver of the family planning programme over the past two decades, has declined to below 5% in the past few years. The unmet need for family planning has, however, remained at 13%. Consistent with these improvements, the fertility rate has gradually declined from 4.3 to 3.6 children per woman, as has the adolescent fertility rate, dropping from 102 births per 1,000 women aged between 15 and 19 to 99 births for the same age group over the same period. Disparities in the contraception prevalence rate on the basis of place of residence, social status, and age group continue to manifest in most of these key indicators.

MAJOR CHALLENGES TO ACHIEVING MDG 5

Progress across the targets for MDG 5 has not been uniform. The status and trends information and programme-specific data all point to areas where further support is required. Major challenges and constraints still exist and these are discussed below in the context of accelerating progress towards meeting MDG 5.

The Maternal Mortality Ratio[3]

The leading causes of maternal mortality are AIDS-defining illnesses (25.5%); post-partum haemorrhaging (14.4%); hypertension/eclampsia (13.1%); puerperal sepsis (7.8%), complications arising from abortion (5.8%); and malaria (5.8%). Institutional delivery, skilled attendants at birth, and the type of religious affiliation are factors that significantly affect the risk of maternal deaths. From these causes, the policy and service delivery constraints are thus noted as:

- The deteriorating capacity of and responsiveness of the healthcare system. For example, 80% of midwifery posts in the public sector are vacant
- The implementation of maternal health interventions that do not address the HIV and AIDS risk and burden on women and families. Despite the fact that HIV is the leading cause of maternal mortality, only 5.4% of pregnant women knew their HIV status before pregnancy, and just 34% of pregnant women were tested for HIV during pregnancy
- Health services are organised in a manner that does not adequately address the religious concerns and beliefs of certain faith groups

- A health system financing mechanism that is not pro-poor. User fees remain a significant barrier to access to reproductive health
- Task-shifting or task-sharing related to scaled-up HIV and maternal health services.

5

Universal Access to Reproductive Health

The unmet need for family planning has remained static for the past 20 years. Major challenges remain, namely:

- The need to strengthen the relatively poor method mix. Currently, the programme is dominated by the oral contraceptive pill, thus limiting the choice for women
- The declining contribution of the community-based distribution network as a source of contraceptive products and information. Public health facilities have become the dominant source of contraceptive commodities, making them less accessible to women.

REQUIREMENTS FOR ACHIEVING MDG 5

It is unlikely that Zimbabwe will meet the MMR target by 2015 as the capacity of the healthcare system has deteriorated significantly and the MMR has increased. If there is to be real progress in this regard, more efforts and investment are required to strengthen the healthcare system and scale-up coverage of maternity waiting homes, including adopting and implementing pro-poor, predictable and enhanced health-financing policies and mechanisms. At community level, coverage by village health workers and addressing those religious and cultural practices that limit institutional deliveries need to be addressed in a way that balances the right to life and the respect for religious and cultural beliefs of individuals. Revamping the village health worker programme would provide a tried and tested way of scaling-up selected interventions.

The target set for universal access to contraception is likely to be achieved by 2015. However, commendable gains in family planning need to be

safeguarded and 'quick win' interventions instituted to both address the unmet need and to increase demand. Investing in improving the contraception method mix, strengthening the availability of information and commodities at community level, and sustaining the current support to commodities supply chain management would likely further improve the contraceptive prevalence rate. These interventions have to be seen within the broader context of strengthening comprehensive reproductive health services, covering the pre-pregnancy, antenatal, delivery, and postnatal periods.

Notes

1 ZMPMS, 2007.
2 MIMS, 2009.
3 MoHCW (2007), *Zimbabwe Maternal and Perinatal Mortality Study*, Harare, pp. 16, 18.

Combat HIV and AIDS, Malaria, and Other Diseases

COMBAT HIV AND AIDS, MALARIA, AND OTHER DISEASES

6

TARGET	INDICATORS	TREND
Target 6a Halt and begin to reverse the spread of HIV and AIDS	1 *HIV prevalence among males and females aged 15-24* 2 *Condom use at last high-risk sex* 3 *Proportion of population aged 15-24 with comprehensive knowledge of HIV and AIDS*	1 *The prevalence rate is declining. It fell from 23.7% in 2001 to 18.1% in 2005–06 for those aged between 15 and 49* 2 *Condom use by men aged 15-24 is 68%. For women of the same age group it is 42.4%* 3 *Not available*
Target 6b Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it	1 *Proportion of population with advanced HIV infection with access to anti-retroviral drugs*	1 *At the end of 2009, 53% of all HIV-positive patients (public and private) were on anti-retroviral therapy (ART)*
Target 6c Halt and begin to reverse the incidence of malaria and other major diseases	1 *Incidence and death rates associated with malaria* 2 *Proportion of children under 5 sleeping under insecticide-treated nets* 3 *Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs* 4 *Incidence, prevalence, and death rates associated with TB* 5 *Proportion of tuberculosis cases detected and cured under directly observed short course treatment*	1 *Zimbabwe has already met the Abuja target of an incidence rate of 68 per 1,000 people* 2 *27% of all at-risk households have at least one insectide-treated net (MIMS 2009)* 3 *Not available* 4 *TB incidence rates have significantly increased, rising from 97 per 100,000 people in 2000 to 782 per 100,000 in 2007* 5 *78% of all TB cases were treated successfully in 2007, but detection rates remain below 40%*

STATUS AND TRENDS

Zimbabwe has continued to register a gradual decline in HIV prevalence, as demonstrated by the trend in prevalence rates over the past decade. In 2001, the estimated HIV prevalence in adults aged 15 to 49 years was 23.7%, but it dropped to 18.1% in 2005/2006.[1] This was the first decline in prevalence noted in the country's generalized HIV epidemic. The national HIV estimates of 2009 revealed a further decline in the adult prevalence rate – it now stands at 14.3% (Figure 6.1).

The decline in HIV prevalence has been attributed to behaviour change, including delayed sexual debut, decrease in the number of sexual partners, and increased condom use. The country also experienced an increase in mortality due to AIDS before the

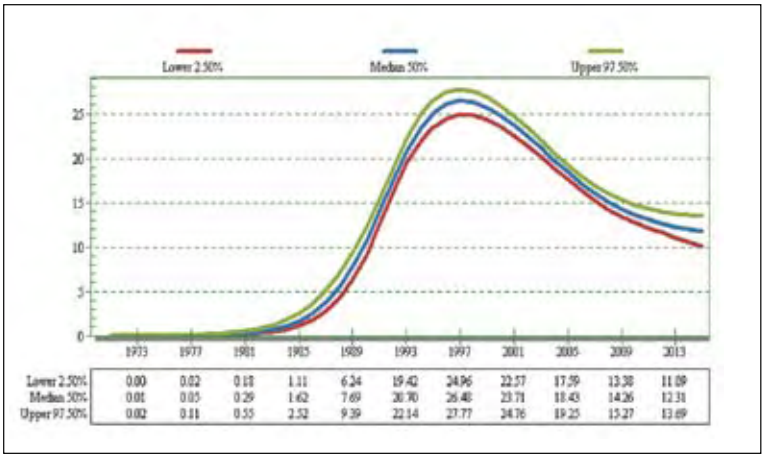


Figure 6.1 Trends in estimated adult HIV/AIDS prevalence (age 15–49), 1970–2013

Source: Zimbabwe National HIV/AIDS Estimates, 2009

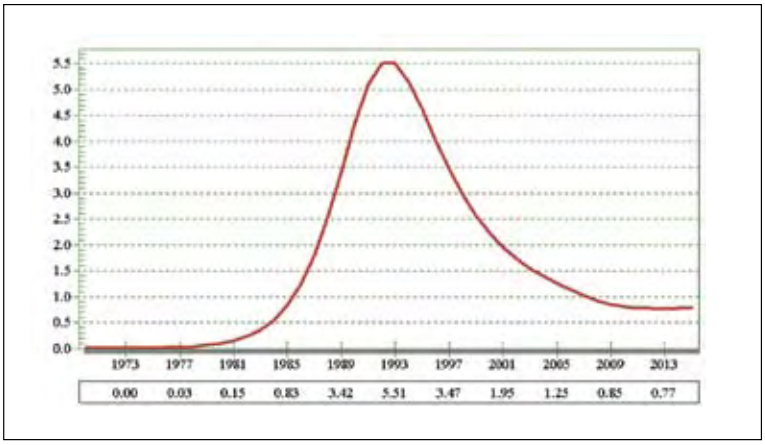


Figure 6.2 Trends in HIV incidence, 1970–2015

Source: Zimbabwe National HIV/AIDS Estimates, 2009

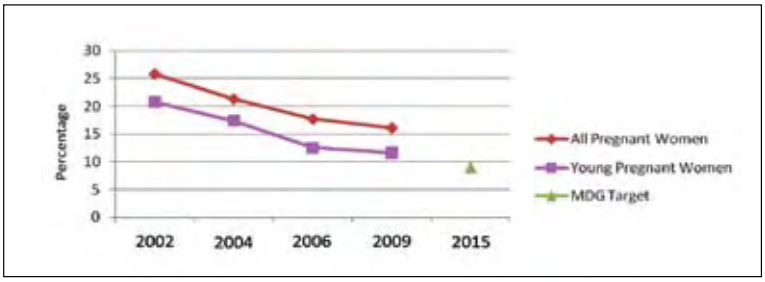


Figure 6.3 Trends in the estimated HIV/AIDS prevalence for all pregnant women (15–49) and young pregnant women (15–24), 2002–2009

Source: National Survey of HIV and syphilis prevalence among women attending antenatal clinics in Zimbabwe, 2009

introduction of the anti-retroviral therapy (ART) programme.[2] The achievements of the prevention of mother to child transmission (PMTCT) programme have also contributed immensely to the decline in HIV prevalence. The incidence of HIV peaked in 1993, at 5.51% for the adult population. In 2008 it was estimated to be 0.91% and this has further declined to 0.85% in 2009.

It is expected that the incidence will level out or continue to decline as Zimbabwe continues to scale up prevention efforts in the HIV-negative population, thus leading to reductions in new infections. Scaling up treatment will also result in reduced infection, which may translate into lower transmission rates and thus reduced incidence in the population. A combination of both prevention efforts and scaling up treatment is likely to have a greater impact than either singular effort.

HIV AND AIDS PREVALENCE IN PREGNANT WOMEN

Similar declines are evident in the HIV prevalence rate for pregnant women. This rate fell from 25.78% in 2002 to 21.3% in 2004, to 17.7% in 2006, and finally to 16.1% in 2009.[3] The decline in the incidence of HIV in pregnant young women (15-24 years of

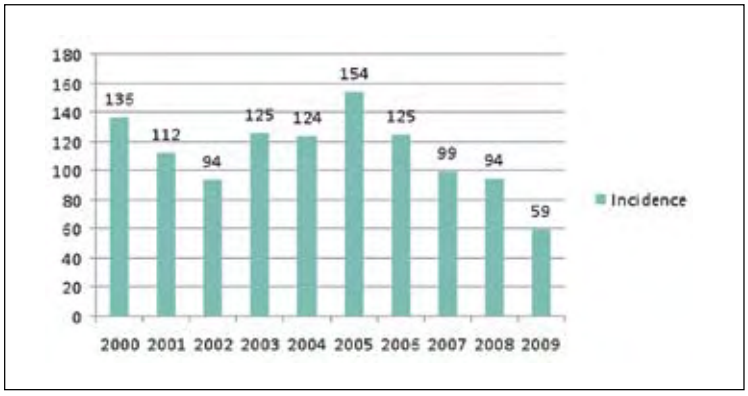


Figure 6.4 Malaria incidence rates per 1000 people

Source: MoHCW, unpublished figures

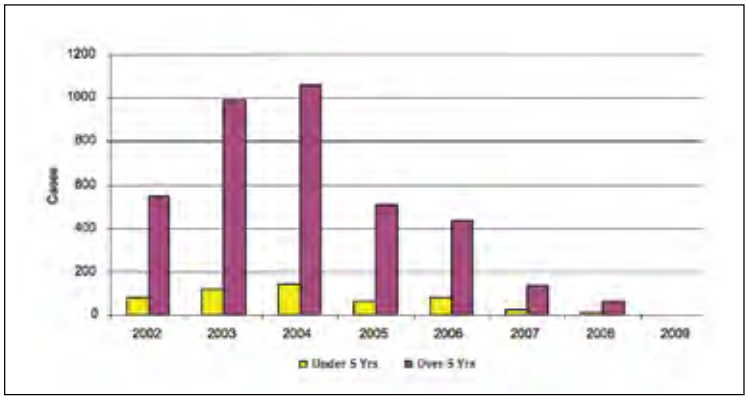


Figure 6.5 Annual number of deaths due to malaria by age group

Source: RDNS

age) typically reflects a similar decline in HIV and AIDS incidence in general (Figure 6.3). In 2002, the prevalence for this age group was estimated to be 20.8%, but declined thereafter, falling to 17.4% in 2004, 12.5% in 2006, and 11.6% in 2009.[4] These trends show that great achievements have been made in this area and indicate that Zimbabwe is likely to attain the MDG target of 9% for HIV prevalence in pregnant women aged between 15 and 24 .

According to the Zimbabwe Demographic and Health Survey (ZDHS) 2005–06, condom use by those aged between 15 and 24 was 43.7% for women and 45.6% for men. The proportion of young people who reported use of a condom during their last high-risk sexual encounter was 42.4% for women, compared to 68% for men.

MALARIA

Malaria was the third leading cause of hospital admissions in Zimbabwe in 2009. Controlling malaria is one of the government's main priorities. In 2000, the Government of Zimbabwe signed the Abuja Declaration, agreeing to try to meet the target of reducing malaria cases by 50% between 2000 and 2010, and by 75% by 2015.[5]

The incidence of malaria has been in decline since 2005. According to the Abuja targets, Zimbabwe was aiming for an incidence rate of 68 per 1,000 by 2010, a rate the country has already achieved. The current rate stands at 59 per 1,000 (Figure 6.4). Indications are that the rate declines as the government's prevention programme scales up interventions. It is not yet possible to quantify the contribution of each factor to the reduction of the disease. The case fatality rate, particularly for the group aged five years and above, has been also been gradually declining since 2004 (Figure 6.5).

The national malaria control programme has been strengthened through financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund has also supported scaling up of case management training, the procurement of anti-malarial drugs, and indoor residual household spray commodities.

Zimbabwe has made efforts to control malaria through vector control, ensuring that at-risk

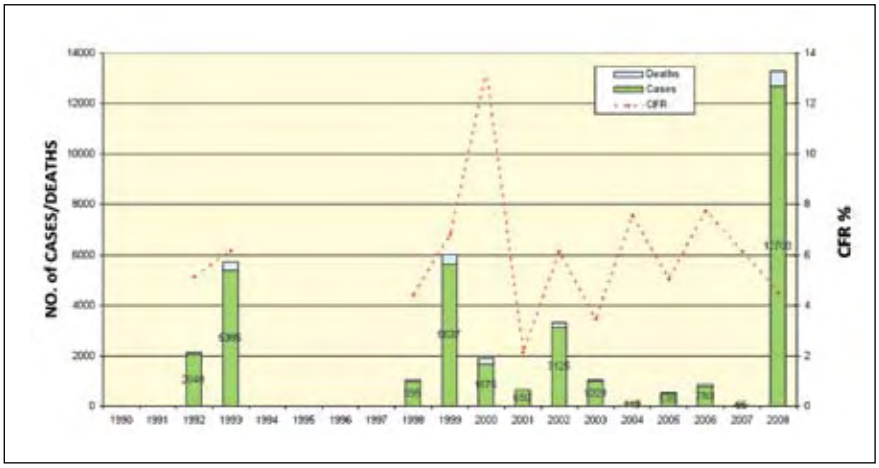


Figure 6.6 Zimbabwe and WHO-notified cholera causes and deaths
Source: WHO

households receive sprays and free or subsidised mosquito nets (MIMS, 2009). According to the Ministry of Health and Child Welfare (MoHCW), in 2009, Zimbabwe achieved coverage of 74%, which is not far from the WHO target of 85% (WHO, 2009). However, the 2009 Multiple Indicator Monitoring Survey (MIMS) reported that only 27% of all at-risk households had at least one insecticide-treated net. Through Global Fund resources, 1.2 million nets have been procured and will be distributed when they arrive. This will see a great leap in the coverage.

The country still faces challenges in the community-based treatment of malaria; these are now being addressed by the national malaria control programme, with the southern part of the country earmarked for malaria pre-elimination. This will entail the provision of additional resources, including human resources, to ensure active case follow-up.

TUBERCULOSIS (TB)

Zimbabwe currently ranks 17th out of the world's 22 high-burden TB countries. Its TB incidence rates significantly increased during the last decade, rising from 97 per 100,000 people in 2000 to 411 per 100,000 people in 2004 and to 782 per 100,000 in 2007.[6] This increase is attributed to the high incidence of HIV and AIDS and it is estimated that 72% of all TB patients are co-infected with HIV.

In addition to the targets set for MDG 6, Zimbabwe has made considerable efforts to adhere to international and regional TB-related strategies such as the 'Global Plan to Stop TB 2006–2015'. Zimbabwe adopted the 'Stop TB Strategy' in 2006, as recommended by the WHO. The country has also developed a five-year strategic plan for national TB control. In relation to the global indicator for the rate of successful TB treatment, Zimbabwe attained a record high of 78% in 2007. However, this is still low in comparison to the global benchmark target of 85% recommended by WHO. Likewise, TB case detection rates have not improved; they continue to hover below 40%, far below the target of 70%.[7]

The MoHCW has made recent moves to improve the diagnosis of TB by revamping the functionality of its 115 diagnostic centres and ensuring that non-functioning sites become operative. The health delivery system has suffered greatly as a result of the economic decline, experiencing a skills flight amongst health professionals as well as the deterioration of diagnostic equipment.[8] The training of microscopists is a current priority. Due to high TB/HIV co-infection, there have been efforts to scale up collaborative TB/HIV activities at all levels of the health delivery system. Joint collaboration between the TB and ART programmes has seen 69% of TB patients accessing HIV testing services and cotrimoxazole preventive therapy. However, due to lack of funding and the weakening of the health system, only a minority of TB patients are accessing ART.[9]

CHOLERA

Zimbabwe has experienced several cholera outbreaks since the early 1970s, but these have typically

occurred in 5- to 10-year cycles. However, since 1998, cholera has been a yearly occurrence. While previous outbreaks were relatively quickly contained by emergency approaches supported by a sound health delivery system, the most recent outbreak (August 2008 to June 2009) saw a total of 98,592 reported cases and 4,288 deaths (WHO 2009) and was the severest on record (Figure 6.6).

The majority of the cases (68.6%) were reported from the provinces of Mashonaland West, Harare, Manicaland, and Masvingo. Poor water and sanitation provisions, particularly in urban areas of Harare and those including Kadoma, Chinhoyi, Chegutu, Beit Bridge, and Norton, gave the outbreak a distinct urban preponderance at its outset. From January 2009 it assumed a more rural outlook, with 2,631 deaths (61.4%) occurring at community level. Access to health services was a major challenge and one of the major reasons for the prolonged nature of the outbreak.

The National Cholera Command and Control Centre provided technical guidance to its health, water, sanitation and hygiene (WASH) partners in their response activities, coordinated information and communication among the partners, and distributed cholera-related commodities to all affected provinces and districts. At the beginning of the outbreak the national health information system faced challenges in ensuring communication of data on cases and deaths (OCHA, 2009). However, this improved significantly after January 2009, when toll-free lines were set up at all provincial offices and at some district offices.

TYPHOID

In addition to cholera, the recent outbreak of typhoid in Zimbabwe is also a cause for concern as it indicates the continued challenges to the provision of clean water and good sanitation, especially in high-density urban areas. Between February and the end of May 2010, 448 cases and 8 deaths from typhoid were reported, mainly from Mabvuku and Tafara, two of Harare's high-density suburbs.

MAJOR CHALLENGES TO ACHIEVING MDG 6

The major challenge is the unstable human resource base, arising from high staff attrition. There is also a shortage of essential medicines and equipment for high-quality care. Further, user fees levied by public facilities that do have the drugs and equipment deter many clients from accessing them.

Cholera and other diarrhoeal disease outbreaks will continue to occur until the water and sanitation situation improves. Both urban and rural areas are now at risk. The breakdown and poor maintenance of water and sanitation infrastructure needs large capital investment to rectify, which a major challenge towards halting and reversing the incidence of diarrhoeal diseases by 2015.

Conclusion

Zimbabwe appears to be on course to achieving the MDG target of reducing the prevalence of HIV to 9% by 2015. This is due to the efforts being made to increase coverage of HIV counselling and testing services, to improvements in the quality of PMTCT services, and to mobilising communities to support and use these services. The scaling up of early infant diagnosis, early infant treatment, and collaborative TB/HIV interventions has also had a profound impact, as have improvements in quality of care and treatment services, the establishment of policies that support scale-up and decentralisation of services such as task-shifting, and the strengthening of local production of HIV- and AIDS-related medication.

Notes

1 ZDHS, 2005–2006; United Nations General Assembly Special Session (UNGASS), 2008-2009.
2 UNAIDS report, 2005.
3 UNGASS, ibid.
4 Ibid, p. 10.
5 WHO, Malaria Report, 2009.
6 WHO, Global Tuberculosis Control: Surveillance, Planning, Financing, 2009 (WHO/HTM/TB/2009.411).
7 Speech by the Hon. Minister of Health and Child Welfare, Dr H. Madzorera, on World TB Day, 24 March 2010.
8 UNGASS, ibid.
9 Speech by the Hon. Minister of Health and Child Welfare delivered at the first anniversary of Zimbabwe's inclusive government, May 2010.

7

Ensure Environmental Sustainability

ENSURE ENVIRONMENTAL SUSTAINABILITY

7

TARGET	INDICATORS	TRENDS
Target 7A Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	1 *Proportion of land covered by forest* 2 *CO_2 emissions – total per capita and per $GDP (PPP)* 3 *Consumption of ozone-depleting substances (ODS)*	1 *Increased deforestation estimated loss of 100,000-320,000 ha per year of forest cover; uncontrolled veld fires* 2 *Country is a net carbon sink* 3 *An ODS total phase-out in tobacco nurseries, horticulture, and grain fumigation was achieved in 2010, five years ahead of the 2015 deadline*
Target 7B Reduce biodiversity loss, achieving by 2010 a significant reduction in the rate of loss	1 *Proportion of fish stocks within safe biological limits* 2 *Proportion of total water resources used* 3 *Proportion of terrestrial and marine areas protected* 4 *Proportion of species threatened with extinction*	1 *Not available* 2 *Not available* 3 *Occupation of designated forestry and wildlife areas and increased levels of poaching* 4 *Not available*
Target 7C Halve, by 2015, the proportion of people without access to safe drinking water and basic sanitation	1 *Proportion of the population using an improved drinking water source* 2 *Proportion of the population using an improved sanitation facility*	*65% of all water points in rural areas non-functional; the percentage access to safe water in rural areas decreased from 70% in 1999 to 61% in 2009; persistent water shortages in urban areas* *The percentage access to improved sanitation rural areas decreased from 60% in 1999 to 30.5% in 2006* *In 2008 an unprecedented cholera outbreak affected all ten provinces and both urban and rural areas; evidence of effluent and raw sewer outflows in fresh water sources (rivers and dams); urban water shortages, impacting on both health and hygiene* *Five years is needed to raise safe water coverage from the present 61% to 85% and sanitation from 30.5% to 71%*
Target 7D By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers	1 *Proportion of the urban population living in slums*	*Estimated shortage of one million urban housing units. This figure likely to increase due to increased urbanisation rate estimated at 5-6%. There has been a significant decrease in public and private funding for low-cost housing since 1999*

STATUS AND TRENDS

As the economic crisis deepened between 2000 and 2008 a significant proportion of the population was forced to rely more heavily on natural resources for their livelihood. These resources included firewood, bush meat, traditional medicines, and wild fruits and vegetables, and caused biodiversity loss. The government has made efforts to ensure environmental protection in resettled areas through the Integrated Conservation Plan for the land reform programme.

The sporadic power cuts that began in 2007, coupled with inaccessibility of paraffin (the main energy source for low-income urban-dwellers), led to significant deforestation, particularly in peri-urban areas. Estimates suggest that between 100,000 and 320,000 hectares of forest cover per annum were lost during this time.

Prior to the economic crisis, Zimbabwe had sound systems in place for the management of protected areas. However, the capacity of state institutions to enforce environmental laws was severely weakened during the crisis period, resulting in the illegal occupation of protected forest and wildlife areas as well as other negative environmental practices such as illegal alluvial gold mining, diamond mining, accidental and deliberately set bush fires, all of which destroyed both plant and animal biodiversity. It also saw the loss of human life.

The country has done well in phasing out ozone depleting substances (ODS). It reached the target five years ahead of the 2015 deadline set under the Montreal Protocol. For example, by 2010, a total phase-out of methyl bromide in the tobacco, grain fumigation and horticulture industries was achieved. Studies on greenhouse gas (GHG) inventories, as reported in Zimbabwe's first national communication produced in 1997, indicated that the country was a net carbon sink. Taking into account the near decade-long reduction in industrial activity due to the economic crisis, CO_2 emissions could have been significantly further reduced. However, increased savannah burning and land use changes emerged as new sources of GHG emissions. Zimbabwe is

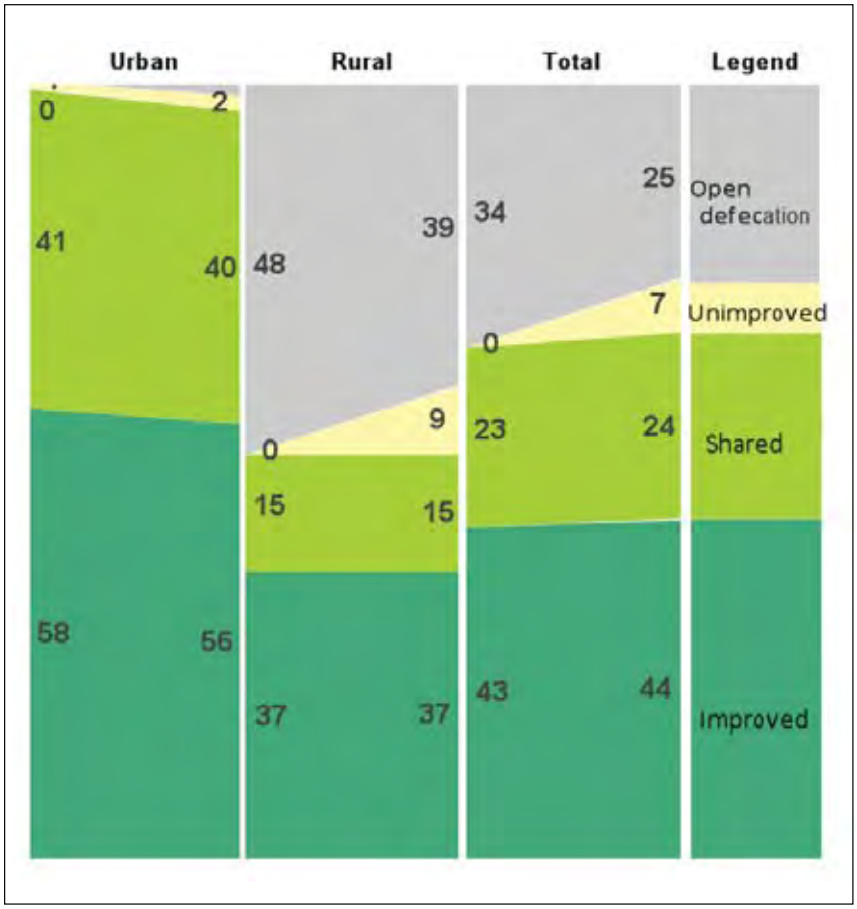


Figure 7.1 Sanitation Trends in Zimbabwe, 1990–2008

Source: WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation (2010), Progress on Sanitation and Drinking Water: 2010 Update

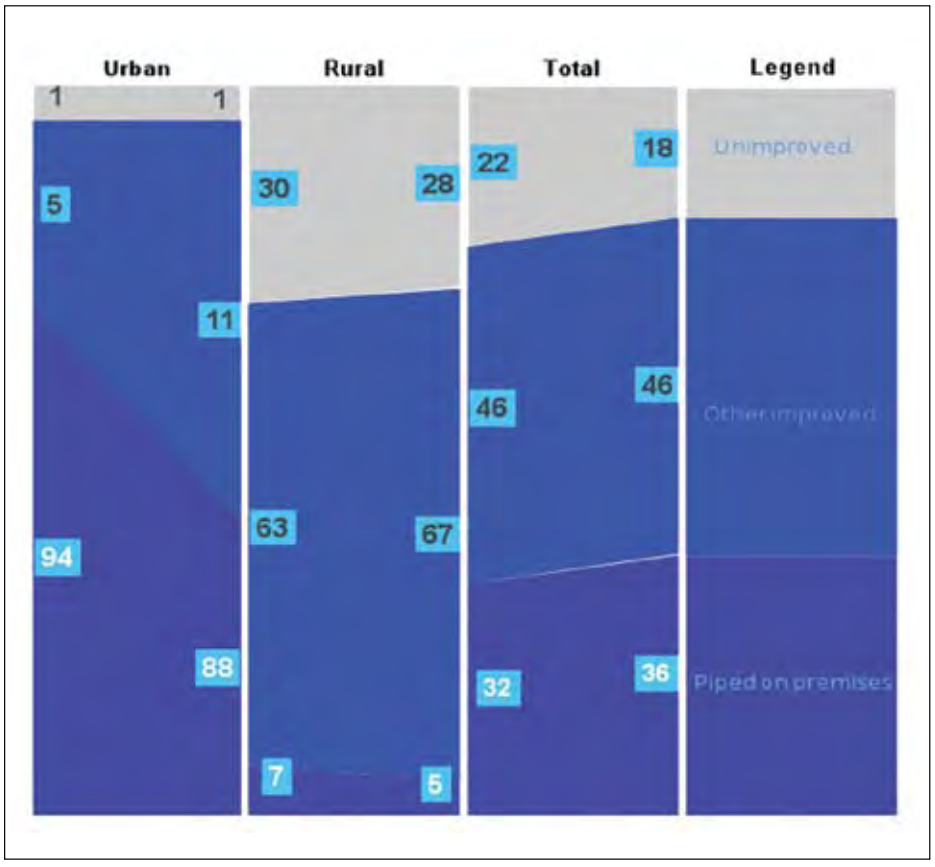


Figure 7.2 Water Supply Trends in Zimbabwe, 1990–2008

Source: WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation (2010), Progress on Sanitation and Drinking Water: 2010 Update

in the process of preparing its second national communication to the UN Framework Convention on Climate Change (UNFCCC) and the report will reveal the current levels of GHG emissions.

CLIMATE CHANGE

Despite being a low emitter, there is observed global warming in Zimbabwe. A set of climatic extremes show that the monthly highest daily maximum temperatures for most of the country are on the increase, by about 2°C per century, and the percentage of days with low temperatures is decreasing at a rate of about 15 days per century. Assuming that GHG emissions continue along the predicted trajectory, it is predicted that temperatures will rise by between 0.5°C and 2°C by 2030, and 1°C and 3.5°C by 2070. National average rainfall declined by about 5% between 1900 and 2000, notwithstanding the episodes of wetter than average conditions in the 1920s, 1950s, and 1970s. The 1980s and early 1990s witnessed what were most likely Zimbabwe's driest periods of the twentieth century. There has been a noted shift in agricultural seasons, as evidenced by late onset and sometimes late cessation of the rainy season. Longer-term rainfall predictions for Zimbabwe are less certain. Various models predict that rainfall patterns are likely to change and that extreme events such as drought and floods are likely to increase in frequency. Certain models predict that there will have been a 10-20% decline in rainfall by 2050.

WATER AND SANITATION

The inability of vulnerable populations to access safe water and basic sanitation has seen frequent diarrhoeal and cholera outbreaks in the country. The 2008 cholera outbreak was unprecedented, affecting urban and rural areas in all ten provinces. Diarrhoea remains one of the top ten diseases affecting children under the age of five in Zimbabwe (MIMS 2009). Reports from urban settlements give a consistent picture of effluent and raw sewage

outflows entering rivers and dams, which are the country's major sources of water supply. Many sewers are blocked, water treatment plants lack chemicals, and many distribution systems are in need of repair.

Results from the 2009 Multiple Indicator Monitoring Survey (MIMS) indicate that the proportion of people in rural areas with access to safe drinking water declined from 70% in 1999 to 61% in 2009. Furthermore, according to the Department of Infrastructural Development, more than 65% of all rural water points are non-functional at any given time. Zimbabwe's extensive rural sanitation programme has also experienced a sharp decline in quality. The 2005/2006 Zimbabwe Demographic and Health Survey (ZDHS) revealed that, since 1999, 69.5% of all rural households had no access to hygienic sanitation facilities. The peri-urban areas rank amongst the worst affected in terms of water and sanitation access and coverage as there is no guiding policy framework. The water and sanitation trends in Zimbabwe for the period 1990 to 2008 are shown in Figures 7.1 and 7.2.

Progress in achieving water and sanitation targets is off track. For rural areas, the country has five years to raise safe water coverage from 61% to 85% and to raise access to good sanitation from 30.5% to 71%.

MAJOR CHALLENGES TO ACHIEVING MDG 7

On the overall policy arena, the major challenge that the country faces to ensuring environmental sustainability is the effective and timely implementation of the Environmental Management Act. The Environmental Management Agency (EMA) plays a key role in translating the objectives of the Act into reality, but it lacks both human and financial resources. The low level of environmental awareness among key law enforcement agencies such as the Judiciary and the Police further hinders both the success of domestic self-financing mechanisms through fines and penalties to replenish the Environmental Fund and halt negative practices. The capacity to implement multilateral environmental agreements (MEAs), as well as to coordinate the various actors on the part of the Ministry of Environment and Natural Resources Management (MoENRM) is constrained. Key policy frameworks such as a national climate change strategy are not in place, making it difficult for the country to engage effectively on climate change. Financial resources for implementing EMAs have mainly come from external sources, but this inflow dried up when sanctions were imposed on Zimbabwe.

The political buy-in of instruments meant to mainstream environmental issues in the land reform process has been slow, as evidenced by the lack of operationalisation of the forest- and wildlife-based land reform policies and the integrated conservation plan for fast-track land reform programme. Both of these have the potential to deal with issues of poaching, illegal mining, land degradation, and illegal settlements in protected areas, and to enhance the participation of the poor in sustainable, natural resource-based livelihood activities.

The major challenges affecting the provision of clean water and good sanitation include eroded institutional and community capacity at all levels in terms of human, financial, and material resources, a weak policy framework, and a weak sector information management and monitoring system. In addition, failure to invest in the routine maintenance of water and sanitation facilities has resulted in deterioration of physical assets and, inevitably, failure to provide a safe and reliable basic level of service in most cities and towns and in the rural areas.

REQUIREMENTS FOR ACHIEVING MDG 7

Major achievements can be made between 2010–2015 if the following actions are taken:

- Environmental capacity-strengthening of key law enforcement agencies such as the Police and the Judiciary
- Institutional strengthening of the EMA

and the MoENRM for mainstreaming environmental issues, including climate change, across all sectors

- Ensuring more robust approaches towards leveraging both domestic and international environmental financing
- Undertaking fiscal and institutional reforms to accelerate the uptake of renewable and clean energy technologies in households and industry, including the resuscitation of the biodiesel project
- Adopting public-private partnerships in water, energy, and housing provisioning.
- Ensuring clear and decisive government leadership in order to safeguard the water and sanitation sector. The roles and responsibilities in sub-sectors need to be clearly and transparently allocated on the basis of efficiency and effectiveness
- Prioritising the development of rehabilitation programmes with the objective of restoring the existing water and sanitation infrastructure in both urban and rural areas, accompanied by a large-scale sanitation behaviour change programme targeted at eliminating open defecation
- Prioritising investment in water, sanitation and hygiene on the national development agenda. Parallel to this, donors should move towards full financing of the World Bank's multi-donor trust fund (MDTF) for urban and water resource investments and UNICEF's Water and Sanitation Transition Fund for rural investments
- Preparing an updated and comprehensive Zimbabwe water, sanitation and hygiene policy that covers water resources in both urban and rural areas
- Instigating a water, sanitation and hygiene sector-wide assessment and full asset inventory – this being a necessary a basis for future planning – followed up with an investment plan to put Zimbabwe back on track to achieve MDG 7.

Develop a Global Partnership for Development

DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

8

TARGET	INDICATORS	TRENDS
Target 12 Develop further an open, rule-based, predictable, non-discriminatory, trading and financial system	*Total trade-to-GDP ratio*	*0.92*
Target 14 Address the special needs of the country's landlocked status	*Cost of transport per kilometre by rail, road, and air*	*2010 projections are:* *Rail – $0.01* *Road – $ 0.02* *Air – $0.03*
Target 15 Deal comprehensively with the debt problem	*Total debt as a percentage of GDP*	*162% of GDP (IMF)*
Target 16 In cooperation with strategic partners, develop and implement strategies for decent and productive work for all	*Overall structural unemployment*	*Not available*
Target 17 In cooperation with pharmaceutical companies, provide access to essential drugs	*Proportion of population with access to affordable essential drugs on a sustained basis*	*60% of the population have access to essential drugs in all hospitals and healthcare centres (64% urban, 46 % rural)*[1]
Target 18 In cooperation with the private sector, make available the benefits of new technologies, especially those related to information and communication	*Personal computers per 1,000 people*	*65*

Sources: RBZ; Mof; MEPIP; 2009 Lagatum Prosperity Index

Year	Mobile	Fixed Network	Internet users per 100 people*
2008	*1,333,000*	*345,000*	*13.9*
2009	*4,151,000*	*385,000*	*14.0*
2010	*5,600,000*	*386,000*	*14.2*

Table 8.1 Trends in the Growth of the ICT Sector, 2008–2010

Source: POTRAZ, 2010

* Although the figures for potential internet access are high, these need to be seen in terms of frequent power cuts and ISP-related problems.

STATUS AND TRENDS

In recent years, Zimbabwe has faced serious economic challenges that have eroded its capacity to remain competitive in regional and international markets. Added to this, the country continues to face sanctions from some western countries and withdrawal of funding from international financial institutions due to the non-payment of its debt obligations.

As such, Zimbabwe has very limited access to international finance for development and has had to largely rely on sharply depleted internal resources. Currently, its only international reserves consist exclusively of the IMF's Special Drawing Rights (SDR) from a Global Finance Facility equivalent to US$510 million (SDR 262 million), equivalent to about two months' import cover.

The country's balance of trade position has suffered from the fall in international commodity prices experienced during the first half of the decade 2000–2010 and the global economic crisis in the latter half. Between 1980 and 2008, exports grew by 0.4% while imports grew by 0.3% a year, which is an indication of significant decline.[2] These disruptions were further accentuated by the ongoing domestic financial crisis. The 2009 account deficit 30% of GDP was increasingly financed by the further accumulation of external payment arrears, the draw-down of dwindling reserves, and short-term suppliers' credits.

Zimbabwe's deterioration in performance in the export market could be attributed to an over-reliance on commodity exports, distortions in foreign exchange market, particularly during the crisis period, and declining competitiveness. On the ease of doing business, Zimbabwe was ranked position 159 out of 183 countries in the *2010 Doing Business Report*.[3]

The Inflation Rate, Average Year-on-Year

Runaway inflation was brought under full control with the adoption of the multi-currency basket in 2009. As a result, year-on-year inflation decelerated rapidly from a peak of 500 million per cent in December, 2008, down to -7.7% in December 2009. Current estimates show that inflation will not exceed 5% by year-end 2010.

The External Debt Position

Zimbabwe's external debt obligations grew rapidly by a significant 30.3% over the five-year period 2005 to 2010, which is a stark contrast to the deceleration of -1.63% in the previous five-year period 1999–2004. This sharp deterioration in the management of debt can be explained by the accelerated economic decline that occurred during the latter period, and which compromised the country's ability to service its debt obligations in a timely manner.

Benefits from New Technology, especially Information and Communication Technology (ICT) and the Distribution of Personal Computers

The penetration rate or tele-density for the mobile network in 2010 has risen by 40% to 17.52 lines per 100 inhabitants since 2007 (Table 8.1). Government

continues to encourage investments in this sector by permitting duty-free importation of related equipment. Econet Wireless, one of the three mobile companies, launched its 3G technology in 2009 and the 4G version in May 2010. Telecel Zimbabwe is on its way to launching 3G technology. Currently, mobile network companies are installing city and intercity fibre optic links. Connectivity with Botswana, Malawi, Mozambique, South Africa, and Zambia will be completed before the end of 2010. At this point, Zimbabwe will be linked to both Seacom and the Eassy Cable undersea fibre optic cables.

In relation to computing, the number of personal computers in the country has increased, rising from 620,000 in 2003 to 895,000 in 2009 (POTRAZ 2010). The rate of progress in PC availability has been slow, largely due to ten years of domestic economic crisis.

Economic Partnerships with Strategic Neighbours

Zimbabwe is part of a strategic partnership in the Southern African Development Community (SADC) for road, railway, and air travel. It is also an important trade route for the Common Market for Eastern and Southern Africa (COMESA) bloc. Existing partnership arrangements within SADC include Economic Development Corridors (EDCs) or Spatial Development Initiatives (SDIs)/Transport Routes.

International Migration for Development

A significant proprtion of the population currently resides outside the country, mainly in South Africa and in the United Kingdom. According to the UNDP Working Paper 11, 'The Potential Contribution of the Zimbabwe Diaspora to Economic Recovery', it is estimated that Zimbabwe receives about US$1.4 billion in remittances annually, which translates to around 7% of the country's GDP.

Official Development Assistance (ODA)

Following difficult relations with some bilateral partners, the imposition of sanctions by some western countries, and the withdrawal of financial assistance by the Bretton Woods Institutions and the African Development Bank, Zimbabwe does not benefit from direct budget support. In the past few years, the limited Official Development Assistance has been mainly in the area of humanitarian support.

REQUIREMENTS FOR ACHIEVING MDG 8

Zimbabwe has made only limited progress on striking strategic partnerships. Hence the country may not meet the targets in MDG 8 unless it comprehensively addresses the issues of competitiveness and promotes integration with regional and global markets. The country also needs to implement a debt and arrears clearance strategy.

Notes

1 ZNHP, Zimbabwe National Health Profile, 2006.
2 UNDP, 2009.
3 UNDP, 2009; IFC Report, 2009.

ANNEX A
COUNTRY FACTSHEET

A

		SOURCE*
Population, 2008	12.2-12.4 million	CSO
Population, percentage female, 2008	51.9	CSO
Area	390,757km^2	CSO
Gross domestic product, 2010	US$5.099 billion	IMF
External debt, 2010	US$7.144 billion	IMF
External debt as a percentage of GDP, 2010	162%	IMF
Population growth rate, 2007–2008	0.6%	CSO
Urban population, 2008	28.8%	CSO
Infant mortality rate per 1,000 live births, 2009	67	MIMS 2009
Under-five mortality rate per 1,000 live births, 2009	94	MIMS 2009
Orphanhood rate among those under 18 years, 2009	25%	MIMS 2009
Maternal mortality rate per 100,000 births, 2009	725	ZMPMS 2007
Births with skilled assistance, 2009	60%	MIMS 2009
HIV infection rate among 15- to 24-year-olds, 2009	11.6%	MIMS 2009
Households living below TCPL (i.e., poor), 2003	72%	PASS 2003
Net enrolment ratio, primary school, 2009	91%	MoESAC
Female students as a percentage- lower secondary school, 2009	49%	MoESAC
Female students as a percentage– upper secondary school, 2009	35%	MoESAC
Female students as a percentage – universities/polytechnics, 2009	40%	MoHTE
Female parliamentarians as a percentage share, 2009	18.55%	Parliament

** MoESAC – Ministry of Education, Sport, Arts and Culture; MoHTE – Ministry of Higher and Tertiary Education; MIMS – Multiple Indicator Monitoring Survey; PASS – Poverty Assessment Survey Study; ZMPMS – Zimbabwe Maternal and Perinatal Mortality Study*

ANNEX B
MDGs AT A GLANCE

GOAL	TARGET	STATUS
1 Eradicate Extreme Poverty and Hunger	a) Halve, between 2002 and 2015, the proportion of people whose income is less than the TCPL b) Halve, between 2000 and 2015, the proportion of people in human poverty, as measured by the HPI c) Achieve full and productive employment and decent work for all, including women and young people d) Halve, between 2002 and 2015, the proportion of people suffering from hunger e) Reduce by two-thirds, between 2002 and 2015, the proportion of malnourished children under the age of five	Population living below the TCPL stood at 72% in 2003 and may have increased with onset of the economic crisis HPI stood at 24% in 1995; 40.3% in 2005; and 34% in 2009 The percentage of underweight under-fives increased from 13% in 1999 to 18% in 2003, but dropped to 17% in 2005. In 2010 it now stands at 15%
2 Achieve Universal Primary Education	a) Ensure that between 2000 and 2015 all Zimbabwean children, both boys and girls, are able to complete a full programme of primary education	The national enrolment rate stood at 91% in 2009. Primary school completion rates fell from 82.6% in 1996 to 68.2% in 2006.The literacy rate of 15- to 24-year-olds stood at 99% in 2009 – an increase of 14% since 1994 (85%)
3 Promote Gender Equality and Empower Women	a) Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015 b) Increase the participation of women in decision-making in all sectors and at all levels to 50:50 by 2015	There is near parity in enrolment in lower secondary school by gender. However, girls comprise only 35% of the pupils currently in upper secondary education. The completion rate for secondary school is higher for boys than it is for girls There are good laws in place but they are inadequately implemented. The percentage share of women in politics stands at about 18%; for women in public service decision-making it is 26%
4 Reduce Child Mortality	a) Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	The under-five mortality rate increased from 79 per 1,000 in 1990 to 94 per 1,000 in 2009

B

5 Improve Maternal Health	a) Reduce by three-quarters, between 2000 and 2015, the maternal mortality rate	Maternal mortality increased from 283 per 100,000 in 1994 to 725 per 100,000 in 2009. The target is 174 per 100,000
6 Combat HIV and AIDS, Malaria, and Other Diseases	a) To have halted, by 2015, and begun to reverse the spread of HIV and AIDS b) By 2015, to have halted and begun to reverse the increasing incidence of malaria, TB and diarrhoeal diseases	HIV and AIDS prevalence rates in adults aged 15-49 declined from 23.7% in 2001 to 18.1% in 2005. Current estimates are at 14.3% (2009) Globally, the country ranks 17 out of 22 high-burden TB countries. The incident rate increased from 97 per 100,000 in 2000 to 782 per 100,000 in 2007
7 Ensure Environmental Sustainability	a) Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources b) Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation c) By 2020, achieve a significant improvement in the housing condition of at least one million slum dwellers and peri-urban and high-density lodgers	Increased deforestation has seen an annual estimated loss of 100,000-320,000 ha forest cover and increasing uncontrolled veld fires Zimbabwe is a net carbon sink Serious problems led to outbreaks of cholera and typhoid. Urban water and sanitation systems are in urgent need of renewal There is an estimated shortage of one million urban housing units. This figure is likely to increase due to an increased urbanization rate estimated at 5-6%. There has been a significant decrease in public and private funding for low-cost housing since 1999
8 Develop a Global Partnership for Development	a) Further develop an open, rule-based, predictable, and non-discriminatory trading and financial system b) Deal comprehensively with debt problems c) In cooperation with strategic partners, develop and implement strategies for decent and productive work for everyone d) In cooperation with pharmaceutical companies, provide access to affordable essential drugs e) In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	Macro-economic changes: price liberalisation, removal of quasi-fiscal expenditures, introduction cash budgeting and tax reforms to simplify system and improve on collection and revenue Consensus on how to handle debt is being developed, but there has been sharp deterioration in the management of Zimbabwe's external debt position over the last five years. Between 2005 and 2010 it grew by 30.3% Employment creation strategies are weak Zimbabwe has several good-quality pharmaceutical plants and is able to supply essential drugs to 60% of the population Access to new technologies is increasing. The penetration rate for mobiles phones now stands at 40%. The number of internet users has risen to 14.2 per 100 people. Zimbabwe will have full fibre optic connectivity in place by the end of 2010

ANNEX C
MONITORING AND EVALUATION OF THE MDGs[1]

GOAL	DATA GATHERING	QUALITY OF SURVEY INFORMATION	STATISTICAL TRACKING	STATISTICAL ANALYSIS	STATISTICS INTO POLICY	MONITORING AND EVALUATION
1 Eradicate Extreme Poverty and Hunger	FAIR Data-processing capacities need to be improved through the use of modern techniques. Too many gaps exist in data collection, especially for new targets. PASS III is long overdue	FAIR Data quality is good, but there are delays in analysing and publishing information	WEAK At present, there is no institutionalised mechanism for monitoring poverty trends. Those institutions that were responsible were Weakened during the crisis period	FAIR Previously, the human resource capacity was available and good, but equipment for statistical analysis is inadequate. There is currently a need to bolster both financial and human resources	FAIR There is a general problem of incorporating statistical data into planning and policy-making. The Ministry of Labour and Social. Services (MoLSS) requires additional support in this area.	FAIR Institutional coordination on poverty monitoring and evaluation remains problematic. No single institution is responsible for this task
2 Achieve Universal Primary Education	FAIR There is a need to strengthen data collation at district level	STRONG The quality of information collected is high	STRONG Establishing the Education Management Information System database has greatly strengthened statistical tracking	FAIR Statistical analysis capacity exists at Head Office and ZIMSTAT	STRONG The capacity to incorporate statistical analyses is good	FAIR Although there are many institutions and organisations involved in monitoring and evaluation, there is a need to strengthen the sharing of information
3 Promote Gender Equality and Empower Women	FAIR The capacity to gather gender differential data at macro, sector and grassroots levels needs strengthening	FAIR National capacity to design appropriate survey instruments needs strengthening	WEAK The national capacity to track statistical data – in all sectors – needs strengthening	WEAK The capacity of ZIMSTAT to analyse available gender-disaggregated data is weak	WEAK The capacity for policy formulation using data is weak	WEAK There is no system for gender monitoring and evaluation

ANNEX C (ctnd)

GOAL	DATA GATHERING	QUALITY OF SURVEY INFORMATION	STATISTICAL TRACKING	STATISTICAL ANALYSIS	STATISTICS INTO POLICY	MONITORING AND EVALUATION
4 Reduce Child Mortality	FAIR Data gathering capacities for public institutions is strong, but it does not cover private institutions	FAIR QualityoftheZimbabwe Health Demographic Survey (ZDHS) is good, but there is room for improvement in terms of frequency and timeliness	FAIR Statistical tracking is comprehensive, but it is weak in remote, rural areas.	FAIR Fairly good at national level, but needs strengthening at provincial and district levels	FAIR Recent survey data is not readily available to various stakeholders for their policy-planning purposes	FAIR There is a need to decentralise the analysis of data for effective monitoring and rapid response at local level
5 Improve Maternal Mortality	FAIR Data gathering capacity for the public institutions is Strong, but it is not comprehensivebecause it does not cover the private institutions	FAIR There is a need to capture all maternal deaths as specified in the definition of 'maternal mortality' under the NHIS	FAIR This area needs improvement	WEAK Very good at national level, but need strengthening at decentralised levels	FAIR Recent survey data is not readily available to various stakeholders	FAIR Baseline data needs to be accurately set
6 Combat HIV and AIDS, Malaria, and Other Diseases	FAIR The data gathering capacity of public institutions is strong, but it lacks comprehensiveness	GOOD Quality of the (ZDHS) is good, but there is room for improvement in terms of frequency, timeliness and completeness	WEAK Tracking capacity is weak. A tracking system does exist, but it is not comprehensive and needs enhancement	GOOD These are very good at national level, but are constrained by resources. They need strengthening at lower levels	FAIR There is capacity to incorporate statistical analysis, but it is constrained by a lack of adequate resources	WEAK Monitoring and evaluation mechanisms exist, but they are weak. There is a need to decentralise the analysis of data for effective monitoring at local levels

ANNEX C (ctnd)

GOAL	DATA GATHERING	QUALITY OF SURVEY INFORMATION	STATISTICAL TRACKING	STATISTICAL ANALYSIS	STATISTICS INTO POLICY	MONITORING AND EVALUATION
7 Ensure Environmental Sustainability	FAIR There is a reliance on secondary data and there are capacity limitations in terms of human and financial resources as well as equipment	STRONG For food security assessments, crop forecasts and vegetation maps, the quality of data is good. However, no reliable data on housing condition for slum-dwellers or the number of housing units is produced annually. No data is available on the amount of land area covered by forest lost each year by fire and deforestation or on GDP per unit of energy use	FAIR There were inadequate resources and time to investigate this area	FAIR There are limitations in terms of financial resources and software	WEAK There is inadequate political will	WEAK There are limited financial and human resources and equipment. However, the 2015 target of eliminating the use of methyl bromide in tobacco seed beds has already achieved. Additionally, methyl bromide is no longer used in the cut flower business – alternative chemicals for fumigation are already available. A local factory has been set up to manufacture floating seed trays, but it cannot operate because of lack of power. Other alternative technologies found for controlling pace under storage by the GMB that are friendly to the ozone layer

ANNEX C (ctnd)

GOAL	DATA GATHERING	QUALITY OF SURVEY INFORMATION	STATISTICAL TRACKING	STATISTICAL ANALYSIS	STATISTICS INTO POLICY	MONITORING AND EVALUATION
8 Global Partnership for Development	FAIR There is apathy in the business sector in filling in the questionnaires. There is also the problem of timeliness of the information. New efforts are being made by ZimStats to have quarterly statistics gathered from firms in the productive sectors of the economy on capacity utilisation, output, costs, etc., and to update data on costs for different modes of transport	FAIR There is a lack of capacity to quickly analyse and disseminate survey information. The quality in the years prior to 2005 was good and reliable with quick analysis and dissemination on firms in the productive sector. The remaining data is collected from secondary sources	WEAK Problems with database management systems. Currently, no activity is taking place as systems have broken down because of funding problems and lack of personnel. Tracking has taken place for some of the targets and a few indicators	WEAK There is a need to improve analysis capacity. Very little, if any, statistical analysis has been carried out, except for a few targets and indicators	FAIR A lack of resources constrains the incorporation of the statistical analysis into policy	FAIR In the main, monitoring and evaluation is largely donor-driven and donor-funded and is thus unsustainable

1 The MDG statistical, monitoring and evaluation system needs to be strengthened to enable the country to monitor the key indicators under each goal, as well as the additional indicators provided in these annexures.

ANNEX D
LAWS ENHANCING THE STATUS OF WOMEN IN ZIMBABWE (1980–2010)

LAW	PROVISIONS
Equal Pay Regulations (1980)	Provided for equal pay for work of equal value. Before 1980 pay was structured on the basis of race and sex, with black women at the bottom of the ladder
Legal Age of Majority Act (LAMA) (1982)	Confers majority status on women. Before this law came into being African women were regarded as perpetual minors
Labour Relations Act (1984) (Chapter 28:01)	Prohibits employers from discrimnation against employees on ground of sex
Public Service Pensions (Amendment Regulations, (1985))	Provisions for female workers in the public servie to contribute to their pension at the same rate as male contributors
Marriage Act (1987) Section 21 (Chapter 5:11)	Sets the miminum age of majority for both girls and boys at 18, to be in line with the Legal Age of Majority
Customary Marriages Act (1987) (Chapter 5:07)	All spouses in unregistered customary marriages are required to certify their marriages before competent authorities
Matrimonial Causes Act (1987) (Chapter 5:13)	Extends the jurisdiction over and dissolution of all types of marriages to magistrates' courts and chiefs
Maintenance Amendment Act (1989)	Requires a negligent non custodian parent to contribute regularly to children in the custody of the other parent
The Electoral Act (1990)	Allows women to participate in general and by elections for the Presidency or in Parliamentary and local elections as voters or candidates without any discrimination

ANNEX D (ctnd)

D

The Administration of Estates Amendment Act (1997)	Protects the inheritance rights of surviving spouses and children
Criminal Law (Codification and Reform) Act – The Sexual Offences Act (2001)	Protects women from sexual abuse and criminalises marital rape and wilful transmission of HIV and AIDS. The Act also prohibits trafficking of persons for purposes of prostitution and imposes stiffer penalties for violations
The National Gender Policy (2000	Provides a framework for mainstreaming gender in all sectors of the economy
The Interpretation Act (2004)	The Government came to realise that the use of the language that denotes the masculine gender in legislative instruments perpetuates discrimination against women. The act has therefore been amended to use language that denotes feminine concurrency with that of masculine gender
General Law Amendment Act (Section 12, chapter 8:07)	Women in Zimbabwe are legally entitled to take up political and public offices
Domestic Violence Act (2007) and its Regulations (2008)	Provides for protection of survivors of domestic violence and criminalises such acts as abuse derived from any cultural or customary rites or practices that discriminate or degrade women
Anti-Domestic Violence Council	Launched in 2009 to spearhead the implementation of the Domestic Violence Act
SADC Protocol on Gender and Development	Ratified 22 October 2009. Among other things, it advocates for gender parity (50:50) in politics and other decision-making bodies

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