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The State and Dynamics of Social Policy Practice and Research in Zimbabwe

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ABSTRACT

This paper discusses the results of the study on the State and Dynamics of Social Policy Practice and Research in Zimbabwe. The paper observes that factors that have influenced the formulation of social policies include racial segregation, ideology, politics, availability of resources and the influence of bilateral and multilateral aid agencies. The paper also observes that the process of policy formulation is a preserve of government technocrats and politicians and there is very little involvement of civil society. It further argues that most social policies in Zimbabwe are remedial and fragmented and reflect a fusion of elements including selectivity and universality in service provision. It is noted that social policy research in Zimbabwe has tended to be too sectoral and that it rarely informs social policy.

Introduction

The study focused on three areas of social policy, namely, education, health and social welfare. In order to understand the state and dynamics of social policy practice and research in Zimbabwe, it is important to give an overview of social policies in these selected areas of social policy. The provision of social welfare services is a shared responsibility between the government, non-governmental organisations and local authorities. However, the Department of Social Welfare in the Ministry of Public Service, Labour and Social Welfare has overall responsibility for providing and coordinating social welfare services. When social welfare services were introduced during the colonial period, they were primarily intended for the white settler community (Hampson & Kaseke, 1987).

At independence, in 1980, the government removed the discriminatory practices and decentralised its services in order to improve accessibility. Today these services include promoting the welfare of children through the Children's Protection and Adoption Act (Chapter 33) which provides for fostering, adoption and institutionalisation of children in need of care. Social welfare services also include the provision of social welfare assistance to destitute members of society, the care

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of the elderly through institutionalisation and the rehabilitation of persons with disabilities. There is also a contributory social security scheme, namely, the Pensions and Other Benefits Scheme which provide social protection against the contingencies of old age, invalidity and death.

Health policies were also based on racial segregation during the colonial period and because they were designed primarily for the benefit of the white settler community, there was an urban bias in their provision (Agere, 1987). Furthermore, health services were generally curative in line with the disease pattern among the European population. The neglect of rural areas by the colonial governments forced missionaries to take corrective measures, thereby assuming greater responsibility for the provision of health services in rural areas (Gilmurray, et al, 1979).

At independence, the government sought to address the imbalances of the past by providing integrated health services which were development-oriented. A major innovation was the development of the primary health care model based on the principles of acceptability, affordability, accessibility and appropriateness of health services.

As in the provision of health services, missionaries also pioneered the provision of African education. There was a dual system of education which was consolidated by the enactment of the Compulsory Education Act in 1930. This Act made education compulsory only for European children and also allowed for the provision of free education to day scholars among the European population only (Riddell, 1980).

At independence, the government sought to transform the education system by abolishing the dual system and by expanding school enrolment significantly (Auret, 1990). Auret observes that by 1986 the number of schools had increased by 21%. Primary education was made free in 1980 but economic hardships forced the government to reintroduce fees in urban primary schools.

The Study

Objectives

The objectives of the study were as follows:

- to identify the determinants of social policy;
- to investigate the nature and scope of social policies and the process in formulating same;
- to identify the agents involved in policy formulation, implementation and the roles that they play; and
- to identify social policy researches that have been done, and establish the extent to which the results have influenced social policy formulation and implementation.

Methodology

Data were collected between January and March 1996. Five provinces out of the country's 10 provinces were randomly selected and these were Bulawayo, Harare, Matabeleland North, Manicaland and Masvingo. Target populations were policy-makers; implementors of social policies (at provincial level) in the three Ministries, namely Higher Education and Culture, Health and Child Welfare and Public Services, Labour and Social Welfare; and beneficiaries of the social policies and programmes.

Sampling

For each province, purposive sampling of three districts (one urban and two rural) was done for the focus group discussions. Four policy-makers representing the ministries were interviewed as key informants. Also a total of 15 officials (3) per province were interviewed, representing implementors.

Data Gathering Techniques

Interviews using semi-structured interview guides were held with policy-makers and implementors. Focus group discussions with beneficiaries were also undertaken and relevant documents were analysed.

The Determinants of Social Policy in Zimbabwe

Content analysis of the policy documents and interviews with policy makers revealed that the major factors or determinants that have influenced social policy in Zimbabwe over the years include racial segregation, ideological issues, availability of resources, politics, culture and multilateral agencies.

Racial Segregation

Social policies which were developed during the colonial era revolved around the notion of racial segregation and were designed to promote the supremacy of the white settler community. In the area of social welfare/social security, the Old Age Pensions Act of 1936 is illustrative of the influence of the notion of racial segregation in shaping social policy. The Old Age Pensions Act provided means-tested old age pensions to all non-Africans above 60 years of age.

The same discriminatory provisions were evident in the public assistance programme which restricted assistance to urbanised Africans only. In the area of education, racial segregation as a determinant factor was reflected in the Compulsory Education Act of 1930 which made education compulsory for all non-African children aged between 6 and 15 years (Riddell, 1980) and there were also separate education systems for Africans and non-Africans. The situation was also similar for the health sector.

Ideological Issues

Ideology has been a major determinant of social policy both before and after independence. During the colonial period, colonial governments adopted both the laissez-faire and liberal ideologies. The laissez-faire ideology was closely associated with social policies targeted at the African population whilst the liberal ideology was largely responsible for shaping social policies targeted at the white population. Ideology became a major determinant of social policy at independence when the government declared socialism as its guiding philosophy. This ideological orientation was more evident in education and health where it was used as an instrument for correcting the injustices and imbalances of the past. Consequently, social policies at independence enshrined the notions of social justice and egalitarianism or redistribution. These were reflected in the policy of free primary education and health introduced at independence.

Resources

The deterioration of the economy in the late 1980s forced the government to review its policies on social service provision. The decline in the performance of the economy meant a dwindling of resources available to support free primary education and free health services for people earning less than Z\$150 per month. Thus, in the area of education, the government reintroduced tuition fees for primary education, but in urban areas only.

Although in the area of health there was no explicit policy shift, reduced government funding to local authorities and mission hospitals forced these institutions to charge persons earning less than Z\$150 per month fees in order to recover the costs incurred in providing medical treatment.

Politics

The social policies introduced by the ZANU (PF) government at independence on free primary education and free health services for persons earning less than Z\$150 per month are reflective of political considerations. The policy shifts were necessary in order to correct the imbalances of the past. The ZANU (PF) government saw these policy shifts as demonstrating that it was a people-oriented government committed to the eradication of the injustices of the past and also committed to the creation of a new social order.

Culture

Successive governments have considered culture as an important factor in the determination of social policy. The policy on public assistance which requires individuals to seek support from their own families in the first instance takes

cognisance of the culturally determined obligations of family members to support one another. In the area of health, the government recognised that most of the African people utilised traditional healers and it therefore sought to acknowledge the contribution of traditional medicine by enacting the Traditional Medical Practitioners Act of 1981. Even the incorporation of traditional mid-wives in the health delivery system is reflective of cultural considerations.

Influence of Bilateral and Multilateral Agencies

The declining performance of the economy forced the government to embark on economic structural adjustment in 1990 with the assistance of the International Monetary Fund and World Bank with a view to revitalising the economy and creating sustainable levels of economic growth. Assistance to Zimbabwe has also been flowing through bilateral aid. One of the prerequisites for structural adjustment is introducing cutbacks on social services expenditure and instituting cost-sharing measures.

In the area of social security, although the government took the initiative to develop a social security scheme, the ILO was instrumental in shaping the Pensions and Other Benefits Scheme. The scheme was modelled on the ILO framework for social insurance schemes even though it meant excluding those who need the protection most.

Process of Policy Formulation

The responsibility for formulating social policies in the selected areas of social welfare, social security, health and education rests with the relevant government ministries. According to the key informants these agents include government technocrats, politicians, churches and to a lesser extent non-governmental organisations.

Interviews with key informants revealed that government technocrats constitute one of the most powerful agents in policy formulation. The influence of technocrats in policy formulation continues in independent Zimbabwe but the technocrats are now able to draw more from the inputs at the different levels of planning structures introduced through the Prime Minister's directive of 1984.

The extent to which politicians participate in formulating policies seems to be limited to parliamentary debates. However, there are instances when politicians initiate policies but leave the finer details of policy formulation to technocrats. Policies on drought relief and on the compensation of war victims are examples of policies that emerged from the direct participation of politicians. The influence of churches in the formulation of social policies is more discernible in the area of health where the Zimbabwe Association of Church-Related Hospitals has been

quite active. According to a key informant in the Ministry of Health, churches have influenced the formulation of policies on duty-free importation of drugs and related equipment by church-related health centres.

Some key informants pointed out that NGOs have had minimal influence in the formulation of social policies. While NGOs have been and still are in the forefront in providing care to vulnerable members of society, they have not played a significant role in influencing policy formulation partly because they have not always had a permanent mechanism through which to do so. It is noted, however that those NGOs which form part of the Drug and Alcohol Council and AIDS organisations have played a part in their respective areas.

The Nature and Scope of Social Policy in Zimbabwe

Social policies developed during the colonial era were residual in nature, and also fragmented on racial lines in order to safeguard and promote the interests of the white minority. For example there were no state schools for blacks up to 1920 and there were two Departments of Education, one for Africans and the other for Europeans. The 1979 Education Act classified schools into Group A, B and C, with the Group A schools catering exclusively for non-African children.

The situation was not any different in the health sector, as the health policies were also fragmented and segregated along racial lines. The health policy favoured the white population both in terms of access and quality of services. Fragmentation in health policies resulted in the churches shouldering the burden of extending health care to the African population.

The social welfare system was based on the residual model and as a result the services were very limited in scope and were also urban-biased. Only destitute white people and urbanised Africans were eligible for assistance and assistance was withdrawn as soon as the individuals became self-supporting.

Zimbabwe's colonial social security system was not comprehensive and it was also fragmented along racial lines. There were no formal social security provisions for blacks apart from the limited protection provided to urbanised Africans under the public assistance programme. Private occupational pension schemes were the major social security provision at the time but the schemes catered exclusively for white employees. For blacks, membership in these schemes was voluntary and because of their low earnings only an insignificant percentage of Africans was covered by these schemes. At independence there was a major overhaul in the nature and scope of social policies in an endeavour to meet the aspirations of the people in line with the demands of the new social order. The system of education was revamped in order to provide equal opportunities in life for all. The policy of

free primary education was an attempt to make primary education universal.

The government adopted the primary health care policy at independence in an endeavour to achieve equity and better quality of service through making the services more affordable, accessible and appropriate to the needs of the majority. The primary health care policy emphasises preventive rather than curative care.

In the area of social security, it is noted that Zimbabwe does not have a comprehensive social security system. There is too much fragmentation owing to the existence of a number of schemes which do not complement each other. The scope and coverage is also very narrow and this is largely attributed to the fact that the main schemes are contributory, yet about 70% of the population do not have the capacity to contribute to social security schemes.

Welfare assistance, on the other hand, is still remedial and restrictive in coverage. There is, however, a developmental thrust in some aspects of the Social Dimensions Fund particularly those relating to the re-training of retrenched persons and assisting them to start small businesses.

Implementation of Social Policy

During the colonial era, the education, health and social welfare policies were implemented by various authorities with varying degrees of involvement. These include the government, local authorities and voluntary organisations and after independence the government assumed a more active role in funding and implementing the social policies.

Problems of Implementation

A number of problems have been realised in the implementation of social policy and these are:

- ***Inadequate Financial Resources***

The successful implementation of social policies depends on the availability of resources. Zimbabwe has limited resources and Auret (1990:22) states that *"the expansion of education services, which began in 1980 necessitated an immediate increase in the education vote from Z\$121.6 million in 1979/80 to Z\$218.0 million in 1980/81."* In 1990, the vote for primary and secondary education was further increased to Z\$1 billion. Similarly in the health sector, the budget allocation in 1980/81 was Z\$83.7 million and by 1989, it had increased to Z\$352.9 million. The budget allocation for the Department of Social Welfare was increased to cater for drought relief programme. By 1990 however, the government realised that it did not have adequate resources.

- ***Lack of Political Will***

The implementation of social policies depends largely on the extent to which politicians are prepared to channel resources towards the realisation of policy objectives. While it was clear that at independence the government did commit massive resources to the health and education sectors, the same cannot be said for social welfare. It can only be assumed that this is so because most of the functions of the Department of Social Welfare are not viewed as priority by politicians.

- ***Manpower Problems***

The expansion of the social sector resulted in a great demand for staff to implement social policies and the demand for services has been so great that the present levels of staff have not been adequate to serve those who require these services amid growing poverty in the country. Furthermore, many service providers feel that the government has not remunerated them in accordance with the amount of work done and neither does the remuneration take cognisance of the cost of living which has gone up significantly in the past sixteen years. Zimbabwe has consequently suffered from the brain drain phenomenon, particularly in the areas of health and education, with trained personnel joining private organisations or migrating to neighbouring countries or even abroad. Zimbabwe has to rely heavily on expatriate teachers and medical staff who are usually not familiar with the customs and practices of the local people. Consequently, those who remain behind have to work extra hard. Posts that are left vacant get 'frozen' as government does not have adequate funds to pay salaries for new staff. Many health care centres, schools and welfare offices are therefore being manned by demotivated, frustrated and poorly paid staff whose major preoccupation is how to make more money. Long queues of patients and clients characterise health centres and welfare offices respectively.

- ***Transport Shortages***

Development work requires professionals to go out to the people, therefore transport becomes a crucial ingredient in the implementation of social policies. In the area of health, it was noted that there is an inadequate number of ambulances resulting in some patients not getting treatment on time, especially in the rural areas. The Department of Social Welfare has been hit hardest because of low budget allocations and yet most of its functions demand that officers go out to investigate family circumstances, particularly in child welfare cases. The problems associated with transport include inadequate numbers of vehicles allocated to a ministry, low budget allocations for mileage and poor maintenance of vehicles, including the shortage of spare parts. The shortage of transport has resulted in a situation where officers just sit in their offices waiting for clients to come for assistance. This situation poses problems for the majority of clients who may be too poor to afford transport costs or who may not even know where the offices are.

- ***Means-Testing***

The implementation of the social policies has raised a lot of problems because officers have to apply a means-test in order to determine eligibility. For example, in the area of health and education, the present policy is that those who apply for assistance from the Social Development Fund should have a monthly household income of up to Z\$400. The targeting does not take cognisance of the size of the family and as a result many deserving applicants are denied assistance.

It was also noted that in order for individuals to get help whether at the clinics, schools or at the Department of Social Welfare, councillors had to vet and recommend that person for assistance. This system was seen as problematic because some of the councillors recommend their friends or relatives who are in most cases able to pay for themselves. Another problem experienced by many individuals was that there was a tendency among some councillors to favour individuals who belong to a particular political party and thus deny help to those who may be in dire need, simply because they belong to a different party. This problem was more prevalent in towns than in the rural areas.

- ***Participation***

While government had strongly advocated the participation of the people in the implementation of social programmes, the extent to which this has happened in reality is questionable. In the health field, participation in urban areas has been very limited, but in rural areas people have been involved in the building of clinics, 'blair' toilets (ventilated pit latrines) and digging of wells. Schools have also been built with the participation of the people. There are very clear distinctions between urban and rural areas with the poor being involved more than the well-to-do people in urban areas.

Lack of Coordination of Implementing Agencies

While there have been efforts to ensure that there is a multisectoral approach to implementation, the degree of cooperation has not been as expected. It was observed that some geographical areas have adequate services while others do not. For example, in some areas, there were non-governmental organisations providing rations of beans and cooking oil, while in others people did not get them despite being needy. This problem was apparent in the rural areas which were hit hard by the 1994/95 drought.

- ***Gaps and Inconsistencies***

It was quite apparent to respondents that there was a gap between the government promises and the fulfilment of these promises. This was more apparent after the introduction of the Structural Adjustment Programme. There are also gaps be-

tween policy in intent and policy in practice. The principles of equity and social justice were being compromised because of lack of financial resources. Another contributory factor was that some of the implementors were ignorant of certain provisions and procedures of the policies they were supposed to implement. This caused a lot of confusion among beneficiaries.

- **Accessibility**

As noted before, government embarked on a major decentralisation programme to ensure that individuals had access to education, health and social welfare services. On this aspect, the respondents felt that most of the services were generally accessible. They were particularly satisfied with the drought relief programme which they noted as a success even though at times the amounts of food given were not enough. They however, suggested that there was room for improvement. They observed that the Department of Social Welfare needed to extend its services to other remote areas, just as the health sector had clinics in remote areas. It was felt that more primary and secondary schools (in both rural and urban areas) need to be built to avoid 'hot-seating' in urban areas. Health care centres would also benefit from visiting doctors, telephones and more ambulances.

The State and Dynamics of Social Policy Research

Research is a major tool in policy planning and implementation as it provides data to policy makers so that they can come up with sound and effective policies to deal with development issues. Social policy research should be a priority in developing countries where policies and programmes are being implemented in order to alleviate poverty.

At independence, research was viewed as an important tool for the realisation of development. Many government ministries therefore set up research departments or units which were tasked to carry out research on relevant topics. Non-governmental organisations and local authorities also followed suit. Some strengthened their organisational capacity to carry out research while other organisations were set up specifically to carry out research. Institutions of higher learning also strengthened their research courses.

An examination of the social sectors under study revealed that there was intrasectoral collaboration, particularly in the area of health. For example, the Ministry of Health and Child Welfare, in partnership with relevant organisations (City Health Department, the School of Medicine at the University of Zimbabwe, and Blair Research Station) have carried out useful studies (eg, nutrition surveys) which have provided a policy framework for dealing with health problems. Other

researches in the health sector have tended to focus on specific health problems such as sexually transmitted diseases, especially AIDS, abortions, infertility and the prevention of malaria and bilharzia, to name a few.

The Ministry of Education, particularly through the Department of Curriculum Development, has carried out researches that have influenced changes in the curriculum in order to make it more responsive to the needs of society. However, there has been very little research on substantive social policy issues. In the area of social welfare, the Department of Social Welfare has benefited from researches such as children under difficult circumstances and the sentinel surveillance studies which are being used to reformulate relevant social policies.

The Initiation and Funding of Researches

It was evident that at independence, donors were interested in supporting research projects financially and technically. Donors had their specific areas of interest which they funded and still fund. For example, UNICEF has supported a lot of research projects which focus on children and women. The three social sectors have benefited tremendously from support from UNICEF. UNESCO has funded studies which have a bearing on education. Other donors such as CIDA, SIDA and NORAD have also supported many sectoral studies. Many studies which have been donor-funded have tended to be large and at times nationwide because of the financial and technical resources required. Government ministries have also initiated studies but these are usually small because of resource constraints. Universities and other institutions of higher learning have carried out research and these are usually donor-funded as well.

Utilisation of Research Results

While there is evidence that many researches have been carried out in Zimbabwe, the extent to which the results were utilised to inform social policy was difficult to establish. The utilisation of social policy research depends on who has initiated the research and for what purpose. The results which emanated from researches initiated and funded by the United Nations agencies have influenced specific aspects of social policy, particularly in the health sector. For example, the health and demographic surveys have influenced specific aspects of health policy. However, studies that have been carried out in institutions of higher learning tend to be for academic purposes rather than for influencing social policy. Furthermore, there does not seem to be enough effort on the part of policy-makers, implementors and academics to collaborate with a view to exploring how researches can be used to address policy issues. There has been a tendency on the part of the policy-makers and implementors not to value research that has been carried out by academics as

they are believed to be theorists. For example, many research projects carried out as dissertations and theses provide a lot of useful information but the extent to which these are used by practitioners is questionable. On the other hand, some academics have produced reports that are too technical to be of much use to policy-makers and implementors.

The other problem that was identified was that some researches carried out have emphasised the use of quantitative rather than qualitative research methods. Qualitative methods can generate more useful data which can be used to inform social policy. Most key informants felt that there was no utilisation of participatory research methods. Furthermore the research areas were usually defined by researchers and they never go back and inform the respondents on the findings. There are therefore no discernible benefits that accrue to the respondents. The research process itself was also considered as a handicap as it takes too long to complete the research process. For example, many donors require elaborate project proposals, including budgets. They also require sophisticated reporting procedures. This process may take a long time and by the time the process is completed it may be too late to implement the recommendations as the findings may have become irrelevant.

Conclusion and Recommendations

The study has shown that it is not possible to isolate any single factor as being responsible for shaping social policies in Zimbabwe. However, the picture that emerges seems to suggest growing external influence in shaping policies and in particular the influence of multilateral agencies.

The study has also shown that the responsibility for the determination of social policy rests with the government technocrats and the politicians. Although the civil society was said to have an influence in shaping social policies there was however no evidence in the study to suggest that civil society is involved in the social policy process. Whilst the government has set up structures that serve as instruments for popular participation, the study revealed, however, that these structures are not working well as they should. It was noted that policy initiatives do not reflect the inputs of the various structures namely, the VIDCO, WADCO, and DIDCO.

As far as the nature and scope of social policy is concerned, the study revealed that there have been shifts largely as a result of changes in ideological orientation and also as a result of limitations imposed by lack of resources. The picture that emerges is one that reflects a fusion of elements of selectivity and universality in the provision of social services. This perhaps represents an attempt to put a 'human face' to structural adjustment programmes. It was noted that the majority of the social policies were not developmental in character.

The study revealed that the implementation of social policies was fraught with problems. A major problem reported was the gap between policy in intent and policy in practice. The gap between policy in intent and policy in practice arises because of different interpretation of social policies by the implementors. It was also reported that some politicians were interfering with the implementation of social policies, particularly in the area of social welfare and were using social welfare services to reward their supporters and their relatives. The end result is that people who do not qualify for assistance end up benefiting, while those deserving assistance may go without assistance.

Lastly, as far as social policy research is concerned, the study revealed that whilst a number of researches have been carried out there is no evidence to suggest that these have been used to inform social policy generally except in the health sector where research has influenced some technical aspects of social policy. It was also noted that there was limited dialogue between researchers, policy-makers and implementors. Overall, the study revealed that there was very little relationship between social policy research and practice.

Recommendations

The following recommendations arise from the study:

1. There is need for government to strengthen the development structures that serve as instruments for popular participation.
2. There is need for clearly defined mechanisms for dialogue between NGOs and government in order to make it possible for NGOs to contribute to the social policy process.
3. There is need for more political commitment to the realisation of equity and social justice ideals if social policies are to enhance the well-being of the people, particularly those who, because of history and accident of birth, find themselves marginalised.
4. The allocation of resources for the social sector needs to reflect the centrality of the social sector in improving the quality of life.
5. There is need for integrated and action-oriented researches which address the substantive issues in social policy.
6. There is need for dialogue between researchers, policy-makers and implementors in order to facilitate coordination and utilisation of research results.

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