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A Collaborative Rationality To Leave No One Behind

Early Experiences On Contextualising The Health Related Sustainable Development Goals In Zimbabwe

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This practice paper illustrates how a deliberate, participatory approach to SDG contextualisation in some of the most deprived areas of Zimbabwe can lead to the prioritisation of health outcomes and actions. It draws attention to the reconsideration of collaborative rationality as a practice that can not only break through stalemates but also facilitates dialogue and produces creative solutions to complex and sometimes controversial difficulties, winning stakeholders' cooperation for action and results. While collaborative rationality practice is not a panacea, our case study in Zimbabwe suggests it is underutilised; when fully utilised it has the potential to reduce conflict, offer new alternatives in real situations and reframe difficult problems to leave no one behind. Such desirable results are contingent, however, on properly designed and managed participatory processes that approximate the ideal of collaborative rationality. These ideals can spur contextualisation processes which are essential to the delivery of SDG 3 and other health-related targets. Three key messages emerge from our work in Zimbabwe:

A deliberate, participatory process built on the practice of collaborative rationality provides the means towards contextualising the SDGs for communities.

To truly reach the most marginalised, an inclusive process of SDG contextualisation needs to sit alongside any country-specific refined set of goals. The practice of collaborative rationality asserts prioritisation of local goals and collaboration among participants on these goals as essential for a continuous learning process and for dealing with complex development planning problems at the community level. Collaborative processes are adaptive, combine decision making centres at the top with bottom-up operations in the community and can thus tolerate changes. Engaging various groups in the community creates multiple interactions and non-linear dynamics, which facilitate the creation of new knowledge and creativity, as well as the transformation of values, desires and understandings.

SDG contextualisation is essential to the delivery of SDG3 and other health related targets, and by its very nature demands a focus on leaving no one behind in planning, implementation and reaping the benefits of improved health outcomes.

For the health sector, the process of SDG contextualisation demands joint effort in both planning and implementation by decision making centres, local stakeholders and communities. These can include the health ministry directors and managers, District Health Executive Teams, Provincial Health Teams and the Urban and Rural District Councils, together with lay health workers and civil society working in rural Zimbabwe. These various stakeholders show promise to make significant progress on localising and contextualising SDG implementation.

An analysis of the SDG contextualisation process must be subjected to a lifecycle perspective that pays strong attention to the temporal dimension of pockets of effectiveness and underlying events, actions and outcomes.

The contextualisation of the SDGs is not a one-off event, and its effectiveness is also relative to time. While SDG symposiums do work as kick-starters of the contextualisation process at the local level, they can also degenerate into ineffective arrangements or have their upward and downward tendencies while struggling to persist. Analysis on what works for SDG contextualisation must give particular analytical focus on the turning points or periods of time in the SDG contextualisation processes that emerge as either pockets of effectiveness or of degeneration.

1. Introduction

This practice paper considers Innes and Booher's (2010) conception of collaborative rationality to make a case for contextualising the SDGs. At the centre of this paper is a discussion on what the discourse on the contextualisation of the SDGs entails in-situ for local communities. The analysis is guided by a careful analysis of secondary literature and documentation of evidence from early implementation experiences of three community symposiums on SDG 3 – '*Ensure healthy lives and promote well-being for all at all ages*' – in three of Zimbabwe's rural districts.

The community symposiums were an exercise to test an SDG local participatory implementation approach (collaborative rationality) that tailors SDG 3 targets to local needs. This perspective looks at the frequent but largely unexplored phenomenon of 'pockets of effectiveness' (PoE). These PoE are viewed as organisations which create institutional arrangements that facilitate effective service delivery despite struggling and often ineffective governments (see section 3). The symposiums aimed to explore how the practice of collaborative rationality in real situations could facilitate the emergence of these pockets (SDG progress points at community level) and identify the broader political processes that underlie their formation and existence. This was especially important as it created new knowledge and lessons on the practicalities of the actual SDG contextualisation process. Contextualising the SDGs is increasingly viewed as a possible route to broad-based sustainable development that leaves no one behind. While SDGs are globally agreed, they must make sense at the national level and should be contextualised at the community level if no one is to be left behind. But the underlying processes of SDG contextualisation are considerably more complicated than hitherto assumed. Drawing on the aforementioned notions of collaborative rationality, this paper makes the case for an approach that engages various groups in the community to jointly make decisions in the context of ever-changing and sometimes multiple conflicting information sources. It suggests how joint community centred initiatives on making health decisions and monitoring SDG targets can be more effective with diverse agents, involving many interactions and non-linear dynamics with other community groups including engagement with responsive high-level decision-making stakeholders. These high-level stakeholders must be included because they often make decisions and have power – and are 'deal makers' or 'deal breakers'. Communities must actively participate because they not only need information but are also most likely to be affected by the outcomes of the process. The inclusion and full participation of all relevant stakeholders is necessary for consistent and efficient actions to emerge (Turner and Hulme, 1997). Collaborative rationality sees the world as imperfect and assumes that while there may be multiple and better options for proceeding in planning and policy than the status quo, there is hardly a single best solution (Innes and Booher, 2010). To this end, processes in this approach tend to not only guide communities in jointly finding new ways forward but also build the capacities of these communities to be resilient in the context of inevitable new challenges (Turner et al., 2015).

Zimbabwe's rural context was particularly important for this research because more than 65% of its total population still reside in the rural areas and more than 75% of the country experiences poverty and deprivation. Zimbabwe, therefore constitutes a significant proportion of some of the world's most impoverished populations and individuals 'left behind' (see section 3.1). Although the focus is on Zimbabwe's rural context and health-related goals, many of the SDG contextualisation issues in real situations raised in this paper also apply to other developing-country settings.

This paper is organised into three main sections. Following this introduction is an exploration of the imperative to contextualise the SDGs and the concept of leaving no one behind in local contexts. This is followed by the Zimbabwean experience, which outlines the action implemented to localise SDG 3 and the stakeholders involved. The paper concludes by way of a discussion of lessons learnt from Zimbabwe and the implications for policy.

2. Contextualising Development: Is This New?

While the discourse around contextualisation is in vogue, it is not new, and it is reminiscent of long-standing development debates around the importance of the 'periphery' and putting those perceived last, first, as argued by Robert Chambers (1986). This discourse in its reincarnated form also has roots in the arguments of economists like Sen (1985) and Ostrom (1990), who in the middle of the 1980s were proffering a vaunted critique of large-scale investments in agricultural and industrial growth as development orthodoxy. They and other scholars saw this orthodoxy as inherently disempowering and top-down, arguing instead for more bottom-up and deliberative approaches to development. These approaches were thought to allow for 'common sense' and to build the 'social capital' of communities to be central to decisions that affected their locales (Masui and Rao, 2012). The discourse around contextualisation (especially as sponsored by Chambers (1986), Hulme and Turner (1990) and led by Chambers and Conway (1992), Turner and Hulme (1997), Turner et al (2015) amongst others) took a planning and policy lens as well as a turn that placed sustainable community livelihoods at the centre of development discourse (Scoones, 2009).

Contextualisation discourse has developed in leaps and bounds, rising in prominence on account of its emergence as a counter to globalisation through the rise of the concept of 'thinking globally and acting locally'. As such, while this contextualisation discourse is not new, it is re-emerging with a refreshing and renewed impetus around the leave no one behind mantra which suggests ownership of development process by local communities.

However, as has been demonstrated in the literature, particularly in the ODI report *Localising the Post-2015 Agenda: what does it mean in practical terms? (*Lucci, 2015), this renewed impetus is contingent on context and has its own shortcomings. In most instances what is 'local' is either ill-defined or conflated with the 'national' especially given the global nature of the SDGs. When this conflation is avoided, the discourse around contextualisation usually favours cities, or gives pride of place to local authorities (UCLG, 2015; Boex, 2015). In this mode, contextualising the SDGs is often understood as relating to how the local government can support the implementation of the SDGs and their achievement through bottom-up action, and provide a framework for domestic development policy (UNDP et al., 2016). This discourse also predominantly favours contextualising the SDGs as a function of data collection for policy action instead of for a community's 'actual' and tangible development.

3. The Imperative To Contextualise SDGs

Several high level political forums on sustainable development have held serious discussions on the growing involvement of local governments in the dissemination and adaptation of the SDGs at the local level (UCLG, 2017). However, given the nascent form of the conversations, several questions are still to be satisfactorily answered. For instance:

- What is involved in the actual process of contextualising the SDGs? What lessons can be gleaned from early implementation experiences of SDG contextualisation, especially in resource contained contexts?
- Does contextualisation of the SDGs encourage community participation in ways that improve the targeting of public benefits such as social welfare? Does this contextualisation improve the targeting of public goods such as health care to the poor? Does it lead to the empowerment of social groups that have traditionally been left behind? In particular, does it increase inclusivity and the capacity for joint community action, and reduce the possibility of benefits from localised projects being 'captured' by powerful local elites?

Early attempts at answering these pertinent questions have spawned two basic views. The first, optimistic, view posits that SDG contextualisation is tacitly premised on participatory development that is not top-down and is empowering and effective. Furthermore, it hinges on collective agency in improving well-being, through institutions that put people first by working systematically at the local level. This view cuts across variations of understanding SDG contextualisation, whether informed by notions of Chambers' (1986) community led development; Sen's (1999) shift from material well-being to a broad based 'capability' approach; or Freire's (1970) radical leftist perspective of '*dialogical action*' and '*revolutionary action*' where the '*oppressed*' unite to improve their own destinies. The current wave of development practitioners are enjoying an explosive re-birth of a new development planning agenda driven by the *leave no one behind* mantra which appears inclined towards these ideologies of bottom up (localised) participatory development.

The second more pessimistic view posits that SDG contextualisation is a reincarnation of what development researchers have in the past called the 'local trap', where practitioners incorrectly assume that localized decision-making is inherently more socially just or ecologically sustainable (Agarwal and Gibson, 1999; Purcell and Brown, 2005). The main criticism of SDG contextualisation is that arrangements for locally led development are socially constructed through political struggle – they are never given. In other words, there is nothing inherently positive about development in any local space. Therefore, an arrangement in which resources or decisions are controlled locally is no more likely to lead to ecologically sustainability or equitable outcomes than an arrangement in which the national or global decision-making arrangement predominate. Because arrangements for local decision making and subsequent development implementation are produced through socio-political struggle, the outcomes of a local development arrangement are dependent on the political agenda(s) of those empowered by the arrangement. In part, this pessimistic view of contextualisation is justified, as indeed an inherent positivity should not be ascribed to contextualisation by default. Local political and ecological dynamics that may be idiosyncratic warrant deeper understanding through objective critical inquiry. It is this understanding that informs the key question: *how do we 'actually' localise SDGs in-situ for the community? And how can the poor be empowered to be part of their own development through local led problem analysis and solution development?*

The preceding view on the contextualisation of the SDGs suggests two serious challenges that the discourse and practice of contextualisation must deal with:

First, efforts at community participation have not been particularly effective at targeting the poor.

A review of the conceptual foundations of SDG contextualisation from the *SDG contextualisation Roadmap* (UNDP et al., 2016) and an analysis of evidence on the effectiveness of community led development shows that projects reliant on community participation have not been particularly effective at targeting the poor (Ghazala and Vijayendra, 2011). While some evidence suggests that such projects create effective community infrastructures, very few studies establish a causal relationship between outcomes and participatory inputs of locally-led development projects. In most instances, elites dominate such projects, with both targeting and project quality tending to be markedly worse in more unequal social groups (see Hulme and Turner, 1990).

Second, the sustainability of contextualisation depends on enabling institutional arrangements.

UNDP et al. (2016) define SDG localisation as a process that 'relates both to how local governments support the achievement of the SDGs through bottom-up action, and how SDGs can provide an approach for local development policy'. This definition, however, fails to locate institutional arrangements that can enable or disable the contextualisation agenda. A growing number of qualitative studies (e.g. Ghazala and Vijayendra, 2011) indicate that the sustainability of community-based contextualisation initiatives crucially depends on enabling institutional arrangements. These arrangements demand the commitment of government, and good public accountability practices to avoid an overly skewed development scenario, e.g., supply-driven or demand-driven development. The popular definition of SDG contextualisation says very little about these practicalities.

These gaps are some of the reasons why the imperative for SDG contextualisation remains a priority concern. However, a look at lessons learnt from early implementation experiences of SDG contextualisation in resource constrained contexts can provide the first steps to understanding contextualisation of the SDGs in-situ and for the poor.

3.1. The Zimbabwean Context: The State Of Development Indicators

Zimbabwe is relatively young demographically, with 41% of its population below the age of 15, and only 4% aged 65 or more (ZimSTAT, 2012). Almost 70% of the population resides in rural areas, and most people die young and prematurely from preventable causes – life expectancy at birth is 38 years (ZimSTAT, 2012). Food poverty[1], is more common in rural than urban districts. Nkayi District for instance, in Matebeleland North, has a 66% food poverty prevalence, ten times higher than that of Harare (6 %) (UNICEF et al. 2016).

Over the course of the last two decades (1997 to 2017), Zimbabwe has faced severe economic, social, and political challenges. These challenges are variously attributed to political contestations and economic uncertainty (see for example Chitiyo, Vines, and Vandome, 2016), and smart sanctions from the west (Chingono, 2010), and have manifested in severe social and economic problems. For instance, between 1998 and 2008 the economy shrank by 50%, with an 18% decline in 2008 alone (Bond and Shariffe, 2012). By 2014, employment had become largely informalised, with 95% of employment found in the precarious and insecure informal economy (ZimSTAT, 2014).[2] The health sector also struggled, with dire consequences for national health outcomes, including low life expectancy at birth, high maternal and child health mortality rates, poor nutrition, and the spread of (non) communicable diseases. Chikanda (2006) estimates that 80% of doctors, nurses, pharmacists, radiologists and therapists trained in the 1980s left during this period, and at a time when the country was ailing under one of the worst cholera epidemics in Africa's modern history.

Despite this, there is a discernible commitment from the Government of Zimbabwe's Ministry of Health and Child Care (MoHCC) on the attainment of the SDGs – SDG 3 in particular – and the concept of *leaving no one behind* (LNOB). This is manifest in the country's *National Health Strategy 2016-2020: Equity and Quality of Health: Leaving No One Behind* (MoHCC, 2016). The fact that the LNOB mantra is part of the nomenclature of the policy is a good sign and suggests a commitment to achieving improved health outcomes for all social groups across the country. This national strategy's goals are in tandem with Agenda 2030's health targets and especially targets under SDG 3 (see Table 1).

Other positive signs include the fact that 59% of the country's administrative wards enjoy the services of Village Health Workers (VHWs), and Health Center Committees (HCCs) who provide a link between the health service and the community (MoHCC, 2015). However, the VHW program, though in line with the Alma Ata Declaration of 1978 on Primary Health Care, remains underdeveloped and suboptimal.

The above context with its challenges and opportunities provided the testing ground for SDG 3 contextualisation initiation through community symposiums.

3.2. Sites For SDG Contextualisation In Rural Zimbabwe

Three community symposiums on SDG 3 were held in Chikwaka Communal Lands (Goromonzi District), Dema (Seke District), and Mbire District (see Table 2.)

1 A household is food poor or extreme poor when total household consumption per capita is below the food poverty line. The food poverty line in Zimbabwe refers to the total amount of expenditure (US$30.86 per person per month) needed to meet minimum food needs (UNICEF et al. 2016).

2 The informal sector is largely deemed insecure and precarious because workers in the sector, while fulfilling full time employment tasks, often do so for unpredictable returns, while not enjoying workers' rights and their subsequent protection under the law, in an unstable sector, which is often criminalised. This is in addition to lower wages (often relegating them to being working poor), dangerous working conditions, with no social benefits, and no organised union representation.

Table 1: Zimbabwe National Health Strategy 2016-2020 Strategic Objectives And Agenda 2030 Targets Under SDG 3

Zimbabwe National Health Strategy 2016-2020: Strategic Objective	Agenda 2030 Corresponding SDG 3 Target
Strategic Objective 1-5: reduce morbidity and mortality due to malaria, Schistosomiasis, HIV, tuberculosis and timely detect epidemics	3.3: end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and other communicable diseases.
Strategic Objective 6-9: reduce NCDs, disability and improve population mental health, overall life expectancy and elderly persons' quality of life.	3.4: reduce NCDs through prevention and treatment and promote mental health and well-being.
Strategic Objective 10-13: reduce malnutrition maternal, neonatal and under-five mortality.	3. 1: reduce maternal mortality ratio; 3.2: end preventable deaths of new-borns and children under the age of 5 years; 3.7: ensure universal access to sexual and reproductive health-care services, including for family planning.
Strategic Objective 14: strengthen environmental health services, early detection of disease outbreaks and man-made disasters	3.6: reduce deaths and injuries from road traffic accidents; 3.9: reduce deaths from hazardous chemicals and air, water and soil pollution and contamination; 3.d: Strengthen early warning, risk reduction and management of national and global health risks.
Strategic Objective 15-18: improve both primary care and hospital service delivery platforms and ensure universal access to preventive and curative services	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services for all.

Table 2: Poverty Outcome Indicators For Goromonzi, Mbire And Seke Rural Districts In Zimbabwe

	Goromonzi District	Mbire District	Seke District
Population (ZimSTAT 2012)	224,987	82, 380	100,756
Province	Mashonaland East	Mashonaland Central	Mashonaland East
Average Poverty Prevalence* (UNICEF et al. 2015)	Average Poverty Prevalence is 62.4%. The district is divided into two categories. Communal areas: 53% to 77% Farming resettlement areas: 61% to 72%.	Average Poverty Prevalence is 81.0%. Generally, the district is divided into two main categories high poverty prevalence of 73% to 84% and 85% to 96% respectively.	Average Poverty Prevalence is 56.0%. The southern part of the district covering the Ringa area has the highest prevalence: 61% to 72%. The situation is better in commercial farms and in the Beatrice area: 36% to 48%
Food Poverty Prevalence** (UNICEF et al. 2016)	Food Poverty Prevalence in Wards ranges from 10.7% & to 25.2%	Food Poverty Prevalence in Wards ranges from 31% to 44%	Food Poverty Prevalence in Wards ranges from 8% t0 18%

** Poverty Prevalence (also known as the headcount index) represents the total population (either people or households) whose consumption expenditures fall below the poverty line as a proportion of the total population.*

*** A household is food poor or extreme poor when total household consumption per capita is below the food poverty line. The food poverty line refers to the total amount of expenditure needed in Zimbabwe to meet minimum food needs: FPL = US$ 30.86 per capita per month*

3.3. Aims Of SDG Community Symposiums

The symposiums were an exercise to test an SDG local participatory implementation approach that tailors SDG 3 targets to local needs, and the three districts were trial runs from which a model approach to contextualising SDG engagement and participation could be developed. Its purpose was thus to manage the risks associated with SDG local implementation. The success factors presented in this paper (see Section 4) highlight what works, how and why. This perspective looks at the frequent but largely unexplored phenomenon of 'pockets of effectiveness' (PoE) existing in weak governance states (see Leonard, 2008; Roll, 2014). PoE are viewed as organisations which create institutional arrangements that facilitate effective service delivery in contexts characterised by a largely ineffective government. The symposiums aimed to test how the practice of collaborative rationality could lead to the emergence of these pockets and identify the broader political processes that underlie their formation and existence. While this paper touches upon these questions, it focuses on what the lessons from these symposiums teach us about contextualising the SDGs in communities and in particular, how processes organised to promise highly achievable, visible and practical

benefits relatively quickly are likely to be received and possibly sustained by communities. For the objectives of the symposiums, see Box 1.

3.4. Multi-Level, Multi-Sector, And Multi-Stakeholder Composition

The community symposiums attracted over 500 participants across gender, age, occupational, and political spectrums. The Chikwaka symposium attracted the most participants (approximately 250), while the Seke symposium attracted the least (approximately 100). Stakeholders were drawn from both the supply side and demand side of the health delivery system. This multi-stakeholder approach aimed to create ownership and co-responsibility among all actors. The panoply of stakeholders allowed for candid conversations on SDG 3 along the continuum of care at the local level in terms of both the health services supply chain[3] and system[4], making for nuanced conversations on the quality of care between providers and recipients of health services. The initial points of contact in preparation for the symposiums were four fold:

- First, the researcher engaged the sector ministry to ensure buy-in and secure a commitment to community engagement from policy makers.
- Second, the researcher engaged lay health workers including HCCs and VHWs in respective districts to secure their buy-in and commitment to candid engagement with ordinary people in the community.
- Third, the researcher engaged the respective Rural District Councils and traditional councils to partner on the initiative.
- Finally, the researcher approached partners including academia, research entities and donors for collaboration.

The above processes allowed the researcher to get a sense of community specificities and other boundary partners essential to the success of the symposiums. This information also informed the researcher on the culturally accepted ways to contact local political, traditional, and social leadership in the target communities. The processes above also assisted the researcher to secure the 'authorisations' of putative 'gate-keepers' at both policy and national level, as well as local community level (see Table 3).

3.5. Diagnosis Of Needs To Define Priorities For Contextualisation

The specifics of what would be discussed at the community symposiums was informed by community consultations. From initial contact with HCCs and VHWs, the researcher recruited 15 individuals (5 women, 5 men and 5 youths) to canvass the community for pertinent health issues. This team was tasked with targeting a maximum of 15 households each for short exploratory interviews. Each was equipped with an interview guide with one open ended question: *what is your priority health need and why?* After 15 interviews, each interviewer would have reached qualitative enquiry content saturation. This engagement process also acted as publicity for the symposiums, spreading information about

Box 1: Objectives Of The Community SDG Symposiums

- Test an SDG local implementation approach that tailors SDG 3 targets to local needs, to identify lessons that point to *what works, how and why* in the contextualisation of SDGs for communities
- Working in three rural communities, explore (learn by doing) how SDG contextualisation could be institutionalised at the lowest tier of the health system (where people are) by mobilizing and building partnerships with different local stakeholders. This would include bringing together most sectors of society, encouraging their participation, and drawing from their knowledge and experiences – in other words, collaborative rationality.
- Raise awareness on SDG 3. This would primarily focus on its importance and relevance to communities, and how the community can get involved based on their knowledge, and through social accountability monitoring.
- Identify local SDG champions to be actively involved in awareness-raising, collecting data, tracking and reporting progress at the district level.
- Facilitate dialogue between boundary partners on SDG 3 (actors in the national health system, role players in community health, local business and communities), and develop a road map for continued and enhanced community participation in SDG 3 dialogue, implementation and pursuit.

3 Policy-makers, administrators, and clinicians.

4 Politicians, economists, development experts, academics, and ordinary community members.

Table 3: Multi-Level, Multi-Sector, Multi-Stakeholder Composition In SDG Contextualisation

SDG 3 (Health) sector Policy actors	Other related sector stakeholders	Local government	Community	Partners and Donors
– MoHCC-HQ secretary for health office – MoHCC-HQ principal directorates and respective directorates – Provincial Health Teams – District Health Teams; Local clinic staff; District AIDS Coordinators	– Ministry of Education, Head teachers and teachers – Ministry of Agriculture community extension officers – Ministry Gender and community development local officers – Ministry of Social Welfare	– Rural District Council – Traditional leadership (Chiefs and herd men) – Local Members of Parliament and Councillors – Army and Police	– HCCs; Community Home Based Facilitators and VHWs – Ward and Village Health Committees and HIV/AIDS committees – Health Civil society and local NGOs working on Health – Environmental Health Technicians; CBOs; Business; Churches	– Academic institutions: University of Zimbabwe; University of Manchester – Research Organisations: RTI international; Overseas Development Institute (ODI), Training and Research Support Centre (TARSC) – UN partners: UNFPA – Donors and National NGOs

its intentions and the stakeholders it would gather, as well as the opportunity it would present for the community to be heard through presenting their priority issues to the MoHCC, RDC, universities, UN, researchers and donors.

After the community consultation process, the researcher convened a knowledge sharing session with the full 15-member community research team, along with the local clinic, to discuss emerging issues and aggregate them into categories of women's issues, men's issues and youth issues. This platform helped the group to cluster and clean issues, as well as to agree on who would present them at the symposium, with presenters not restricted to the research team. The process allowed the community to own the issues, present them, and also assisted VHWs in retaining collective community ownership of the issues.

Post-consultation, the researchers, HCCs and VHWs set up a separate logistics committee to assist with community mobilisation, observing local community protocols in sending invitations (especially to the traditional leaders), cooking, booking the venue, and getting police clearance for the event. As an aid, the symposium publicity fliers were distributed before the event at local growth points and shops, bars and night clubs, farms and traditional ceremonies, schools and churches – stating the venue, date, Ministry guests, and the objective of the event. A letter of support was secured from the MoHCC's highest office and this officially invited the community stakeholders (local leaders, Chiefs and Councillors) and assisted with the process of police clearance.

3.6. Ownership And Co-Responsibility For Implementation

On the day of the symposium, the process began by following traditional rights and salutations. Elderly women and men started by clapping, ululating and whistling in some traditional greeting rites which also served to seek blessings from ancestral spirits and the Mambo (Chief). On this occasion, men showed respect by removing their hats, while women stared at the ground to symbolise respect. Once the Mambo responded, taking the chance to put in a word with his thoughts on the process, whistles and further ululations followed, accompanied by a fast beating drum to symbolise happiness and the acceptance of the blessings. Soon after the traditional opening ceremony, Christians demanded a short prayer to ask blessings from God. The prayer was short but passionate, and punctuated by an occasional 'Halleluiah' and 'Amen'. This traditional greeting rite symbolised a process of a community 'reclaiming power' to own events in their localities and fashion them in ways that they think is best and respectful.

Following these opening rites the District Administrator, who is the overseer of all community activities in the respective district, made formal welcome remarks. Following this, the Provincial Medical Director gave an overview of the program while the District Medical Director outlined the district health profile and district health challenges. An SDG 3 awareness-raising session preceded the presentations on community priority needs based on views collated before the event, presented by selected community representatives. After this session, government officials, partners, donors, and communities each taking ownership of issues raised by communities took turns responding to questions raised and

committing to one or more forms of action. The final session consolidated the needs, collaborative actions, and roles into an action plan which the local HCC would monitor working directly with the local clinic. The action plan was presented by the RDC and MoHCC HQ directorate before an official closure was given by the District Nursing Officer, a member of parliament or a community representative of that area.

3.7. What Do Communities Really Want?

While this paper aims to report the process of SDG contextualisation experienced in Zimbabwe, it also seeks to deliver an account of the nuanced narrative of the discussions at the SDG symposiums. From this methodological consideration, the paper does not seek to present verbatim accounts, nor follow the chronological pattern of actual events and processes. This section does not seek to respond to and list all the specific health needs, issues and questions raised by communities along with responses from local authorities. Rather, it is a presentation of the most reported issues across the three districts. The list (see Table 4) is not exhaustive, but it helps to highlight a glimpse of the possibilities and difficulties of health delivery in Zimbabwe. Responses from authorities suggest that, if given a chance, these symposiums can function as the first step towards the SDG contextualisation process. Table 4 also highlights the SDG targets that would be tackled if commitments are pursued and achieved. There are two overarching factors emerging from the dialogue between communities and stakeholders on SDG contextualisation – interdependence and direct dialogue (see Box 2)

Box 2: Collaborative Rationality – Key Factors For Successful Contextualisation Of SDGs

Interdependence

- The Ministry of Health and Child Care depends to a significant degree on other stakeholders working in communities for effective service delivery. That is, as is true in all rural district negotiations, each stakeholder has something that the others want. This condition ensured that symposium participants maintained a degree of keenness and zeal required to engage each other, and push stakeholders for agreement. As a group, therefore, they could establish action points that allowed each stakeholder and community member to get more of what they prioritise most without reducing the priority and value that accrued to others. (Innes and Booher, 2010; Turner et al., 2015)

Direct Dialogue

- Communities engaged directly with senior decision makers in the Ministry of Health and Child Care, the Rural District Council, the National AIDS Council, and other stakeholders in an open, public and direct engagement which made parties sure that claims were accurate, comprehensible, and sincere. These decision makers did not dominate deliberations with their power; instead, everyone involved had equal access to all the relevant information and ability to speak and be heard. Communities could challenge public pronouncements by the health ministry, local government or the National AIDS Council without any fear, creating a sense of direct and fair 'talk' where nothing was off the table. Communities used information from their everyday lives and knowledge constructed jointly through interaction with other parties to engage decision makers. Decision makers used the platform to answer questions, and collaboratively plan with communities on next steps.

Table 4: Community Health Needs And Proposed Action From The Community Symposiums

Health Needs/Requested Action By Communities	Response By The Mohcc, Rdc, Nac And Unfpa	Health Targets For Sdg 3 And Other Health Related Goals
Many women are dying due to pregnancy, childbirth and afterbirth complications. The clinic should have at least two midwives instead of none or one.	Village Health Workers to increase coverage and intensity of community education programs for pregnant women, their partners and their families for increased awareness and appreciation of antenatal care, birth plans and complication-readiness. These are crucial for timely access to skilled maternal and neonatal services from the local health facilities. Nurses in Charge at rural health centres to work with VHW to support community health visits, awareness and related projects	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
Men are not fully involved in antenatal care to increase positive maternal and newly-born health outcomes.	Promote local gender programmes targeting men and mainly promoting their role in supporting safe motherhood. Increasing community awareness and knowledge about the importance of male involvement and increasing accessibility of antenatal clinics should be part of the gender awareness program targeting men. Although men at the symposium perceived antenatal care as necessary for pregnant women, most agreed they have a passive attitude concerning their own involvement. Some of the identified barriers to male involvement included: traditional perceptions on gender roles, perceived low accessibility to join women on ANC visits and previous negative experiences in health facilities.	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births. 3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, aim to reduce neonatal mortality to at least as low as 12/1000 live births and under-5 mortalities to at least as low as 25/1000 live births. 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health
Mwanza clinic (like some other rural health facilities but not all), does not have running water and soap for handwashing. This lack of services compromises the ability of health providers to provide essential health services.	The MoHCC proposed an action plan to achieve universal water, sanitation and hygiene (WASH) coverage in healthcare facilities (HCFs) by 2030 in its current National Health Strategy. Working with the local government, some of its existing policy actions include a WASH pledge for all MoHCC partners to support the Ministry by drilling a borehole or contribute towards the drilling of a borehole at one chosen health facility in Zimbabwe. The aim is to make water and sanitation accessible to all users at the premises. Rural health centres are Zimbabwe's primary care facilities and frequently the first point of care, especially for those in rural areas (67% of the population). They are critical in responding to disease outbreaks, such as cholera or typhoid.	Goal 6: Ensure availability and sustainable management of water and sanitation for all 6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all 6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations
There is no routine cancer screening in the rural areas and yet many people are dying of cancers. We do not know much about prostate, cervical and breast cancer.	The MoHCC district hospital superintendent (District Medical Officer) pledged to support rural health centres with cancer screening using visual inspection with acetic acid (VIA) screening equipment which are mostly available at the district hospitals and not the rural health centre level. The VIA screening would be provided in rural health centres twice every year and would be accessible to the majority of at-risk women. The service would be accompanied by appropriate educational programmes directed towards health workers, village health workers, primary care nurses, Health Centre Committees, women and men to ensure correct implementation and high participation	3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

Health Needs/Requested Action By Communities	Response By The Mohcc, Rdc, Nac And Unfpa	Health Targets For Sdg 3 And Other Health Related Goals
People with obstetric fistulae suffer discrimination and stigmatisation because most people believe obstetric fistula is a curse for witchcraft, promiscuity or cannibalism. Because of incontinence and pain, a woman has difficulty with her chores thus devaluing her role at home and in the family. Women are divorced, abandoned, abused and assaulted by their husbands and ridiculed by friends. Loneliness and shame leads to depression and suicidal thoughts. What is the Ministry doing about this problem?	The UNFPFA in Zimbabwe is supporting the institutionalisation of obstetric fistula care in communities and health facilities across the country. The aim is to restore the women's dignity and to address the causes of preventable obstetric fistula. In particular, UNFPA Zimbabwe is working with community behaviour change facilitators, village health workers, trained health workers and policy decision-makers to support work that enhances community appreciation of ways to prevent fistula. The program is improving access to treatment, helping to reduce discrimination and stigma against fistula and supporting the reintegration of women and girls living with fistula. At the symposium, the UNFPA urged the MoHCC, local government and partners to work with communities to strengthen an evidence base for approaches to improve fistula care and scale-up application of indicators for prevention and treatment that can be employed in routine monitoring & evaluation.	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
There are shortages of medicines and ARVs are sometimes in short supply and there are no HIV viral load tests in our clinics. We need them here because we don't want to travel too long a distance to provincial hospitals for viral load tests.	The National AIDS Council of Zimbabwe is working with the MoHCC to allocate up to 15% of total budget for HIV programs in health facility costs. Part of these funds would be directed towards laboratory testing, including training and support for laboratory personnel. The NAC also pointed at efforts to invest in transport for viral load samples, reporting tools, databases which can be leveraged to benefit other diseases too, accelerating diagnostic access overall as well as strengthening health systems.	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
There is a shortage of rabies (Chimbwampengo) vaccines and lack of treatment of snakebite envenomings. We experience common snake bites from snakes such as Mhungu (Black Egyptian Cobra), Chiva (Puff Adder) and Nyamafingu (Snouted Cobra). Most people in rural communities who get bitten by snakes develop persistent sequelae, and very few seek hospital treatment (because there is hardly any treatment available). Most victims end up consulting a local n'anga (African traditional doctor/herbalist).	The Rural District Council, pledged to work with local councillors and Chiefs to help in the vaccination of dogs to help prevent rabies in people. This programme would be accompanied by a programme to support community awareness on rabies; the prevention of dog bites for both children and adults and immediate measures after a dog bite; and education on dog behaviour and responsible pet ownership. The lack of availability of effective snake anti-venom immunoglobulins to treat the specific types of snakebite envenomings is a critical health issue in Zimbabwe. The local nurses in all three sites expressed concern on the shortages of these immunoglobins.	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Health Needs/Requested Action By Communities	Response By The Mohcc, Rdc, Nac And Unfpa	Health Targets For Sdg 3 And Other Health Related Goals
Young people, including our children and young adults, are at increased risk of psychiatric disorder and suicidal behaviours because of the poor socio-economic status of the country. This is mostly because of a lack of opportunities, jobs and income sources as well as a lack of food, family conflict, the death of a family member, poor health and bleak futures. The shortage of mental-health professionals, the low capacity and motivation of non-specialist health workers to provide quality mental-health services and the stigma associated with mental disorder makes it all the harder to address the challenge.	The District Medical officers advocated for a response with a series of levels, from the community through to specialist services. The self-limiting disorders in an early stage might respond to simple measures, such as psychosocial support, self-help strategies, and education typically at home, school and the workplace. The traditional family spaces (madzisekuru, madzisahwira, nemadzitete) that supported mental health care could be helped with information and knowledge on how to deal with these problems in non-clinical settings. These interventions could be developed in youth-friendly channels and disseminated through community-based mechanisms, such as school health clubs and church social clubs.	3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Source: Field notes (Authors)

4. Successful SDG Contextualisation: Lessons Learned

Implementing the three symposiums on SDG 3 in Zimbabwe provided some tentative lessons on SDG contextualisation. It also showed that without a particular focus on resolving some of the challenges associated with contextualisation's previous incarnations as highlighted in sections 2 and 3 of this paper, the wave to contextualise the SDGs will be ephemeral. The lessons below stem from the literature on collaborative rationality and the direct experience of implementing community symposiums in Zimbabwe

Bottom-up contextualisation of the SDGs works better for communities when the centre (top decision making authorities) are supportive

At an elementary level and in theory, SDG implementation, promotion, and experience of their benefits may continue to be limited as long as people at the local level perceive them as something being brought down to them by the state, or as part of an abstract global initiative. To promote the attainment of Agenda 2030, we need to view the poor and marginalised not just as targets for assistance and beneficiaries of the global development agenda, but as collaborators in their development and contributors to the cause of global development that leaves no one behind. What matters to poor people, as to others, are their own experiences, and whether or not they can realise their aspirations for themselves and their families. Those usually left behind are still part of local communities and can play a significant role in the pursuit of sustainable development, not just as passive recipients of services they require, but also as active agents who can participate in the co-production, funding and governance of said services. People at the periphery of development, politics and economic life – those existing at the social margins – can get behind the SDG programme if it is impressed upon them in both words and deeds that this agenda is their agenda. Local communities can support the SDG implementation agenda and assist in measuring progress if they know that such exercises are theirs, not just 'for their own good,' and also not just as some abstract exercise in statistical data collection. In short, contextualising the SDGs successfully engenders the understanding that people support what they are part of and party to creating, and resists that which seems to be an imposition from above.

Collaborative rationality provides a roadmap for local SDG contextualisation

The ambitious nature of Agenda 2030 demands the conscription of a broad range of actors at multiple levels. From the evidence presented in this paper, effort must, therefore, be invested to ensure that interventions do not turn the very poor and marginalised into mere recipients of good-will and possible data points, but also as active participants with the agency to change their lives with the support of governments, and a willing and able international community. Contextualisation of the SDGs entails an active role for local government plus civil society, community interest groups, and local business. Making such a broad range of local actors party to the contextualisation of the SDGs has the distinct advantage of allowing the state and global development partners to identify the fine-grained nature of horizontal inequalities between and within communities at local levels, something that looking at just the national picture often belies. In this outlook, planning and policy in SDG contextualisation are not about finding the best solution because there is no single best solution, but rather they are about recognising that there will always be multiple means to proceed outside of the status quo – this is a part of collaborative rationality. A nuanced understanding like this allows those at the margins to participate while providing for well-calibrated interventions to specific goals, monitoring of (health-related) SDGs that are appropriate for different communities, and speaking to urgent local needs allied to the SDG agenda. While communities can monitor their own progress, local clinics may also provide support by providing relevant routine disaggregated health data to facilitate evidence-based bottom-up interventions that speak to real challenges. This process is about engaging with other members of a community to jointly learn and work out how to get better together in the face of ever changing conditions, alongside sometimes multiple and conflicting sources of information. Thus, these processes are about finding new ways to progress.

Contextualisation of SDGs is contingent on contextual dynamics

While governments have committed to Agenda 2030, it is still essential for SDG contextualisation processes to take context in general, and especially political context, into consideration. In theory, this narrative is key as the disposition of political leaders towards the SDGs and their implementation, as well as extant political settlements, can be an enabler or disabler of SDG contextualisation. Without a clear-eyed view of the political context, otherwise noble initiatives can fail because they are not adapted to work 'with the grain' of local political and social cultures that can facilitate locally-led and owned change processes (Booth, 2012). Part of this process includes the much talked about but seldom implemented idea of 'taking politics into consideration', which entails SDG implementers developing a keen understanding of the political settlements in a particular location and the arrangement of political power (Di John and Putzel, 2009) as well as an understanding of ongoing and adaptable political processes (Laws, 2012). As such, while SDG contextualisation is a development process, it is one that can be aided by implementers thinking and acting politically, i.e. incorporating sound and participatory political economy analysis into interventions and actions.

5. Conclusion

Our findings from the extant work on the contextualisation of the SDGs in Zimbabwe makes a case for some key factors of collaborative rationality. This entails bringing together disparate parties and interests through shared platforms and developing consciousness between the central state, the local state, local business, local NGOs, and communities. This approach recognises that meeting the commitment to leave no one behind requires new focuses and ways of working across a range of issues and strategies.

In particular, political interests and other motivations can lead to a situation in which top civil servants find it more rational to make the contextualisation of the SDGs work and enable the contextualisation outcomes to benefit the community. Another critical finding which adds nuance to our understanding of SDG contextualisation for communities is that if the centre (senior decision makers) is interested in supporting the contextualisation agenda and if they are present to listen to communities, this can bring about change. This change can build the energy that's needed to sustain the pocket of potential productivity (in other words, a pocket of effectiveness). However, the contextualisation of the SDGs is not a one-off event, and its effectiveness is also relative to time. While these symposiums could have emerged as starting points to kick-start the contextualisation process, they can also degenerate into ineffective arrangements or have their upward and downward tendencies while struggling to persist. This tendency suggests that an analysis of what works for SDG contextualisation must be subjected to a lifecycle perspective that pays strong attention to the temporal dimension of events, actions and outcomes. Such a perspective must give a particular analytical focus on the turning points or periods of time in SDG contextualisation processes that emerge either as pockets of effectiveness or areas of degeneration.

References

Agarwal, A. and Gibson, C. (1999) 'Enchantment and disenchantment: the role of community in natural resource conservation'. *World Development,* 27, 629-631

African Civil Society Circle (2016) *The Roles of Civil Society in Contextualising the Sustainable Development Goals*. Cape Town: African Civil Society Circle.

Boex, J. (2015) 'A Post-2015 Local Governance Agenda'. Washington: Urban Institute.

Bond, P. and Sharife, K. (2012) 'Zimbabwe's clogged political drain and open diamond pipe'. *Review of African Political Economy*, 39(132), 351-365.

Booth, D. (2012) 'Development as a collective Action Problem': Addressing the Real Challenges
of African Governance'. *Africa Power and Politics Programme(APPP) Synthesis Report*. London: Overseas Development Institute.

Chambers, R. (1986) 'Putting the last first' in Ekins, P. (ed) *The Living Economy: A New Economics in the Making*. London and New York: Routledge and Kegan Paul.

Chambers, R. and Conway, G. (1992) 'Sustainable rural livelihoods: practical concepts for the 21st century'. *IDS discussion paper,* 296. Brighton: IDS.

Chikanda, A. (2006) 'Skilled health professionals' migration and its impact on health delivery in Zimbabwe'. *Journal of ethnic and migration studies*, 32(04), 667-680

Chingono, H. (2010) 'Zimbabwe Sanctions: An Analysis of the Lingo Guiding the Perceptions of the Sanctions and The Sanctionees'. *African Journal of Political Science and International Relations*, 4(2), 066-074.

Chitiyo, K and Kibble, S. (2014) *Zimbabwe's International Reengagement: The Long Haul To Recovery*. London. Chatham House.

Chitiyo, K., Vines, A., and Vandome, C. (2016) *The Domestic and External Implications Of Zimbabwe's Economic Reform and Re-Engagement Agenda*. Chatham House. London: Chatham House.

Di John, J. and Putzel, J. (2009) 'Political Settlements: Issues Paper'. Birmingham: Governance and Social Development Resource Centre, University of Birmingham.

Faust, J. (2010) 'Policy experiments, democratic ownership and development assistance'. *Development Policy Review*, 28(5), 515-534.

Ghazala, M. and Vijayendra, R. (2011) 'Evaluating Community Based and Community Driven Development: A critical review of the Evidence'. Working Paper, Development research Group. Washington, DC: World Bank.

Hulme, D. and Turner, M. (1990) 'Sociology and development: Theories, policies and practices'. New York. Harvester Wheatsheaf.

Laws, E. (2012) 'Political Settlements, Elite Pacts and Governments of National Unity'. *Development Leadership Programme Background Paper,* 10. Birmingham. Policy and Practice for Developmental

Innes, J.E. and Booher, D.E. (2010) *Planning with complexity: An introduction to collaborative rationality for public policy*. London. Routledge.

Leonard, D.K. (2008) *Where are 'pockets' of effective agencies likely in weak governance states and why?: a propositional inventory*.

Lucci, P. (2015) *'Contextualising' the Post-2015 agenda: what does it mean in practice?*. London. Overseas Development Institute.

Mansuri, G., & Rao, V. (2012) *Contextualising development: does participation work?* New York: World Bank Publications.

MoHCC (Ministry of Health and Child Care) (2015) *Zimbabwe Services Availability and Readiness Survey*. Harare: MoHCC

MoHCC (Ministry of Health and Child Care) (2017) *National Health Strategy 2016-2020: Equity and Quality of Health: Leaving No One Behind*. Harare: MoHCC

Ostrom, E. (1990) *Governing the Commons: The Evolution of Institutions for Collective Action*. New York: Cambridge University Press.

Purcell, M. and Brown, J.C. (2005) 'Against the local trap: scale and the study of environment and development'. *Progress in development studies*, 5(4), 279-297.

Roll, M. ed. (2014) *The Politics of Public Sector Performance: Pockets of effectiveness in developing countries.* London. Routledge:

Scoones, I. (2009) 'Livelihoods perspectives and rural development'. *The Journal of Peasant Studies*, 36:1, 171-196

Sen, A. (1985) *Commodities and Capabilities*. Amsterdam: ElsevierTurner, M. and Hulme, D. (1997) *Governance, administration, and development: Making the state work*. Colorado. Kumarian Press Books:

Turner, M., Hulme, D. and McCourt, W. (2015) *Governance, management and development*. London: Palgrave

UCLG (United Cities and Local Governments) (2015) *The Sustainable Development Goals What Local Governments Need to Know*. Barcelona: UCLG

UCLG (United Cities and Local Governments) (2017) *Local and Regional Governments to the 2017 HLPF: National and sub national governments on the way towards the contextualisation of SDGs*. Barcelona: UCLG

UNICEF, World Bank and ZimSTAT (Zimbabwe National Statistical Agency) (2015) *Zimbabwe Poverty Atlas. Small Area Poverty Estimation*. Statistics Poverty Eradication. Harare: UNICEF

UNICEF, The World Bank and ZimSTAT (Zimbabwe National Statistical Agency) (2016) *The Food Poverty Atlas: Small area food poverty estimation statistics for addressing food and nutrition insecurity in Zimbabwe*. Harare: UNICEF

UNDP, Global Taskforce of Local and Regional Governments, and UN Habitat (2016) *Roadmap for contextualising the SDGs: implementation and monitoring at subnational level*. Geneva: UNDP

ZimSTAT (Zimbabwe National Statistical Agency) (2012) *Zimbabwe Population Census 2012*. Harare: ZimSTAT

ZimSTAT (Zimbabwe National Statistical Agency) (2014) *Labour Force Survey*. Harare: ZimSTAT

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