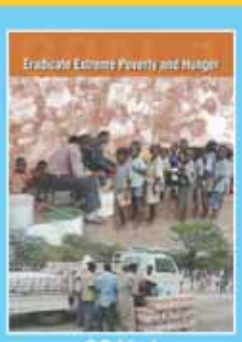
ZIMBABWE

UNITED NATIONS

Zimbabwe Millennium Development Goals

2004 Progress Report



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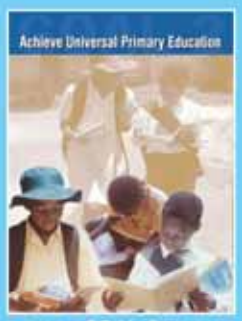

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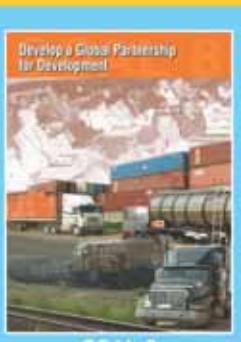

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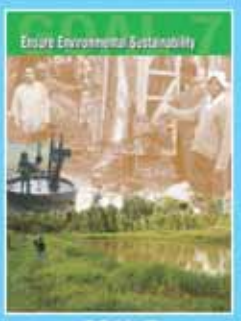

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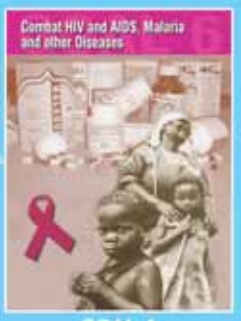

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GOAL 5

GOVERNMENT OF ZIMBABWE

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Zimbabwe Millennium Development Goals

2004 Progress Report

Zimbabwe Millennium Development Goals
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to the United Nations.

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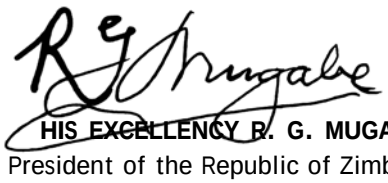
Foreword

The Government of Zimbabwe is proud to be one of the successful implementers of the Millennium Declaration adopted by Heads of State and Government at the Fifty-Fifth Session of the United Nations General Assembly in September 2000. This first Zimbabwe Millennium Development Goals (MDG) Report seeks to re-affirm our commitment to social development and poverty eradication so that no man, woman or child in our country will be subjected to abject and dehumanizing conditions of extreme poverty.

This 2004 Zimbabwe MDG Progress Report is our endeavour to adapt the eight MDGs adopted by the Fifty-Fifth Session of the UN General Assembly to the capacities, values and aspirations of the people of Zimbabwe. The Report provides an analytical summary of the development progress made so far, the key challenges, priority areas for intervention by both ourselves and our development partners and how much these will cost in order to achieve the set national targets by 2015. The social development challenges before our Nation require quantum investments in the social sectors in order to reinforce our leading role as a social development model in Africa, especially in the areas of education, health and social safety nets.

As we continue to consolidate our political and economic independence, the poverty reduction objective has now acquired a central position in our development policies. The MDG targets we have set for ourselves as a Nation, will now serve as social development benchmarks for all our development policies and interventions. As such, our national economic and social development plans, will henceforth seek to achieve the poverty reduction goals and targets outlined in this Report. By recognizing the strong link between poverty, gender and the HIV and AIDS epidemic, the Report draws attention to Goals 1(Poverty), 3 (Empowerment of Women) and 6 (HIV and AIDS), as the national priority goals, which underlie the achievement of MDGs in Zimbabwe.

I would like to challenge and urge the whole Nation – business, labour, farmers, bureaucrats, politicians and the civil society - to mainstream these nationally set MDG targets into all their development activities. Through this unity of purpose, and with the necessary support from our development partners, our people will enjoy better living standards in the new millennium. The Government of Zimbabwe remains committed to supporting a broad-based economic recovery process as one of the key pillars to meeting our nationally set 2015 MDG targets. In meeting this challenging development endeavour, the Government and People of Zimbabwe will continue to welcome international support.



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

Acknowledgements

The compilation of this important 2004 Zimbabwe Millennium Development Goals (MDG) Report would not have been possible without the participation of many representatives of Government Ministries and Departments, the United Nations Country Team, Private sector and Civil society organizations. The Government of Zimbabwe would like to acknowledge the tireless efforts of all its officers, sector Ministries, as well as civil society representatives in shaping the content of this Report.

The broad consultative process was facilitated by the following sector Ministries who coordinated and chaired the various thematic groups.

Sector Ministry	Thematic Group and Goals
Ministry of Public Service, Labour & Social Welfare	Chair of the National MDG Taskforce
Ministry of Public Service, Labour & Social Welfare (Department of Social Services) and Ministry of Agriculture and Rural Development	Social Development and Agriculture **(Goal 1)**
Ministry of Health and Child Welfare	Health **(Goals 4 & 5)** HIV and AIDS **(Goal 6)**
Ministry of Education, Sport and Culture	Education **(Goal 2)**
Ministry of Youth Development, Gender and Employment Creation	Gender **(Goal 3)**
Ministry of Environment and Tourism	Environment **(Goal 7)**
Ministry of Finance and Economic Development	Global Partnership **(Goal 8)**

In addition, the Government of Zimbabwe would like to acknowledge the invaluable technical and financial assistance by the United Nations Development Programme (UNDP) and the UN Country Team (UNCT) who backstopped the thematic groups. Their support included the provision of relevant literature, technical direction, costing the goals, financial resources to facilitate the entire Report production process, as well as the recruitment of a team of local consultants to compile the report.

In this regard, the Government of Zimbabwe would like to acknowledge the following UN agencies for backstopping the thematic groups in their respective areas of expertise:

UN Agency	Thematic Group and Goals
UNDP	Overall backstopping of the MDG process
UNDP Country Office & UNDP SURF	All thematic groups (**Goals 1 - 8**)
UNICEF, UNFPA, UNIFEM, ILO, FAO, UNIDO, WORLD BANK, IMF	Social Development and Agriculture **(Goal 1)**
UNESCO, UNICEF	Education **(Goal 2)**
UNIFEM, WHO,	Gender **(Goal 3)**
WHO, UNFPA, UNFPA CST, UNICEF	Health **(Goals 4 & 5)**
UNAIDS, WHO	HIV and AIDS **(Goal 6)**
UNDP	Environment **(Goal 7)**
UNDP, UNDP/SURF, WORLD BANK, IMF	Global Partnerships **(Goal 8)**
UNIC & UNDP	MDG Advocacy Campaign preparation

HON. Paul MANGWANA
Minister for Public Service, Labour & Social Welfare and Chairman, Cabinet Social Services Action Committee (SSAC) and the National MDG Taskforce

J. Victor ANGELO
UN Resident Coordinator & UNDP Resident Representative

GOVERNMENT OF ZIMBABWE

UNITED NATIONS

Introduction

The United Nations and International Millennium Declaration Development Goals (MDGs)

Since 1990, the United Nations has held a series of world summits and global conferences with a view to laying out a comprehensive rights based development agenda. These series of conferences culminated in the formulation of the Millennium Development Goals

Zimbabwe was among the 189 Heads of State and Governments, which agreed to the Millennium Declaration at the Millennium Summit of September 2000. The International Development Goals (IDGs), which were drawn from UN global conferences[1] and the goals contained in the Millennium Declaration were merged to produce the Millennium Development Goals (MDGs).

The Millennium Development Goals (MDGs) comprise of quantitative goals, time targets and numerical indicators for poverty reduction, combating HIV AND AIDS, and improvements in health, education, gender equality and women empowerment, the environment and other aspects of human welfare. The targets set are to be achieved over a 25-year period – between 1990-2015.

This first National Millennium Development Goals report for Zimbabwe aims at beginning a nationally owned process of tracking progress towards achieving these goals. It also places the long-term national development priorities within the global context of the MDGs. Through the process of preparing this key public affairs document, it is hoped that awareness will be raised, alliances will be built among all stakeholders and commitment by both policy makers and donors alike to the development of this country renewed. The purpose is to generate a strong feeling of optimism so that policy makers and their development partners are reminded of development commitments.

The Zimbabwe MDG Report is a result of a consultative process spearheaded by the Government of Zimbabwe, through the Ministry of Public Service, Labour and Social Welfare, in their capacity as the chair of the Cabinet Committee on Social Services (SSAC), and coordinated by the United Nations Development Programme / Zimbabwe office (UNDP). To assist in the preparation of the report, a National MDG Taskforce consisting of Government and Civil Society was established. In addition, seven MDG thematic groups were formed, which are Health, HIV and AIDS, Education, Gender, Social Development and Agriculture, Environment and Global Partnership. These multi-stakeholder thematic groups were responsible for the production of the report.

In support of this national process, a United Nations Country Team (UNCT) MDG taskforce was also formed to work alongside the National task force. This taskforce consisted of all UN Agencies, including the International Monetary Fund (IMF) and the World Bank. The report is, therefore, a result of collaborative efforts of Government, Civil Society and all UN agencies resident in Zimbabwe.

At country level, realigning development planning and programmes to the achievement of the MDGs provides a coherent operational framework. It is in light of this that this report goes a step further than most of the first generation MDG reports by giving an indication of resource and economic growth requirements for achieving the MDGs. The report also indicates a strategy for financing the goals, which include: national budget restructuring, strategy for economic growth development, productive asset redistribution, and enhanced global partnership.

It is hoped that the development challenges highlighted in this report will constitute the new development vision and planning framework for Zimbabwe. The participatory process undertaken in preparing this first Zimbabwe MDG report indicates a strong need for the various stakeholders to collaborate in both the implementation and monitoring of the MDGs.

[1] The major UN Conferences since the nineties include: World Summit for Children (1990), The Rio Summit (1992), The International Conference on Population and Development (Cairo, September 1994); The World Summit for Social Development (Copenhagen, 1995), The Beijing Conference (1995), World Food Summit (1996), HABITAT II (1996), Earth Summit (1997), Population Conference (1999), Beijing+5 (2000), Millennium Summit (2000), Financing For Development (2002), Special Session on Children (2002), Food Summit (2002), WSSD (2002).

The report starts by presenting the development context of Zimbabwe, followed by eight sections that cover each of the 8 MDG goals. Under each goal, the status and trends, the challenges, identified supportive environment, national development priorities, development assistance needs, monitoring and evaluation, and a brief assessment of the resource requirements for attaining the 2015 targets are presented. The report ends with a chapter on financing the goals, a proposal for an institutionalised MDG and poverty monitoring mechanism at both the policy and technical levels, and a detailed set of indicators.

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> We confront a world divided between rich and poor as never before in human history. Around one sixth of humanity has achieved levels of well-being that were impossible to contemplate even a few decades back. At the same time, another one sixth of humanity struggles for daily survival, in a life-and-death battle against disease, hunger and environmental catastrophe. In between, are around four billion people in developing countries, who no longer live right on the cliff-edge of disaster, but who remain very far away from the security, capabilities and material well-being enjoyed by the peoples of the developed world.
>
> *(United Nations Secretary General's Report: MDG 31 July 2002.)*

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List of Abbreviations and Acronyms

AREX	Agricultural Research and Extension
AIDS	Acquired Immune Deficiency Syndrome
BEAM	Basic Education Assistance Module
BEST	Better Environmental Science Teaching
BSPZ	Better Schools Programme Zimbabwe
CAMP FIRE	Communal Area Management Programme for Indigenous Resources
CBD	Convention of Biological Diversity
COMESA	Common Market for Eastern and Southern Africa
CSO	Central Statistical Office
CSSAC	Cabinet on Social Services Action Committee
DEAP	District Environmental Action Plan
DEO	District Education Officer
DOTS	Directly Observed Treatment Short Course
EFA	Education For All
EMIS	Education Management Information System
EOC	Essential Obstetric Care
FDI	Foreign Direct Investment
FPL	Food Poverty Line
GDI	Gender Related Development Index
GDP	Gross Domestic Product
HDI	Human Development Index
HPI	Human Poverty Index
HPSP	Health Promoting Schools Programme
IDG	International Development Goals
IDT	International Development Targets
IMF	International Monetary Fund
IPMAS	Integrated Poverty Monitoring Analysis System
ITN	Insect Treated Nets
MDGs	Millennium Development Goals
MDGR	Millennium Development Goal Report
MERP	Millennium Economic Recovery Programme
MOESC	Ministry of Education Sport and Culture
MOLARR	Ministry of Lands Agriculture and Rural Resettlement
MOPSLSW	Ministry of Public Service Labour and Social Welfare
NACP	National AIDS Coordination Programme
NERP	National Economic Revival Programme
NGO	Non Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation of Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
PASS	Poverty Assessment Survey Study
PMTCT	Prevention of Mother to Child Transmission
PSC	Public Service Commission

RBZ	Reserve Bank of Zimbabwe
RDC	Rural District Council
SDA	Social Dimension of Adjustment Programme
SME	Small and Medium Enterprises
TCPL	Total Consumption Poverty Line
TB	Tuberculosis
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing
WDI	World Development Indicators
WSSD	World Summit on Sustainable Development
ZDHS	Zimbabwe Demographic Health Survey
ZHDR	Zimbabwe Human Development Report
ZIMPREST	Zimbabwe Programme for Economic and Social Transformation
ZINTEC	Zimbabwe Integrated National Teacher Training Course
ZVAC	Zimbabwe Vulnerability Assessment Committee
..?	Data not available
.?	Category not applicable

Zimbabwe: Development Context

Zimbabwe: Development Context

Map of Zimbabwe

Zimbabwe is a landlocked country with a land area of 390 757km^2, of which 85% is agricultural land and the remaining comprises national parks, state forests and urban land. Official population figures are 10.4 million for 1992, 11.8 million for 1997 and 11.6 million for 2002. The annual average inter-censal population growth rate between 1997 and 2002 was 1.1% as compared to 2.2% between 1992 and 1997.

Some key social indicators began deteriorating during the 1990s, in comparison to a commendable improvement in the same indicators during the 1980s. For example, the human development index (HDI), which peaked at 0.621[2] in 1985, has since declined to 0.496 by 2001. The life expectancy at birth is estimated at 43 years for the period 2000-2005, as compared to 61 years in 1990. In 2002, about 34%[3] of the adult population was HIV AND AIDS infected. The impact of HIV AND AIDS on the reduction of life expectancy and other social indicators cannot be over-emphasized. The estimate of 43 years for Zimbabwe in 2000-2005 is 26 years lower than it would have been without AIDS. The impact of the epidemic has also been compounded by the negative impact of economic decline, droughts and floods.

Post Independence Development Progress and Challenges in Zimbabwe: 1980-1995

In 1980, Zimbabwe inherited a dual economy characterized by a relatively well-developed modern sector and a largely poor rural sector that employed about 80% of the labour force. The newly independent government sought to address some of these inequities through a "*Growth with Equity" Strategy* published in 1981, as well as the *Zimbabwe Transitional National Development Plan* (1982-1985) and the *Zimbabwe first five-year National Development plan* (1986-90). Priority was given to poverty reduction, and government spending was geared towards increased social sector expenditures, expansion of rural infrastructure and redressing social and economic inequality including land reform. Immunization programs were expanded to cover most children, primary health care services were subsidized, and primary school enrolment became almost universal. By 1995, Zimbabwe had registered a net enrolment rate of 86%, thus signalling the near attainment of universal primary education. The overall outcome of these policies was very strong social indicators for Zimbabwe.

However, the decade of the 1990s witnessed a turnaround of economic fortunes, as economic decline set in and structural problems of high poverty and inequality persisted. Some of the explanations behind this turnaround include recurring droughts and floods, as well as, the non-realisation of the objectives of the structural adjustment programme (ESAP). During the period between 1991 and 1995, real GDP growth averaged about 1.5% per year. Considering population growth, this economic growth rate was insufficient for poverty reduction and employment creation. Extreme poverty increased significantly during the 1990s, with an estimated 35% of households living below the poverty line in 1995 compared to about 26% in 1990. Based on the total consumption poverty line, households in poverty increased from around 40% in the late 1980s to 62% by 1995/96.

Development Progress and Challenges in Zimbabwe: 1996 - 2003

This period has been marked by accelerated deterioration in the socio-economic situation. The Government replaced ESAP with a "home-grown" reform package the *Zimbabwe Programme for Economic and Social Transformation (ZIMPREST)* in April 1998. However, the lack of resources to implement this reform package undermined its effective implementation. In yet another attempt to address the declining economic performance, the *Millennium Economic Recovery Programme (MERP)* was launched in August 2001 as a short-

[2] The Human Development Index (HDI) measures human development by combining three dimensions of development – life expectancy at birth, adult literacy, and income. It ranges from a minimum of 0 to a maximum of 1, which puts Zimbabwe in the medium human development range.
[3] Current 2003 adult (15-49 yrs.) prevalence of HIV is estimated at 24.6% (range 20-28%), a figure lower than the 33.7% estimate of 2002. I t is acknowledged that the lower prevalence could be due to measurement methodological differences.

term 18-month economic recovery program. Its objective was to restore economic vibrancy and address the underlying macroeconomic fundamentals. Unfortunately, MERP was also rendered 0ineffective largely due to the withdrawal of the international donor community. In February 2003, Government launched yet another 12-month stabilisation programme the *National Economic Revival Programme (NERP): Measures to Address the Current Challenges,* while considering options for long term economic recovery. Though NERP was received with more optimism by donors, private sector and other stakeholders, more than half-way through its implementation, the programme has not yet managed to generate the foreign currency required to support economic recovery. It must be noted however, that these "home-grown" reform efforts are commendable efforts.

The undermined reform efforts since 1996, combined with the negative impacts of recurring droughts and floods, international isolation, and the HIV AND AIDS epidemic, have given rise to severe macroeconomic difficulties. These difficulties are characterised by the following; hyper-inflation of over 400%, low foreign exchange reserves, a build-up in external arrears, and a decline in investment, resulting in a real GDP contraction of around 30% cumulative since 1999. Zimbabwe is currently ineligible for financial assistance from the IMF and the World Bank because of the arrears situation.

As part of continuing efforts to redress past inequalities, the government has embarked on general asset redistribution (land redistribution, ability of public to own shares on the stock exchange, etc.) as one approach to addressing structural imbalances in the economy, so as to reduce poverty and inequality. The challenge is to consolidate the land reform programme into a sustainable agrarian reform programme. This would help the country cope with recurring humanitarian challenges.

For a summary of Zimbabwe's key development indicator's since 1990, see table 1.

TABLE 1: KEY DEVELOPMENT INDICATORS

	1990	1995	2000	2002	2003[1]
Real GDP Growth %	7.0	0.2	-8.2	-14.5	-13.9
Per capita Real GDP growth %	5.5	-1.3	-7.7	-14.7	-14.1
Inflation, %	15.5	22.6	55.9	133.2	525.8[2]
ODA Flows (US$ Million)	295.9	347.7	192.6	- -	- -
Net Foreign Direct Investment, US$ (million)	-12	98	16	23	5[1]
Population (million)	10.4[3]	11.8[4]	- -	11.6[5]	11.87[1]
Population growth rate, %	2.5[6]	- -	2.5[7]	1.1[8]	0.3[9]
HIV /AIDS prevalence (Population aged 15-49 years) %	..	..	25[10]	34[11]	34[1]
Life expectancy at birth, years	61	55	43[12]	43[12]	43[12]
Structural unemployment	- -	- -	- -	> 50	> 50
Population with access to safe water (rural), %	65[13]	73[14]	75[15]	- -	- -

Note: 1 = Provisional, 2= October 2003, 3= 1992, 4=1997, 5= 2002 Preliminary Population Census Results, 6= 1982/92 7= 1992/97, 8 = 1992/2002, 9 = 2002/2003, 10=1999, 11= 2001, 12=UNAIDS estimate, 13= 1992, 14=1997, 15= 1995-99.

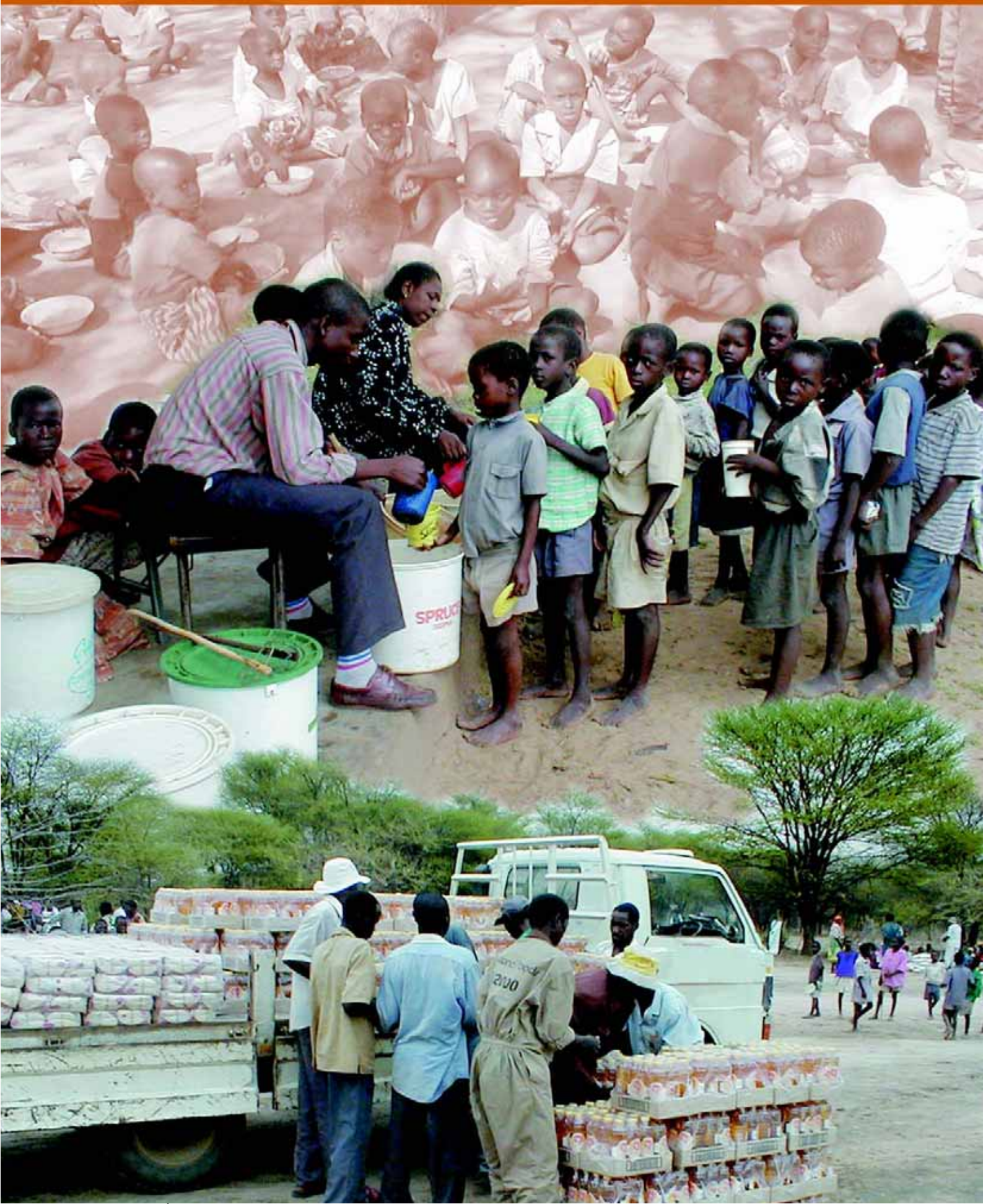
Therefore, at the time of setting the 2015 MDG targets for Zimbabwe, the country is no doubt confronting a complex set of development challenges. These challenges will need to be addressed in the context of a long-term broad-based macroeconomic growth and development strategy for poverty reduction.

Zimbabwe's development context clearly shows that the Millennium Development Goals (MDGs) are interrelated, such that the achievement or non-achievement of certain goal(s) will impact on the others. Even though the report presents an analysis of individual goals, the inter linkages should always be kept in mind. Zimbabwe's priority MDG goals are Goal 1 on *Eradicating extreme poverty and hunger* Goal six on *Combating HIV AND AIDS* and Goal 3 on *Gender Equality and Empowerment of Women*. The reason being that the non-attainment of these three goals would undermine achievement of the rest of the MDG goals.

Poverty Monitoring & Evaluation Environment

Note: The Poverty Monitoring and Evaluation Environment for each of the eight goals is presented in Table 3 at the end of the report.

Eradicate Extreme Poverty and Hunger



Eradicate Extreme Poverty And Hunger

TARGET 1:

a) Halve, between 2002 and 2015, the proportion of people whose income is less than the Total Consumption Poverty Line[4] (TCPL).

b) Halve, between 2000 and 2015, the proportion of people in human Poverty, as measured by the Human Poverty Index (HPI).

INDICATORS:

1. Percentage of people below the Total Consumption Poverty Line (TCPL)
2. Human Poverty Index (HPI)

TARGET 2:

a) Halve, between 2002 and 2015, the proportion of people who suffer from hunger.

b) Reduce by two-thirds, between 2002 and 2015, the proportion of under-five children who are malnourished.

INDICATORS:

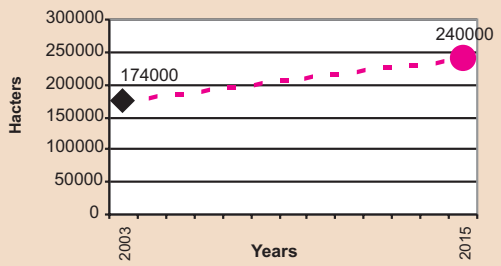
3. Percentage of the population below the Food Poverty Line[5] (FPL).
4. Percentage of under-five children that are malnourished.
5. Proportion of under-fives having at least three meals per day.

STATUS AND TRENDS

Zimbabwe is an agricultural based economy, with about 70% of its population residing in rural areas and earning a living largely from subsistence agriculture. Agriculture is still a major contributor to GDP at 24.7 percent, followed by the manufacturing sector at 11.5 percent, as at 2001. The average annual growth in agriculture GDP was estimated at 3.5% during 1981-1991, rising to 4.3% in 1999, before recording a steep decline of –17.6% in 2001. The situation, however, is expected to improve in the medium term when the agrarian reform process begins to yield results.

A major contributing factor to increasing agricultural productivity is expected to be the area under irrigation and the newly resettled farmers. Currently, the country has a total of 174,000 hectares under irrigation. Of this area, 139,000 hectares is in the former large-scale commercial agricultural sector. The total irrigation potential for Zimbabwe is estimated at 240,000 hectares, of which 90,000 will be in the small-holder sector. The target is to reach this full irrigation potential by 2015 (see figure 1.1)

Figure 1.1: Total Area under Irrigation For Zimbabwe, 2003 - 2015



Source: Ministry of Lands, Agriculture and Rural Resettlement, Zimbabwe, 2002

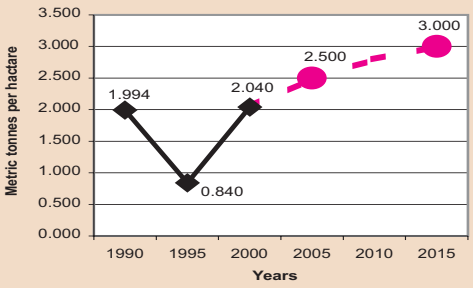
Key

- ◆ Actual
- ● Target
- Current rate of progress
- Rate of progress required to reach goal

[4] Total Consumption Poverty line – The level of income at which people can meet their basic food and non-food needs.
[5] Food Poverty Line – A level of income at which people can meet their basic needs.

Maize is the staple food in Zimbabwe, and as such, hunger is commonly associated with its shortage in the country. Maize productivity has been erratic since 1990, mainly due to the recurring droughts and floods, as well as the initial impact of the land reform programme. Figure 1.2 shows that maize productivity was 1.994 metric tonnes per hectare in 1990, dropping sharply to 0.840 metric tonnes per hectare in 1995, and rising to 2.040 metric tonnes per hectare in 2000. In order to ensure food security in the country, the target is to steadily increase maize productivity to 3.000 metric tonnes per hectare by 2015.

Figure 1.2: Maize Productivity (Yield Per Hectare), Metric Tonnes, Zimbabwe 1990-2015

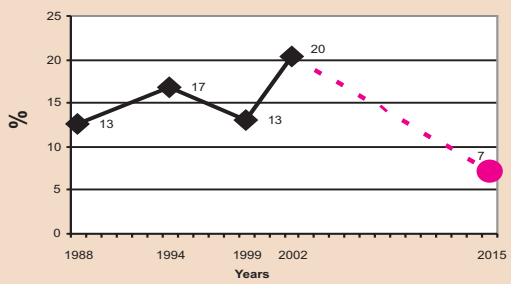


Source: Ministry of Lands, Agriculture and Rural Resettlement, Zimbabwe, 2002

Zimbabwe is currently facing a major humanitarian challenge. The humanitarian situation has resulted in a higher incidence of vulnerability of the population. According to the 2002 Zimbabwe Vulnerability Assessment, the number of people in need of food aid rose from 6.7 million in 2001 to 7.2 million in 2002. Coupled with this is the HIV and AIDS epidemic, of which an estimated 2.2 million people are infected. The deadly combination of food shortages, malnutrition and HIV and AIDS in the face of economic decline is a great challenge. Government's desire is to achieve food security at the national level at all times.

Malnutrition is a major problem associated with poverty. According to the Ministry of Health & Child Welfare, 13% of the under-fives were under-nourished in 1999, rising to 20% in 2002 (see figure 1.3). The 2002 National Nutrition Assessment Study estimated that 11% of the children in urban areas and 26.5% of the children in rural areas were malnourished. The target is to reduce under-five malnutrition by two-thirds to 7% by 2015.

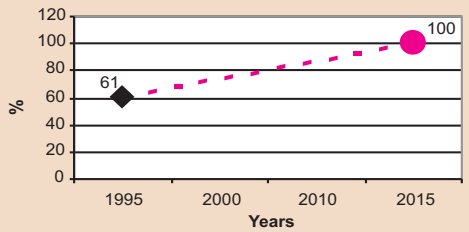
Figure 1.3 Percentage of Under Five Year Olds who are Under Nourished,1988,1994,1999, 2002 and 2015



Sources:CSO, Demographic and Health Surveys 1988, 1994 and 1999. Ministry of Health 2002, Note: For 1988 and 1994 its for children 3-35 months and not under five years.

Another indicator of child malnutrition is the proportion of under-fives taking at least three meals per day. According to the Poverty Assessment Survey of 1995, 61% of the under-fives were taking at least three meals per day (see figure 1.4). It is also important to give attention to maternal nutrition, as this is strongly linked to the child nutrition challenge. The target is to reach 100% by 2015.

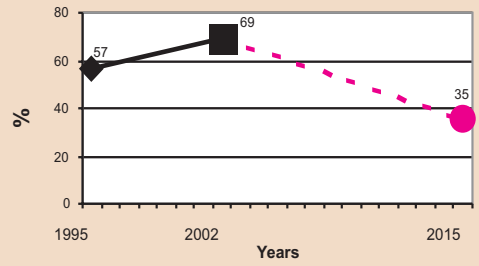
Figure 1.4 Percentage Of Under Five Year Olds Who Have Taken At Least Three Meals In The Preceding Day, Zimbabwe, 1995



Source: Ministry of Public Service, Labor and Social Welfare,Poverty Assessment Study Survey,1995, Zimbabwe

The 1995 Poverty Assessment Study indicated that 57% of the Zimbabwean population lived below the Food Poverty Line (FPL), rising to an estimated 69% in 2002 (see fig. 1.5). The target is to halve food poverty to 35% by 2015.

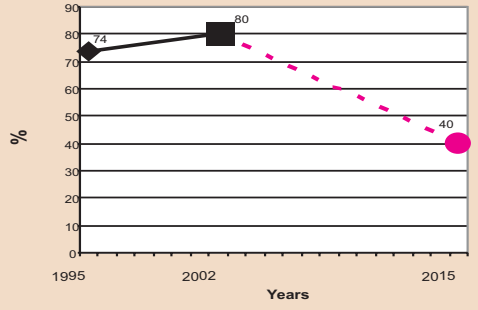
Figure 1.5: Percentage of the Total Population Below the Food Poverty Line, Zimbabwe,1995-2015.



Source: Ministry of Public Service, Labour and Social Welfare, Poverty Assessment Study Survey,1995, Zimbabwe

According to the same survey, in 1995 74% of the population fell below the total consumption poverty line, rising to an estimated 80% in 2002 (see figure 1.6). The target is to halve total consumption poverty to 40% by 2015.

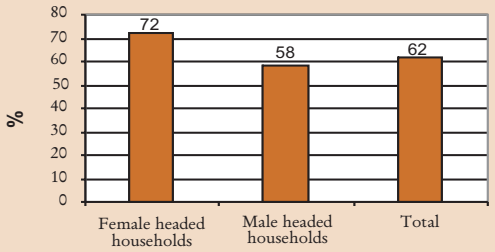
Figure 1.6: Percentage of the Population below the Total Consumption Poverty Line, Zimbabwe,1995-2015.



Source: Ministry of Public Service, Labour and Social Welfare, Poverty Assessment Study Survey,1995, Zimbabwe

Current trends indicate that poverty is on the increase in both rural and urban areas. Poverty is more common in female-headed households at 72% than in male-headed households at 58% (see figure 1.7).

Figure 1.7 Poverty by Gender of Head of Household, 1995.

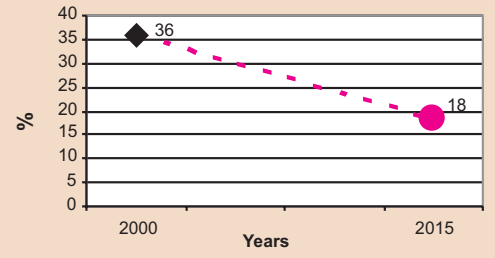


Source: Ministry of Public Service, Labour and Social Welfare, Poverty Assessment tudy 1995, Harare, Zimbabwe

Another major contributory factor to the current levels of poverty is the high levels of inequalities in the country, measured by the Gini coefficient estimated to be 0.57[6].

While food poverty and consumption poverty give indications of income poverty, the human poverty index provides a more holistic measure of the complexity/multidimensional nature of poverty. Zimbabwe's human poverty index was estimated at 36% of the total population in 2000. The target is to reduce human poverty by half to 18% by 2015 (see figure 1.8).

Figure 1.8: Human Poverty Index, Zimbabwe, 2000-2015.



Source: UNDP, Human Development Report 2002

To achieve the set targets of eradicating extreme poverty and hunger, economic decline will need to be reversed, followed by sustained growth rates of above 6% *(see costing exercise at end of the chapter)*, a reduction of inflation to single digits and a remarkable shift from mainly rain fed agriculture to irrigated crop production in the smallholder sector.

If the current trends in poverty and economic decline continue, the target of halving poverty by 2015 will not be achieved.

CHALLENGES

In order for Zimbabwe to achieve the goal of eradicating extreme poverty and hunger, the following challenges have to be addressed:

Creating an enabling environment for pro-poor economic growth

The challenge is to address high inflation, in order to facilitate economic revival, sustained growth, and poverty reduction. In this regard, it is worth noting that peace and security are pre-requisites for any nation to pursue sustainable development.

Employment creation

The challenge is to encourage job-creating economic growth and investment. One such strategy is to support small to medium size enterprises and help them graduate from the informal sector.

Support for the land reform programme

The challenge is to support the agrarian reform process to make it viable, so as to enhance household and national food security.

Reduce dependency on rain-fed agriculture and increase agricultural productivity

The majority of smallholder farmers are heavily dependent on rain fed agriculture. The challenge is to expand irrigation development to small-holder and communal farmers, so as to increase their productivity.

Addressing malnutrition with limited resources under the HIV and AIDS epidemic

The challenge is to address malnutrition in the wake of reduced public sector expenditure, and the negative impact of the HIV and AIDS epidemic.

Addressing Maternal and Child malnutrition

Nutrition highlights the importance of addressing community's food needs through the food cycle from production, harvesting, storage, processing, preparation, and consumption. In addition, issues relating to availability of local food crops, diet diversity and quality are important. The challenge, therefore, is to ensure sustainability in food production cycles and food diversity.

Establish a comprehensive food and nutrition surveillance system

The challenge is to establish a comprehensive food and nutrition surveillance system that will provide accurate, credible and timely information. This will help to facilitate appropriate decision making at all levels, from community to policy making, for improved food security and nutrition outcomes.

Expand social protection and security systems

The challenge is to increase the capabilities of

[6] The Gini coefficient is a number between zero and one that measures the degree of inequality in the distribution of income in a given society. The coefficient would register zero inequality (0.0=minimum inequality) for a society in which members received exactly the same income and it would register a coefficient of one (1.0=maximum inequality) if one member got all the income and the rest got nothing.

households to manage risk. Humanitarian crises have become a regular feature of the Zimbabwe landscape, associated largely with droughts, floods and the impact of the HIV AND AIDS epidemic.

Combating HIV and AIDS

HIV and AIDS poses a serious threat to all development efforts, in particular poverty reduction. The challenge is to design and implement strategies that will halt and reverse the spread of the epidemic.

Developing a land information and natural resource database

As a result of recent structural changes in the economy, particularly with respect to resource ownership, information on land and natural resources have become outdated. The challenge is to conduct a land and natural resource audit in order to update the database.

Design a Poverty monitoring database

Currently, there is no centralized comprehensive database to monitor poverty. The challenge is to design such a database to enable focused targeting and the design of appropriate poverty reduction responses.

SUPPORTIVE ENVIRONMENT

The government is committed to the eradication of extreme poverty and hunger as indicated by the various initiatives undertaken so far. These include:

National Economic Revival Programme (NERP)

The programme aims at putting in place measures to enhance the country's capacity to generate foreign exchange, to facilitate economic recovery.

Land Reform Programme

The current land reform programme aims at providing the majority of the people with land to support their agricultural production capacity.

Undertaking a Second Poverty Assessment Study (PASSII)

The government is preparing to undertake a nation-wide Poverty Assessment Study to get an in-depth understanding of the poverty status in the country. The findings of the assessment are expected to be the basis of the country's Poverty Reduction Strategy.

Social Security and Protection Policies

Various policies have been drafted and implemented that have a direct bearing on poverty eradication. These include Food Security Policy and Strategy, National Drought Policy, National Employment Policy, National Social Security Policy, Social and Civil Protection AIDS Orphans Policy, Children in Difficulty Circumstances and Support for the elderly.

Agricultural production and Marketing Policies

In the recent past, government embarked on a number of policy and institutional reforms designed to increase agricultural production. These include the conversion of Agricultural Finance Corporation (AFC) to Agribank, with flexible financing for the smallholder sector, as well as the amalgamation of agricultural research and extension into AREX to ensure that research is farmer driven. Other support mechanisms include farmer input support schemes, and commodity producers' associations such as Cotton Producers Association and Horticultural Producers Association.

Ratification of nutrition-related International Conventions

Zimbabwe has ratified many of the international goals and conventions such as the International Conference on Nutrition (1992), World Summit Goals for Children (1990), World Food Summit (1996) etc., which are supportive to nutrition outcomes.

The National Food and Nutrition Policy and the Food and Nutrition Council

The country has in place a national food and nutrition policy framework to guide nutrition interventions, as well as, experienced technical capacity to implement effective programmes

In addition, a food and Nutrition council was established under the auspices of the Office of the President and Cabinet to oversee and guide a national response to the food and nutrition challenges facing Zimbabwe regularly.

There are several nutrition programmes in place, among them the child supplementary feeding programmed, which are supported by Government and development partners.

PRIORITIES FOR DEVELOPMENT AND DEVELOPMENT ASSISTANCE

To achieve the target of halving poverty and hunger by 2015, the following priorities will need to be addressed:

Formulating and Implementing a pro-poor macroeconomic policy strategy

Formulating and implementing a pro-poor macro-economic policy strategy that is participatory, inclusive and people-cantered to ensure sustainable economic growth. Such a framework will need external support.

Consolidation of agricultural and rural development strategies

Enhance opportunities for the majority through equitable distribution of the means of production, including land, agricultural finance, inputs,

research, market access, extension services and infrastructure development.

Strengthen disaster management systems

The disaster management system is weak and in need of strengthening. In addition, social protection systems need to be strengthened to ensure that every Zimbabwean can manage risk and shocks.

Develop a nutrition advocacy strategy for people living with HIV and AIDS

There is need to develop a sustainable advocacy and communications strategy on nutrition, within the context of HIV and AIDS control programmes, to improve the quality of life for people living with HIV and AIDS.

Establish a comprehensive food and nutrition surveillance system

There is need to establish a comprehensive food and nutrition surveillance system that will provide accurate, credible and timely information. This will help to facilitate appropriate decision making at all levels, from community to policy making, for improved food security and nutrition outcomes.

Consolidate formal sector employment strategies:

There is need to develop strategies around job-creation based growth and investment policies for the formal sector.

Strategies for reversing HIV and AIDS and support for people living with HIV and AIDS

Given the strong linkages between HIV and AIDS and poverty, there is need to put in place broad-based strategies to reverse HIV and AIDS and provide support for people living with HIV and AIDS.

Development of Land Information Management Systems

A Land information system is the basis upon which productive land use patterns will be established. For example, the expansion of small- holder irrigation is one way of optimising land and increasing food production.

Consolidate existing nutrition programmes

Government and its development partners will need to strengthen all nutrition-related programmes as one approach to addressing hunger.

COSTING THE REDUCTION OF EXTREME POVERTY & HUNGER

Overview: For Zimbabwe to achieve the millennium development goals and targets, it will be necessary to have both an improvement to the policy environment as well as an increase in resources to ensure progress. The first goal emphasizes the need to reduce the number of persons living in extreme poverty. In the case of Zimbabwe, two variables are considered, consumption poverty and food poverty. The calculation for reducing extreme poverty by half is based on 13 years, from 2002 to 2015.

Reduction of consumption poverty and food poverty[7]: The target is to reduce consumption poverty from the current estimate of 80% (2002)[8] to 40%, and food poverty from the current estimate of 68% to 34% by 2015. The required growth rate in national income, as measured by real GDP per capita to achieve this target, is 5.5% per capita per annum, based on a compounded growth formula[9]. This figure assumes a population growth rate of 1.1% per annum (*inter-censal 1992 to 2002)*. Hence, the required average rate of growth of real GDP is approximately 6.6% per annum until 2015.

Development Challenge: Given the relatively high rates of growth in GDP required for Zimbabwe to halve the proportion of people living in extreme poverty by 2015, the question to pose is whether Zimbabwe's economy can grow at an average rate of 6.6% per annum over the 13-year period until 2015? Considering the extent of economic decline over the past decade, especially the negative and worsening growth rate in the past 4 years, it is difficult to envisage that the country will achieve such high growth rates. From 1991 to 1999, the economy registered a real growth in GDP[10] of 2.5% per annum. The growth worsened from 2000 to date, recording a negative growth rate of about 6.4% per annum on average. Therefore, taking into consideration the length of time required to reverse the negative trend and to raise the economy to higher growth levels, a more realistic assumption would be in the range of 4% to 5% per annum over 13 years (see table 2, scenarios 2 & 3). This would reduce both consumption and food poverty by 27% instead of 50%. Therefore, consumption poverty will move from the current level of 80% to 53% (rather than the target of 40%), and food poverty from the current 68% to 41% (rather than the target of 34%). Thus with scenario 2, poverty will not be reduced by 50%, but by 27% in 2015. The halving of poverty under a 5% real GDP growth rate will only take place by 2020 (scenario 3).

The Poverty, Inequality and Growth nexus: The derived elasticity for poverty[11] (or income

[7] Poverty measures relate to head count ratio.
[8] UNDP and Government sources
[9] Poverty in 2015 = Poverty in 2002 (1+ per capita growth)^{13}
[10] GDP is Gross Domestic Product at factor cost.
[11] Hanmer L and Nashold F ' Attaining the International Development Targets: Will Growth be Enough?' Development Policy Review vol. 18 No 1.

elasticity) for Sub-Saharan Africa, as indicated by numerous studies, is around –1.5. When applied to Zimbabwe, it suggests that Zimbabwe has to grow by at least 5.5 % per annum to make any inroads towards poverty reduction. It is important to note, however, that this will still not address the issue of inequality. For effective poverty reduction, how to reduce inequality without disrupting the growth process is the key issue in Zimbabwe. The latest income Gini coefficient for Zimbabwe is 0.57 (2001). Reductions in inequality, in their own right, are a worthy goal to pursue. In this regard, Zimbabwe is pursuing an asset redistribution (land and other productive assets) strategy to try and address issues of poverty, inequality and growth.

The 5% real GDP growth rate, combined with global partnership resources, should support an MDG 2015 poverty reduction total resource requirement of at least US$600 million (excluding HIV and AIDS Anti-Retroviral drugs) to US$2.2 billion (including ARV drugs). These costs were estimated from the cost of meeting specific goals in health, education and environment.

In addition, the Consumer Price Index (CPI) basket contains "food and beverages" that account for 50% of all items. As such, policies designed to reduce inflation will have a significant impact on the affordability of food purchased by the poor. This will help considerably to attain the Hunger reduction goal.

Growth rate and time scenarios for achieving goal 1 (see table 2)

Scenarios 1 and 2 already discussed above are an attempt to answer the following questions: What is the required real GDP growth rate in order for poverty to be halved by 2015 from its current level? What is a more realistic growth rate, considering the current status of the economy and, hence, how far can poverty be reduced by 2015? In scenarios 3, 4 and 5, the attempt is to answer the question, given realistic expectations of real GDP growth, "How long will it take to halve poverty?" Scenario 3 is a realistic option, both in terms of GDP growth (5% p.a.) and the time period required to halve poverty (18 years to 2020). Scenario 4 is a realistic option in terms of GDP growth (4 p.a.), but unacceptable in terms of the long time period required to halve poverty (24 years to 2026). The last, option 5, is unacceptable for addressing the poverty reduction challenge, as it presents a weak 3 percent GDP growth and a very long period to poverty reduction target achievement (37 years to 2038).

TABLE 2: GROWTH RATE & TIME SCENARIOS FOR ACHIEVING GOAL 1

SCENARIOS	Real GDP Growth required (%)	Poverty Reduction Outcome	Year of Outcome Achievement	General Comment
I	6.6	Reduced by 50%	2015	**13 years** Unrealistic in terms of the high GDP growth rate required
II	4 to 5	Reduced by 27%	2015	**13 years** A more realistic option in terms of the required real GDP growth rate
III	5	Reduced by 50%	2020	**18 years**. A realistic option, both in terms of GDP growth and the time period required.
IV	4	Reduced by 50%	2026	**24 years**. A realistic option in terms of GDP growth, but unacceptable in terms of the long time period required.
V	3	Reduced by 50%	2038	**37 years.** Generally unacceptable for addressing the poverty reduction challenge.

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GOAL 2

Achieve Universal Primary Education

Achieve Universal Primary Education

TARGET 3:

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

INDICATORS:

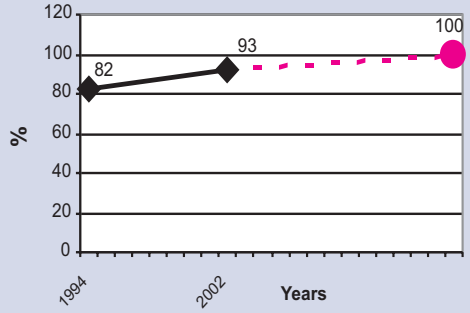
6. Primary school completion rate
7. Net enrolment ratio in primary education
8. Literacy rate of 15-24 year olds
9. Teacher pupil ratio

STATUS AND TRENDS

By the mid-1990s, Zimbabwe had achieved near universal primary education for all. In 1994 the Net Enrolment Ratio was 81.9%, improving to 93.0% in 2002 (fig. 2.1). Consequently, literacy levels for 15 – 24 year olds rose from 95% to 98% between 1992 and 1999 (Fig. 2.3). However, during the same period, the primary school completion rate[12] was 82.6%, declining to 76.1% by 1995, and further to 75.1% by 2000 (fig. 2.2).

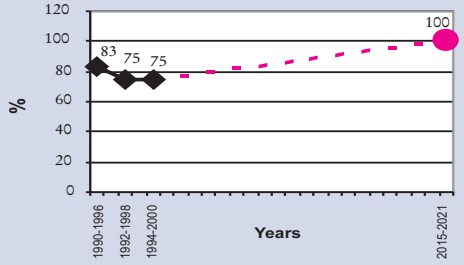
The achievement in high enrolment and literacy rates was mainly due to the universal primary education policy adopted soon after independence. By 1990, Zimbabwe had 4,530 primary schools, increasing to 4,741 in 2000, (an increase of 9.6%). During the same period, primary school enrolment increased from 2,119,881 to 2,400,669, an increase of 13%.

Figure 2.1: Net Enrolment Ratio, Primary Education, Zimbabwe,1994-2015.



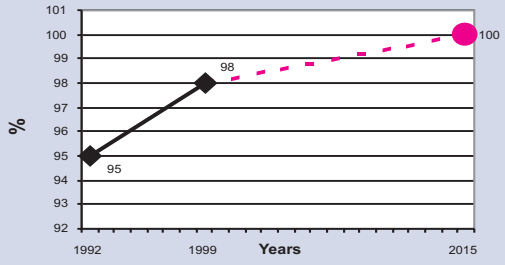
Source: Ministry of Education, Sports and Culture, Zimbabwe, 2002.

Figure 2.2: Completion Rates, Zimbabwe,1990-1996 to 2015-2021



Source: Statistics Unit: Education Management Information System: Ministry of Education Sports and Culture, 2001

Figure 2.3: Literacy rate 15-24 Years of Age, Zimbabwe, 1992-2015



Source: Central Statistical Office, Harare, 1992 Population Census and 1999 Indicator Monitoring, Labour Force Survey

Key

- Actual
- Target
- Current rate of progress
- Rate of progress required to reach goal

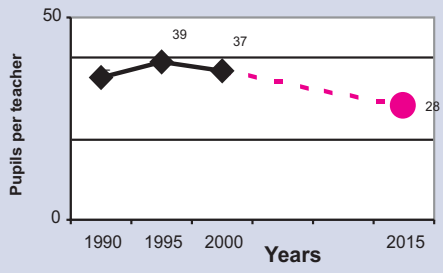
There were also significant improvements in the quality of teaching personnel in the primary education sector. In 1990, 51.5% of the 60,886 primary school teachers were trained, while 48.5% were untrained. By 2000, the proportion had

[12] Completion rate- Measures the proportion of children, in a cohort, who complete the education cycle of a particular stage

increased to 88.4% trained and 11.6% untrained, out of an increased total of 66,640 primary school teachers.

In spite of the general improvement in the provision of primary education, the quality of education has been falling, due to a high teacher to pupil ratio averaging 1:37(fig. 2.4), but is as high as 1:50 in some cases, against the desired ratio of 1:28; high book to pupil ratio; high attrition levels; and economic hardship. This situation has been exacerbated by human resource depletion due to HIV and AIDS, as well as, the need to provide for the newly resettled families under the land reform program.

Figure 2.4: Pupil /Teacher Ratio, Primary Schools, Zimbabwe, 1990-2015.



Source: Statistics Unit: Education Management Information System: Ministry of Education Sports and Culture, 2001

On gender disparities, there is a relatively higher non-participation rate of the girl child, estimated at 10%, compared with 4.9% for boys in 2000.

Thus, Zimbabwe's progress towards achieving universal education appears to be under threat especially with the current population movements into newly resettled areas, the high staff attrition levels, brain drain and the impact of HIV and AIDS.

CHALLENGES

There are various challenges that the country is faced with in achieving universal primary education:

Inadequate financing of education

While education has consistently received the highest share of resources within the national budget in nominal terms, these resources remain inadequate in real terms to maintain the desired high quality of education. This has resulted in the following:

- Low per capita and equalisation[13] grants;
- Inadequate basic teaching materials;
- High pupil to book ratio of 8 to 1 in 1997;
- High teacher to pupil ratio averaging 1:37, but as high as 1:50 in some cases in 2000, compared with a recommended ratio of 1:28;
- Poor environment for learning; and
- Inadequate infrastructure, (classrooms space, teacher accommodation and libraries, and ablution facilities).

Mapping of Primary School dropouts

In order for Zimbabwe to achieve its target of 100% primary school completion rate by 2015, the challenge is to understand the profile of school dropouts through a mapping exercise so that these can receive targeted intervention.

Population movements under Land reform

Population movements under the current land reform programme present new challenges to the provision of primary education for all children. The challenge, therefore, is to provide adequate primary school infrastructure in the newly resettled areas.

Low Teacher Morale and Brain Drain

Morale among teachers is generally very low due to the following:

- low salaries (which have been acutely eroded by the high inflationary environment) and poor staff accommodation, especially in rural areas.
- increased working loads which have worsened the working conditions and resulted in low teacher morale.

These factors have partly contributed to the massive brain drain of qualified teachers. The challenge is to continuously address teacher remuneration and working conditions.

Implementation of Decentralised Management Structures

In an effort to right-size management levels in the education system, the supervision machinery was adversely affected e.g. the abolition of the former District Education Officers Post (DEO). The challenge is to implement effectively the process of decentralised management structures.

Poverty and Hunger

General poverty and hunger, particularly in rural areas and disadvantaged communities, contribute to low enrolments, erratic school attendance, and dropouts. The challenge is to consolidate supplementary feeding programmes and other education support programmes to enable children from disadvantaged households to attend school.

HIV and AIDS

The HIV and AIDS pandemic is seriously undermining the education system, indiscriminately affecting pupils, their parents and teachers. The challenge is to reverse the spread and mitigate the impact of HIV and AIDS especially for those children orphaned by the epidemic.

[13] Equalization grants are provided to former Group B schools attended by the majority of children, in order to bring them at par with the former Group A schools with respect to facilities.

SUPPORTIVE ENVIRONMENT

As noted earlier, education continues to receive the largest vote allocation of the annual national budget since 1980. Education is also supported by other policies and programmes, such as:

Policies

a) Universal Primary Education policy adopted soon after independence,
b) 1987 Education Act, which made primary education tuition free,
c) Zimbabwe Integrated National Teacher Training Course (ZINTEC), which facilitated on-the-job teacher training, and
d) Decentralisation of functions and responsibilities to district schools and communities.

Programmes

e) Basic Education Assistance Module (BEAM), which supports children from disadvantaged communities,
f) Strong partnership support e.g. Better Schools Programme Zimbabwe (BSPZ), Education Transition and reform Programme (ETRP), Better Environmental Science Teaching (BEST), Health Promotion Schools Programme (HPSP), Management skills training for primary heads.
g) Supportive parents and communities have always had a strong commitment in education cost-sharing in the form of school fees, levies, uniforms, labour and other learning materials.
h) programs such as rural electrification, combined with ICT for development, constitute a highly supportive environment for education.

The highly supportive policy and community environment has greatly enhanced access to primary school level education.

PRIORITIES FOR DEVELOPMENT

To achieve the target of universal primary education, the following national priorities need to be addressed:

Extend school system to newly resettled areas;

Providing education and related social infrastructure in the newly resettled areas.

Allocation of additional resources for primary education development expenditure;

Rationalize budget priorities to free additional resources for development expenditure on primary education. Some resources must be targeted at combating the problem of school dropouts.

Address HIV and AIDS in the education sector;

Consolidate strategies to reverse HIV and AIDS prevalence and its impact in the education sector.

School infrastructure development.

Expansion of school infrastructure and the provision of better learning conditions for children and good working environment for teachers.

Address Brain Drain

Even though sufficient numbers of primary school teachers have been trained, many have left the education sector due to poor working conditions. Thus addressing teacher's working conditions (salaries, accommodation, water) is a national priority.

Provide for children with learning disabilities

Provision of facilities for disabled children in the national school system to enable the disabled attend school.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Zimbabwe's progress towards achieving universal and quality primary education could be enhanced by focusing on the following priorities for development assistance.

- Provision of support for school infrastructure development, including learning and teaching materials.
- Support for the prevention and mitigation of HIV and AIDS to children and education personnel.
- Provision of facilities that cater for children with physical disabilities in the regular schooling system.

COSTING THE UNIVERSAL PRIMARY EDUCATION GOAL

Overview: The MDG focuses on the completion rate of Primary education. In this regard, two considerations are worth mentioning. First and foremost, the affordability of parents - the demand side of education - to send the child to school without interruption for 7 years of schooling, including the fact that some parents may be able to afford the cost of education, but may not think that it is a priority, especially for girls. The second consideration - the supply side of education - is the Government's willingness and ability to allocate more resources for education to bring about a higher enrolment rate and improvement to the quality of education. Combining the demand and supply sides, it is reasonable to conclude that simply allocating more government resources will not necessarily result in higher enrolment or completion rates, given constraints such as

weaknesses in service delivery and cases where low enrolment rates are concentrated in certain parts of the country. As such, in order to ensure higher enrolment rates, more resources from the Government will need to be equally matched by a rise in household incomes.

Costing Method for Primary Education: The approach used for calculating the cost of meeting the primary education goal is the application of 'Unit Cost' method. The unit cost for a particular year is obtained by dividing the expenditure incurred in providing the education by number of children enrolled. The figures for expenditures are generally available on a yearly basis as budget-revised estimates and actual or via audited accounts of government. However, data on enrolment rates, dropout rates and completion rates are harder to ascertain on a regular basis. Therefore, not only do the allocation of spending become difficult, but also assessing the impact of spending.

Projected Cost on Primary Education[14]*:* The goal for Zimbabwe is to increase completion rates from 76% in 2000 to 100% in 2015, also taking into consideration an annual 1.1% increase in population.

Without quality improvement:

Basic assumptions (in year 2000):

- *Students enrolled = 2.4 mn*
- *Completion rate = 75%*
- *Budget expenditure = Z$25,585 mn*
- *Per child expenditure = Z$ 6618.8*
- *Per child expenditure = US$ 120.3*

Given these assumptions, annual real increase in expenditures to attain 100% (including 1.1% population increase) completion rate by 2015 is 4.5% per annum. Average spending over the period should increase to US$ 171 per child. The total resource requirement, under this scenario, amounts to US$381million, or an average of US$25.4 million per annum.

With quality improvement:

The goal for Zimbabwe is to achieve the above, but, additionally, to improve the quality as defined by;

- Average class size being reduced from the current pupil teacher ratio of 37 to 28.
- Number of teachers increased by 4.3% per annum between 2000 and 2015.
- An increase in real spending (based on 2000) in salaries and wages of 11% per annum until 2015.
- Supplies per child increased in real terms by 50% between 2000 and 2015, implying an increase of 3.3% per year.

Given these assumptions, annual real increase in expenditures to attain 100% (including 1.1% population increase) completion rate by 2015 is 6.5% per annum. Average spending over the period should increase to US$ 198 per child. The total resource requirement under this scenario amounts to US$447.8 million, or an average of US$29.8 million per annum.

[14] The average unit cost is derived from Budget Estimates 2000 (Vote 17- Education, Sport and Culture) and statistics available for net completion rate, numbers of students enrolled in primary education in 2000. Both recurrent and capital expenditures are taken in to account in estimating Unit Costs.

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Promote Gender Equality and Empower Women

Promote Gender Equality And Empower Women

TARGET 4(A):

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

INDICATORS:

10. Net enrolment ratios by gender, primary education level
11. Net enrolment ratio by gender, secondary education level
12. Literacy rates of 15-24 year olds by gender
13. Net completion rates by gender, for primary and secondary education
14. Percentage of enrolment and completion rate in universities

TARGET 4(B):

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 women in Parliament) by 2005 and to 50:50 balance by 2015.

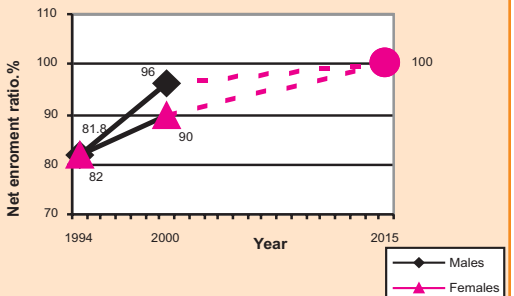
INDICATORS:

15. Percent of women in parliament
16. Percentage of women in the Civil service who are at Under Secretary level and above
17. Percentage of women in the private sector who are at managerial level
18. Percent of women in local government decision-making bodies

STATUS AND TRENDS

Significant progress has been made in narrowing gender disparities in both primary and secondary education. In 1994, net primary school enrolment ratio was 81.8% male and 82% female. By 2000, a gender disparity had begun to emerge with the primary school net enrolment ratio for male rising to 96% and female to 90% (see fig. 3.1). The target is to reach 100% for both genders by 2015.

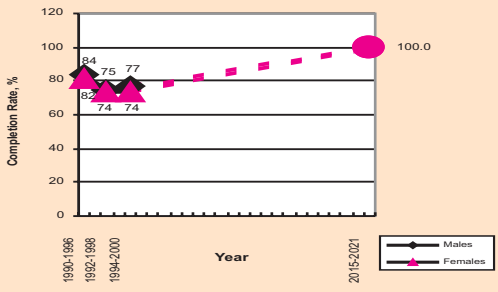
Figure 3.1: Gender Disparities in Primary School Enrolment, Zimbabwe,1994-2015.



Source : Ministry of Education and Culture, Statistics Unit, Education Management Information System 2001

In 2000, Primary school completion rate was 77% male and 74% female (see figure 3.2). Net secondary school enrolment in 2000 was 42% male and 40% female, with completion rates of 82% male and 73% female (see figure 3.3). The target is to reach 100% enrolment and completion for both genders by 2015.

Figure 3.2: Gender Disparities in Primary School Completion Rates, Zimbabwe,1992-2015.

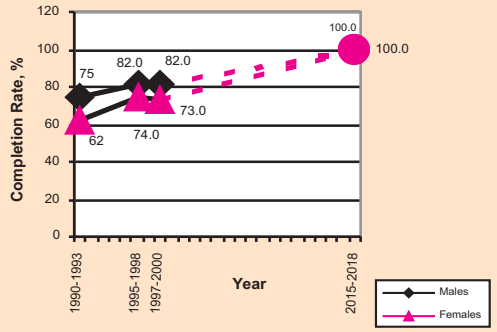


Source :Ministry of Education and Culture,Statistics Unit, Education Management Information System, 2001

Key

- Actual
- Target
- Current rate of progress
- Rate of progress required to reach goal

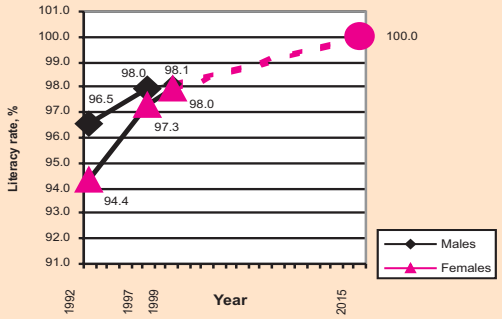
Figure 3.3: Gender Disparities in Secondary School Completion Rates, Zimbabwe,1992-2015.



Source : Ministry of Education and Culture, Statistics Unit, Education Management Information System, 2001

Literacy rates of 15 – 24 year olds in 1999, by gender, were 98.1% male and 98% female (see fig. 3.4). The target is to reach 100% literacy rate for this age group by 2015.

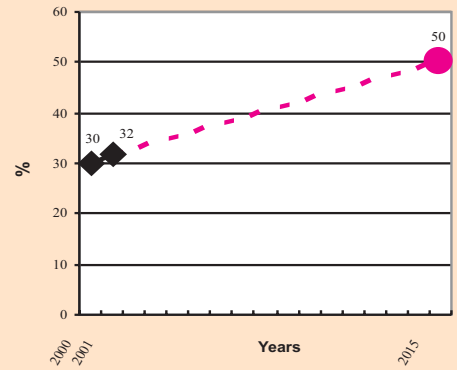
Figure 3.4: Literacy rates of 15-24 year Olds by Gender, Zimbabwe,1992-2015.



Source: Central Statistical Office, 1992 Population Census, 1997 Intercensal Demographic Survey and 1999 Indicator Monitoring, Labour Force Survey.

The higher one progresses in the education system, the lower the representation of women. For example, enrolment in Universities shows that in 2000 30% of enrolment in the five main state and private universities were women. This figure rose slightly to 32% in 2001 (see figure 3.5). This is despite the fact that there is an affirmative action policy being implemented in the country. The target is to reach 50% by 2015.

Figure 3.5: Enrolment in Universities*, % Women Zimbabwe, 2000-2015.



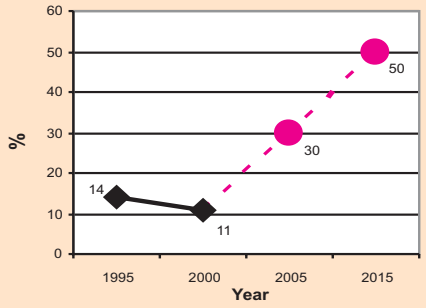
Source: Ministry of Higher Education And Technology, Zimbabwe, 2002 .
*Note : * Refers to 5 Universties where data is available namely University of Zimbabwe, Bindura University, National University of Science and Technology, Solusi University and Africa University*

Despite the current economic problems the country is facing, the target of eliminating gender disparity in primary and secondary education, preferably, by 2005 and at all levels not later than 2015 is achievable.

The status of women in Zimbabwe, though being continuously addressed, remains low. This is because the issue of gender inequality goes beyond empowerment to encompass issues of social justice and discrimination. For this reason, it is important that adequate measures are taken not just to encourage the empowerment of women, but also to address those imbalances driven by customary practices at different levels (political, social and economic) of society.

For example, women are still under represented in political decision making, particularly in Parliament. In the first two parliaments after independence, women constituted fewer than 10% of Members of Parliament. In the third parliament (1990-1995), there was an improvement in female representation to 14%. And this proportion has since fallen to 11% by 2000 (fig. 3.6). The target is to reach 30% by 2005, and 50% by 2015.

Figure 3.6: Women in Parliament, Zimbabwe,1995-2015.

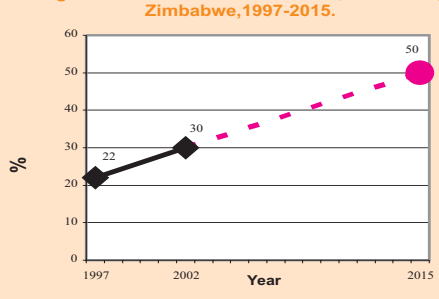


Source: Parliament of Zimbabwe, 2002

In the area of decision-making in 2003, 3 out of 21 cabinet ministers are women, and of the 8 provincial governors, only 1 is a woman.

In 1997, about 22% of senior civil service positions were held by women, which rose to 30% in 2002 (see figure 3.7). The target is to reach 50% by 2015.

Figure 3.7: Senior* Civil Servants , % Women, Zimbabwe,1997-2015.



Source: Public Service Commission, Zimbabwe, 2002,
*Note : *Senior refers to Under Secretary Level and Equivalent*

Though statistics are not available on the number of women executives in the private sector, it is common knowledge that the situation of women in the private sector is less representative than that of the public sector.

The past years have seen a dramatic increase in the number of women that suffered from physical and sexual violence. This is partly explained by the deteriorating socio-economic situation, as well as, the negative cultural beliefs related to the cure of HIV and AIDS and STIs.

CHALLENGES

There are a number of challenges associated with promoting gender equality and empowering women in Zimbabwe. These include:

- **Cultural factors**

Certain negative cultural practices and norms continue to constrain women's enjoyment of rights, such as matrimonial, inheritance and reproductive rights, as well as, protection from all forms of violence. The challenge is to do away with such negative cultural practices.

- **Elimination of gender disparity in education**

While the achievement to date in gender equality for education is commendable, the challenge is to prevent the widening gap in enrolment and completion rates in secondary and tertiary education, as well as, ensuring high quality education at all levels. After all, education is the main tool for women empowerment.

- **Political and Economic empowerment**

The current weak economic performance has worsened the gender imbalances in the economy. The challenge is to design and implement a broad-based economic growth and development strategy that is pro-poor and pro women empowerment. On the political side, the challenge is to implement a quota system to achieve fair representation of women.

- **HIV and AIDS**

If the gender dimensions of HIV and AIDS are not clearly addressed, then the nation risks undermining the achievements made so far in all sectors of the economy. The challenge is to adopt a gender and human rights approach to HIV and AIDS interventions at all levels.

- **Attitude Change in women**

Generally, women have resigned themselves to accepting certain culturally stereotyped roles. The challenge is to educate and expose women and girls to non-traditional role models of their gender, so as to create a new positive attitude in them with respect to what they can be and do.

- **Gender Mainstreaming**:

Implementing gender mainstreaming into all national policies and programmes is a critical challenge that requires financial, human and technical capacity.

- **Gender disaggregated data**

Lack of gender disaggregated data makes informed policy formulation and evaluation difficult. The challenge is to instil a tradition of disaggregation of data by gender at all levels.

SUPPORTIVE ENVIRONMENT

The post independence period saw the formulation of policies and programmes that were designed to create an enabling environment for the attainment of gender equality and empowerment of women.

- **Adoption of the National Gender Policy and legislation**

The National Gender Policy adopted in 2002 is expected to guide the implementation of gender sensitive programmes and policies. This is also supported by various legislation which include: Equal Pay Regulation, Legal Age of Majority Act (LAMA), Sexual Discrimination Removal Act, Amendment of the Administration of the Deceased Estates Act and the Sexual Offences Act. In addition, the country is a signatory to the most important global instrument that protects the rights of women, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).

- **The Establishment of a Gender Department**

The establishment of a Gender Department in the Ministry of Youth Development, Gender and Employment Creation enhanced the institutional framework for addressing gender issues.

- **Mainstreaming Gender in Education**

In addition to the other educational policies enacted by government, there is the Basic Education Assistance Module (BEAM), where 50% of the benefits go towards education for the girl child from primary to secondary schooling.

PRIORITIES FOR DEVELOPMENT

To achieve the target of promoting gender equality and empowering women by 2015, the following national priorities need to be addressed:

- **Accelerated and sustained effort in Education**

There is need to sustain the effort of gender equality in education at all levels, particularly at secondary and tertiary levels, and without

compromising quality. As such, education must remain a priority sector in the national budget so as to improve completion rates for boys and girls.

Political and Economic Empowerment

There is need to design and implement a broad-based economic growth and development strategy that is pro-poor and is supportive of women empowerment. Political empowerment will, in the first instance, require the application of affirmative action or the quota system to facilitate the achievement of targets in parliament and other political decision making bodies.

Gender Dimension to HIV and AIDS

The gender dimensions to HIV and AIDS will need to be addressed explicitly in policies and programmes in all sectors. The multi- sector response to HIV and AIDS should emphasize the gender and human rights approach to HIV and AIDS interventions at all levels. There is need to build national capacity in the collection and analysis of gender disaggregated data for policy intervention.

Gender Mainstreaming

Since the issues of gender are closely linked to HIV and AIDS, it is important to build the national capacity to mainstream gender and HIV and AIDS into national policies and programmes. This mainstreaming will also need to be monitored for impact to ensure effectiveness.

Cultural factors

In order to overcome entrenched cultural attitudes that discriminate against women, there is need to undertake countrywide advocacy campaigns to do away with such negative cultural attitudes. In addition, internalising already ratified international conventions and declarations on gender would help consolidate all efforts.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Zimbabwe's progress towards promoting gender equality and women empowerment could be enhanced by channelling development assistance to the following areas:

- Gender targeted credit and ancillary support services
- Capacity building for collection and analysis of gender policy and disaggregated data
- Supporting gender equitable education
  Public awareness campaigns to eliminate discriminatory practices and attitudes including domestic and sexual violence
- Support to HIV AND AIDS gender awareness campaigns and home-based care programmes.

COSTING THE GENDER EQUALITY AND WOMEN EMPOWERMENT GOAL

Overview: Since target 4 (A) under this goal is primarily about gender equality and empowering women through education, the assumption is that the costs for attaining this goal are partially captured under the primary education goal (Goal 4). To fully cost gender, it would require information on how much it costs to get an equal proportion of women into secondary and tertiary education, as well as an estimate of the skills gap for some of the critical skill areas, such as medical doctors, engineers, economists, business executives, R&D scientists, etc. In addition, target 4 (B) can also be argued to be partially captured in the costing of the poverty and health goals, which are linked to economic empowerment and the general welfare of women. The overall costing of gender, therefore, has a heavy data demand, which could not be met during the preparation of this first report. It is hoped that the attempt to cost this goal will be made in subsequent reports.

While it is useful to know the costs associated with the attainment of gender equality and women empowerment, the greatest challenge in attaining this goal is in the implementation of gender equality and women empowerment strategies in all sectors of the economy. This implies that the implementation of the other MDG goals in a gender sensitive manner is of greater importance.

"As a Nation with Oneness of Purpose, Together we can Score this Goal!"

Reduce Child Mortality

Reduce Child Mortality

TARGET 5:

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

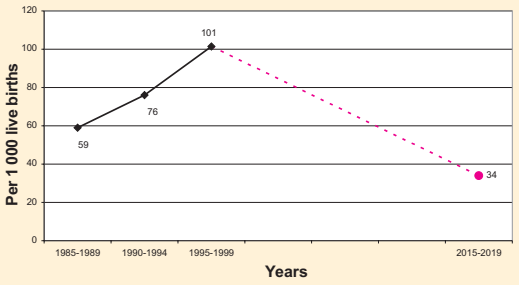
INDICATORS:

19. Under-five mortality rate[15] (deaths per 1000 live births)
20. Infant mortality rate[16] (deaths per 1000 live births)
21. Percentage of under-fives who are undernourished
22. Percentage of children vaccinated against measles

STATUS AND TRENDS

During the 1980s, infant and child mortality had declined. By the 1990s, however, overall mortality as well as infant and child mortality began to rise as shown in Figure 4.1. The rise in mortality is mainly attributed to the direct and indirect impact of the HIV and AIDS epidemic and the concomitant rise in poverty levels.

Figure 4.1: Under five Mortality Rate , Zimbabwe, 1985 -2015



Source: Central Statistical Office, Zimbabwe, Demographic and Health Survey 1999

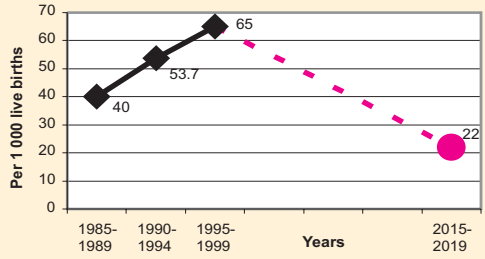
Key

- ◆ Actual
- ● Target
- ——— Current rate of progress
- - - - Rate of progress required to reach goal

Infant mortality increased from 40 to 65 per 1000 live births, while under-five mortality increased from 59 to 102 per 1000 live births between 1985-89 and 1995-99 (see Figures 4.1 and 4.2). This implies that one in 15 children will die before their first birthday and that one in ten children will die before attaining the age of five years, respectively.

The Zimbabwe Demographic Health Survey (ZDHS) 1999 indicates that the infant mortality rate for the ten year period preceding the survey was 47 deaths per 1000 live births in urban areas compared to 65 deaths per 1000 live births in rural areas. The target is to reduce under-five mortality from 102 per thousand during the period 1995-99 to 34 per thousand by 2015, while infant mortality is targeted to be reduced from 65 per thousand during 1995-99 to 22 per thousand by 2015. Furthermore, the same survey also revealed that there is a strong association between a mother's level of education and a child's chances of survival. While the children of mothers with no education experienced an under-five mortality rate of 119 per 1000, those of women with higher than secondary school education experienced mortality rates as low as 21 per 1000. This illustrates that better-educated mothers are likely to have greater knowledge of nutrition, hygiene and other practices related to childcare and are more likely to use health services. Moreover, 25% of households have no access to safe water and 42% have no access to sanitation, which further exposes children to the risks of water-borne diseases.

Figure 4.2: Infant Mortality Rate, Zimbabwe, 1985-2015

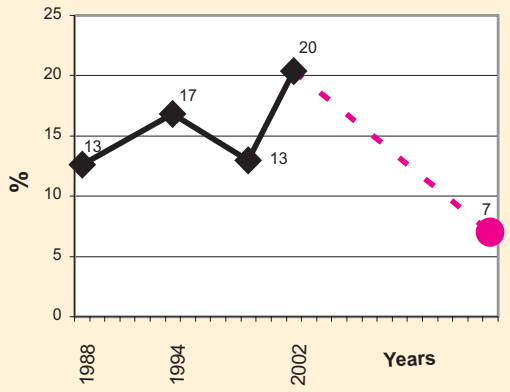


Source: Central Statistical Office, Zimbabwe, Demographic and Health Survey 1999

[16] The probability of dying between birth and the first birthday.

The proportion of under-fives who are undernourished (weight-for-age) increased in recent years, from 13% in 1999 to an estimated 20% in 2002 (see Figure 4.3). About 34% of child deaths in Zimbabwe are attributable to malnutrition. The target is to reduce under-five malnutrition from the national average of 20% in 2002 to 7% by 2015.

Figure 4.3: Percentage of Under Five Year Olds who are Under Nourished,1988,1994,1999, 2002 and 2015

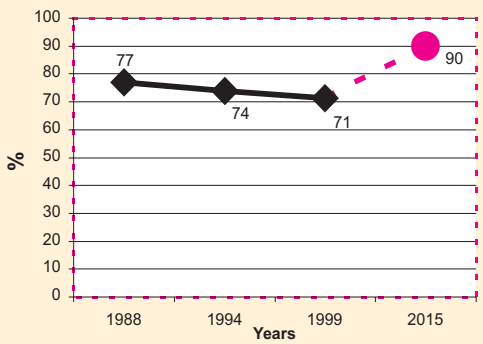


Sources: CSO, Demographic and Health Surveys 1988, 1994 and 1999. Ministry of Health 2002,
Note: For 1988 and 1994 its for children 3-35 months and not under five years.

Prevention programmes such as immunisation against childhood illness also contribute to the reduction of prenatal, neonatal and child mortality. The Zimbabwe Expanded Programme on Immunisation (ZEPI) was introduced in 1982 and the country's development objective was to increase coverage of all ZEPI vaccines to 90% by the year 2000. The completion of the Primary Course of Vaccination (PCV) is one of the criteria for the assessment of the quality of the programme and its effectiveness. There was a general rise in the trend of PCV coverage during the period 1992-1994. By 1997, the PCV coverage had risen to 96.6%.

However, measles immunization has been on the decline from 77% in 1988 to 74% in 1994, declining further to 71% in 1999 (see Figure 4.4).

Figure 4.4: Measles Immunisation, Children Under Five Years of Age, Zimbabwe,%



Source: Central Statistical Office, Zimbabwe, Demographic and Health Surveys, 1988, 1994 and 1999. Note: For 1988 it is the % of children under 5 years who are immunoised as recorded on the Health Card.

The decline in measles vaccination is attributed to a weakening health delivery system, shortage of drugs, high staff shortages and the presence of child and grandparent headed households due to the HIV and AIDS epidemic. The target is to reach 90% measles immunization by 2015.

CHALLENGES

There are a number of challenges in the reduction of infant and child mortality rates by two-thirds, between 2000 and 2015.

HIV and AIDS and other diseases

The HIV and AIDS epidemic has placed children under an increased state of vulnerability. In addition, other main causes of infant and child mortality are acute respiratory infection, malnutrition, malaria and diarrhoeal diseases and pulmonary tuberculosis. The challenge is to reverse the HIV and AIDS epidemic, as well as reduce the incidence of other child killer diseases.

Parent-to-child transmission of HIV

The growing phenomenon of parent-to-child transmission at birth is largely responsible for the worsening infant and child mortality trends in Zimbabwe. The challenge is to reduce the transmission of HIV from mother to child, while at the same time reversing the prevalence of HIV infection. Interventions such as antiretroviral drugs, caesarean section and alternative infant feeding options can significantly reduce the percentage of transmission.

Poverty, Hunger and Malnutrition

The ability of households to take care of their children is affected by the magnitude of poverty. In the absence of public feeding programs, children from poor households are more prone to suffering from hunger and malnutrition. Infant and child mortality rates are higher among poor households. Thus the increase in poverty levels in both rural and urban areas impacts negatively on the mortality of children. The challenge is to stimulate broad-based sustainable economic growth and development as well as to consolidate effective child-feeding public programmes.

Weakened Health Delivery System

While the health budget has increased in nominal terms over the past years, in real terms it has decreased due to the hyperinflationary environment. This has made the procurement of essential drugs and equipment, as well as the retention of staff difficult. In addition, the impact of HIV and AIDS and brain drain on human resources in the health sector has been particularly severe. The challenge, therefore, is to protect social sector expenditure within the national budget in order to support the

strengthening and transformation of the health delivery system given the HIV and AIDS pressures.

Information, Education, and Communication (IEC) in Child care

Improved awareness in childcare by mothers has a direct positive impact on child mortality. The challenges are ensuring education of the girl child and access to information on childcare for all mothers, in particular those in the remote parts of the country.

Safe Water and Sanitation

Provision of safe drinking water and adequate sanitation are preconditions for improved child welfare. The challenge, therefore, is to provide safe drinking water and sanitation in order to combat the impact of water borne diseases, such as diarrhoea.

Universal Immunization of Children

The declining trend in measles immunization is a source of concern. The challenge is to ensure universal immunization against all child killer diseases.

Adolescent pregnancies

Children born to adolescent mothers are vulnerable to inadequate childcare due to inexperience and lack of resources. In addition, they are more likely to have low birth weight, which increases their mortality risk. Also, pregnant teenagers are more likely not to have antenatal and postnatal care when compared to mature women. The challenge is to reduce adolescent pregnancies by encouraging, among other things, the education of the girl child.

SUPPORTIVE ENVIRONMENT

Zimbabwe has various policies and programmes that are supportive to the reduction of infant and child mortality. Some of these include:

HIV and AIDS Emergency declaration

The Government has declared a state of emergency for the next five years in order to facilitate the procurement of antiretroviral and related drugs, including PMTCT to mitigate the impact of the HIV and AIDS epidemic.

Re-introduction of the village health worker

The government has reintroduced the Village Health Worker programme to strengthen communities. As a result, IEC and child-care and mothers' health will be strengthened.

Free treatment of the under five and pregnant women in public institutions

Free treatment of the under five and pregnant women in public institutions, in both rural and urban areas, has a direct positive bearing on the health of the child and the mother, particularly when the health institutions are well equipped.

Expanded Programme on Immunization:

The Expanded Programme on Immunisation (EPI) has maintained a high coverage of above 90%. Zimbabwe observes and conducts National Immunisation days and institutes effective surveillance, thus creating a conducive environment for universal immunization of children.

Child Supplementary Feeding Programmes

The Child Supplementary feeding Programme provides supplementary food for under-five children, particularly during periods of food shortages.

Orphan Care Policy

Support to orphans is a state obligation under the Convention of the Rights of the Child. The Orphan Care Policy adopted by the Cabinet in 1999 covers free health care and food subsidies/ supplements to under fives. This has created a conducive environment to protect children from hunger and malnutrition.

Supportive education policies and programmes

Child friendly programmes, such as BEAM and affirmative action, help to keep the girl child in school, thus reducing the risks of adolescent pregnancies. In addition, the educated girl child faces a better chance of becoming a good mother, with respect to child-care.

PRIORITIES FOR DEVELOPMENT

To achieve the target of reducing child mortality by 2015, the following national priorities need to be addressed:

Increase coverage of immunisation programme

There is need to sustain the high coverage of immunization against most childhood killer diseases, and particularly to increase and sustain high child immunisation against measles.

Prevention of Parent To Child Transmission (PPTCT)

Take full advantage of the extended declaration of emergency on the HIV and AIDS infection to procure and administer drugs on PPTCT to reduce child mortality.

Improved Access to Health Care facilities (particularly in the new resettlement areas)

Strengthen the health delivery system in general, given the increased demand from the HIV and AIDS epidemic. Particular attention should be given to newly resettled, rural and remote areas.

Availability of essential medicines and vaccines, especially antiretroviral drugs for PPTCT

Rationalize further priorities within the national

budget, so as to release more resources for the health sector, with an emphasis on improving working conditions for health personnel.

Access to safe water and adequate sanitation.

Consolidate and expand existing coverage of safe-water and sanitation programmes in both rural and urban areas and in particular to the newly resettled areas.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Major areas for development assistance to meet the challenges for reducing child mortality are as follows:

- Sustained increase in immunization coverage
- Procurement of Essential drugs and Health infrastructure development, including PPTCT antiretroviral drugs.
- Provision of Safe Water and Sanitation

COSTING THE CHILD MORTALITY REDUCTION GOAL

Overview: While many of the comments made under education are also applicable to this goal, the health sector has its own characteristics. The main one has to do with the kind of priority accorded by the household to healthy living and longer survival. Government, in turn, has to judge carefully how much of its health budget should be divided between preventive care and curative care. In general, allocating comparatively more funds to preventive care has a greater impact on reducing infant, Under-5 and maternal mortality. A majority of infant and child deaths are caused by not having access to clean water and, in such cases, it may be useful to spend more in the water sector. In addition, there are other preventive factors, such as better education for mothers that help to reduce child mortality. It suggests, therefore, that attaining certain health targets will require not just spending in the health sector alone, but also spending in other sectors such as water and education.

Given these related factors, it makes the projecting of unit cost for the child mortality goal a complex one. It follows, therefore, that the expenditure requirements for each of the sectors needs to be assessed carefully, and only by getting the mix of spending correctly will this target be achieved. Furthermore, as stated under primary education, it is important to know how the cost of treatment should be shared between the Government and Household. Additionally, given that the parent of the child has to pay part of this cost, an assessment on the income and affordability of the household should be made on a regular basis.

Unit cost on Child Mortality and projections

The Zimbabwe targets, in accordance with MDG, are to reduce;

- Infant mortality by 66%, from 65 per 1000 live births in 2000 to 22 per 1000 live births by 2015.
- Under-5(U-5) mortality by 66%, from 102 per 1000 in 2000 to 34 per 1000 by 2015.
- Maternal mortality by 75%, from 695 per 100000 in 2000 to 174 per 100000 by 2015.
- Additionally, Zimbabwe aims to improve on such input indicators as – doctors per patient, supplies per patient,
  bed per patient etc.

The average cost estimates are based on Budget Estimates of 2000 (Vote 16 – Health and Child Welfare) and Statistics on mortality indicators available for 2000. Both recurrent and development budget estimates of the health sector are used to derive average unit cost. Within the Health budget, 100% of preventive care services expenditure and 10% of all other expenditures are taken in calculating unit cost for the projections. Due to data limitations, it is assumed that all three mortality indicators are grouped in to one unit cost. With more des-aggregated data that is reliable and more frequently available, the unit costs of each mortality goal can be estimated separately.

Given these assumptions, annual real increase in expenditure to attain the above-defined goals (including 1.1% population increase), health expenditure per child/mother should increase at 3.5% per year. Average spending over the period should increase from the current level of US$ 35.4 per child/mother to US$ 46.4 per child/mother. In parallel, total health spending over the period to 2015 should be US$43.2 mn.

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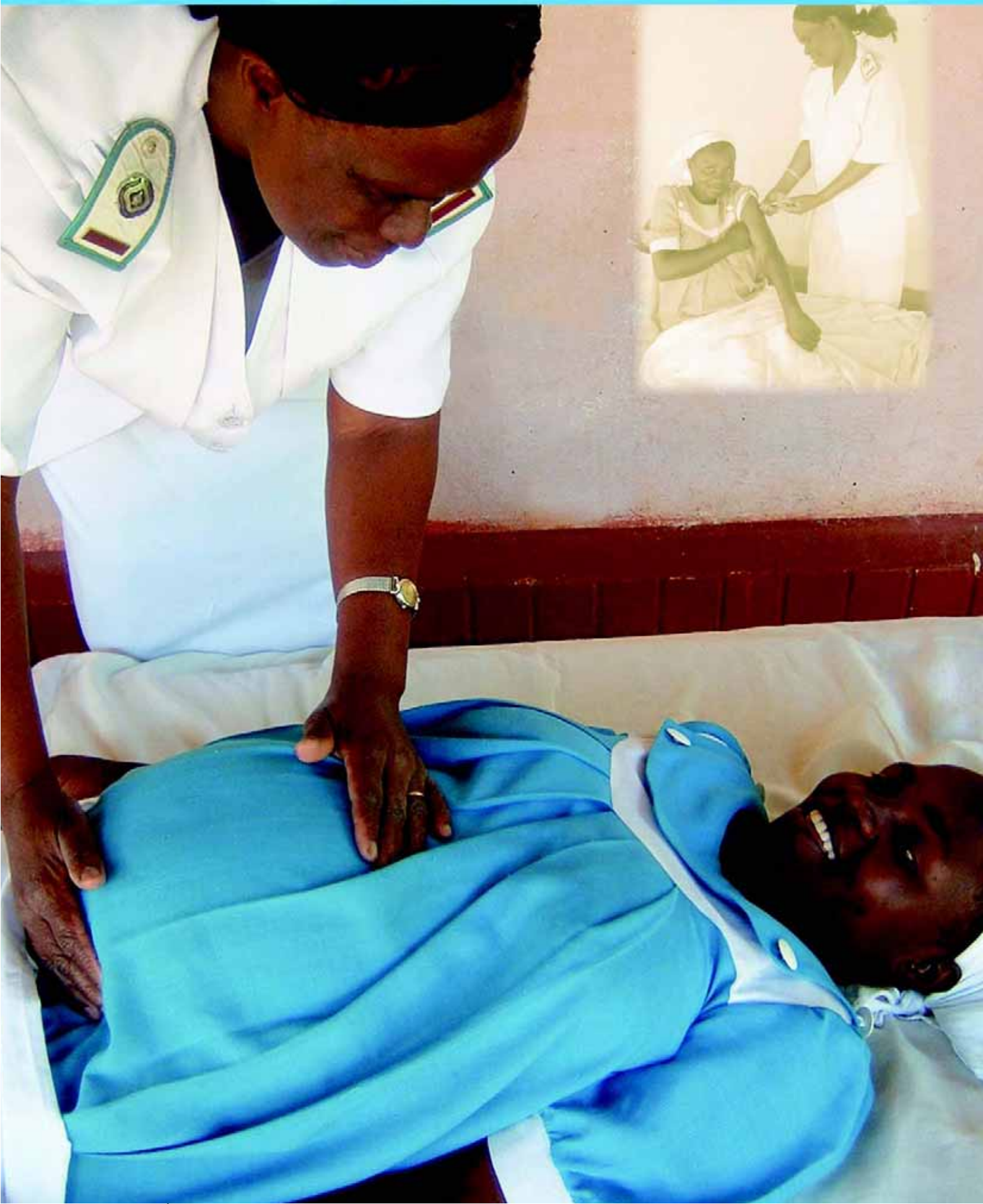
Improve Maternal Health



Improve Maternal Health

TARGET 6:

Reduce by three-quarters, between 2000 and 2015, the maternal mortality ratio.

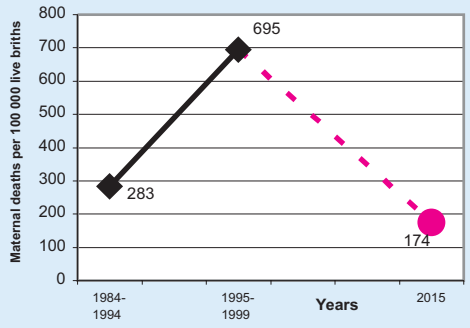
INDICATORS:

23. Maternal mortality ratio
24. Proportion of births attended by skilled health personnel

STATUS AND TRENDS

Maternal mortality continues to be a major problem in Zimbabwe. Based on estimates from the early 1980s, maternal mortality figures were estimated to be 283 deaths per 100 000 live births in 1984 -1994 rising sharply to 695 per 100 000 live births in 1995 –1999, as shown in figure 5.1. This sharp rise in maternal mortality rate is largely explained by the rapid spread of the HIV AND AIDS epidemic.

Figure 5.1: Maternal Mortality Ratios, Zimbabwe, 1994-2015.



Source: Demographic and Health Survey, Zimbabwe 1999

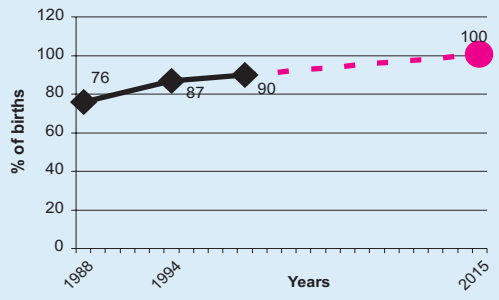
Key

- ◆ Actual
- ● Target
- Current rate of progress
- Rate of progress required to reach goal

The magnitude of maternal deaths can be reduced if mothers have access to antenatal, delivery and post-natal care. The lack of maternal care is reflected in delays in seeking medical care, receiving care, referral to an upper level hospital, and shortage of labour and essential obstetric care equipment. In addition, addressing specific maternal nutrition and diet-related problems, such as under nourishment, micro-nutrient deficiencies (iron and vitamin A) and diet related chronic diseases such as diabetes and cardiovascular disorders will go a long way in reducing maternal mortality.

According to ZDHS (1999), 72.2% of births nationally take place in health facilities. The survey states further that, 11.6% of deliveries were assisted by a doctor, 60.9% by a nurse, 17.6% by a traditional midwife and 6.3% by relatives or other people. This implies that about 90% of births were attended to by skilled health personnel (doctor, nurse or traditional birth attendant) in 1999. This is an improvement from the level of 87%[17] in 1994 and 76%[18] in 1988, as shown in figure 5.2.

Figure 5.2: Births attended to by Skilled Personnel, Zimbabwe 1988 - 2015, %



Source: Demographic and Health Survey, Zimbabwe 1999 Note: For 1988 and 1999 it is births in 5 years preceding the survey and in 1994 it is 3 years

CHALLENGES

Zimbabwe is faced with a number of challenges in the area of reducing maternal mortality. These include:

[17] Refers to live births in the three years preceding the ZDHS 1994
[18] Refers to live births in the five years preceding the ZDHS 1999

HIV and AIDS epidemic

The HIV and AIDS epidemic has placed mothers under an increased state of vulnerability. The challenge is to reverse the HIV and AIDS epidemic and mitigate its impact through the provision of antiretroviral drugs and other measures.

Essential and Emergency obstetric care services

The challenge is to mobilize both domestic resources and development assistance to ensure the availability of essential drugs and equipment necessary for the provision of high quality obstetric care.

Inadequate access to health delivery services

While health facilities in urban centres are generally within reach, in rural areas, mothers are often discouraged by the long distances they have to travel to reach a health facility. The immediate challenge is to extend primary health care facilities/clinics to rural populations.

Training and Equipping Traditional Birth Attendants

While there is need to consolidate the training of traditional birth attendants in most communal areas, the immediate challenge is to expand the programme into newly resettled areas, where health facilities are generally not available.

Addressing Maternal Malnutrition

Nutrition highlights the importance of maintaining good maternal health, given that it is generally women who sustain the food cycle from production, harvesting, storage, processing, to preparation, and consumption. In addition, issues relating to availability of local food crops, diet diversity and quality are important. Given the centrality of women in rural households, the challenge is to ensure that the nutrition of mothers is a priority at the household level.

Improving the data collection method in the maternal mortality ratio

Without an accurate measurement of the maternal mortality ratio, it will be difficult to assess the progress that the country is making in reducing mortality rates. The challenge is to develop appropriate methods of measuring maternal mortality.

Gender inequalities

Generally, in Zimbabwe, women still have limited control over their sexuality and reproductive rights. The challenge is to improve education for women and to reduce the gender inequity that prevents women from making reproductive choices.

Negative cultural practices

Culture and tradition have a significant influence on the decision to seek antenatal care. The challenge, therefore, is to empower women through IEC to enable them to make informed decisions concerning their maternal and general health issues.

SUPPORTIVE ENVIRONMENT

Although the issue of maternal health has not received as deemed necessary, the Government has put in place a number of policies and programmes in support of the goal of improving maternal health. Some of these include:

HIV and AIDS Emergency declaration

The Government has declared a state of emergency for the next five years in order to facilitate the procurement of antiretroviral and related drugs to mitigate the impact of the HIV and AIDS epidemic.

The Essential Obstetric Care Package

The Essential Obstetric Care (EOC) refers to an abbreviated list of services designed to save the lives of women with obstetric complications. The practical application of this package has a potential to lower the current maternal mortality ratio.

Free health services to pregnant women in the public sector

This programme assists women, especially the poor in both urban and rural areas, to access medical services at both prenatal and postnatal stages.

Maternity-leave with full pay

The introduction of maternity leave with full pay creates a conducive environment for the good health of mother and child.

PRIORITIES FOR DEVELOPMENT

In order to improve maternal health and well being, the following priorities need to be addressed:

HIV and AIDS

Take full advantage of the extended declaration of emergency on the HIV and AIDS infection to procure and administer antiretroviral drugs to reduce maternal mortality.

Expansion of the Essential Obstetric Care Programmes.

Mobilize both domestic resources and development assistance to ensure the availability of essential drugs and equipment necessary for the provision of high quality obstetric care.

Training of traditional midwives

Consolidate the training of traditional birth attendants with priority being given to newly resettled areas, where health facilities are generally not available.

Establishment of fully equipped referral facilities

Establish primary health care facilities/clinics in newly resettled and remote areas. At the same time, overall access to comprehensive health

delivery services should be improved for both urban and rural populations.

Addressing Maternal malnutrition

Given the centrality of women in rural households and for national food security, it is important to ensure the good health of women, in general, and for child-bearing mothers in particular.

Capacity strengthening in maternal mortality data collection and analysis

Strengthen the capacity at all levels for the collection of data and measurement of maternal health.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Major areas for development assistance to meet the challenge of improving maternal health are as follows:

- HIV and AIDS Emergency declaration for assistance in drug procurement.
- Expansion of Essential Obstetric Care Programmes.
- Establishment of fully equipped referral health facilities.
- Capacity strengthening in skilled human resources and maternal health data collection and measurement.

COSTING THE MATERNAL HEALTH IMPROVEMENT GOAL

Overview: While many of the comments made under education are also applicable to this goal, the health sector has its own characteristics. The main one has to do with the kind of priority accorded by the household to healthy living and longer survival. Government in turn has to judge carefully how much of its health budget should be divided between preventive care and curative care. In general, allocating comparatively more funds to preventive care has a greater impact on reducing infant, Under-5 and maternal mortality. A majority of infant and child deaths are caused by not having access to clean water and, in such cases, it may be useful to spend more in the water sector. In addition, there are other preventive factors, such as better education for mothers that help to reduce child mortality. It suggests therefore, that attaining certain health targets will require not just spending in the health sector alone, but also spending in other sectors such as water and education.

Given these related factors, it makes the projecting of unit cost for the child mortality goal a complex one. It follows therefore, that the expenditure requirements for each of the sectors needs to be assessed carefully, and only by getting the mix of spending correctly will this target be achieved. Furthermore, as stated under primary education, it is important to know how the cost of treatment should be shared between the Government and Household. Additionally, given that the parent of the child has to pay part of this cost, an assessment on the income and affordability of the household should be made on a regular basis.

Unit cost on Child Mortality and projections

The Zimbabwe targets, in accordance with MDG, are to reduce;

- Infant mortality by 66%, from 65 per 1000 live births in 2000 to 22 per 1000 live births by 2015.
- Under-5(U-5) mortality by 66%, from 102 per 1000 in 2000 to 34 per 1000 by 2015.
- Maternal mortality by 75%, from 695 per 100000 in 2000 to 174 per 100000 by 2015.
- Additionally, Zimbabwe aims to improve on such input indicators as - doctors per patient, supplies per patient, bed per patient etc.

The average cost estimates are based on Budget Estimates of 2000 (Vote 16 – Health and Child Welfare) and Statistics on mortality indicators available for 2000. Both recurrent and development budget estimates of the health sector are used to derive average unit cost. Within the Health budget, 100% of preventive care services expenditure and 10% of all other expenditures are taken in calculating unit cost for the projections. Due to data limitations it is assumed that all three mortality indicators are grouped in to one unit cost. With more des-aggregated data that is reliable and more frequently available, the unit costs of each mortality goal can be estimated separately.

Given these assumptions, annual real increase in expenditure to attain the above defined goals (including 1.1% population increase), health expenditure per child/mother should increase at 3.5% per year. Average spending over the period should increase from the current level of US$ 35.4 per child /mother to US$ 46.4 per child/mother. In parallel, total health spending over the period to 2015 should be US$43.2 mn.

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Combat HIV and AIDS, Malaria and other Diseases

Combat HIV And AIDS, Malaria And Other Diseases

TARGET 7:

Have halted, by 2015, and begun to reverse the spread of HIV and AIDS.

INDICATORS:

25. HIV prevalence among 15-24 year old pregnant women.
26. Number of children orphaned by HIV and AIDS

TARGET 8:

Have halted, by 2015, and began to reverse the increasing incidence of Malaria, TB and Diarrhoeal diseases.

INDICATORS:

27. Incidence of Malaria
28. Incidence of TB
29. Incidence of diarrhoeal diseases

STATUS AND TRENDS

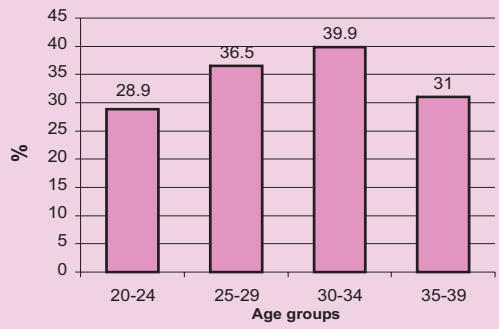
The HIV and AIDS epidemic, malaria, TB and diarrhoeal diseases are bringing additional pressure on the health sector. Overall, there has been a reported increase of incidence in all these diseases in the past 10 years.

HIV and AIDS

The first HIV and AIDS case in Zimbabwe was reported in 1985. By the end of 2002, UNAIDS estimated that 2.3 million people had been infected and the adult prevalence rate was 34%. The country is experiencing one of the world's most severe HIV and AIDS epidemics and is the second highest in prevalence after Botswana at 36% in 2002. Recent data from ante-natal clinic 2000 and surveillance surveys indicate that prevalence increased from 29% in 1997 to 34% 2000. However, in 2001 ante-natal information revealed a prevalence rate of 30.4% among pregnant women.[19]

Infection rates among women aged between 20-39 years are very high. According to the same antenatal survey of 2000, the prevalence rate among the 15-24 age group was 32%. Other age group HIV prevalence rates were as follows: age group 20-24 years at 28.9%, 25-29 years at 36.5%, 30-34 years at 39.9%, and 35-39 years at 31% see (figure 6.1). Although the sex ratio between males and females is about 1:1, HIV prevalence of women below the age of 20 is five times higher than their male counterparts.

Figure 6.1: Pregnant Women who Attended Antenatal Clinic Who are Infected by HIV by Age Group, Zimbabwe, 2001



Source:MOHCW 2001, National Survey of HIV and Syphyllis Prevalence Among Women Who Attend Antenatal Clinic In Zimbabwe, 2001

Key

- ♦ Actual
- ● Target
- Current rate of progress
- Rate of progress required to reach goal

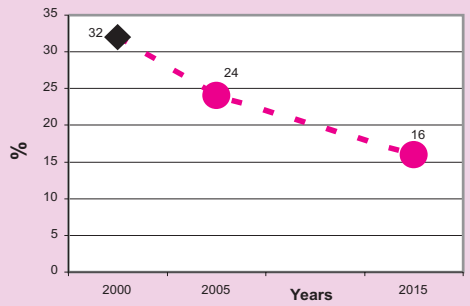
According to the Ministry of Health AIDS Programme, by 2003, an estimated 600,000 people would have full blown AIDS out of a total of 2.1 – 2.3 million persons infected with HIV.

[19] Ante-natal used by UNAIDS

The number of children orphaned by AIDS in Zimbabwe is estimated at around 780,000 in 2001. Of the total Zimbabwean children (0-14 years), 240,000 were estimated to be living with AIDS in 2002. 70% of hospital admissions in medical wards are due to HIV and AIDS related conditions, while among the under-fives, HIV and AIDS is now considered to be the number one killer.

The national targets are: to reduce HIV prevalence in the medium-term (2005) to 24%; and to 16% by 2015 (in the 15-24 age group) see Figure 6.2.

Figure 6.2: HIV/AIDS Prevalence among 15-24 year old Pregnant Women, Zimbabwe

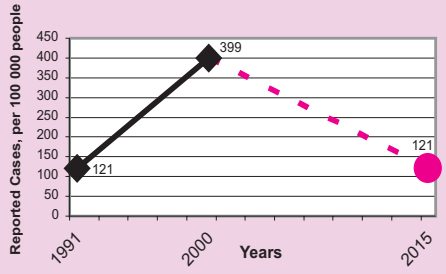


Source: MOHCW 2000, National Survey of HIV and Syphillis prevalence among women who attend Antenatal Clinics in Zimbabwe, 2000

TUBERCULOSIS

Rising poverty levels, poor environments and the HIV virus have contributed to the resurgence of TB, which thrives on immune systems weakened by chronic infections and by malnutrition. It is currently estimated that the number of TB cases increased by five-fold in the last 15 years, from 9,132 cases in 1990 to 30,831 cases in 1995, and 51,918 cases in 2000. The incidence of TB increased from 121 cases per 100,000 people in 1991 to 399 cases per 100,000 in 2000. The national target is to return to 121 cases per 100,000 people by 2015.

Figure 6.3: Tuberculosis Incidence, Zimbabwe, 1991-2015.

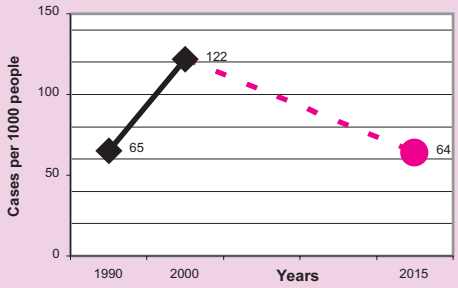


Source: Zimbabwe National Health Profile 1999, MOHCW and MOHCW

MALARIA

Overall, there has been an increase in the incidence of clinical malaria from 65 per 1000 people in 1990 to 122 per 1000 in the year 2000 (see figure 6.4). HIV and AIDS has compromised the general immunity in the population, thus making people more vulnerable to malaria-related illnesses and deaths. In 1999 for example, an estimated 2,201 people died from malaria related complications. Pregnancies are also put at risk through malaria, yet few pregnant women have access to effective intervention. In addition, recent natural disasters such as floods have contributed significantly to the spread of the breeding grounds for the vector carrying mosquitoes. The national target is to reduce clinical malaria incidence to 60 per 1000 people by 2015.

Figure 6.4: Clinical Malaria Incidence, Zimbabwe, 1990-2015.

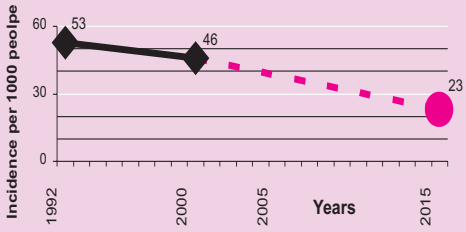


Source: Zimbabwe National Health Profile 1999, MOHCW and MOHCW: Note:These are cases reported at the Out Patient Departments.

DIARRHOEAL DISEASES

In 1999, it was estimated that about 25% of households were without access to safe water supply and 42% lacked access to improved sanitation. Diarrhoeal diseases, largely preventable through access to safe drinking water, sanitation and food hygiene, are responsible for frequent deaths. There has been a slight improvement in the incidence of diarrhoea/ dysentery, from an incidence of 53 cases per 1000 people in 1992 to 46 per 1000 in 2000 (see figure 6.5). Many of these deaths could have been avoided by the use of simple and inexpensive oral re-hydration salts. The national target is to reduce the incidence of diarrhoea/dysentery to 23 cases per 1000 people by 2015.

Figure 6.5: Incidence of Diarrhoea/Dysentry, Zimbabwe, 1992-2015.



Source: Zimbabwe National Health Profile 1999, MOHCW and MOHCW

CHALLENGES

This is the priority goal that underlies the achievement of all other goals. As such, the major challenge faced by the nation is to combat and reverse the spread of HIV and AIDS within

the immediate future (4-5 years). Some of the operational challenges in this area are as follows:

Behavioural Change

It is estimated that over 96% of the sexually active population (age 15 years and above) are generally aware of the dangers associated with HIV infection. This knowledge has, however, not been translated into behavioural change (condom use, reducing multiple sexual partners, etc.). The challenge is to understand what continues to drive the epidemic in Zimbabwe, in spite of all the knowledge, institutional mechanisms and programmes put in place to date.

Improving Access to Essential Drugs

One of the major challenges beyond prevention is making HIV and AIDS drugs available at affordable cost as well as establishing an adequate and responsive drug distribution system. Of key importance is the provision of antiretroviral drugs and essential drugs for the treatment of opportunistic infections. The current shortage of foreign currency stands as a limiting factor in the areas of drug procurement.

Inadequate resources to combat the epidemic

The health sector is experiencing a significant reduction in its budget in real terms, while at the same time undergoing human resource depletion due to HIV and AIDS related deaths and brain drain. The brain drain phenomenon is largely induced by a decline in real wages and generally unattractive conditions of service. The challenge is to revamp the health delivery system by availing the sector more resources and continuously improving working conditions.

Stigma and discrimination

HIV and AIDS related stigma and discrimination continue to sustain the HIV and AIDS epidemic. Stigma and discrimination prevent those in need from accessing care, treatment and support, and increase the vulnerability of others to HIV infection. Tackling the root causes of vulnerability to HIV and AIDS, therefore, requires that particular attention be paid to the causes of stigma and discrimination, and how they reinforce stereotypes and inequalities related to gender, ethnicity, race, sexuality and social status. The challenge is to declare HIV and AIDS a public health disease to reduce the stigma.

Coordination of AIDS programmes

The response to HIV and AIDS requires a multi-sector, bio-medical and developmental approach. The challenge, therefore, is to design appropriate developmental interventions for each economic sector, as well as strengthening the newly established National AIDS Council (NAC) for it to be effective in implementing and coordinating the broader multi sector strategy.

Care and Support for orphans

The rapid increase in the number of children orphaned due to HIV and AIDS is a cause of concern. For children, this may lead to increased pressure of social disintegration (e.g. child labour, street kids, child abuse etc). The challenge is to provide care and support as well as putting in place prevention strategies for the increasing numbers of orphans.

Gender

High levels of poverty and harmful cultural and traditional practices in sexual and reproductive health and relationships are some of the factors that make women more vulnerable to HIV infection. The challenge is to effectively address gender inequalities in the economic and cultural spheres through empowerment via education.

Poverty reduction

High poverty levels underlie the vulnerability of the population at large to the HIV and AIDS epidemic. The biggest challenge in addressing HIV and AIDS is to tackle vulnerabilities through designing and implementing broad-based national poverty reduction strategies.

TUBERCULOSIS

To control tuberculosis, the challenge is to expand and increase the Directly Observed Treatment Short Course (DOTS) coverage as well as combating the HIV and AIDS epidemic.

MALARIA

A major challenge in malaria control is the need to substantially increase the use of preventive strategies (insecticide treated nets, etc.).

DIARRHOEA

The challenge is to provide safe water and sanitation to the entire population, with particular attention being paid to newly resettled areas.

SUPPORTIVE ENVIRONMENT

There has been an enhanced political commitment to the fight against HIV and AIDS, malaria, TB and other diarrhoeal diseases in Zimbabwe.

In 1985, at the onset of the HIV and AIDS epidemic, the Government of Zimbabwe set up the National AIDS Coordinating Unit under the National AIDS Coordinating Programme to address the challenge of the HIV and AIDS pandemic. It was through the National Aids Control Programme that the National AIDS Policy was produced and, later through an Act of Parliament the National AIDS Council, was established. Other policies include HIV Prevention in the Workplace and The Orphan Policy.

In addition, a Cabinet Committee on HIV and AIDS was set up to focus on HIV and AIDS issues. In order to scale up the national response and to raise resources, a National AIDS Trust Fund was set up with funding from a 3% levy on personal incomes of formal sector employees.

The Government of Zimbabwe has also fostered strong partnerships with various stakeholders and other development agencies in the fight against HIV and AIDS. Zimbabwe's membership in the Global Fund to fight AIDS is testimony to this partnership.

The setting up of voluntary counselling and testing (VCT) centres, provision of life skills education in schools, the piloting activities on the prevention of mother-to-child transmission and peer education programmes in the uniformed forces and parliament are all initiatives for combating the HIV and AIDS epidemic.

On TB control, the country has committed itself to expanding the Directly Observed Treatment Short Course (DOTS) and continues to participate in the Global Plan to stop TB, launched in October 2001.

On malaria control, the country has also committed itself to the Roll Back Malaria Programme initiated in 1998.

On water and sanitation, the Government has entered into partnerships to expand the provision of safe water and sanitation in the rural and remote areas of the country.

PRIORITIES FOR DEVELOPMENT

In order to facilitate the reversal of the epidemic, three main areas of intervention have been identified, namely, prevention, care and support.

In the area of Prevention, the following priorities have been identified:

Reversing the spread of HIV and AIDS epidemic

Reducing HIV transmission, through promoting behavioral change will be central to combating the epidemic. It is important to recognize that behaviour change will not take place until strategies are put in place to address the current developmental vulnerabilities being experienced by the population. These vulnerabilities are primarily responsible for risky sexual behaviour, which underlies the epidemic. Thus designing and implementing broad-based national poverty reduction strategies is a national priority.

Combating stigma and discrimination

There is need to address issues of stigmatisation and discrimination, by reconsidering the public health classification of the disease.

Gender equality in all spheres, including Reproductive Health

As a way of reducing women's vulnerability to the epidemic, there is need to promote gender equality in all spheres of life, respect for each other's sexuality, gender sensitive HIV and AIDS programmes, and combating gender violence.

Information, Education and Communication (IEC) about HIV, AIDS and STIs

There is need for the dissemination of clear and accurate information on HIV and AIDS/STI at all levels of society. Such information should promote positive family and cultural values. IEC promotional materials should be developed together with stakeholders and include the supportive role of mass media on the epidemic.

HIV and AIDS/STI Research

Research should be multi-disciplinary, collaborative and participatory, focusing on priority needs for Zimbabwe. Research should feed into the design of programme interventions to facilitate the holistic approach to combating the epidemic.

In the area of Care, the following priorities were identified:

Effective management of the national response to HIV and AIDS

There is need to strengthen the newly established National AIDS Council (NAC) for the effective delivery of services to the intended beneficiaries with minimum bureaucracy. For example, the utilization of the AIDS levy and other resources for multi-sector programming should face minimum delays in disbursement.

Care and support for people living with HIV and AIDS

There is need to consolidate and expand the following programmes:

- Medical and Nursing care,
- Community home-based care (CHBC) with institutional support,
- Nutrition support to slow the onset and progression of AIDS,
- Counselling and psychosocial support,
- Voluntary counselling and testing, etc.

In the area of Support, the priorities are as follows:

Rights of children or young people infected or affected by HIV and AIDS

There is a need to protect and respect the rights of children and young people infected or affected by HIV and AIDS. In this respect, support is required in the following areas:

- Orphaned children require support to grow up with respect and dignity, while in their communities.
- Children and young people need protection from sexual abuse, and provision of necessary information on sexual behaviour and protection.

- Nutrition support to slow the onset and progression of AIDS.

Need for essential Health Sector imports

Government should endeavour to ensure that the health sector has sufficient resources to import drugs and equipment requirements to ensure sustained combating of HIV and AIDS, Malaria, TB and other diseases.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Major areas for development assistance to meet the challenges of halting and reversing the spread of HIV and AIDS and control of Malaria, TB and other diarrhoeal diseases are as follows:

- Support for economic revival and sustained growth and development.
- Capacity development to respond to the HIV and AIDS epidemic.
- Support for scaling up HIV and AIDS interventions for young people.
- Orphans Care and Support.
- Need for essential Health Sector imports.
- Increase in the coverage of DOTS and (Insecticide Treated Bed Nets) ITN.
- Water and sanitation.
- Data collection on HIV and AIDS, Malaria and other diseases.

COSTING THE HIV and AIDS GOAL

Overview: The comments made under the health goals, particularly the kind of priority accorded by the household to healthy living and longer survival are also relevant to this goal. The HIV costing represents a compromise between the anticipated needs based on the projected scale of the pandemic, on the one hand, and the response capabilities, absorptive capacities and scope for scaling up responses of the various sectors, on the other. The cost estimates have been informed by the expenditures of some sectors to date, finding proposals submitted to the National Aids Council (NAC) since the establishment of the National Aids Trust Fund, as well as the costing work by Kumaranayake and Watts (October 1999).

The costing elements: The costing only relates to HIV and AIDS and not the other diseases under this goal. The six strategic areas of intervention were costed as follows:

1. Prevention strategies and activities
2. Care strategies and activities
3. Mitigation strategies and activities
4. Enhanced sector response strategies,
5. Monitoring and evaluation, and
6. Development of District Aids Action Plans.

The costing was done in two parts; a conservative option and a pragmatic option over a five-year period (2001-2005).

Cost on HIV and AIDS projections (1999 US$)

Reversing the spread of HIV AND AIDS over the 13 year period, 2002-2015, will cost an estimated US$32 million *(conservative option)* to US$38 million *(pragmatic option),* or between US$2 million to US$3 million per year. These cost estimates do not include full-scale provision of anti-retroviral drugs for the estimated 600,000 full-blown cases, or the 3.3 million sufferers of the disease as at 2003.

HIV AND AIDS COSTING 2001- 2005 AND PROJECTION FOR 2015 (IN 1999 US$)

	Conservative Option	Pragmatic Option
1. Prevention strategies & activities	US$ 6,483,636	US$ 7,209,090
2. Care Strategies & activities	US$ 2,881,818	US$ 4,409,090
3. Mitigation Strategies & activities	US$ 872,727	US$ 872,727
4. Enhanced Sector response strategies	US$ 1,490,909	US$ 1,563,636
5. Monitoring & Evaluation	US$ 72,727	US$ 272,727
6. Development of District Aids Action plans	US$ 181,818	US$ 281,818
TOTAL	**US$ 11,983,635**	**US$ 14,609,088**
Cost Per Year	**US$ 2,396,727**	**US$ 2,921,817**
Projected cost to 2015	**US$ 31,157,451**	**US$ 37,983,628**

Source: Ministry of Health & Child welfare, Zimbabwe National AIDS Council, UNAIDS/Harare (1999)

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Ensure Environmental Sustainability

Ensure Environmental Sustainability

TARGETS:

9. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.
10. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.
11. By 2020, achieve a significant improvement in the housing condition of at least 1,000,000 slum dwellers, peri-urban and high density lodgers.

INDICATORS:

30. Proportion of Land area covered by forest.
31. Land area protected to maintain biological diversity.
32. GDP per unit of energy use (as proxy of energy efficiency).
33. Proportion of people with sustainable access to an improved water source.
34. Proportion of people with access to improved sanitation.
35. Number of housing units produced annually.

STATUS AND TRENDS

Since independence, Zimbabwe has registered commendable progress in environmental management. For example, afforestation programmes, land reclamation and natural resource conservation programmes have helped to transform previously degraded parts of the country into natural resource reservoirs.

However, because of the continued impact of the historical structural imbalances, it is worrying to note that the state of the environment continues to deteriorate in certain segments of rural and urban areas. In rural areas, for example, over crowded communal lands, resulting in poor forest management, excessive timber extraction, and collection of fuel wood, still remain among the major causes of deforestation.

In the newly resettled areas, land clearing by new settlers for the purposes of agriculture, materials to construct houses and fuel wood, is contributing to a gradual degradation and deforestation of the environment. While this land clearing is necessary, there is need to ensure that it is implemented in a sustainable manner. While the exact figure for the rate of deforestation in Zimbabwe is unknown, estimates suggest that deforestation ranges between 100,000 – 320,000 ha per year.

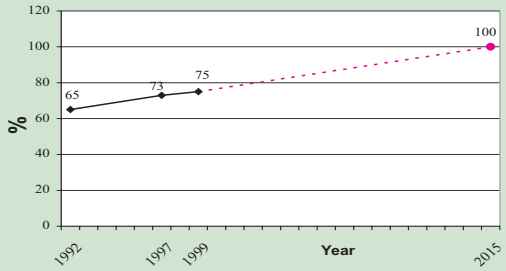
In addition, the importation of alien and exotic species has led to the loss of indigenous biodiversity in some parts of the country, particularly in the eastern highlands where commercial forest plantations are the major industry. Activities of major mining firms have not been sensitive to environmental concerns either. Similarly, small-scale gold and diamond panning has become a common practice in various parts of the country. This activity, while increasing incomes, has contributed to the siltation of major surface water bodies as well as the destruction of community infrastructure. As such, there is need to regulate this activity to ensure that it is carried out in a sustainable manner.

Droughts and floods are another important factor in the degradation of cultivated lands and rangelands in many parts of the country, impacting on plant cover, livestock numbers and consequently household agricultural productivity. Besides these negative impacts of nature, there have been increased reports of wildlife poaching in the national parks and wildlife conservatories. If this trend continues, the country will witness a reduction of tourism capacity.

On the issue of rural water and sanitation, great progress had been made, but with the movement of people under the Land Reform programme, as well as the damage caused by Cyclone Eline, new and additional facilities will now be required. It is

estimated that by 1997, 73% of rural households had access to safe water rising to 75% in 1999 (see fig. 7.1).

Figure 7.1: Households with Access to Safe Water, Rural Areas, Zimbabwe



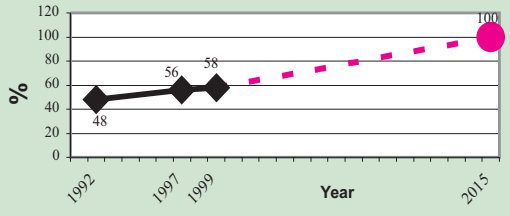
Source: Central Statistical Office, 1992 Population Census, 1997 Intercensal Demographic Survey, 1999 Indicator Monitoring , Labour Force Survey.

Key

- ◆ Actual
- ● Target
- ━━ Current rate of progress
- - - Rate of progress required to reach goal

With regards to safe sanitation, 56% of rural households had access to safe sanitation, later increasing to 58% in 1999 (see figure 7.2). The target is to reach 100% for both households with access to safe water and access to sanitation by 2015. More specifically, the target is to ensure that every household has access to a toilet within the homestead, and to potable water within 250 meters by 2015.

Figure 7.2: Households with Access to Safe Sanitation, Rural Areas, Zimbabwe



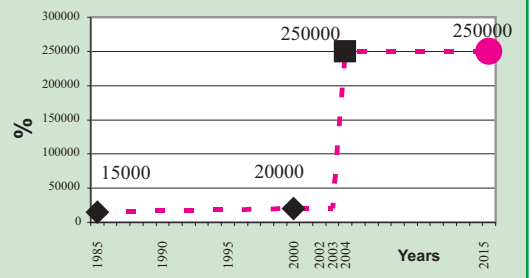
Source: Central Statistical Office, 1992 Population Census, 1997 Intercensal Demographic Survey, 1999 Indicator Monitoring, Labour Force Survey.

Zimbabwe is faced with the challenge of rapid urbanization. In the urban and peri-urban areas, the problem of air and water pollution has resulted in a significant increase in respiratory and water borne diseases as suggested by anecdotal evidence. In addition, industrial, domestic and municipal waste poses a serious health problem in most urban areas.

The mushrooming of unplanned settlements in both the urban and peri-urban areas is compounding the problems associated with urban environmental planning and management. It is estimated that the current urban housing backlog stands at one million (1 000 000) families. The urban population stands at 4.456 million and is estimated to be increasing at a rate of 5% to 6% per annum, which is almost 5 to 6 times more than the current national population growth rate of 1.1% per year. This implies that the urban population is expected to rise to 7.6 million by 2015.

Available information indicates that the government had planned to construct 162,500 housing units annually during the period 1985 to 2000, so as to alleviate the housing backlog. However, the actual annual production during that period was between 15,000 to 20,000 housing units, which falls far below the target figure. A review of recent statistics shows that housing production has further declined since the year 2000. By the end of 2002, only 5,500 stands were serviced in eight urban areas in that year. The goal is to reduce the housing backlog to zero by 2015. In order to meet this target, a total of 250,000 housing units need to be produced annually. (See figure 7.3)

Figure 7.3: Urban Housing Expansion, (Housing Units per year) Zimbabwe,1985-2015.



Source : Ministry of Local Government, Public Works and National Housing

A number of urban centres have sub-standard housing units that were built under the former regime for the purpose of housing the "bachelor" workforce. Most of these 'bachelors' were married men, who have since moved their families to town and are living in cramped structures with communal water and sanitation facilities. A poor quality housing upgrading program was started by government in the mid-1980s with a view to providing decent housing, of at least three rooms, and individual water and sanitation facilities. The goal is to complete this upgrading program by 2015.

To reverse the current trend of environmental degradation, the integration of the principles of sustainable development into country policies and programmes becomes a priority. Specific areas that would need attention are continued provision of cleaner energy to both rural and urban populations, access to safe water and sanitation, provision of decent housing, waste management, reversing biodiversity loss and land degradation and minimising water and air pollution.

CHALLENGES

There are a number of challenges in the area of environmental sustainability. Some of these include:

Implementing Land Resettlement in a sustainable manner

The challenge is to implement the integrated conservation plan for the resettlement program, to ensure that land resettlement is done in a sustainable manner. There is need to improve capacity building efforts of institutions in environmental management and poverty reduction in these areas.

Provision of decent housing in urban areas

Rising populations in urban and peri-urban areas will continue to raise the challenge of decent housing provision for some time to come.

Provision of safe water and sanitation, particularly in rural areas

In the rural areas, the challenge is to provide safe water and sanitation to all households.

Establish waste management practices to combat air and water pollution

The current waste management systems are increasingly becoming ineffective due largely to growing urban and peri-urban populations. The challenge is to strengthen research efforts on pollution (both air and water) and land degradation. There is need to design and implement programmes that will combat the current levels of air and water pollution.

Implementation of the Provisions in the newly enacted Environment Management Act

The Environmental Management Act (EMA), which was enacted in 2002, provides a framework for mainstreaming environment into national policies and programmes. The challenge is to build capacity at both national and local levels to ensure effective implementation of the Act, as well as link EMA with other legal instruments, such as the Traditional Leaders Act, to make environmental management more effective.

Implementation of Multilateral Environmental Agreements

Zimbabwe is signatory to a number of multilateral environmental agreements that provide a good basis for international cooperation in addressing global and regional environmental issues. The challenge is to balance the conservation effort with the benefits that accrue to the communities from use of the natural resource.

Energy Provision

The current national energy demand for domestic and industrial use far outstrips the supply. The challenge is to develop a comprehensive energy policy and strategy that address the country's energy problems, more specifically, the provision of renewable energy for use in remote rural areas.

SUPPORTIVE ENVIRONMENT

Zimbabwe's participation at the 1992 Rio Conference on Environment and Development was a milestone in raising national awareness on the need to integrate environment and development. Follow-up summits, such as the 2002 World Summit on Sustainable Development (WSSD), which resulted in the Johannesburg Plan of Action, provide a useful framework for ensuring environmental sustainability. The establishment of the Ministry of Environment and Tourism was a basis for initiating national programmes of environment management. The recent enactment of the Environmental Management Act has also created a conducive framework for implementing appropriate programmes on environment.

There are a number of institutional frameworks that also provide a supportive environment for implementing programmes of sustainable development. These include:

- Multi-stakeholder consultative and planning forums e.g. taskforce on the Convention to Combat Drought and Desertification (CCDD).
- World Summit on Sustainable Development (WSSD) task force on National Response Mechanisms (NRM).
- Environmental Management Act (EMA) and the Traditional Leaders Act (TLA).
- The District Environmental Action Plan (DEAP) and the Communal Area Management Programme for Indegenous Resources (CAMP FIRE).
- The provision of safe water and sanitation in rural areas is a traditional area for donor support.
- New Water Act, Rural Electrification Programme and the introduction of environmental science in schools.
- Urban and peri-urban councils responsible for the provision of decent housing. There is an urban housing expansion programme already in place. Under this programme, Central and Local Government, together with the private sector would provide serviced land for home seekers and the home seekers would build their own homes. Government will introduce schemes to assist home seekers access to housing development finance and appropriate technology, building materials and designs to reduce costs whilst maintaining safety standards. The implementation strategy for this scheme is in place. There is also in existence a poor quality housing upgrading program, which is designed to provide decent housing for increasing numbers of urban dwellers by 2015.

PRIORITIES FOR DEVELOPMENT

To achieve the goal of ensuring environmental sustainability by 2015, the following priorities need to be addressed:

Environmental awareness

To achieve sustainable management of natural resources, there is need for continued environmental awareness raising at all levels. In addition, special attention should be paid to waste management practices in urban areas as well as sustainable land resettlement.

Strengthen development of appropriate alternative renewable energy resources.

In order to reduce over reliance on natural resources for energy by the majority of the rural people and an increasing proportion of urban dwellers, the country needs to invest in the development of renewable energy resources (solar, wind biogas).

Provision of descent housing in Urban areas.

There is need to implement fully the urban housing expansion program, as well as to continue regularising peri-urban areas and unplanned settlements, as part of on-going urban development programmes.

Consolidation of the rural water and sanitation programme

Water and sanitation programmes need continuous expansion to cover all rural areas, including newly resettled areas.

Improved Management of urban environment

Establishment of waste management programmes to combat air and water pollution, particularly in urban areas.

Expand biodiversity

Expand biodiversity as it relates to indigenous trees and crops that have nutritional and medicinal value.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Implementation of Multilateral Environmental Agreements

Zimbabwe's progress towards ensuring environmental sustainability could be enhanced by the participation of development partners in the implementation of the various multilateral agreements, including the WSSD outcomes. There is need for capacity building of institutions involved in the coordination and implementation of these multilateral agreements.

The challenge is to support the implementation of the Zimbabwe national Johannesburg Plan of Implementation (JPI) – the response action programme.

Environmental Awareness

Environmental awareness programmes will need to be expanded throughout the country.

Capacity building in data collection and analysis

Given the scarcity of data on the environment, development assistance will be required to strengthen data collection and analysis systems.

COSTING THE ENVIRONMENTAL SUSTAINABILITY GOAL

Overview: In relation to unit cost, many of the statements made under Primary Education and Health targets apply to this sector. However, the main difference is that most of the cost that Government has to incur is with regard to maintenance, rehabilitation and capital construction of water-supply schemes. The household/community also shoulders some responsibility in maintaining water supply. A Housing costing provided by the Ministry of Local Government, Public works & National Housing would be adopted for this report. Other issues relating to environment sustainability, such as deforestation, air and water pollution, etc., are not costed. The challenge is to be able to cost these in subsequent reports.

Unit cost on access to water

The Zimbabwe target, in accordance with the MDG, is to move from the current 75% safe water coverage to 100% by 2015.

Estimates are based on Budget Estimates 2000 (Vote 9 – Rural Resources and Water Development). Current assumptions are;

- 75% of the population have access to clean water.
- The whole budget has been taken into consideration in estimating costs.

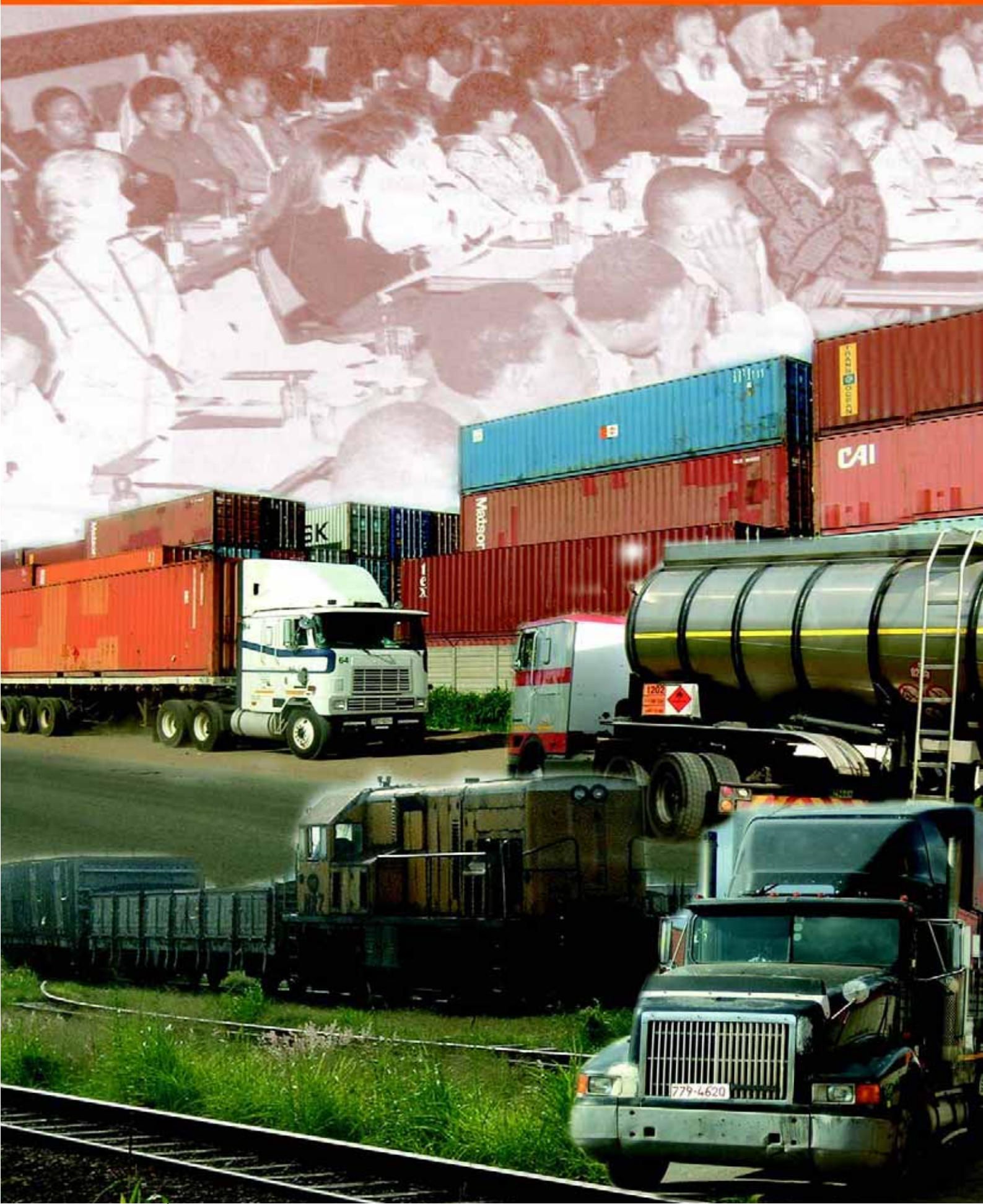
Given these assumptions, annual real increase in expenditure to ensure that 100% of the population (including 1.1% population increase) have access to clean water is 4% per year. Average spending over the 15-year period to 2015 should increase from the current level of US$38mn to US$48.6mn.

Urban housing expansion costing

In monetary terms, it would require Z$1.25 billion (US$ 250,000) annually to service 250,000 stands. A further Z$26 billion (US$5.2 million) will be required annually to acquire land for urban expansion, as most urban centres have run out of land for developments. Therefore, the total annual housing expansion requirement to meet the MDG target is US$5.45 million annually or US$71 million to 2015.

"As a Nation with Oneness of Purpose, Together we can Score this Goal!"

Develop a Global Partnership for Development



Develop A Global Partnership For Development

TARGETS:

12. Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.
13. Not Applicable
14. Address the special needs of the country's landlocked status.
15. Deal comprehensively with the debt problems.
16. In cooperation with strategic partners, develop and implement strategies for decent and productive work for everyone.
17. In cooperation with pharmaceutical companies, provide access to affordable essential drugs.
18. In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.

INDICATORS:

36. Total Trade to GDP ratio
37. Not Applicable
38. Cost of transport per kilogram per kilometre by rail, road and air
39. Total debt as a percent of GDP
40. Overall structural unemployment
41. Proportion of population with access to affordable essential drugs on a sustainable basis
42. Personal computers per 1000 people
43. Real GDP Growth

STATUS AND TRENDS

Zimbabwe is facing serious socio-economic and development challenges. These have been compounded by general international isolation and a changing political landscape. Rekindling relations with the international community is important in addressing the issues of finance, trade, investment debt and aid flows, which are critical for economic revival.

Finance and Investment: In the last five years, Zimbabwe has witnessed dramatic drops in the flows of both Official Development Assistance (ODA) and Foreign Direct Investment (FDI).

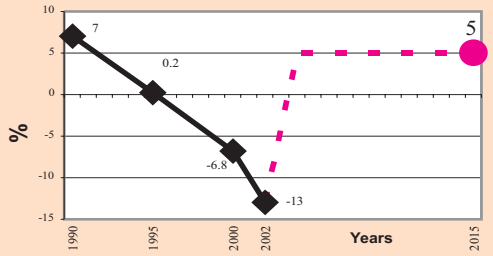
For example, ODA flows declined sharply by 67% from a peak of US$400.31 million in 1995 to just US$132.98 million in 2001, while Net FDI experienced a 95% decline from about US$98 million in 1995 to US$ 5 million in 2001.

Moreover, gross capital formation (total investment) declined significantly from 24.9% of GDP in 1995 to just 8.8% of GDP in 2002. Much of the decline in capital formation is attributable to the sharp fall in private investments, which fell from 18.8% of GDP to 5.3% of GDP between 1995 and 2002, as compared with public sector investment, which experienced a lesser drop from 6.2% of GDP in 1995 to 3.5% of GDP in 2002.

The decline in public investment can be explained by recurring drought and floods in the region, which diverted resources towards drought relief , while the sharp decline in private investment is linked to the unstable domestic macroeconomic environment. Capital formation has declined as a result of the depreciation of the local currency, which has resulted in resources being channelled largely to consumption spending rather than investments. Furthermore, the negative perceptions by international community on issues of political and economic governance have dented

the country's image. Confidence in the economy is at its lowest ebb as a result, adversely affecting private investment and tourism.

Figure 8.1: Real GDP Growth Rate (%), Zimbabwe, 1990-2015.



Source : Reserve Bank of Zimbabwe

Key

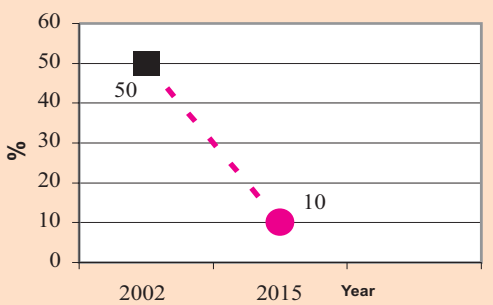
- Actual
- Target
- Current rate of progress
- Rate of progress required to reach goal

Trade: Zimbabwe is committed to maintaining an open trade system that is beneficial to developing countries. This is reflected in her membership in various regional and international bodies such as SADC, COMESA, WTO and ACP-EU.

The Government has established and maintained, since the conclusion of the Uruguay Round (1994), a permanent structure to monitor and review developments in the Multilateral Trading System (MTS) in the form of a multi-sector/multi-institutional 'National Standing Committee on Trade Policy'. At the regional level, Zimbabwe has signed the Free Trade Agreement on Trade within SADC and COMESA.

However, recent economic decline associated largely with foreign currency shortages, and a severe budgetary constraint, is impacting negatively on trade. Since 1995, export earnings have dropped by 40%, while imports have declined by 21%. This has put pressure not just on resource availability, but it has also starved industry and forced numerous company closures, further worsening unemployment and poverty (see figure 8.2).

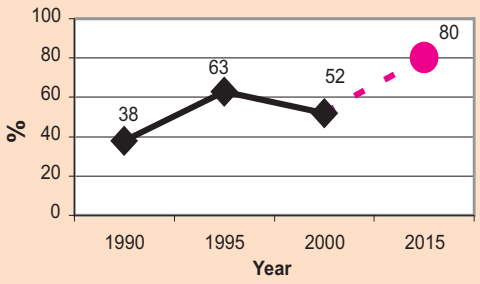
Figure 8.2: Structural Unemployment, Zimbabwe, 2002-2015.



Source : Budget Statement , 2002

Consequently, Zimbabwe's level of openness, as measured by total trade to GDP, has been on a downward trend since the mid-1990s (see Figure 8.3).

Figure 8.3: Total Trade to GDP Ratio, Zimbabwe, 1990-2015.

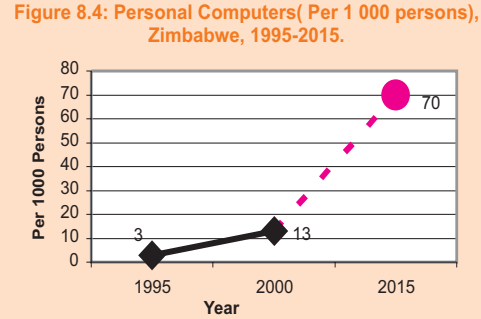


Source : Reserve Bank of Zimbabwe

Competitiveness: Zimbabwean industry is largely uncompetitive mainly as a result of inheriting import substitution practices, which used to guarantee most firms the domestic market. On the international market, a small number of firms are sustained through past arrangements such as the Zimbabwe-South Africa Trade Agreement and, recently, the Lome Convention. These characteristic features have made Zimbabwean industry unable to compete in a fully liberalized trade regime.

The current unstable macroeconomic environment has further exacerbated industry's poor competitiveness. Zimbabwe's competitiveness problems are further worsened by its lack of access to the sea. High transportation costs and fuel shortages have meant that most goods in the country are either traded far above their market value or are in short supply. It is currently estimated that Zimbabwe has 41.3 telephone lines per 1000 people and 12 personal computers per 1000 people, well below global averages. It has been suggested, therefore, that achieving the world average of 70 personal computers per 1000 people would help enhance the country's competitiveness (see Figure 8.4).

Figure 8.4: Personal Computers(Per 1 000 persons), Zimbabwe, 1995-2015.



Source : World Bank : World Development Indicators, 2002

The role of the financial sector is pivotal to enhancing competitiveness in Zimbabwe. Though Zimbabwe's financial system is open and fairly liberalised, the country's financial coverage has stagnated at around 42% of GDP for the last ten years. An expansion of the financial sector to make it more supportive of the Small to Medium Enterprise (SME) sector would contribute immensely to the growth stimulus, while making significant inroads to poverty reduction.

External debt: Zimbabwe's total external debt is currently estimated at US$5,182 million as at September 2003, of which external arrears amount to some US$1,682 million. The total external debt to GDP ratio has worsened from a high of 64% of GDP in 1998 to 173% of GDP in 2003. This suggests that Zimbabwe's debt is currently unsustainable, based on international criteria.

CHALLENGES

The greatest challenge for Zimbabwe's future development is formulating a global partnership strategy, in the context of a broad-based, pro-poor macroeconomic policy framework. The global partnership strategy should seek to address the following:

- Enhanced market access from the ACP/EU Economic Partnership Agreement (EPA) negotiations.
- Benefits of the WTO Doha negotiations for Zimbabwean agriculture, industry (including pharmaceutical manufacturing) and services;
- The impact of regional trading bodies (SADC, COMESA, TICAD, SOUTH-SOUTH Cooperation etc.) on Zimbabwean industry;
- To extract maximum benefits from New Partnership for African development (NEPAD) for Zimbabwe; (forging economic linkages with global economy)
- Opening new markets for Zimbabwean products (south-east Asia, Central Asia etc.).

SUPPORTIVE ENVIRONMENT

To lay the foundation for economic recovery and to prepare the country for the challenges of globalisation, decisive action is needed. The major issues to address in the medium to short-term would be to design and implement a broad-based, pro-poor macroeconomic policy framework that would guide the economy towards full recovery and lay the foundations for macroeconomic stability, sustained economic growth and development for poverty reduction. So far, building blocks are being put in place in the form of a *National Poverty Reduction Strategy* and a *Macroeconomic Consistency Framework*. In the meantime, there is in place short-term measures to address economic recovery under the 12-month *National Economic Revival Programme (NERP).*

In addition, given the country's advantage of its existing human resource endowment, physical infrastructure and natural resource base, there is the strong possibility for a quick turnaround of the economy to support the attainment of the millennium development goals and 2015 targets set out in this report.

"As a Nation with Oneness of Purpose, Together we can Score this Goal!"

TABLE 3: MONITORING AND EVALUATING THE MILLENNIUM GOALS*

	EXISTING CAPACITY FOR:					
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 needs to be improved through the use of modern techniques	**Fair:** Data quality is good, but there are delays in analysing and publishing information.	**Weak:** Currently, there is no institutionalised mechanism for monitoring poverty trends.	**Fair:** The human resource capacity is available and good, but equipment for statistical analysis is inadequate.	**Fair:** There is a general problem of incorporating statistical data into planning and policy making.	**Fair:** Institutional coordination on poverty monitoring is still problematic
2: Achieve Universal Primary Education.	**Fair:** There is need to strengthen the collation of data at district level.	**Strong:** Quality of information collected is high.	**Strong:** Since the establishment of the Education Management Information System (EMIS) database.	**Fair:** Statistical analysis capacity exists at Head Office and Central Statistics Office (CSO)..	**Strong:** Capacity to incorporate statistical analyses is good.	**Fair**: Although there are many institutions and organisations involved in monitoring and evaluation, there is need to strengthen the sharing of information.
3: Promote Gender Equality and Empower Women	**Fair:** National 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:** National Capacity to track statistical data, in all sectors needs strengthening.	**Weak:** Capacity of the Central Statistics Office (CSO) to analyse available gender disaggregated is weak.	**Weak:** Capacity for policy formulation using data is weak	**Weak:** There is no system for gender monitoring and evaluation
4: Reduce Child Mortality	**Fair:** Data gathering capacities for the public institutions is strong, but does not cover the private institutions	**Fair:** The quality of the Zimbabwe Health Demographic Survey is good, but there is room for improvement in terms of frequency and timeliness.	**Fair:** Statistical tracking is comprehensive but 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 need to decentralise the analysis of data for the effective monitoring and rapid response at local levels.
5: Improve Maternal Mortality	**Fair:** Data gathering capacities for the public institutions is strong, but it is not comprehensive because it does not cover the private institutions.	**Fair:** There is need to capture all maternal deaths as specified in the definition of maternal mortality under the National Health Information System.	**Fair:** Needs improvement.	**Weak:** These are very good at the national level, but need strengthening at lower levels.	**Fair:** Recent survey data is not readily available to various stakeholders.	**Fair:** Baseline data needs to be accurately set.

EXISTING CAPACITY FOR:						
Goal	**Data gathering**	**Quality of survey information**	**Statistical tracking**	**Statistical analysis**	**Statistics into policy**	**Monitoring and evaluation**
6: Combat HIV AND AIDS, Malaria and Other Diseases	**Fair:** Data gathering capacities for the public institutions is strong, but it is not comprehensive because it does not cover the private institutions.	**Good:** The quality of the Zimbabwe Demographic Health Survey is good, but there is room for improvement in terms of frequency, timeliness of data and completeness.	**Weak:** The tracking capacity is weak. Some tracking system exists but it is not comprehensive and needs enhancement.	**Good:** These are very good at the national level, but are constrained by resources. Needs strengthening at lower levels.	**Fair:** There is capacity to incorporate statistical analysis but it is constrained by resources.	**Weak:** M&E mechanisms exist but are weak. There is need to decentralise the analysis of data for the effective monitoring at local levels.
7: Ensure Environmental Sustainability	**Fair:** Reliance on secondary data, capacity limitations in terms of human and financial resources and equipment.	**Strong:** For food security assessment, crop forecast and vegetation maps, the quality of data is good.	**Fair:** Inadequate resources	**Fair:** Limitation in terms of financial resources and software	**Weak:** Inadequate political will	**Weak:** Limited financial and human resources and equipment
8: Global Partnership for Development	**Fair:** Apathy in the business sector in filling the questionnaires. There is a problem of timeliness of information.	**Fair:** Lack of capacity to quickly analyse and disseminate the survey information.	**Weak:** Problems with database management systems.	**Weak:** There is need to improve the analysis capacities.	**Fair:** Lack of resources constrain the incorporation of the statistical analysis into policy	**Fair:** Mainly donor-driven and funded M&E which is not sustainable

Note:

*The MDG statistical ,monitoring and evaluation system will need to be strengthened to enable the country monitor the key indicators under each goal, as well as, the additional indicators provided in the annex of this report

Financing The Goals

Financing The Goals

ZIMBABWE

INCOME POVERTY

Reduce extreme poverty by half by 2015:

2002- food poverty incidence = 68%
2015- poverty incidence target = 34%

2002- consumption poverty incidence = 80%
2015- consumption poverty incidence target = 40%

Required real GDP per capita growth rate = 5.5% per annum over 13 years. Assuming that population is likely to grow by 1.1% per annum, a GDP growth rate of 6.6% is needed.

A more realistic forecast for Zimbabwe, given an average GDP growth rate of 2.6% during the period 1990 to 1999 and an average GDP of -8.5% in the period since 1999, is 5% per annum from 2003 to 2015. This growth rate corresponds to scenarios 2 & 3 in our list of options in table 2. With scenario 2, however, poverty will not be reduced by 50%, but by 27% in 2015. The halving of poverty under a 5% real GDP growth rate will only take place by 2020 (scenario 3). Scenario 2 suggests, therefore, a per capita growth rate of 3.9% per annum. Under this scenario, consumption poverty will be reduced by 31%, from 80% currently to 49% in 2015. Food poverty, under the same growth assumption, will be reduced by 27%, thus falling from 68% currently to 41% in 2015. These results are based on an income distribution (gini coefficient) of 0.57. If income distribution improves, say to a desired gini coefficient of 0.4, then it may be possible to attain a greater reduction in poverty under the same growth assumption.

Lower rates of inflation are critical to achieving any significant positive rate of GDP growth. To attain the growth rates required, inflation would need to be brought down to single digits to attract foreign investment and boost the level of savings in the economy. It is worth emphasising that the consumer basket contains 'food and beverages' that account for 50% of all items. A significant reduction in prices will have a marked impact on food poverty.

Sector contributions, saving / investment ratios requirements suggest that some sectors are more pro-poor growth than others. Sector development can have a direct effect on meeting the MDG targets. For example, agriculture expansion can result in higher employment and poverty reduction, while infrastructure development can improve incomes, particularly in the agricultural sector where feeder roads help farmers market their products better.

SOCIAL SECTORS

This report has estimated that the required annual expenditures (as per year 2000 US$) to meet the key MDG targets are as follows:

Option 1:

Primary Education	US$381.5mn
Health	US$43.2 mn
Water	US$48.6 mn
Housing	US$71.0 mn
HIV and AIDS	US$32.0 mn
TOTAL	**US$576.3 mn**
Ave spending per year	US$38.4 mn

Option 2:

Primary Education (with quality improvement)	US$447.8 mn
Health	US$43.2 mn
Water	US$48.6 mn
Housing	US$71.0 mn
HIV and AIDS	US$38.0 mn
Anti-Retroviral Drugs	US$1.5 bn
TOTAL	**US$2.2 bn**
Ave spending per year	US$143.2 mn

On primary education, there is a large discrepancy, based on year 2000 statistics, between net enrolment (92.6%) and primary completion rate (75.6%). In order to increase the completion rate to 100% by 2015, not only do public expenditures have to increase, but also household incomes have to increase so that parents will be able to afford to send their children to school. In year 2000, per child expenditure was Z$ 6536 (US$118), based on an enrolment of 2.4mn children. To achieve 100% net primary completion rate by 2015 and assuming a population growth rate of 1.1% per annum, the expenditure per child will need to increase by at least 4% per annum in real terms (2000 base) for the next 13 years. However, without proper functional classification, value for money audits and expenditure efficiency calculations, the costing can be very unrealistic.

Another important issue to address is the quality of education; supplies per child, teacher pupil ratios may have to be increased. If a 100% increase in supplies per child by 2015 would require a real expenditure increase of at least 4% per annum until 2015 (based on 2000), then the increase in enrolment and completion rates would require a 25% reduction in class size (from 37 pupils to 28 pupils per teacher) and a 50% real increase in teacher salaries. This inevitably requires an increase in real spending (based on 2000) in salaries and wages of 11% per annum until 2015. Since household priority surveys are not available, it is not possible to estimate the increase in household incomes and amount of spending required by households to ensure universal primary education by 2015.

On health, it is important to note that more than one ministry/agency is involved in attaining the health targets. For example, the water ministry is responsible for providing access to clean water, which will reduce water borne deceases, thus reducing infant/under-5 mortality. Also important are household income level and their affordability in purchasing drugs and supplies. In order to reduce infant mortality, under five mortality and maternal mortality and reach targets at 2015, expenditure on preventive services (which account for about 11% of health budget) should increase in real terms by 5.6% (including population growth of 1.1% per annum) per annum. However if combating AIDS as a target is taken into consideration, then substantial funding will be needed. A very tentative estimate shows that to reduce the current level of fully blown AIDS of 600,000 persons (plus population growth) by 50% by 2015 through the intake of anti-retroviral drugs *(whose cost is around US$2500 per year per person and assuming prices remain constant),* the average spending over the next 13 years would be over US $ 1bn per year. This is significantly higher than the total health budget, which was US$ 170 mn in 2000.

On water, recent statistics show that in 2000, 75% of the population (rural) had access to clean water. Given this high access, Zimbabwe should aim to reach 100% earlier than 2015, perhaps by 2010. Access to clean water also has significant impact on infant mortality, since many children die of Malaria, diarrhoea - water-borne decease. With reference to the budget estimates of 2000 (Vote 9), a real 5% (including population growth of 1.1%) annual expenditure is required for new expansion to reach 100% target by 2010. However, maintenance and connection charges should be added to this 5% expansion figure. In many countries, this additional expenditure is borne by consumers of water. Once again, better budget classification and budget audits will provide better estimation for accuracy and efficiency.

The Ministry of Local government, Public Works and National Housing's department of Housing and Stateland management provided the costing on housing.

RESOURCES

Government revenue and other domestic resources: Zimbabwe's revenues mainly come from tax revenues, accounting for nearly 95% of total revenue. In the last 3 years, the revenue to GDP ratio has averaged around 28%. It is envisaged that this is likely to continue in the future. If high positive GDP growth rates can be achieved with appropriate macroeconomic policies and sector revival measures, then revenue generation can be enhanced. These revenues will form a significant part of the financing required for attaining the 2015 MDG targets.

It is important to note that the country is being impacted negatively from the current wave of international isolation, which has had the same impact as a country under sanction. Given this reality, the government has embarked on general asset redistribution (land redistribution, ability of public to own shares on the stock exchange, etc.) as one approach to addressing structural imbalances in the economy, so as to reduce poverty and inequality. The Government is committed to meeting its millennium development goals, first and foremost, from its own resources. However, should international relations improve, external inflow of resources (grants and external

borrowing) will go a long way to soften pressures on domestic resources.

Grants: These flows have slowed down significantly in the past 5 years. However, in the late 80's and early 90's Zimbabwe had received grants averaging US$250 million per year. Once macroeconomic performance improves and good international co-operation is restored, Zimbabwe can expect these flows to resume to the same magnitude of US$ 250mn per year in real terms. It is even possible to envisage grants to account for about 10% of GDP provided the country is not burdened with the absorptive capacity constraint. These flows will make a significant contribution to financing and subsequently to the attainment of the goals.

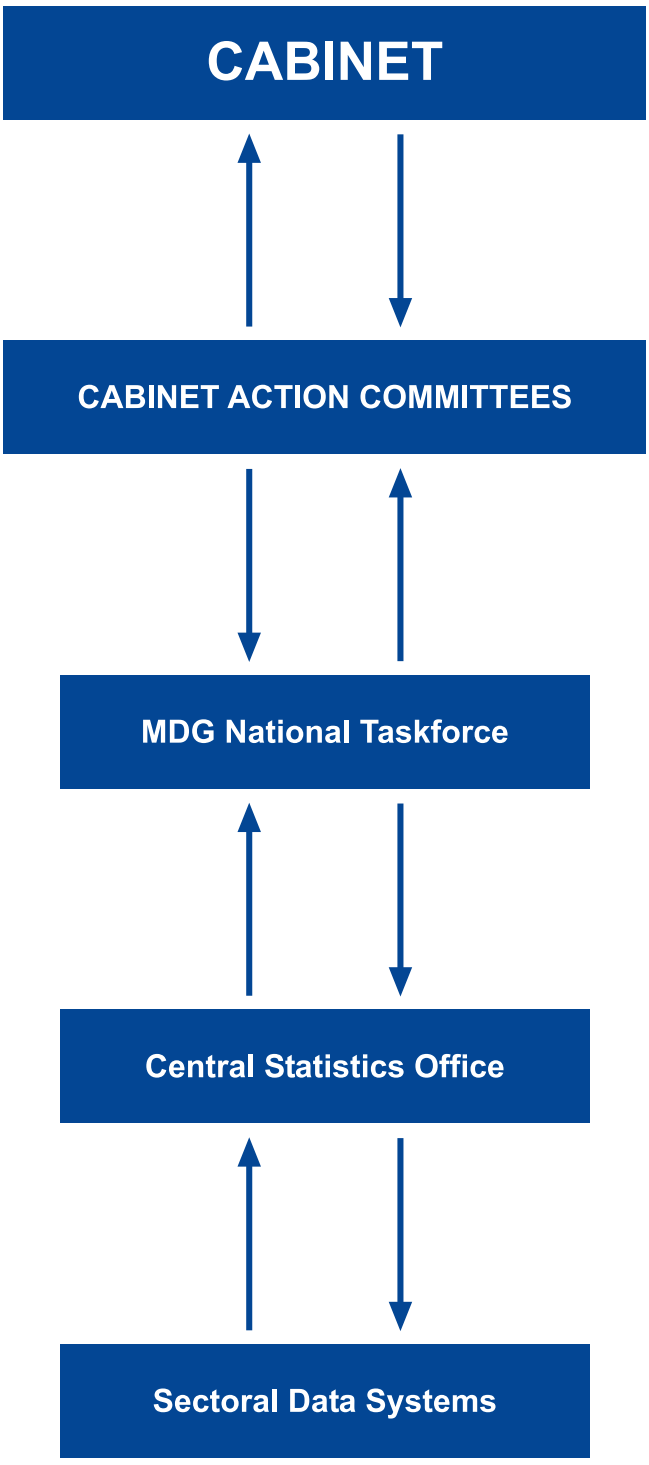
External borrowing: The current debt burden of Zimbabwe is excessively high, with a total external debt stock in excess of US$4 billion. Of this, nearly 1.5billion is in arrears to multilateral, bilateral and other creditors. It is important, therefore, that Zimbabwe takes the necessary steps to clear these arrears, especially the amounts owed to multilateral creditors. Followed by good macroeconomic performance, Zimbabwe can enter into negotiations with other creditors with the view to obtaining further debt relief. Once these initiatives have been completed, Zimbabwe can place itself in a credible position to borrow in the future, but ensuring that the debt situation is always within the sustainable limit. This will require the authorities to formulate and implement sustainable external borrowing policies.

Domestic borrowing: Since mid 1999 (when arrears started to build up), external borrowing opportunities have been drastically reduced to a trickle, leaving the country to raise financing from the domestic sector. This has led to a heavy domestic debt burden comprising short-term treasury bills and bank overdraft facility. Though administered interest rates have been kept low, real interest rates have remained negative, thus resulting in low savings and investment ratios. Heavy borrowing by the Government has also led to crowding out of the private sector. The challenge, therefore, is to have positive real interest rates so as to encourage higher savings and investment in the economy.

Conclusion: It is worth mentioning that Zimbabwe remains committed to working towards meeting its 2015 MDG targets, irrespective of the current state of inaccessibility to external resources (grants and Loans).

The MDG And Poverty Monitoring Structure

The MDGs and poverty will be monitored by existing structures, which will need strengthening to cope with demands of the MDG reporting process. The Cabinet Action Committees will report on the different goals to cabinet. The UN country team and other development partners will provide technical assistance for MDG and poverty monitoring.



Note: Each layer of this MDG and Poverty Monitoring Structure has multiple players.

Annexes

GOAL 1: OTHER INDICATORS

Indicator	1990	1995	2000	2002	2015	Source
Gini coefficient	..	0.57	..	..	0.4	CSO, ICES 1995/96
Human Development Index (HDI)	0.597	0.563	0.551	..	0.800	GHDR various
Poverty Gap ratio	..	0.36	..	..	0.15	MOPSLSW, PASS1995
GDP per capita at constant 1990 prices, Z$	2,196	1,984	1,937	1,796	..	CSO 2001, MOFED 2004
GDP per capita at current prices, Z$	2196	5390	28,090	104,365	..	CSO 2001, MOFED 2004
Agriculture indicators						
Agricultural Productivity						
	1990	**1995**	**2000**	**2002**	**2015**	**Source**
Total value of agricultural output at 1990 prices, Z$m	3188	3119	4345	..	..	MOLARR, 2002
Total value of agricultural output at 1990 prices, Z$m	19349	20084	22855	..	..	MOLARR, 2002
Growth in agricultural output at 1990 prices	1	19.8	4.3	-4.1[2]	..	MOLARR, 2002
Agricultural Output per unit						
Yield per hectare, thousands tones						
Maize	1994	840	2040	..	3000	MOLARR, 2002
Wheat	325	85	250	..	500	MOLARR, 2002
Cotton Seeds	205	101	353	..	500	MOLARR, 2002
Tobacco leaves	134	198	237	..	250	MOLARR, 2002
Agriculture as % of GDP	14.8	13.7	18.4	..	..	CSO
Diversification						
Horticulture, volume of export production, '000 tonnes	14	52	62	..	85	CSO
Horticulture, volume of export production, Z$ millions	84	859	2567	..	..	CSO
Agric exports value, US$m (current prices)	750	895	..	..	..	CSO
Agricultural exports, % contribution to total exports, Z$ m	1796	7139	29675[1]	..	..	CSO
Agricultural exports, value	42.45	39.1	..	..	..	CSO
% of people engaged in agricultural production				..	..	CSO,1999
Total	..	..	58[1]		..	
Male	..	..	48	..	..	
Female	..	..	68.6	..		
Extension worker to farmer ratio	..	..			6000 Extn. W	AREX
Resettlement	..	..	51543[1]	..	162 000	UNDP,2002
Food reserves (tons)						
Maize	..	400 000	357 449	170 000	500 000 to 900 000	MOLARR, 2002
Wheat	..	..	..	..	..	

1- refers to 1999, 2 to 2001, 2 September 2002, 3 June 2002, 4 to 6 December 2002, 5 to 1991.

GOAL 2: OTHER EDUCATION INDICATORS

Indicator	1990	1995	2000	2001	2015	Source
Gross enrolment ratio, primary	114.8[1]	105.4[2]	110.3	..	100	MOESC, 2001
Gross enrolment ratio, secondary	63.6[1]	56.6[3]	58.4	..	100	MOESC, 2001
Adult literacy rate, total	80.38[1]	86[3]	88[4]	..	95	CSO, 1992,1997 and 1999
Pupil/teacher ratio, primary	35	39	37	..	28	CSO,2001
Pupil teacher ratio, secondary	24	27	25	..		CSO,2001
Transition rate from primary to secondary (Grade VII to Form 1),%	68.4	73.7	73.6	..	100	MOESC, 2001
% of trained primary teachers	51.5	74.8	88.4	..	100	MOESC, 2001
Pupil textbook ratio, primary education				8 to 1[3]	1 to 1	MOESC
Early Childhood Education and Care (ECEC)				411851[4]	..	MOESC, 2001
Primary Schools	4530	4633	4741	..	..	MOESC, 2001
Secondary Schools	1533	1536	1555	..	..	MOESC, 2001
Public expenditure on education as a % of GNP	7	6.9		..	..	CSO, 2001

1- refers to the year 1992, 2 to 1994, 3 to 1997, 4 to 1999.

GOAL 3: OTHER GENDER INEQUALITY AND EQULITY INDICATORS

Indicator	1990	1995	2000	2001	2005	2015	Source
Net enrolment ratios,%							MOESC 2002
Primary							MOESC 2002
Females	..	81.9[1]	90	..	..	100	MOESC 2002
Males	..	81.8[1]	95.1	..	..	100	MOESC 2002
Secondary							MOESC 2002
Females	..	30.7[2]	39.6	..	..	100	MOESC 2002
Males	..	29.0[2]	41.5	..	..	100	MOESC 2002
University of Zimbabwe							
Total enrolment	9017	10666	10263	10263	..	..	MOHET
% Females	24	..	31	31	..	50	MOHET
Bindura University							
Total enrolment	.	.	415	325	..	..	MOHET
% Females	.	.	21	22	..	50	MOHET
National University of Science and Technology							
Total enrolment	.	1268	2046	2147	..	..	MOHET
% Females	.	13	16	30	..	50	MOHET
Solusi University							
Total enrolment	.	469	844	694	..	..	MOHET
% Females	.	44	50	48	..	75	MOHET
Africa University							
Total enrolment	.	99	784	725	..	..	MOHET
% Females	.	25	43	44	..	50	MOHET
Teachers' colleges							
Total enrolment	16180	..	16392	17852	..	..	MOHET
% Females	44	..	54	54	..	..	MOHET

Indicator	1990	1995	2000	2001	2005	2015	Source
Enrolment in Technical colleges							
Total enrolment	11683	14761	..	..	..	..	CSO 2001
% Females	..	..	..	..	..	..	CSO 2001
Enrolment in Vocational Training Colleges							
Total enrolment	..	824	1203	..	..	..	CSO 2001
% Females	..	..	..	..	..	..	CSO 2001
Transition rate from primary to secondary (Grade VII to Form 1) females,%	64.9	71.9	72.7	..	..	100	MOESC
Transition rate from primary to secondary (Grade VII to Form 1) males,%	71.8	75.5	74.2	..	..	100	MOESC
% studying science subjects, secondary level							
Females	..	..	..	..	..	..	ZIMSEC
Males	..	..	..	..	..	..	ZIMSEC
Employment in the formal sector,%							
Females	18	21	24	..	30	50	CSO 1992,1997 and 1999
Males	82	73	76	..	60	50	CSO 1992,1997 and 1999
Employment in the informal sector,% [13]							
Females	79[6]	87[7]	88[8]	..	..	..	CSO 1992,1997 and 1999
Males	39[6]	55[7]	59[8]	..	..	..	
Female Administrators and managers share, %	..	15.4	..	..	30	50	GHDR
Female professional and technical workers share,%	..	40	..	..	30	50	GHDR
Share of women in wage employment in the non-agricultural sector, %	18	21	26	..	30	50	CSO 2002
Ministers	2/23[9]	2/23[10]	4/25[11]		8/25	13/25	Parliament
Deputy Ministers	4/16[9]	4/16[10]	4/12[11]		4/12	6/12	Parliament
Governors	1/8[9]	1/8[10]	1/8[11]		2/8	4/8	Parliament
Gender Empowerment Measure		0.428					ZHDR 2000
% Poor and very poor households headed by:							
Females	72	..	..	..	..	..	MOPSLSW
Males	58	..	..	..	..	..	MOPSLSW
Domestic Violence							
Total number of counselling sessions	..	1764[7]	3147[8]	2694[12]	..	..	Musasa Project
Telephone counselling sessions	..	..	..	300[12]	..	..	Musasa Project
New Clients	..	466[7]	2470[8]	2171[12]	..	..	Musasa Project
Returning Clients	..	99[7]	487[8]	223[12]	..	..	Musasa Project
Male clients	..	..	112[8]	..	..	..	Musasa Project

Indicator	1990	1995	2000	2001	2005	2015	Source
Types of Abuse							
Physical Violence	..	..	..	1200[12]	..	..	Musasa Project
Inheritance	..	..	..	525[12]	..	..	Musasa Project
Economic	..	..	..	693[12]	..	..	Musasa Project
Rape/incest	..	..	..	76[12]	..	..	Musasa Project
Other	..	..	..	200[12]	..	..	Musasa Project
Notes: 1 refers to 1994, 2 to 1998, 3 to 1990-1996, 4 to 1992-1998, 5 to 1994 -2000, 6 to 1992, 7 to 1997, 8 to 1999, 9 to 1990-1995, 10 to 1995-2000, 11 to 2000- 2002, 12 to Jan to Oct 2002.							

GOAL 6: HIV AND AIDS AND OTHER HEALTH INDICATORS

Indicator	1990	1995	2000	2001	2015	Source
Estimated deaths due to AIDS per week	516	1464	2386	..	..	UNAIDS
Estimated number of people living with HIV AND AIDS, '000	..	..	1500[1]	2300	..	UNAIDS
Number of adults (15-49) living with HIV AND AIDS, '000	..	..	1400[1]	2000	..	UNAIDS
Number of women (15-49) living with HIV AND AIDS, '000	..	..	800[1]	1200	..	UNAIDS
Estimated number of AIDS orphans	..	..	..	780 000	..	UNAIDS
Note: 1 refers to 1999						

GOAL 8: GLOBAL PARTNERSHIPS INDICATORS

Target 12: Openness of trade and financial system

Indicator	1990	1995	2000	2001	2015	Source
Commercial Banks	..	..	..	15	..	Registrar of Banks
Accepting Houses/ Merchant Banks	..	..	..	6	..	Registrar of Banks
Discount Houses	..	..	..	6	..	Registrar of Banks
Building Societies	..	..	..	5	..	Registrar of Banks
Finance Houses	..	..	..	6	..	Registrar of Banks
Micro financing Institutions	..	..	..	537	..	Registrar of Banks
Mean Tariff	..	..	19.9	19.9	..	RBZ
Imports to GDP ratio (Openness)	21	37	26	..	..	RBZ
Total Trade to GDP ratio	38	63	52	..	..	RBZ
Merchandise exports as a % of GDP	20	..	-6.9	..	..	RBZ
Merchandise imports as a % of GDP	17.2	..	-12.9	..	..	RBZ
Overall balance of Payments as a % of GDP	-0.2	2.7	..	..	..	RBZ
Target 14: Special needs of land locked countries	**1990**	**1995**	**2000**	**2002**	**2015**	**Source**
Cost of transportation of goods to ports, Z$ per kilogram, per kilometre						
Road	..	..	..	..	..	**MOT**
Rail	..	..	..	..	..	**MOT**
Air	..	..	..	..	..	**MOT**

Target 15: Debt	1990	1995	2000	2002[1]	2015	Source
Total debt, Z$ m	23689,25[5]	65816.27	354782.20	530023.35	..	RBZ
Domestic debt, as a % of total debt, Z$ m	33.1[5]	37.5	45.9	63.4[2]	..	RBZ
External debt , as a % of total debt, Z$ m	66.9[5]	62.5	54.1	36.6[3]	..	RBZ
Public debt, as a % of total debt , Z$ m	72.8[5]	82.1	87.5	86.6	..	RBZ
Private debt, as a % of total debt , Z$ m	5.6[5]	10.7	7.5	3.1[3]	..	RBZ
Total arrears, Z$ millions	..	..	26117.0	74136.7[4]	..	RBZ
Total external debt service, Z$ millions	2440[5]	4972	34046	26561	..	RBZ
Total debt as a % of GDP	80[5]	106.2	113.8	54.8	..	RBZ
Total debt as a % of exports	228.2[5]	260.1	252.8	588.9	..	RBZ
Total debt service as a % of exports	23.5[5]	19.6	24.3	29.5	..	RBZ
Total ODA received, Z$ millions	1260[5]	1555	2939	1996	..	RBZ
ODA per capita, Z$millions	125[5]	135	218	..	..	RBZ
ODA as a % of GDP	4.3[5]	2.5	0.9	0.2	..	RBZ
Net Foreign Direct	-12	98	16	1[6]	..	RBZ
Investment, USS millions						
Target 17: Affordable essential drugs						
Proportion of population with access to affordable essential drugs on a sustainable basis, %	..	..	..	..	..	
Target 18: Technology						
Radios per 1000 people	..	96	390	..	..	WDI
TVs per 1000 people	..	29	180	..	..	WDI
Daily newspapers, per 1000 people	..	19	..	..	..	WDI
Telephone lines per 1000	..	14	20.8	..	..	WDI
Mobile phones, per 1000 people	..	0	15.1	..	..	WDI
Internet hosts, per 1000 people	..	0.08	2.61	..	..	WDI
Fax machines per, 100 people	..	0.1	..	..	..	WDI
Other Development Indicators	**1990**	**1995**	**2000**	**2002**	**2015**	**Source**
GDP at current prices, Z$ millions	21494	61974	311890	..	..	CSO 2001
GDP at constant 1990 prices, Z$ millions	21494	22820	22876	..	..	CSO 2001
GDP per capita at constant 1990 prices Z$	2196	1980	1697	..	..	CSO 2001
Budget deficit as a % of GDP	-5.3	-9.4	-21.8	..	..	RBZ
Total debt as a % of GDP	..	..	63		..	RBZ
Inflation, %	15.5	22.6	55.9	365[7]	..	CSO 2002
Money supply growth rate (M3), %	..	30	59.9	144	..	RBZ
Interest rate, (nominal prime lending rate), average of month end data, %	11.50	31.60	55.00	15.00	..	RBZ

Target 15: Debt	1990	1995	2000	2002[1]	2015	Source
Exchange rate, daily average for the year, ZS per USS.	2.5	8.7	55	55	..	RBZ
Gross Capita Formation, ZS millions	3735	15675	42104		..	CSO 2002
Gross Domestic Saving, ZS millions	3003	15675	32783		..	CSO 2002
Note: 1 refers to estimates; 2 refers to Sept 2002; 3 to June 2002; 4 to 6 Dec. 2002; 5 to 1991, 6 to 2001, 7 to June 2003						

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