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Title

A generation in transition: The dynamics of social services provision in Zimbabwe

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Abstract

The period between 1980 and 1990 is sometimes referred to as a period of development in the history of newly independent Zimbabwe. During this period, Gross Domestic Product (GDP) growth was high and public expenditures were geared towards social sector, expansion of the rural infrastructure and these were targeted towards reducing the social and economic inequalities. Such spending on the social sector led to strong positive indicators in education and health. Zimbabwe's economic performance since independence in 1980 can be broken down into three periods: the post-independent era of 1980-90, the economic liberalization period of 1990-2000 and the crisis period from 2000-2008. Zimbabwe made considerable progress in the enactment of laws and formulation of policies for the protection of vulnerable populations. However, notable gaps still exist in the legislation of socio-economic and cultural rights as well as implementation of existing laws and policies. This article examines the current state of social service provision in Zimbabwe.

Key words

development, orphans and vulnerable children, social protection, social services, Zimbabwe

Introduction

Zimbabwe's economic performance since independence in 1980 can be broken down into three periods: the post-independent era of 1980-90, the economic liberalization period of 1990-2000 and the crisis period from 2000-2008. Zimbabwe made considerable progress in the enactment of laws and formulation of policies for the protection of vulnerable populations. However, notable gaps still exist in the legislation of socio-economic and cultural rights as well as implementation of existing laws and policies. This article examines the current state of social service provision in Zimbabwe.

Zimbabwe development context

The period between 1980 and 1990 is sometimes referred to as a period of development in the history of newly independent Zimbabwe. During this period, Gross Domestic Product (GDP) growth rate averaged 3-4 percent per annum and reached a peak of 7 percent in 1990 (United Nations Development Programme (UNDP), 2008:8). During this period, public expenditures were geared towards social sector, expansion of the rural infrastructure and these were targeted towards reducing the social and economic inequalities. Such spending on the social sector led to strong positive indicators in education and health. For example, the Net Enrolment Ratio (NER) for primary education had increased from 81.9 percent in 1994 and peaked at 98.5 percent in 2002 before the gradual decline to a low of 91 percent in 2009 (Government of Zimbabwe (GoZ) and UNDP, 2010).

The Economic Liberalization period, 1990-1996 saw the implementation of the Structural Adjustment Programme (ESAP) introduced in response to poor macro-economic indicators. The introduction of cost-sharing measures in health and education sectors under the ESAP reversed the gains achieved in the health and education indicators with severe consequences for the poor and vulnerable groups who could not afford the user-fees. By 1997, the economic crisis deepened such that the Government replaced ESAP with the "Zimbabwe Programme for Economic and Social Transformation (ZIMPREST), 1996-2001". Notwithstanding the introduction of ZIMPREST, recurrent droughts, the onset of the land reform programme and a decline in the output of the commercial farming sector, a growing budget deficit, and severe foreign exchange shortages all conspired towards further declines in GDP from 0 percent in 1998 to -7.4 percent in 2000 and subsequently -10.4 percent in 2003 (UNDP, 2008).

The second decade after independence (2000 - 2008) can best be termed the "crisis period". During the period, Zimbabwe's economy underwent further declines, with GDP shrinking by an estimated 40 percent between 2000 and 2007. Extremely high levels of inflation, with profound consequences for development and poverty levels were experienced. By 2003, the population living below Total Consumption Poverty Line (TCPL) stood at 72 percent and this may have increased with the onset of the crisis. The structural unemployment was recorded at 63 percent and current estimates suggest a figure of up to 80 percent. There was also a general decline in health and education indicators given that Zimbabwe had initially made significant progress (GoZ and UNDP, 2010).

One consequence of the declining economy was the out-migration of large numbers of both skilled and unskilled labour including social workers. This brain drain severely compromised the capacity of both the private and public sectors. Notwithstanding the poor performance of the economy, Zimbabwe was able to make significant progress in a number of key areas of the MDGs such as universal primary education where enrolments in primary schools have been relatively high with Net Enrolment Ratio (NER) of 91 percent in 2009. (Government of Zimbabwe and United Nations Development Programme, 2010). Zimbabwe also experienced a gradual decline in HIV/AIDS as demonstrated by the trend in prevalence rates over the past decade. The estimated rate for HIV/AIDS adults 15 years and above declined from a high of 23.7 percent in 2001 and down to 18.4 percent in 2005 (National AIDS Council, 2009). The national HIV/AIDS Estimates 2010 Report reveal adult prevalence rates of 16.1 in 2007, 15.1 percent in 2008 and 13.7 percent in 2009 (National Aids Council, 2009). This indeed is a significant achievement for Zimbabwe.

The future outlook of the country looks promising with the formation of the Government of National Unity (GNU) in February of 2009 and the subsequent launch of the Short-Term Emergency Recovery Programme (STERP) which has contributed significantly to the stabilization of the political and economic situation. Positive economic trends began to show in the first quarter of 2009 with the burial of the local currency and the subsequent adoption of the multi-currency. This approach virtually eliminated one of the worst hyperinflationary period the world has ever witnessed. Capacity utilisation figures in both manufacturing and services have also shown some encouraging improvement, though infrastructural deficits, particularly in terms of power generation and distribution still constitute binding constraints on this nascent economic turnaround, while these positive economic developments are still to translate into significantly improved levels of employment (GoZ and UNDP, 2010).

The government of Zimbabwe has also come up with the Medium Term Plan (MTP) which is an economic blueprint seeking to ensure high economic growth covering the period 2011-2015.Through the MTP, government has committed itself to raise foreign direct investment from 4 percent to 29 percent of gross domestic product (The Sunday Mail Business, 2012). The MTP requires US$9 Billion to finance investment projects. However, the foreign debt overhang of over US$8 Billion will prove to be an albatross on the objectives of MTP, thus presenting challenges to social services provision in Zimbabwe.

Legislative and policy framework

Zimbabwe has made considerable strides in ratifying most conventions and international instruments that guarantee fundamental human rights. Some progress has also been recorded in domesticating these instruments into laws and policies. However, it is particularly instructive to note that the Bill of Rights within the Constitution of Zimbabwe guarantees civil and political rights, but it does not guarantee socio-economic and cultural rights. This has been highlighted by civil society groups advocating equity in access to social services for vulnerable populations, particularly children, women, the elderly and the disabled. The Bill of Rights is applicable to all, but civil society also advocates for rights specific to children to be clearly articulated within the Constitution to address their specific needs and offer better protection. For example, the bill of rights in the constitution does not guarantee at least 9 rights guaranteed in Convention on the Rights of the Child (CRC); a significant gap. These include: Child's right to be registered immediately after birth, to have a name, nationality (art. 7 and 8); right to maintain family link. (Art 8, 9and 10), right to be protected from all forms of abuse (art. 19, 34); the principle of best interest of child (Art. 20, 21); right to the enjoyment of the highest attainable standard of health and access to health care (Art, 24); right to be benefit from social security (Art. 26); right of adequate housing. (Art. 27); right to education including free compulsory education (Art. 28, 29); right to be protected from economic exploitation (Art 32); and right to be treated in a manner consistent with the promotion of the child's sense of dignity and worth in criminal procedure. (Art 40).

In the area of child protection and welfare, for example, Zimbabwe has a legal framework that supports children and two key national policies. Legislation pertinent to children includes the Children's Act, the Guardianship of Minors Act, the Maintenance Act, and the Child Abduction Act. Many other statutes which are also relevant to Orphans and Vulnerable Children, includes those pertained to education, birth, death, marriage registration, legal age of consent and majority, criminal law and inheritance. The Children's Ac (Chapter: 5:06) provides categories of children who need care as including those who are destitute or have been abandoned, who are denied proper health care, whose parents are dead or cannot be traced, whose parents do not or are unfit to exercise proper care over them, and whose parents/guardians give them up in settlement of disputes or for cultural beliefs.

National policies include the National Orphan Care Policy and the National AIDS Policy, both adopted in 1999. These policies were developed using a broad-based consultative approach, reflecting Zimbabwe's strengths in traditional ways of doing things, and promote collaboration between government and civil society. These policies also establish the government infrastructure to implement and coordinate services and benefits provided in the policies. The Zimbabwe National Orphan Care Policy identifies opportunities to provide care and support for vulnerable children that are inherent in the country's legislative framework, the cultural tradition of caring and the collaborative approach, which exists between government and the civic society, especially the six-tier safety net mechanism.

In terms of the legislative and policy framework, it can, therefore, be fairly concluded that Zimbabwe does have a basic legislative foundation which could be used as a base to improve and move forward. It should be recognised and appreciated that law makers have made an effort to introduce laws that protect children and other vulnerable groups. Unfortunately, as the above analysis has demonstrated, even with the ratification of certain international conventions such as the CRC, the Constitution does not yet succeed in providing equitable protection or access to certain rights, particularly due to the lack of explicit inclusion of social and economic rights. Even when laws have been passed that can bring further benefit or protection to vulnerable groups the additional resources and improved capacity development necessary for their implementation is not available, making it difficult to lift the provisions of the Act off the paper to translate into something tangible within the community.

Provision of social services in Zimbabwe

The challenges confronting the Government of Zimbabwe, and in particular the DSS as the principal agency charged with responsibility for the social protection of vulnerable groups, can be stated in terms of both demand and supply. On the demand side, the definitions of OVC vary, and there are no definitive and up to date figures

for the numbers of children falling into the different categories of need, but there are estimated to be some 3.5million children living in extreme poverty in Zimbabwe and possibly 1.3million children who have lost one or both parents (National Aids Council, 2009). The Children's Act (Chapter 5:06) of 1972, last amended in 2001 establishes in Section 2 a wide-ranging definition of a "child in need of care" (see section on Legal and Policy Framework above).

The Act establishes the duties and powers of probation officers in relation to the proceedings of children's courts, including adoption proceedings, and the removal of children and young persons to a place of safety. It also confers specific powers and duties on the Minister of Labour and Social Services and the Director of Social Services with regard to the establishment, maintenance and management of places of safety, remand homes and training institutions, the registration of private homes established as places of safety and registration and supervision of children's institutions, the establishment of a Child Welfare Council, the administration of a Child Welfare Fund, and the making of grants-in-aid to institutions for the maintenance of children and young people.

In response to increasing levels of vulnerability and extreme poverty, Zimbabwe is providing a variety of social services. These can be divided into two categories: state provided statutory and public social services; and complementary social services provided by non-state actors including NGOs, private institutions, and private companies. The powers granted to the State by law to protect the rights of children are exercised not just by the Ministry of Labour and Social Services (MoLSS) and the Department of Social Services (DSS), largely through the probation officer function, but also by a number of other institutions including the police, the court system and the health service. In addition to the exercise of these powers, the DSS is responsible for the administration of a number of social assistance schemes which provide material support in cash or in kind to vulnerable individuals or households. Table 1 below summarises some of the schemes provided by the DSS.

Table 1: DSS Social Assistance Interventions

Intervention/Scheme	**Nature of intervention**
Basic Education Assistance Module (BEAM)	Cash for school fees, exam fees and levies
Support to Children in Difficult Circumstances	Monthly cash transfers and material (eg wheelchairs)
Assisted Medical Treatment Orders (AMTOs)	Fee waiver voucher (+ block grant from MoLSS to referral hospitals/ clinics)
Public Works Programme/Drought Relief Support	Cash for work and free cash for labour-constrained households. Works projects supervised by local authorities
Children in Especially Difficult Circumstances	Cash – monthly to vulnerable children – and grants to NGOs/CBOs
Institutional Grants	Per capita grants to residential institutions for children
Support to Families in Distress	Means-tested non-contributory public assistance – cash transfers and travel warrants
Maintenance of Disabled Persons	Disability aids, training, project loans
Care for the Elderly	Means-tested non-contributory public assistance for elderly in institutions
Transfers to Heroes' Dependents	Cash transfers

Source: Gandure (2009)

This is of course not a comprehensive list of social protection or social assistance interventions in Zimbabwe. The coverage of social security schemes in Zimbabwe is still patchy. A case in point is the pension scheme, which is compulsory for the formally employed in Zimbabwe, being administered by the National Social Security Authority (NSSA). The scheme is covering only those employed in the formal sector, estimated around 20 percent of the labour force in Zimbabwe. Some pensioners are currently being given monthly pay outs of less than US$

30. This is way below poverty datum level. Also, an envisaged national health scheme by NSSA was shelved because of resource and capacity constraints.

Social service provision by non-state actors is coordinated through the National Action Plan for Orphans and Vulnerable Children (NAP for OVC), launched by the Government of Zimbabwe in 2005 in response to the scourge of OVC unleashed by the AIDS pandemic. Under a multi-donor fund called Programme of Support (PoS) to the NAP for OVC, over 30 NGOs and 150 CBOs are providing a wide range of services including school-related support, birth registration, psycho-social support, food and nutrition, health care, water and sanitation, child participation, child protection, education on nutrition, health and hygiene, economic strengthening, life-skills and vocational training, cash transfers and shelter. A recent outcome evaluation of programme reveals that about 400,000 OVC had been reached with basic social services by December 2009 (JIMAT, 2010). However, challenge of services provided by NGOs, lies in the fragmented nature of provision. For example, the outcome evaluation reveals that on average, each OVC beneficiary received only 1.6 types of support under the programme (JIMAT, 2010).

Challenges in social service provision

Government suffers from an acute lack of fiscal space to fund social services. As well articulated in the 2010 Midyear Fiscal Policy Review, "owing to the fragility of the economy, revenue collections estimated at US$1,75 billion are consumed largely by current expenditures dominated by a high wage bill constituting over 60% of the Budget" (Government of Zimbabwe (GoZ), 2010:85). This is notwithstanding the fact that the civil servants' remuneration levels currently funded by the budget still fall far below the cost of the minimum food basket. The Lack of fiscal space means that government has limited capacity to fund most of the social protection schemes such as the assisted medical treatment orders (AMTOs), public assistance (PA), Basic Education Assistance Module (BEAM) as well as other critical social services in health, housing, and education.

A major challenge facing the country today in the provision of social services is the acute shortage of social workers as a result of a serious brain drain. Subsequently, the DSS was hard hit by this brain drain which even threatened its aggregate capacity to deliver social services. Many social workers have left Zimbabwe – mainly for the UK, but also to work in neighbouring states – and staff turnover has been high. According to Wytt, Mupedziswa and Rayment (2010) Zimbabwe is in a crisis where the ratio of social workers to the population of children is estimated to be in the range of 49,587:1. The three writers concluded that this is an astonishing finding for a country with a reputation of having the best social protection system in Africa. Figures obtained by the Council of Social Workers show that there are 273 Zimbabweans registered to practise as social workers in England alone. Those left, especially in the districts, tend to be younger, recent graduates and correspondingly inexperienced. They are said by some to be very committed, but they necessarily lack influence and authority in dealing with other public officers at district level. A related issue is whether staff recruited from social science disciplines other than social work have all of the skills and knowledge for some of the tasks required, for example in family assessment and reunification, and if not whether there is adequate in-house training, briefing and guidance to support them (Wytt et al, 2010 and Banda, 2011)

Table 2: Ratio of children to social workers in selected countries in Southern Africa

Country	Population	Population of children	Total numbers of social workers	Ratio of children to social workers
Botswana	1,8 million	784,000	420	1,867:1
Namibia	2,0 million	860,000	200	4,300:1
South Africa	47 million	15,000,000	12,000	1,250:1
Zimbabwe	12,5 million	6,000,000	121	49,587:1

Source: Wyatt et al (2010) Institutional Capacity Assessment: Department of Social Services, Zimbabwe, Final Report

A salient feature of the current situation is that the Government is not in most respects the principal provider of social protection in Zimbabwe. Because of the combined effects of staff shortages and very constrained financial

resources, in the words of one observer "Government social protection programmes are either dormant or have a very low coverage" (Schubert 2010:6). At the same time, very substantial sums of money have been disbursed by international donors through mechanisms which deliberately by-pass governmental systems and aim to convey funds direct to non-state actors for the implementation of approved programmes and projects.

One major challenge of social services provided through NGOs and other non-state actors has been apparent fragmentation service provision. Provision of social services tended to follow individual projects resulting in the fragmentation of social service provision. The impact of the NAP for OVC programme as a whole is therefore compartmentalized according to individual projects implemented by different NGOs.

The other major challenge is increased child vulnerability. The continuing HIV/AIDS scourge, world economic recession and the pre-GNU Zimbabwe economic meltdown have conspired to increase child vulnerability. Zimbabwe is faced with a monumental national problem which requires a coherent national programme approach as projectised approaches to this challenge can longer offer long term sustainable solutions.

The future of social service provision in Zimbabwe

Although its capacity for effective action in social service provision is severely restricted by budget constraints, the Government of Zimbabwe is committed to upholding global standards of child protection and child welfare, as evidenced by the existence of an extensive statutory framework for protecting and enforcing the rights of children in various circumstances, and the continued provision of a number of programmes such as BEAM which were established under the Enhanced Social Protection Programme launched in the 1990s. There is need for prioritisation of social service provision through the national budget allocation as this is an important human capital investment which can spur economic growth and consolidate peace and harmony under the inclusive government. Provision of social services should be seen as a human rights issue that has to be guaranteed by provisions in the constitution of Zimbabwe.

The need now is to develop a strategy through which the DSS can develop its capacity so that it can play a more substantial role in the coordination of NAP for OVC activities and take on direct responsibility for some services that are currently delivered by other providers. In the medium term, envisaging a period of normalisation in which it becomes possible and desirable for development partners to channel assistance through government systems and to reinforce government leadership in accordance with accepted aid effectiveness principles, the key question might be what the DSS needs to be able to do to enable it to take over the management of the multi-donor pooled fund and its grant-awarding machinery. These existing arrangements should provide a useful platform from which to develop the DSS's commissioning capacity and systems, in a way that will secure the continuation of the range of activities in support of OVC currently being delivered in the country, while ensuring their alignment with Government policy priorities and harmonisation with other services, and their administration in accordance with the key attributes for governmental social protection programmes of predictability, consistency and transparency, and durability.[1]

Many of these critical functions require the intervention of the social services officer acting in the role of Probation Officer. The Children's Act was amended in 2001 to make it possible for the Government to appoint a registered social worker who is not a public officer to act as a Probation Officer when a public officer is not available, and the Council of Social Workers has drawn up draft Terms and Conditions for the appointment of self-employed persons or persons employed by other agencies in this way. Such an approach should provide a useful way to bypass in the short term the shortage of registered social workers in the public service, by allowing the role to be discharged by people who are being paid (e.g. by an NGO using grant funding) a sufficient wage to retain them and who may also have sufficient facilities available to help them do the job. In the longer term, however, this short-term fix can only serve to undermine further the governmental function. There is no substitute for a more sustainable solution: providing sufficient financial and technical support for the DSS to carry out its mandate.

The future of social services provision in Zimbabwe also lies in the training and retention of social workers. The School of Social Work of the University of Zimbabwe until recently which had the sole mandate of training social workers has trebled its enrolment from an estimated 30 students in 1990 to 80 students in 2011. Today, the government has introduced the discipline at another state university. The university had its first intake of 164 students in 2010 which is commendable, but they are others with the view that such a large number per intake has a potential to compromise quality. On a sad note, the suspension of the Master of Social Work programme at the University of Zimbabwe as a result of the lack of qualified personnel to teach at that level is a serious drawback to social work education and practice in Zimbabwe. Government should consider measures to attract back highly

qualified Zimbabwean social workers practising outside the country. There is need to also consider to re-introduce the diploma in social work programme.

Conclusion

In conclusion, the magnitude of the problem of unmet needs for social services as highlighted in this paper clearly necessitates a rethink of Zimbabwe's social protection strategies. This must start with lobbying and advocating for the inclusion of social and economic rights in the constitution and the full domestication of all the key international conventions such as the UNCRC. The capacity of the DSS to deliver clearly needs to be reinforced with financial and technical support. The approval of terms and conditions for appointment of social workers outside public service to practice as probation officers need to be expedited in order to unlock the local capacity to deliver critical services for children and other vulnerable groups. Now is the time for action!

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