Briefing note

Contextualising the SDGs to leave no one behind in health

A case study from Zimbabwe

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Key messages

- Community involvement in SDG prioritisation and delivery – here described as contextualisation – is essential; this process, by its very nature, demands focus on leaving no one behind.
- To truly reach the most marginalised, a 'bottom-up', inclusive process of applying the SDGs needs to sit alongside any 'top-down' approaches defining country-specific targets.
- A deliberate, participatory approach to SDG3 contextualisation in some of Zimbabwe's poorest areas shows promise in leading to greater clarity and prioritisation of health outcomes and actions for these communities.

Acronyms

AIDS	acquired immunodeficiency syndrome
HCCs	Health Center Committees
HIV	human immunodeficiency virus
MoHCC	Ministry of Health and Child Care
NAC	National AIDS Council of Zimbabwe
RDC	Rural District Councils
SDGs	Sustainable Development Goals
UCLG	United Cities and Local Governments
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHWs	Village Health Workers
ZimSTAT	Zimbabwe National Statistical Agency

Introduction

The Sustainable Development Goals (SDGs) were agreed internationally. But if there is any hope of achieving the agenda by 2030, they must be understood by and work for everyone – including the most marginalised. This means that global targets need to be adapted at the national and the community level. With their commitment to 'leave no one behind', involvement of those very communities furthest from achieving the goals is paramount. Contextualising the goals – that is, making them specific and relevant to context – by involving communities is one way to better identify priorities and realistic action plans. This brief describes a process for this happening and draws on experience and findings exploring an effort to leave no one behind in health in Zimbabwe (Machingura et al., 2018).

The SDG commitment of 'leaving no one behind' means ending extreme poverty in all its forms, and reducing inequalities among and between individuals and groups. It also means the prioritisation and fast-tracking of actions for the poorest and most marginalised people – which in health is known as 'progressive universalism' (Stuart and Samman, 2017). Explicit and pro-active attempts are needed to ensure populations at risk of being left behind are included from the start, and this necessitates their participation and input on policy decisions that affect them.

But involving communities to make the global work locally is not without complication. First, there is no general standard practice or approach to getting communities to think about how the SDGs apply to their lives. Second, efforts to involve communities have not always been found to be effective at targeting poor and/or marginalised groups (Mansuri and Rao, 2004). And third, very little attention is paid to understanding the enabling institutional arrangements that underpin the delivery of the SDGs at the more local level.

One concept that may offer a way forward for SDG contextualisation and community participation is that of collaborative rationality. Developed by Innes and Booher (2010), this is a practice by which various groups and organisations in the community engage on an issue to inform a joint decision in the context of ever-changing and sometimes conflicting information sources.

This briefing provides an overview of some of the discourse informing contextualisation, problematises the concept and illustrates one attempt to test an approach through a case study on experience in three of Zimbabwe's rural districts engaging with SDG3 ('Ensure healthy lives and promote well-being for all at all ages'). The study explores the extent to which collaborative rationality can contribute to contexutalisation, to deliver progress on leaving on one behind, by building understanding between institutions such as the State and local government, businesses, NGOs and communities (Innes and Booher, 2010; Turner et al., 2015).

What is meant by contextualisation?

While contextualisation is used loosely in development as well as in Agenda 2030 and for the SDGs themselves, it has not been defined. Here we conceive of contextualisation as the process by which communities and community actors are involved in achieving goals from conceptualisation to implementation in partnership with national authorities, donors and other NGOs and charities.

The concept of contextualisation goes further than the more widely used term 'localisation', principally through its focus on engagement of a range of groups. The latter can be problematic as the idea of what is 'local' is either ill-defined or conflated with the 'national', a temptation given the global nature of the SDGs. Even when conflation is avoided, the discourse around localisation usually favours cities or places emphasis on local authorities (UCLG, 2015; Boex, 2015). In this mode, localising the SDGs is often understood as relating to how the local government can support the implementation of the SDGs through providing a framework for domestic development policy (UNDP et al., 2016). In addition, the localisation discourse predominantly favours community engagement as a function of data collection for policy action instead of for a community's 'actual' and tangible development.

In contrast, contextualisation involves moving towards a bottom-up approach whereby local stakeholders inform SDG prioritisation and implementation tailored to their needs. Co-ownership allows communities to reclaim power over their localities and develop plans that equitably divide tasks and oversight (see Kamara, R.D., 2017). A deliberative, participatory process is needed to ensure that no one is left behind when seeking to contextualise the SDGs and deliver on the goals or other local development initiatives (see Innes and Booher, 2010; Turner et al., 2015). Innes and Booher's (2010) concept of collaborative rationality – which is based on the idea that:

> *… a process is collaboratively rational to the extent that the affected interests jointly engage in face to face dialogue [see Box 2], bring their various perspectives to the table, and deliberate on problems they face together (ibid: 6)*

– can inform this effort.

Innes and Booher argue that such an approach can help stakeholders[1] find creative solutions to commonly held challenges, and can permit innovation (see Box 2).

1 National and local government representatives; provincial and district health teams; traditional and elected local authorities; international and national NGOs; faith- and community-based organisations; women, men and youth representatives. The joint interests would represent both community and local government interests. In collaborative processes all stakeholders would ideally win although trade-offs have to be considered by all parties.

Collaborative rationality sees the world as imperfect and assumes that while there may be multiple options for overcoming a challenge, there is rarely a single 'best' solution. The approach not only guides communities to work together to find new ways forward, but also helps build community resilience in the context of inevitable and unknown challenges.

Complexities to contextualising goals

In practice, and long before the SDGs, development efforts have too often failed to reach those left furthest behind. While the study described here draws heavily on participatory approaches, there are conflicting views regarding the role that greater community participation – a key part of the approach to SDG contextualisation described here – can play in strengthening priorities, plans and interventions, and questions about its efficacy remain. The work in Zimbabwe, described in detail below, touches on two questions:

- How can a global agenda be contextualised to address the needs and concerns of marginalised groups?
- Does a participatory process offer potential in improving the targeting of public goods to those left behind?

Attempts to answer these questions in literature fall along two lines. An **optimistic view** holds that participation in development is mostly bottom-up, and therefore empowering and/or effective (Agrawal and Gibson, 1999; Johnson and Walker, 2000). This view hinges on collective agency in improving well-being through institutions that put people first by working at the community level.

The second, more **pessimistic view** posits that localised development is merely a reincarnation of the 'local trap', wherein development practitioners incorrectly assume that localised decision-making is inherently more socially just and sustainable (Purcell and Brown, 2005). This viewpoint highlights the risks of what Mohan and Stokke (2000) term the 'dangers of localism', who caution that the mere focus on localising global agendas tends to underplay the effects of both local inequalities and power relations, as well as national and global political economic forces that shape community level implementation.

Because arrangements for local decision-making and implementation are the products of socio-political arrangements, the pessimists perceive any outcomes of a local development arrangement to be dependent on the political agenda(s) of those who are empowered by the arrangement. They argue that there is nothing inherently positive about development being locally led. This view of localisation is in some ways justified, as there is no basis to ascribe inherent positive outcomes to locally led development processes.

Beyond this tension is the fact that sustainability depends on enabling institutional arrangements such as government, non-government, community-based and international organisations, local structures and networks that are directly or indirectly involved in the implementation of development goals (Biermann et al., 2017). These institutional arrangements serve as mechanisms through which the SDGs could be contextualised, coordinated, implemented and managed, as well as monitored and evaluated (ibid).

Contextualisation of the SDGs alone is not adequate: development practitioners may need to consider the context-relevant institutional arrangements at the local level and how collaborative processes are organised, implemented and ultimately institutionalised to see development goals though. The country's level of development and existing national and local policies

Box 1 Building on past ideas

The issues that emerge in contextualising the SDGs are not new. Building on Robert Chambers' work (e.g. 1986) and drawing on the subsequent discourse of economists such as Sen (1985) and Ostrom (1990), the SDG effort similarly insists on the importance of emphasising greater agency and participation as an effective route to development. In addition, through the 1990s and 2000s, emphasis was placed on planning and policy as well as centring on sustainable community livelihoods, all issues that are re-emerging as priorities in the SDG era (Chambers, 1986; Hulme and Turner, 1990; Chambers and Conway, 1992; Turner and Hulme, 1997; Turner et al., 2015; and Scoones, 2009). A renewed impetus around concepts that serve to 'leave no one behind' indicate a move in ownership of development processes by local communities.

In practice, however, efforts to contextualise global agendas such as the SDGs still often do not reach those left the furthest behind. This is for several reasons, key among them the idea that what is 'local' is either ill-defined or conflated with the 'national', especially given the global nature of the SDGs. Even when conflation *is avoided*, the discourse around contextualisation usually favours cities or places emphasis on local authorities (UCLG, 2015; Boex, 2015). In this mode, localising 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). However, this discourse also predominantly favours community participation as a function of data collection for policy action instead of for a community's 'actual' and tangible development.

also determine how institutional arrangements can be made more useful for contextualising SDGs. While these challenges shed light on why the imperative for SDG contextualisation remains a priority concern, a look at the lessons learned from our experience in Zimbabwe demonstrates how a participatory process of contextualisation can provide initial steps towards making gains for the poor.

Contextualising health goals in Zimbabwe

While contextualisation is a necessary process across the SDG agenda, it is particularly interesting to look at how this can play out for SDG3 on health; see table 1 for a full list of the SDG3 targets examined in this paper. Both this goal and its targets have individual and institutional features, with needs often defined by specific group and geographic characteristics.

Certain aspects must be kept in mind when undertaking the contextualisation of health-related SDG targets, a point which is true for most other SDGs too. First, it must be understood that that SDG implementation, promotion and experience of benefits may be limited by the extent to which the local community perceives targets as being driven by the state or by the global community. The left-behind must be seen as collaborators in their own development, not merely targets of assistance – which will allow state and global development partners to identify specific horizontal inequities between and within communities. Second, the

Table 1 Health targets for SDG3 and other related goals

Goal 3:	**Ensure healthy lives and promote well-being for all at all ages.**
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-five mortalities to at least as low as 25 per 1,000 live births.
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.
3.4:	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
3.7:	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.
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.

Note: 'Other related goals' represents the SDG corresponding to the issues raised by communities and stakeholders at the symposiums.

Box 2 Collaborative rationality: key factors for successful SDG contextualisation

1. Interdependence

In all negotiations, each stakeholder has something that the others want. This ensures that participants maintain interest and requires them to engage each other and push for agreement. From this, participants can establish action points that allow 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).

2. Direct dialogue

When communities engage directly with senior decision-makers and other stakeholders in open, public and direct engagements, parties can ensure that claims are accurate, comprehensible and sincere. When no one decision-maker controls deliberations, everyone involved can have equal access to all the relevant information and ability to speak and be heard. This allows communities to challenge public pronouncements made by more senior decision-makers without fear, which creates a sense of direct and fair 'talk' where nothing is 'off the table'. Communities can use information from their everyday lives and knowledge constructed jointly through interaction with other parties to engage decision-makers. Decision-makers can use the platform to answer questions, and collaboratively plan next steps with communities.

Source: Turner et al., 2015: 201.

political context must be considered when seeking to deliver health and related goals in local communities. Finally, acquiring local data to best contextualise health SDG goals is imperative. Local health service providers should be included in the data collection and monitoring processes; such efforts prove to gain value for health providers by giving local authorities better data to diagnose and fashion solutions to future problems. Box 2 sets out two key factors for successful contextualisation, as drawn from the practice of collaborative rationality.

Health in Zimbabwe

Zimbabwe is a young landlocked country in southern Africa. Of its total population, 41% are below the age of 15, and only 4% are 65 years or more (ZimSTAT, 2012). The average life expectancy is 59 years, and most people die young and prematurely from preventable causes. Furthermore, over the last two decades Zimbabwe has been marked by severe economic, social and political challenges, largely attributable to various political unrest and economic uncertainty (Chitiyo, Vines and Vandome, 2016) and smart sanctioning from Western governments (Chingono, 2010).

This amalgamation of factors has left the country with severe social and economic problems, including in its health sector. For example, over a 20-year period, it is estimated that 80% of doctors, nurses, pharmacists, radiologists and therapists trained in the country have left (Chikanda, 2006), with resulting national health outcomes of low life expectancy at birth, high maternal and child mortality rates, poor nutrition and the spread of non-communicable and communicable diseases. Rural areas (in which almost 70% of the country's population live (ZimSTAT, 2012)) fair worse than urban areas in health indicators. For example, rural women are four times less likely than urban women to receive Ante-Natal Care from a doctor (6% versus 24%) (ZimSTAT and ICF International, 2015). Food poverty is also more common in rural than urban districts: Nkayi District in Matabeleland North, for instance, has a 66% food poverty prevalence – more than 10 times higher than that of Harare (6%) (UNICEF et al., 2016).

But the Government of Zimbabwe's Ministry of Health and Child Care has made a deliberative commitment to achieving the health-related SDGs – particularly SDG3 and the concept of leave no one behind (MoHCC, 2017). This 'top-down' commitment is evident in Zimbabwe's national health strategy, and there are multiple instances of where the strategy's goals align with Agenda 2030 and the SDGs[2] (MoHCC, 2016). There are also some positive signs of good practice in linkages within Zimbabwe's health sector: 59% of the country's administrative wards have access to the Village Health Workers (VHWs) and Health Center Committees (HCCs), who provide a link between the administration of health services and the local community (MoHCC, 2015).[3]

Trialling community symposiums

Zimbabwe's context, with both challenges and opportunities, afforded fertile ground on which to test new approaches to SDG contextualisation based on collaborative rationality through the introduction of community symposiums.

We organised three big community symposiums that were designed to be highly participatory and engaging spaces that brought together local citizens and actors from various government levels as well as non-governmental actors to kick-start a process of prioritisation and planning in relation to SDG3. They facilitated discussion between these stakeholders about what health needs mattered most, what the solutions to addressing these needs were, the follow-up action needed, and how to monitor and report on progress. The approach was trialled in three of Zimbabwe's rural districts – Goromonzi, Mbire and Seke – with a view to scaling up such an approach in other districts across the country. Although these rural districts were randomly selected, their average poverty prevalence rates for 2015 were all above 50% (62.4%, 81% and 56% respectively) (UNICEF, World Bank and ZimSTAT, 2015).

The symposiums had five overarching objectives:

1. To identify lessons that point to what works, how and why in the contextualisation of SDGs for communities.
2. To explore how SDG contextualisation could be institutionalised at the lowest tier of the health system by mobilising and building partnerships with different local stakeholders.
3. To raise awareness on SDG Goal 3.
4. To identify local SDG champions to be actively involved at the district level.
5. To facilitate dialogue between partners on SDG Goal 3 and develop a plan for continued and enhanced community participation.

The symposiums attracted more than 500 participants from across the gender, age, occupational and political spectrums. Stakeholders were drawn from the supply

2 For example, national health strategic objectives 1–5 (reduce morbidity and mortality due to malaria, HIV, etc.) and SDG3.3 (end the epidemic of AIDS, tuberculosis, malaria, etc.), or national health strategic objectives 10–13 (reduce maternal malnutrition, neonatal and under-five mortality) and SDG Goals 3.1, 3.2 and 3.7 (reduce maternal mortality, end preventable under-five deaths, and ensure universal access to sexual and reproductive health services, respectively).

3 However, the VHW program, though in line with the Alma Ata Declaration of 1978 on Primary Health Care, remains underdeveloped and sub-optimal.

(i.e. providers of the health service) and demand (i.e. recipients/health service users) sides of the health delivery system, creating multi-level, multi-sector and multi-stakeholder dialogues. This multi-stakeholder approach aimed to create ownership and co-responsibility among all actors. Flyers were distributed before the event, advertising the symposium objective, venue and date, and confirmed multi sector Ministry guests. A letter of support was secured from the Ministry of Health Child Care's (MoHCC's) highest office and this officially invited the community stakeholders (local leaders, chiefs and councillors) and assisted with the process of police clearance.

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 and a letter of support sought from the permanent secretary for health was used to engage and invite other stakeholders.
- 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. A letter of support sought from the RDC was used to engage the traditional leadership in the respective communities.
- Finally, the researcher, working jointly with a select group in each respective study site, approached partners including academics, research entities, the UN 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. This approach aimed to create ownership and responsibility among all actors, which allowed for candid conversations about SDG3 and nuanced discussion around the quality of care between providers and recipients of health services.

Defining 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, a research team of 15 individuals (five women, five men and five youths) was formed to canvass the community for pertinent health issues, targeting a maximum of 15 households each for short exploratory interviews. This engagement process also acted as publicity for the symposiums, spreading information about its intentions and the stakeholders it would gather, as well as the opportunity it would present for the community to be heard.

After the community consultation process, a knowledge-sharing session was convened with the community research team and the local clinic to discuss emerging issues and aggregate them into categories by demographic. This consultation also helped the group agree on who would present at the symposium, with presenters not restricted to the research team. The process allowed the community to own the issues and present them, and also helped VHWs retain collective community ownership.

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 and symposium logistics.

Ownership and co-responsibility for implementation

Each symposium occurred in six parts, beginning with traditional rights and salutations that symbolised the community 'reclaiming power' over events in their localities. This was followed by introductions from the District Administrator (the overseer of all district-level communities), the Provincial Medical Director and the District Medical Director. After an SDG3 awareness-raising session, selected community representatives presented the priority needs that had been identified through consultation with their community before the event.

Table 1 presents a summary of some of the most reported issues across the three districts that, while not exhaustive, help to highlight both the possibilities and difficulties for health delivery in Zimbabwe. Government officials, partners, donors and communities then took turns to respond to questions raised and to commit to one or more forms of follow-up action. The responses presented in Table 1 suggest that symposiums can in fact facilitate the SDG contextualisation process, and that SDG targets can be better met if commitments are pursued and upheld. The symposiums' final sessions consolidated the needs, actions and roles into a plan that would be monitored by the local HCC in conjunction with the local clinic.

The action plan was presented by the RDC and MoHCC directorate before an official closure was given by the District Nursing Officer, a member of parliament or a community representative. Some of the significant and immediate commitments that would likely have been missed had the traditional local government planning route been taken and this kind of consultation had not happened included:

- cancer screening equipment to be made available at the rural health centre level
- facilitating the initiation of Antiretroviral therapy at the local health facilities instead of the district or provincial hospital which is often far from the poorest social groups

- sinking of a borehole at the local clinic
- community education on obstetric fistula and cancer at village and ward levels.

See more in Table 2.

Our findings from the extant work on the contextualisation of the SDGs in Zimbabwe are not verbatim accounts, neither do they follow the chronological pattern of actual events nor the actual symposium processes. The findings drawn from participant observation and the discussions from the symposiums do 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, they are a presentation of the most reported issues across the three rural districts.

Table 2 Community health needs and proposed action emerging from the community symposiums

Identified health need[i]	Response by the MoHCC, RDC, NAC and UNFPA[ii]	Health targets for SDG3 and other related goals[iii]
Many women are dying due to pregnancy, childbirth and afterbirth complications.	• Village Health Workers (VHW) to increase coverage and intensity of community education programmes for pregnant women, their partners and families. • Nurses in charge at rural health centres to work with VHW to support community health visits, awareness and related projects.	3.1 and 3.7
Men are not fully involved in antenatal care.	• Promote local gender programmes targeting men and promote their role in supporting safe motherhood. • Increase community awareness and knowledge about the importance of male involvement and increasing accessibility of antenatal clinics should be part of the gender awareness programme targeting men.	3.1, 3.2 and 3.7
Mwanza clinic (like some other rural health facilities and not all) does not have running water and soap for handwashing.	• The MoHCC proposed an action plan to achieve universal water, sanitation and hygiene coverage in healthcare facilities by 2030 in its current national health strategy. • Working with the local government, some of its existing policy actions include a water, sanitation and hygiene 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.	6.1 and 6.2
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 screening equipment that are mostly available at the district hospitals and not the rural health centre level. • The service would be accompanied by appropriate educational programmes directed towards health workers, village health workers, primary care nurses, HCCs, women and men to ensure correct implementation and high participation	3.4
There are shortages of medicines and ARVs are sometimes in short supply and there are no HIV viral load tests in our clinics.	• The National AIDS Council (NAC) of Zimbabwe is working with the MoHCC to allocate up to 15% of total budget for HIV programmes in health facility costs. Part of these funds would be directed towards laboratory testing, including training and support for laboratory personnel. • The NAC has 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
Young people, including our children and young adults, are at increased risk of psychiatric disorder and suicidal behaviours because of the poor socioeconomic status of the country, with shortage of mental health services making it hard to address this challenge.	• The District Medical officers have advocated for a response with a series of levels, from the community through to specialist services. • 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* and *nemadzitete*) that have 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

Note: [i]This is the problem identified by the community; [ii]This represents the identified action by stakeholders; [iii]This column represents the SDG corresponding to the issues raised by communities and stakeholders at the symposiums.

Drawing on a qualitative analysis on subjective judgement of what we know about the notions of collaborative rationality and how these were applied in this work, our experience make a case for operationalising this theory of collaborative rationality. This entails bringing together disparate parties and interests through shared platforms and developing consciousness between the central and the local state, local business, NGOs and communities.

Such a process can help to highlight what matters most to communities and streamline efforts for the 2030 Agenda while also helping senior decision-makers in supporting the contextualisation agenda by listening to communities and clarifying efforts – collaborative rationality. While this process brings forth nuances of the observed interdependence between development actors, there are also elements of 'trade-offs' between the same actors, as they jointly work towards a win-win outcome. Thus, collaborative rationality shows us that if facilitated and encouraged, 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 outcomes to benefit the community.

The collaborative process tends to lead to a joint prioritisation process, which can build the energy needed to sustain pockets of effort in constrained contexts. In particular, responses from authorities suggest that, if given a chance, these symposiums can function as the first step towards the SDG contextualisation process. Overall, our work on the contextualisation of SDG3 in Zimbabwe reveals three key findings:

1. Contextualising the SDGs based on the input of the community can streamline and focus efforts for the 2030 Agenda.
2. When senior decision-makers are interested in supporting the contextualisation agenda and listen to communities, priorities can be clarified.
3. Prioritisation can build the energy needed to sustain pockets of effort in constrained contexts.

Conclusion

This briefing note illustrates the advantages of a deliberate, participatory approach to SDG contextualisation in helping achieve improved target outcomes and actions, although more time will be needed to observe such collaborative processes maturing into tangible SDG target outcomes. Zimbabwe's rural context was a particularly useful environment in which to test this approach as its population is one of the world's most impoverished and includes many individuals who are being left behind. This experience makes a case for collaborative rationality – namely bringing together disparate stakeholders and interests through shared platforms and developing a shared position between the state, local businesses, NGOs and communities. It thus provides an illustration of how community health priorities can link directly to SDG targets.

Collaborative rationality shows us that if facilitated and encouraged, 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 outcomes to benefit the community Furthermore, if senior decision-makers are interested in supporting the contextualisation agenda and are present to listen to communities, this can bring about change. This change can potentially generate the kind of energy needed to sustain productivity.

The contextualisation of the SDGs is not, however, a one-off event and its effectiveness is relative to time. In this instance, the symposiums provided a starting point for the contextualisation process, but they are also at risk of degenerating into ineffective arrangements. Any analysis of what works for SDG contextualisation must be assessed over time to account for the changing dynamics of the institutional arrangements that underpin it. While short-term efforts at contextualisation can bring about quick gains, if community perspectives are not systemically incorporated over time, countries are left ill-prepared for SDG achievement in the longer-term and in the event of future crises.

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