

Pathways out of poverty for Zimbabwe

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**Children after the Long Socio-economic
Crisis in Zimbabwe: Situation Analysis
and Policy Issues**

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Executive Summary

Children in Zimbabwe suffered badly during the long socio-economic crisis in Zimbabwe from about 1990 to 2008. During its peak, from 2002 to 2008, health, nutrition, education and other social indicators in Zimbabwe reached extremely low levels. Despite recent improvements in the situation of Zimbabwe's children, many of the effects of the socio-economic crisis on them are long-term, even permanent. Pre-natal and early childhood malnutrition, orphanhood, and disrupted education have all created lasting damage. The Government of Zimbabwe faces several challenges in re-establishing social services for children. The country's fiscal capacity is not what it once was, yet public expectations for improvements are high. In such a situation of high expectations, it is tempting to try to do everything at once. Suggestions are made for focusing on re-establishing basic services, with an emphasis on building quality, equity, coverage and participation.

Introduction

Children in Zimbabwe suffered badly during the long crisis in Zimbabwe from about 1990 to 2008. The first decade after Independence saw important, often dramatic, improvements in the lives of children in Zimbabwe. Free primary schooling was introduced and enrolment increased from 819,000 in 1979 to 2,260,000 in 1986, while secondary school enrolment increased sixfold (Stoneman and Cliffe, 1989). Immunisation against the six major childhood diseases became almost universal and health services spread to within reach of the vast majority of the population, even in rural areas. Beginning in the late 1980s, however, some social indicators began to decline. Initially, the culprit was the HIV-AIDS epidemic, whose scope and importance were completely underestimated by most governmental, donor and private sector actors. To the HIV-AIDS pandemic was soon added a growing fiscal crisis as state expenditures routinely exceeded revenues, leading to government borrowing, crowding out of private investment, money creation and inflation. Then fell the double blow of the droughts of 1992 and 1995, on top of a failed structural adjustment programme. By the late 1990s, it was obvious that Zimbabwe was in trouble.

The long socio-economic decline in Zimbabwe was already underway for a decade or so before the turbulent events of the year 2000 broke out. At the peak of the crisis from 2002 to 2008, health, nutrition, education and other social indicators of the wellbeing of children in Zimbabwe reached levels rarely seen outside of countries experiencing protracted civil

war. The advent of the multi-currency system and the end of hyper-inflation, together with the creation of a coalition government and the relative peace and stability that it has brought, have made possible the re-establishment of some basic social services for children in Zimbabwe. Despite recent improvements, however, social indicators in Zimbabwe are no better than they were 20 to 25 years ago; in the meantime, most other African and developing countries made steady progress. While indicators like school enrolment and immunisation may return to normal levels in Zimbabwe, many of the effects of the long socio-economic crisis on children are long-term, even permanent. Pre-natal and early childhood malnutrition, orphanhood, and disrupted education during the crisis will all have created lasting damage.

The Government of Zimbabwe faces several challenges in re-establishing social services for children. The country's fiscal capacity is not what it once was, yet public demand for improvements is high. Faced with such a tension, it may be tempting for government to try to do everything at once, regardless of the consequences. Another temptation may be to try to re-create the fondly remembered social service system of earlier decades. Neither strategy is likely to be viable. A more promising strategy may be one that is both conservative and radical at the same time. The conservative part consists in focusing on re-establishing a set of basic social services in line with existing and foreseeable resource constraints. The radical part consists of using recent changes in technology and management techniques to put the emphasis on quality, equity,

coverage and participation, based on a strategy of preventing further harm to children, building capabilities, and dealing with past traumas.

The structure of this paper is as follows. First, the paper briefly outlines what is known in the medical, psychological, nutritional, educational and socio-economic literature about the effects of long-term socio-economic crisis on the well-being of children. Second, the paper summarises briefly the state of children in Zimbabwe since Independence, and shows how many of the expected effects of socio-economic crisis on children have manifested themselves in Zimbabwe over the last two decades. In the third main section, policy issues are drawn out for Zimbabwe, given its reduced fiscal capacity, recent changes in technology and management techniques, and other issues.

The Effects of Socio-Economic Crisis on Children

The long-term economic decline of any society implies a decline in the level of resources available to parents, extended families and communities to provide for their children. Economic decline also means that fewer resources are available for health, education and child protection services run by public authorities. Furthermore, economic decline leads to falls in service quality, coverage and equity. Given their age, immaturity and lack of social status, children are amongst those least able to advocate for themselves in public policy debates when tough choices have to be made. When decline becomes crisis and civil public discourse breaks down, the voice of children is even less likely to be heard above the noise. Conflict and epidemic diseases break down the social structures that previously supported families, and erode parents' individual and social capacities to care for their children, sometimes at alarming rates.

In extreme crisis, more children die due to increased malnutrition, epidemic diseases, and/or neglect. These factors often interact with each other, creating a vicious cycle. Less severe but more common effects of crisis include increased malnutrition; decreased school enrolments and higher rates of absenteeism from school; higher rates of disability; and a tearing of the social fabric, which creates greater potential for child abuse and neglect. These more common effects often have long-lasting consequences which sometimes last for generations.

Take malnutrition for example, which in the first three years of life often has irreversible effects on the development of the child's brain (UNICEF, 1998).

These effects include decreased cognitive function, which subsequently leads to poorer educational outcomes once the child enrolls in school and to poorer career prospects later in life. While such outcomes are tragic for each individual child, the social and economic consequences of having a large number of such individuals in a society may be considerable.

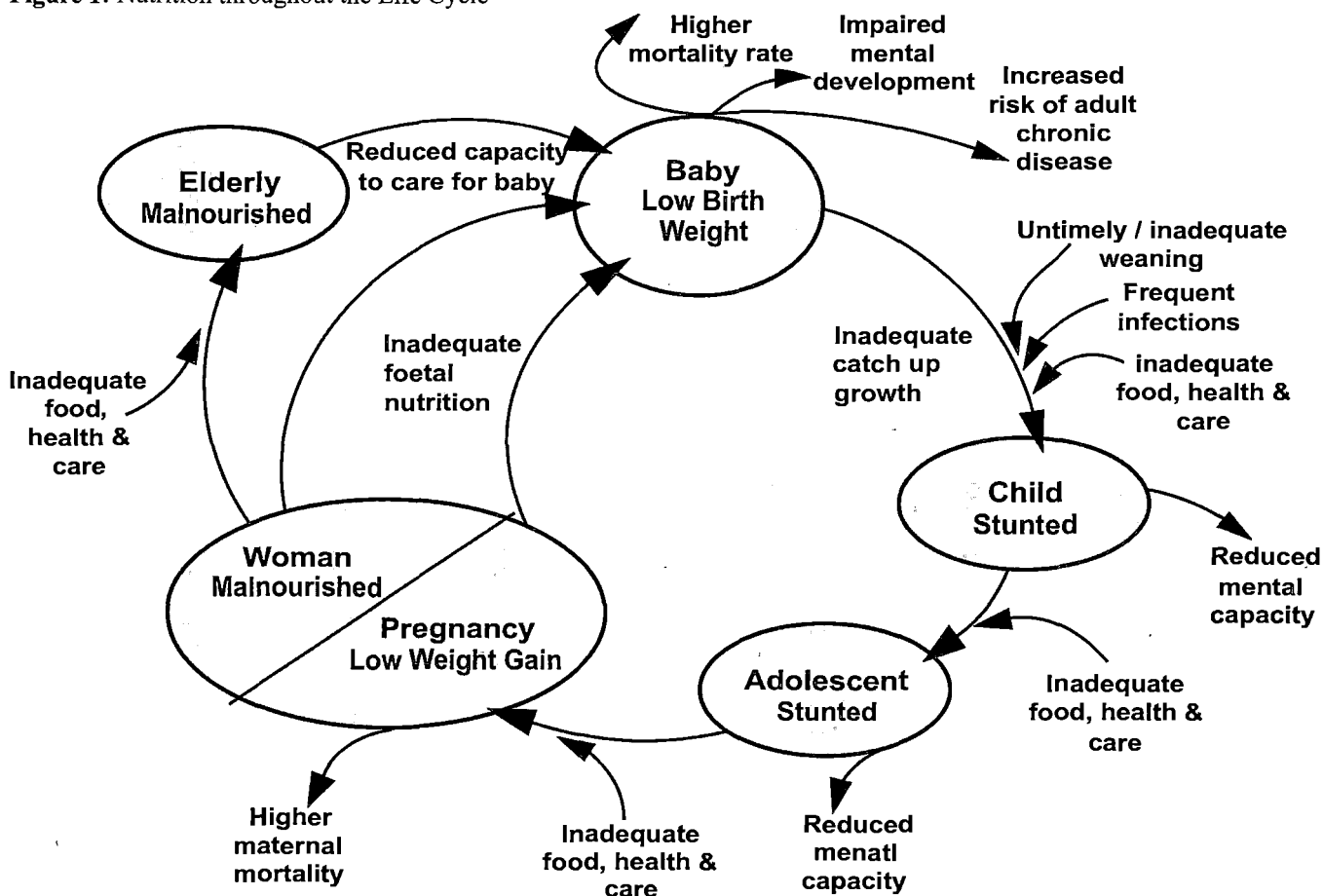
Children may also be permanently damaged even before they are born. Severe malnutrition amongst pregnant women is doubly damaging: to the woman herself and to her unborn child. The latter effect is known as pre-natal malnutrition, which has been shown to lead to increased rates of low birth weight of the children concerned. Low birth weight children are less likely to survive their first year of life, are more prone to infection, are slow to grow and develop physically, and frequently show impaired cognitive development. Such effects have been known for years (e.g. UNICEF, 1998). More recent research shows that severe pre-natal malnutrition leads to increased rates of mental illness in children, possibly doubling the risk of schizophrenia and doubling or tripling the risk of schizoid personality disorder (Neugebauer, 2005). Figure 1 shows the inter-generational effects of malnutrition in mothers and children.

Socio-economic decline and crisis frequently affect the coverage and quality of formal education that children receive. Parents are less able to afford notebooks, pencils and other school supplies, never mind school uniforms. As government funding dries up, textbooks and chalk become scarce. Teachers become demotivated as the purchasing power of their salaries declines in the face of inflation, and sometimes they are not paid at all. The decline in the quality and quantity of schooling leads to lower levels of literacy, numeracy, and life skills; these in turn have impacts on individuals' prospects for employment and social mobility.

What is tragic for an individual child becomes an important social and economic problem when it affects a generation of children. New forms of age- and class-based social cleavage may emerge, as the

children of the privileged classes, mostly in urban areas, ride out the storm while the worst affected children, usually in the rural areas, see their education disrupted the most during the crisis and see their life chances eroded as a result (Bell and Huebler 2011)¹.

Figure 1: Nutrition throughout the Life Cycle



Source: Commission on the Nutrition Challenges of the 21st Century (2000)

Lower rates of school enrolment have inter-generational effects, as well as effects that interact with each other across the conventional boundaries of health, nutrition, education, and child care. For example, women with less education have higher risk of contracting sexually transmitted infections including HIV, are less likely to take their children for appropriate medical care when needed, and face higher risks of their own child dying (ZIMSTAT and UNICEF 2010).

The Situation of Children in Zimbabwe 1980-2010

So, what was the impact of the crisis in Zimbabwe

¹Sadomba (2010) shows, for example, the effects of neglect and alienation of the generation of children and young people whose schooling was disrupted when they went to join the liberation struggle in the camps in Mozambique and Zambia in the 1970s.

and to what extent can we expect to see some or all of the negative effects of the crisis on children outlined above? The collapse of Zimbabwe during the long crisis was dramatic. Gross domestic product per capita (measured in constant 2000 US dollars) averaged US\$534 in the decade 1988-98, peaking at US\$574 in 1998; it then fell for ten consecutive years, bottoming out at US\$284 in 2008 (World Bank 2011)², a fall of over 50 per cent.

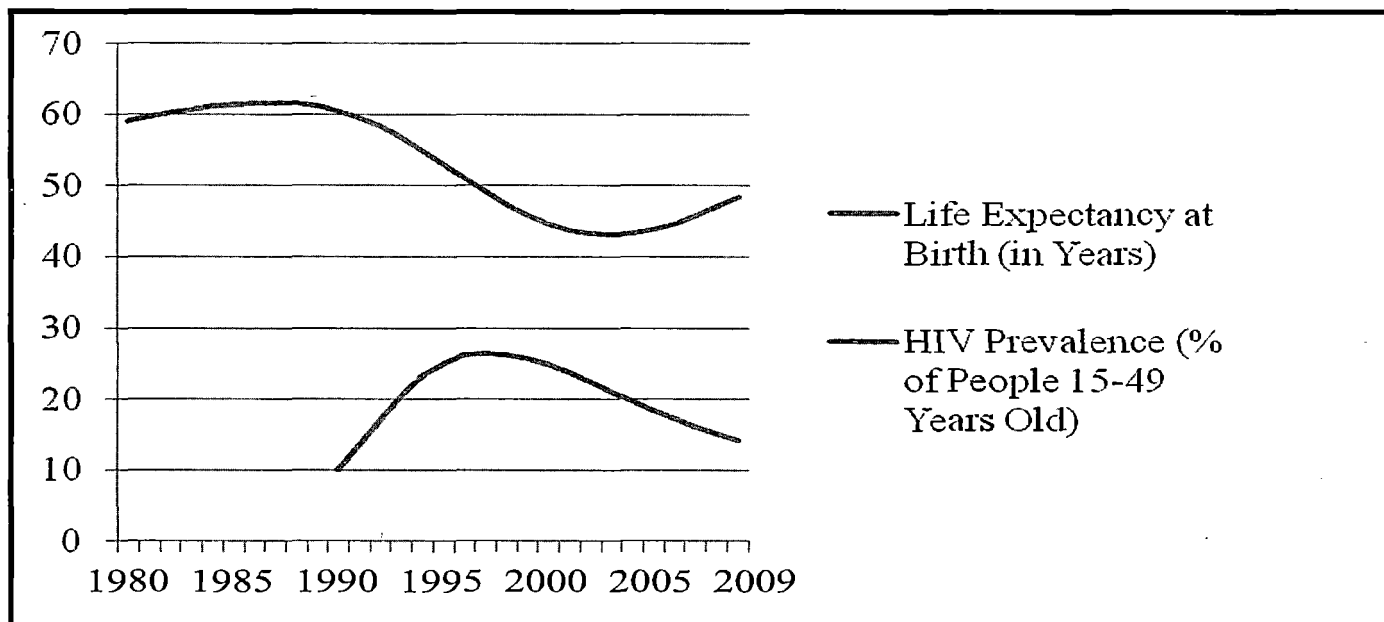
²Different data sources – UN, World Bank, Government of Zimbabwe – all show slightly different levels for the indicators and periods in question. All sources agree, however, that the general trend was sharply downward, and that is the main point. As the crisis deepened, especially into the 2000s, the quality of Zimbabwe’s official statistics became increasingly problematic. I have used those data sources that are both credible and that have comparable time-series data to show trends. Not all data sources meet these two criteria. Hence, I will sometimes use World Bank data, sometimes data from the former Central Statistical Office (now ZIMSTAT), sometimes data from UN or other sources.

Income poverty was rising in Zimbabwe even before the worst declines in GDP per capita. It rose unambiguously from 1990-91 to 1995-96, according to the Central Statistical Office (CSO 1998); in these surveys, the proportion of those under the income poverty line rose from 52.8 per cent in 1990-91 to 75.6 per cent in 1995-96. Another set of income poverty surveys, using different definitions of income

Mirroring the trend in average life expectancy, infant and child mortality soared during the crisis in Zimbabwe. The lowest mortality rates were seen in the late 1980s, and the peak of mortality was in the early 2000s. Again, the relation to the HIV-AIDS epidemic is obvious. See Figure 3.

The nutritional situation of Zimbabwe's children

Figure 2: Average Life Expectancy in Zimbabwe 1980-2009 and HIV Prevalence Rate 1990-2009



Source: World Bank 2011

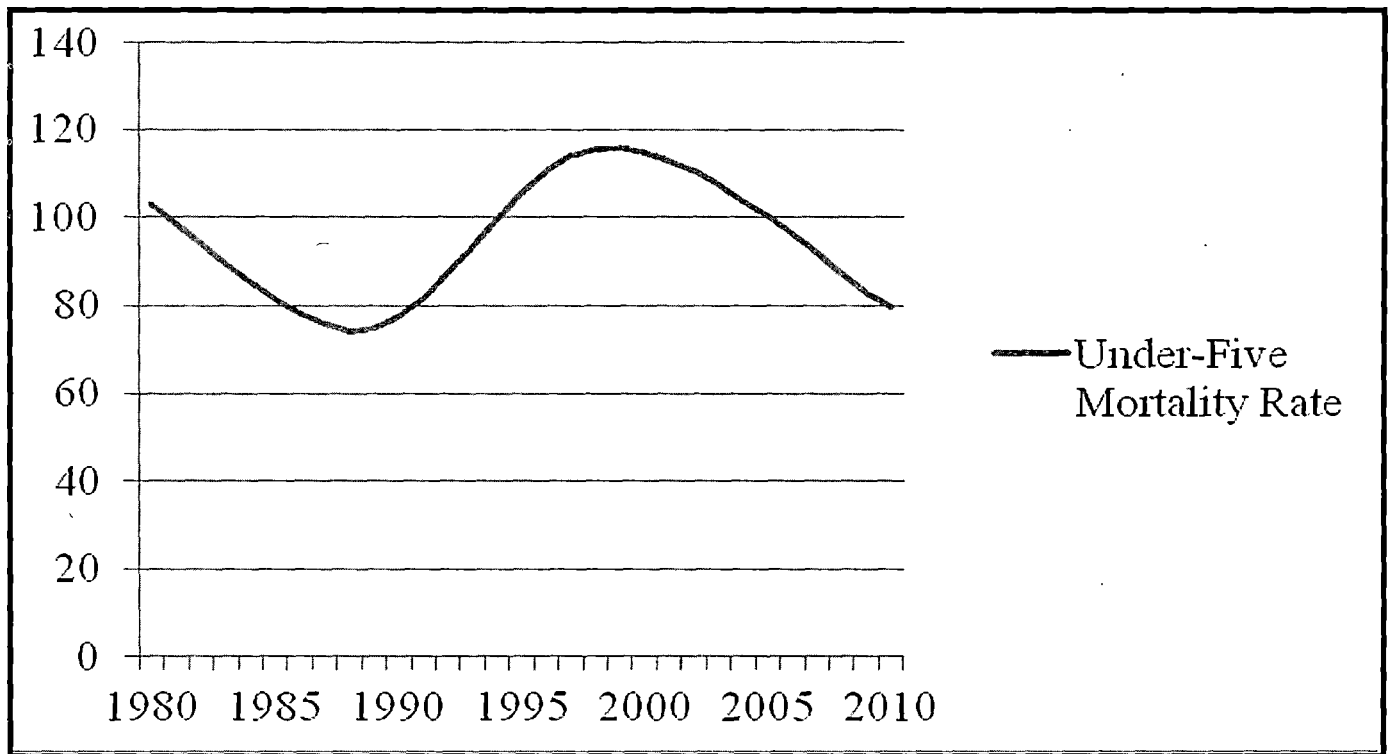
Technical Note: For average life expectancy, the scale on the left is in years; for HIV prevalence, the scale on the left is in per cent. HIV prevalence data before 1990 are unavailable.

poverty and different methods, showed that income poverty continued to rise from 1995 to 2003-04. These Poverty Assessment Study Surveys showed that the proportion living under the poverty line rose from 42 per cent in 1995 to 63 per cent in 2003-04 (GoZ, 2006). No doubt the levels of income poverty surged even higher as GDP dropped sharply from 2004 to 2008.

The economic collapse was accompanied, and in many cases preceded, by a failure in health and other social indicators. Average life expectancy in Zimbabwe peaked at around 62 years in 1986-88, and then began a long steady decline for a decade and a half. By 2002-04, average life expectancy had bottomed out at around 42 years, a fall of almost a third. The changes in average life expectancy in Zimbabwe were driven by HIV prevalence. See Figure 2.

also deteriorated. Unlike average life expectancy and under-five mortality, however, the nutritional status of children has not shown unambiguous improvement as the crisis has abated in the last three years. Figure 4 shows that stunting among children 12-59 months old rose significantly, to over 40 per cent of children, and has remained high, with an unclear trend in recent years. In lay terms, stunting is being short for one's age. Stunting is evidence of chronic malnutrition, usually associated with inadequate food intake over long periods and/or a high burden of disease, especially gastro-intestinal diseases that weaken the child's ability to absorb the nutrients that s/he ingests. Figure 4 also shows that another form of malnutrition, wasting, increased sevenfold during the crisis years, though it has improved in recent years. Wasting, in lay terms, is being thin for one's height. Wasting is evidence of acute malnutrition, i.e. a severe and recent shortage of food, often compounded by disease.

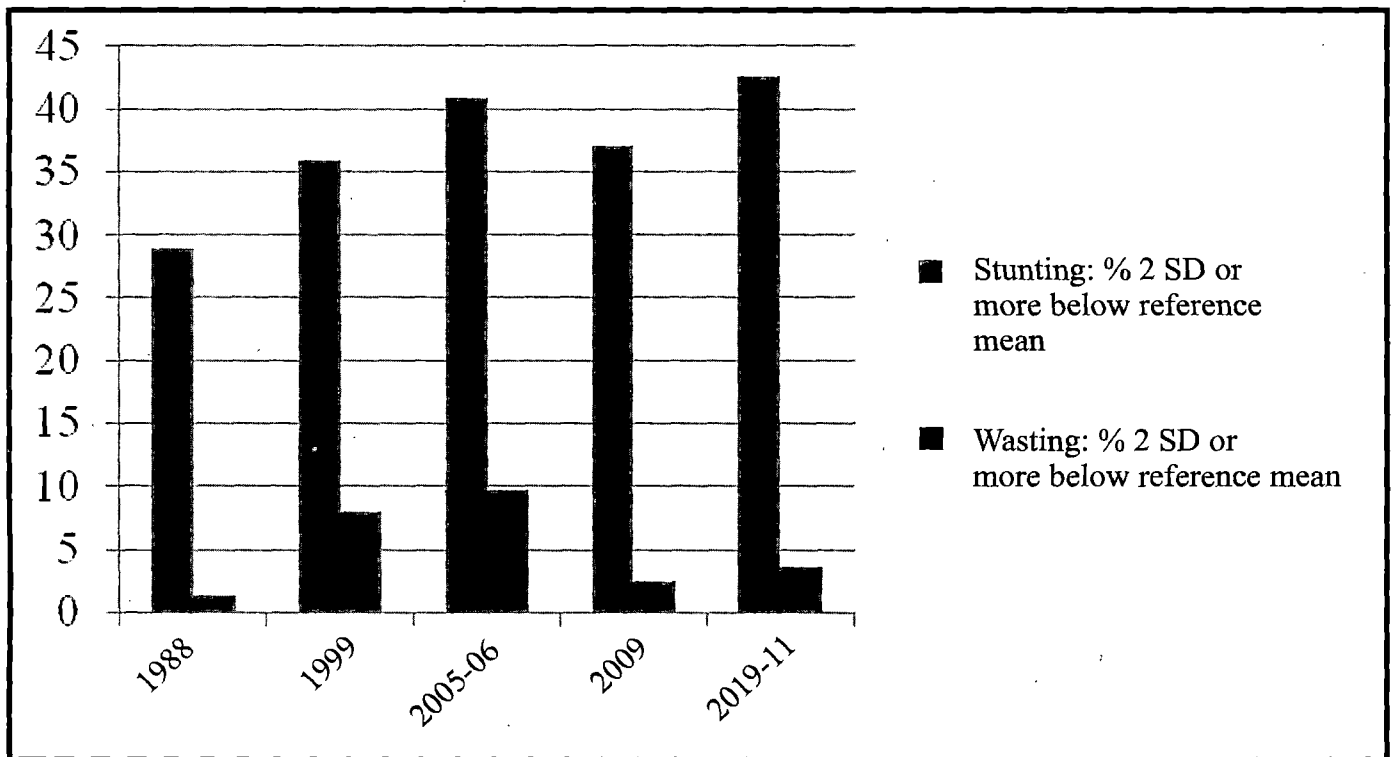
Figure 3: Under-Five Mortality in Zimbabwe 1980-2010



Source: World Bank 2011

Technical Note: Under-five mortality rate is the number of children under 60 months of age who die in a given year, per 1000 live births in that year. The trends for infant mortality follow a similar pattern over the years.

Figure 4: Nutritional Status of Children in Zimbabwe 1988-2011: Prevalence of Stunting and Wasting



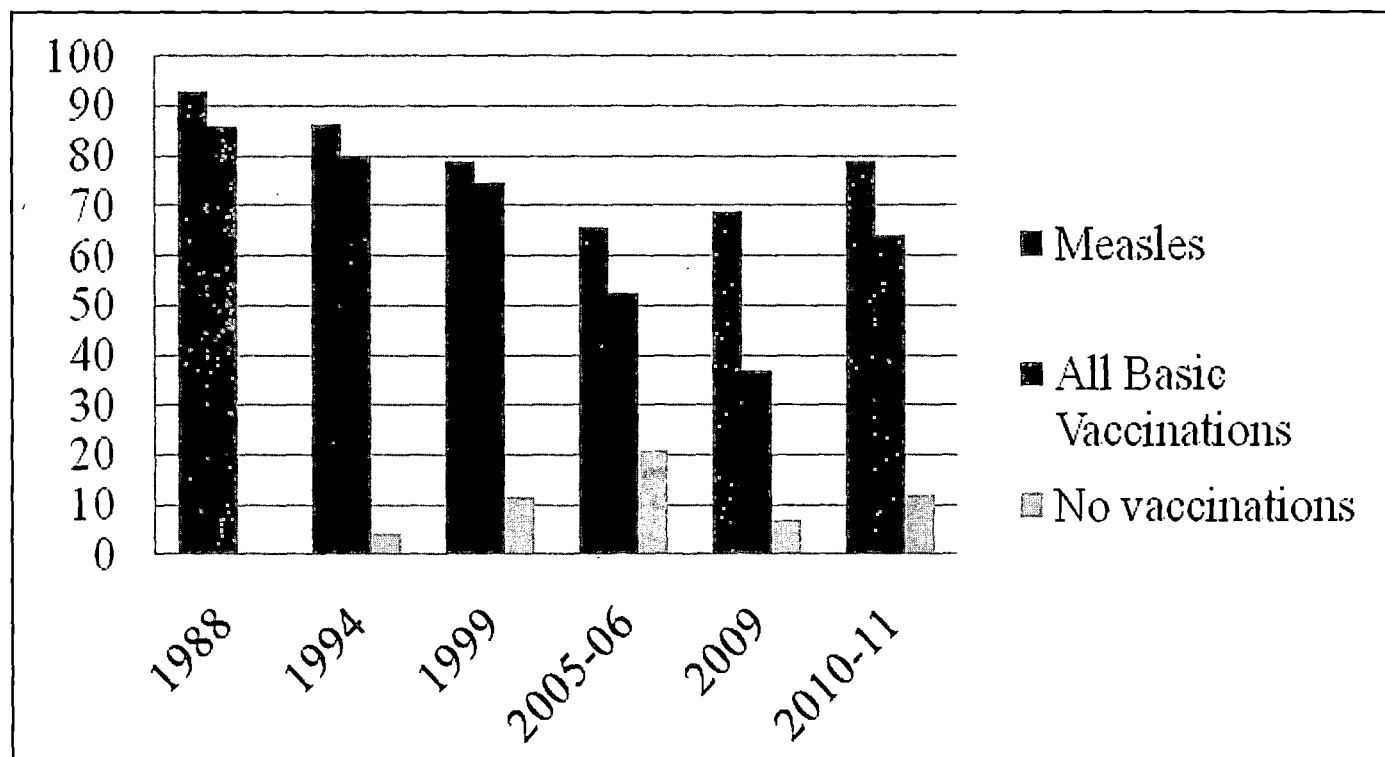
Technical Note: Figure 4 shows the percentage of children 12-59 months old who were two standard deviations or more below the international reference mean of height-for-age, or stunting. It also shows the percentage of those same children who were two or more standard deviations below the international reference mean of weight-for-height, or wasting. The surveys employ comparable measures and methodologies.

The quality of health services is also important to children. While the quality and accessibility of health care are harder to measure than income, mortality or malnutrition, good proxies exist. One such proxy is immunisation rates. Immunisation is important for preventing childhood diseases that can kill or disable the child. Immunisation coverage is an indicator of how successful the health system is at reaching all children with basic care. Figure 5 shows coverage data for one common vaccine (measles) and for all major childhood vaccines (measles, BCG, DPT and

getting no immunisation appears to have peaked in the middle of the last decade, but is still over 10 per cent.

Driven by the HIV-AIDS epidemic amongst the adult population, the numbers of orphans in Zimbabwe soared during the long crisis (Figure 6), peaking at 1.1 million orphans in 2008-09 (World Bank 2011), or almost a quarter of all Zimbabwean children (ZIMSTAT and UNICEF 2010: 137). Such extraordinarily high levels of orphanhood would

Figure 5: Immunisation Rates for Children 12-59 Months 1988-2011



Source: CSO and Institute for Resource Development/Macro Systems Inc. (1989); CSO and Macro International (1995, 2000 and 2007); ZIMSTAT and UNICEF (2010); and ZIMSTAT and Measure DHS, IFC Macro (2011).

Technical Note: The sources for 1988, 1994, 1999, 2005-06 and 2010-11 are the Zimbabwe Demographic and Health Surveys conducted by Central Statistical Office and Macro International Inc. The source for 2009 is the Multiple Indicator Monitoring Survey conducted by ZIMSTAT and UNICEF. The surveys are comparable. In 1988, no DHS data were published on the percentage of children with no immunisation.

polio 3), as well as data on the percentage of children who received no vaccine at all.

Immunisation coverage fell from the late 1980s to the late 2000s, only recovering very recently. The proportion of fully immunised children fell from 86 per cent in 1988 to less than 40 per cent as recently as 2009, disturbing evidence of the inadequacy of the health care system. The proportion of children

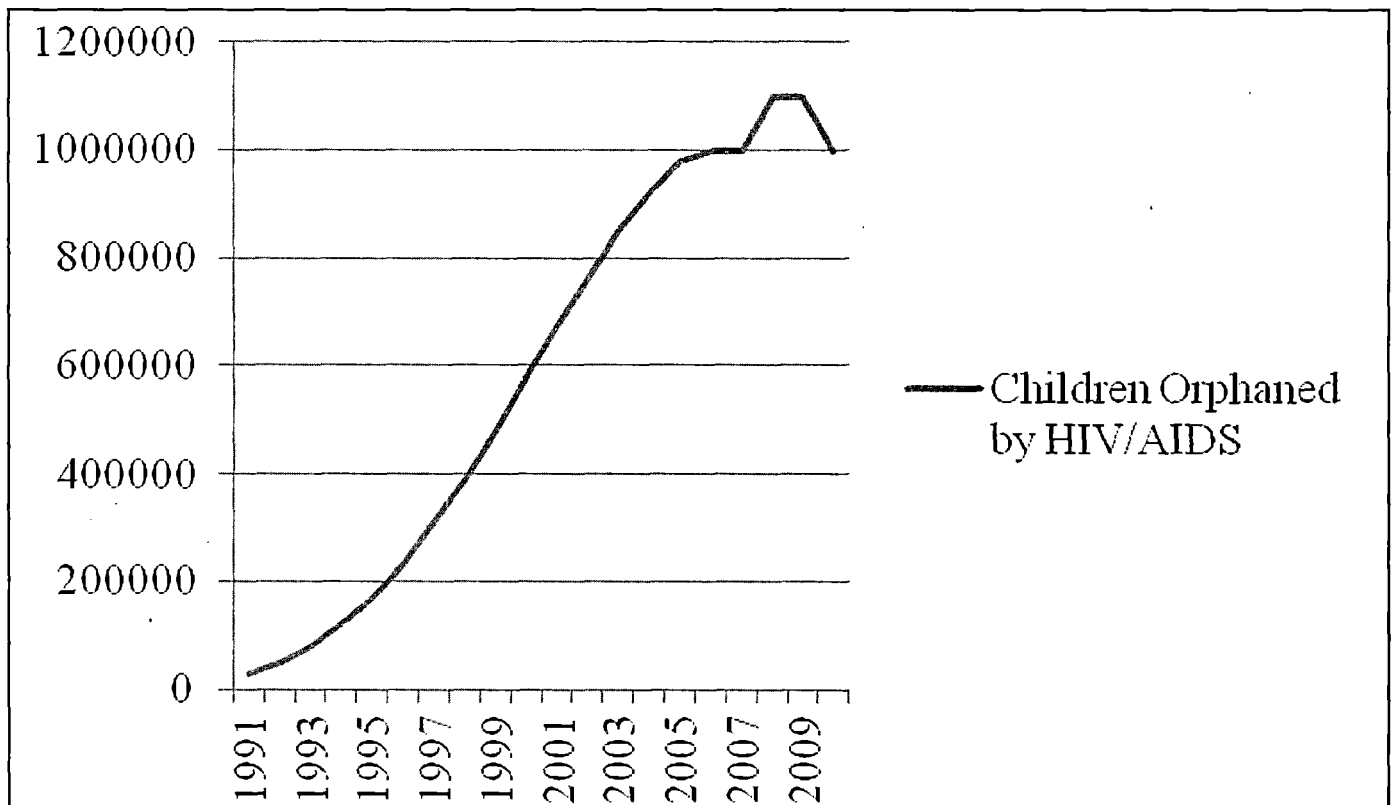
create severe social and psychological hardship at the best of times. But Zimbabwe's orphan crisis occurred during a time of economic collapse and social and political tensions, making matters worse for the children concerned, and their caregivers. In 2000, Zimbabwean orphans were 15 per cent less likely to be enrolled in school than other children (World Bank 2011); in 2009, they were 10 per cent less likely to attend school (ZIMSTAT and UNICEF 2010: 136).

Orphans also suffered higher rates of stunting than other children (41.5 per cent vs. 34.6 per cent) in 2009 (ZIMSTAT and UNICEF, 2010: 141).

In situations of large-scale orphanhood, orphans are likely to receive less psycho-social and health care and to be socialised according to appropriate cultural norms than other children. In Zimbabwe in 2009, only 21 per cent of orphans received any of the social, material, educational, medical or psychosocial care that they were entitled to; only 4.1 per cent had received emotional and psychosocial support in the previous three months (ZIMSTAT and UNICEF 2010: 143 and 292). These figures were slightly worse than the comparable figures for 2005-06: 31.2 per cent and 6.0 per cent respectively (CSO and Macro International 2007: 296).

Orphaned children are more open to abuse and neglect of all forms, and are at higher risk of early sexual activity because they lack adult guidance to help protect themselves (CSO and Macro International 2007: 292-3). Because orphanhood in Zimbabwe is driven overwhelmingly by the HIV-AIDS epidemic, orphans are likely to live in households where one or more adults are sick, possibly dying; such parents are less able than others to look after their children. In 2005-06, Zimbabwean orphans were less likely to have a set of basic material possessions (defined as a pair of shoes, two sets of clothes and a blanket) than other children; only 51.7 per cent of orphans had all three, while 65.8 per cent of non-orphans did (CSO and Macro International 2007: 290). Evidence from South Africa suggests that adult caregivers of orphaned children are more prone to clinical depression than are caregivers of non-orphaned children (Kuo et al. 2012).

Figure 6: number of children orphaned by HIV- AIDS in Zimbabwe 1991-2012



Source: World Bank (2011)

Technical Note: An orphan is a child 0-17 years of age who has lost one or both parents due to HIV/AIDS.

In the first decade after Independence, the expansion of education to virtually the whole population was a great source of pride for Zimbabwe. Indeed, it was an achievement noticed around the world. Long-term trends in gross primary school enrolments are available in World Bank and UNESCO on-line

from primary to secondary school and poor rates of success at standard examinations are indicators of the quality of education in Zimbabwe, again especially in rural schools. In 2000, 2005 and 2006, an average of only 13 per cent of pupils writing O Level exams met the standard of passing five subjects at grade C

Table 1: Net Primary School Enrolment in Zimbabwe, according to Household Surveys

	Nov. 1993	Sept. 1994	Mar. 1996	Mar. 1997	Nov. 1997	Oct. 1999	Jan. 2006	Apr. 2009
Net Primary School Enrolment	83	86	91	92	87	76.6	91.4	91

Source: Inter-Ministerial Committee on SDA Monitoring (1994, 1995, 1996, 1997 and 1999); CSO and Macro International (1999 and 2007); ZIMSTAT and UNICEF 2010.

Technical Note: Table 1 shows the well-known phenomenon that net primary enrolment rates in Zimbabwe tend to be 5-10 per cent higher at the beginning of the school year than at the end (Months earlier in the school year- January, March and April- have higher enrolments than months later in the school year). Some pupils drop out during the school year, often due to inability to pay school fees. The primary school year starts in January. Where the survey period covered several months, I have taken the mid-point. The estimate for October 1999 is likely an underestimate; Government at the time estimated a net enrolment rate of 86.8 per cent (Ministry of Education, Sports and Culture, 2000).

databases only until the late 1990s. From then on, sample surveys suggest that net primary school enrolment rate, i.e. the percentage of 6 to 12 year olds enrolled in school, moved between about 83 per cent and 91 per cent. (See Table 1.)

Enrolment figures are only part of the story. Even before the economic crisis of the 2000s, many rural schools in particular lacked physical equipment, supplies, textbooks and fully trained teachers (Chimhowu et al. 2010: Chapter 6). In its report in 2000 to the World Education Forum, the Government of Zimbabwe admitted that real funding per pupil was one-third less than it had been a decade earlier and that, with almost 95 per cent of the Ministry of Education's budget going to salaries, the funding available for "other educational services such as alternative methods of instruction and other teacher-support systems" were inadequate (Ministry of Education, Sports and Culture, 2000). A similar situation has continued to the present day, with the Government's Medium-Term Plan 2011-2015 reporting that there were three pupils for every English textbook in Zimbabwe's primary schools, and six pupils for every mathematics textbook. "The pupil-textbook ratio is however, worse in rural schools", admits the Government (GoZ, 2011: 186). Poor transition rates

or better.

In short, Zimbabwe has, over the last 20 or so years, witnessed a remarkable decline in its economy and social indicators. What could be predicted to happen in a prolonged socio-economic crisis based on the experience of other societies has all happened in Zimbabwe: rising mortality, declining health and nutrition, poor education, high levels of social and psychosocial disruption, with long-term consequences. The recovery of the last three years is only partial; many challenges remain to be tackled.

Policy Issues relating to Children in Zimbabwe

So, what is to be done? What steps should policy makers take to remediate the situation and to avoid a repetition? The first thing is to realise that, as with all important historical events, the effects of the long crisis in Zimbabwe will live on long after the crisis has passed. The effects will be felt, and will have to be dealt with, at several levels.

At the micro level problems associated with, for example, the long-term effects of malnutrition, and the social dysfunctions created by mass orphanhood, will be deeply felt by the individual victims for years to come. Such problems will impede

individuals' and households' chances for economic betterment and social mobility in the future. This has implications for policies aimed at promoting social mobility.

At the meso-level of public administration and service delivery, the existence of such problems will keep teachers, health workers, social workers, rural extension officials, community workers and many other professionals busy for years to come. Needless to say, this will be in addition to their "normal" workloads.

At the level of the macro-economy, the loss of human and social capital from the long socio-economic crisis will affect productivity, innovation and growth for years to come, notwithstanding the spectacular rebound growth of the economy since 2008.

That is a very thumbnail sketch of the very complex and multi-layered reality that is Zimbabwe today. But it serves to help discern the outlines of the important social, economic and other policy issues relevant to children. I will compare the sort of policy prescriptions that the above analysis suggests to what the Government has proposed to do in its Medium Term Plan 2011-2015 (GoZ, 2011), hereinafter referred to simply as "the Plan". My policy recommendations focus on "preventing further harm to children", and "building capabilities". Admittedly, these are somewhat arbitrary categories in that they are far from mutually exclusive.

Preventing Further Harm to Children

First of all, it is important to prevent further damage to children. This implies above all a commitment to re-establishing a set of basic social services for children throughout Zimbabwe. The aim would be to stop the most obvious and most easily preventable harms from occurring. Such harms include lack of education; pre-natal and early childhood malnutrition; preventable early death; preventable illness, especially diseases and conditions likely to have long-term consequences; and extreme poverty.

In education, the focus should be on enhancing primary education in rural areas. There are several reasons for focusing there. First, the rural areas were those most affected by the crisis. Second, most

Zimbabwean children still live in rural areas. Third, this is where the biggest challenges in Zimbabwean education, in terms of both quality and quantity, have been in the past. The greatest potential for preventing illiteracy and innumeracy and for building life skills thus exists in rural areas. The Plan is quite forthright in its support for primary education, though it lacks a clear focus on rural areas.

The education section of the Plan is silent over the issue of violence in schools. Issues such as corporal punishment and sexual abuse in schools (especially of girls by male teachers) deserve a public airing. If the Plan can commit to "zero tolerance of corruption" in the public administration (GoZ, 2011: 224), could it not also commit to "zero tolerance for violence in schools"?

The health care system has an enormous role in preventing early death and lifelong disability in children. Typical interventions include immunisation (including use of new vaccines against hepatitis and meningitis), micronutrient supplementation, oral rehydration therapy, essential drugs and the correct case management of the most common diseases and conditions. Related public health measures, include health education, nutritional supplementation, sanitation and improved water supply. Prevention is cheaper than cure, and brings life-long benefits. Such preventive measures are also often relatively easy to (re-)establish, are highly cost-effective, have high benefit-cost ratios, and respond to well-known public goods and externality problems. They are good public policy at any time, but especially so in post-crisis situations. The Government's Plan is fairly forthright in its support for "comprehensive primary health care", but it contains no indication of what is included in "comprehensive primary health care services" and has some other disconcerting features, which are dealt with below.

Extreme poverty is perhaps the major source of harm in the long run. The Plan in its front-piece contains a commitment to "sustainable, inclusive growth, human centred development and poverty reduction". In addition, under "social protection", the Plan reviews Zimbabwe's well-known weaknesses in social protection (lack of a comprehensive strategy, the effects of inflation on entitlements, problems

of inappropriate inclusion and exclusion among beneficiaries and target groups, red tape) before moving on to policy targets and measures. The latter include helping “0.4 million chronically poor but non-labour constrained households” to become more self-sufficient through “productive safety nets” and a commitment to help one million vulnerable children stay in school (GoZ, 2011: 203-06). These seem worthy and sensible choices, especially in conjunction with ongoing experiments around cash transfers to chronically poor households (Dumba 2011). At the same time, one must remember that the weaknesses of Zimbabwe’s social protection regime have been known for a long time (e.g. Kaseke et al. 1997) and that the challenge in Zimbabwe’s development has been getting growth and development to benefit the poorest and most marginalised (Kanyenze et al. 2011).

Building Capabilities in and by Children

Education is central to building capabilities in children. In Zimbabwe as elsewhere, literacy, numeracy and the life skills taught in schools are keys to social and economic success for individuals and for societies. Amartya Sen (1999) and others have argued that literacy, numeracy and life skills are central to our full functioning as human beings.

I have already suggested why there should be a focus on re-building primary education in rural areas. Secondary and tertiary education also require attention, not least because the future of the primary schools cannot be assured without a steady stream of higher level graduates to run and teach in them, but that is an issue for the next section. There are other reasons for giving secondary and tertiary education their due. No country has ever reached sustained economic growth for a generation without at least 20 per cent of the population graduating from secondary school, and (barring rare exceptions such as the petro-states of the Persian Gulf) can develop in the long run without a set of higher education institutions that support a national innovation system. Building a balanced education system where all children get a good primary education and the most able can progress to good quality secondary and tertiary levels should be the immediate priority. Quantitative expansion of secondary and tertiary levels should perhaps wait a few years until the foundations are re-

built.

The Government’s Plan proposes a sensible set of priorities, including restoring the quality of education, enhancing the standing of the local examination management system, retaining and attracting human resources to the sector (presumably mostly teachers), review of out-dated curricula, provision of adequate teaching and learning materials and the promotion of gender equity at secondary and tertiary levels (GoZ, 2011: 188). The Plan correctly includes a strong commitment that children should not be denied education due to an inability to pay school fees, and a commitment to the education of people with disabilities.

A problematic measure in the Plan’s education chapter is to “promote access to secondary education by every child”. Admittedly, the verb used is “promote”, and not “ensure” or “guarantee”, and no timeframe is specified. But the promotion of universal secondary schooling is unfeasible in the near future. First of all, even universal access to primary school is not yet achieved; once universal access to primary is achieved, there is the problem of promotion, since the quality of education is insufficient in many cases to get children, especially rural children, up to primary leaving standards. Then there are simply not enough places in secondary schools to accommodate all children. If all goes well, Zimbabwe may in five or ten years be in a position to think of universal access to secondary school. In the meantime, however, scoping studies should be undertaken.

The health system, especially primary health care, is also important in promoting and building capabilities, for all the reasons laid out in the last section. The health section of the Plan, however, is much less impressive than the education section. The Plan’s health “policy objective” is “to achieve 100 per cent access and utilization of comprehensive quality primary health care services and referral facilities by 2015”. The Plan contains no indication of what exactly is included in “comprehensive primary health care services”, and then goes on to lay out a number of unrealistic “policy targets” such as reducing the under-five mortality rate by almost two thirds in six years (something that no country has ever achieved) (GoZ, 2011: 181-3). Furthermore, the Plan proposes

an emphasis on “health tourism” so as to “enable the country to regain its previous status as a regional referral centre” for medical care (GoZ, 2011: 181). Such a measure, if implemented, threatens to suck scarce human and financial resources into an area of little benefit for the average citizen while basic services and ordinary citizens suffer the consequences. The Plan’s sensible health policy targets, such as rehabilitating the health infrastructure to 80 per cent functionality by 2012 and supporting the increase in the availability of vital medicines to 100 per cent by 2012 and to all essential medicines to 80 per cent by 2012, tend to get lost in the mix. Important questions, such as the balance between primary care facilities and referral facilities, the balance between preventive and curative services, the role of health education, and the potential uses of new information and communication technologies for improved health care, go unmentioned. Other important issues such as health care financing and community participation get mentioned only in passing, and children’s participation gets no mention at all.

Conclusion

Re-establishing universal basic services for children should be a priority. The aim of these social services should be to restore confidence, to provide basic preventive services to all children, and to build, and enable the building of, capabilities in and by Zimbabwe’s children. In particular, primary education and primary health care interventions are good public investments at any time. They may be particularly important in post-crisis situations, since the return of such services signals to children and adults alike that a measure of normality is returning; such a signal has positive social and psychological effects. Zimbabwe is lucky in being able to build on strong foundations in health and education. Such a universalist approach should be complemented with targeted interventions for the poorest and most vulnerable children, especially cash transfers to the poorest households and support to enable the poorest children to get education and health care services.

With so many problems facing Zimbabwe and high levels of demand from the public to “do something”, it is tempting for policy makers and advocates alike to come up with long “laundry lists” of interventions and programmes and demands that they be implemented

immediately. Such laundry lists commonly lack any sense of priorities, costing, feasibility analysis or scheduling requirements. These lists are easy to put together in participatory exercises where everyone has a say, no one has a veto, and everyone plays along to get along. Ideologies like the rights-based approach to development favour such long laundry lists since “there are no small rights”³ and every wrong must be remedied immediately. Indeed, the Government’s Plan can be accused of being such a long list of “want-to-haves”.

Such laundry lists are common in national development plans and especially in the social sector, and they are dangerous. They fail to establish priorities; recognise financial constraints; and tackle important implementation issues like scarce administrative capacity and the phasing of interventions. In so doing, such laundry lists can actually discredit serious proposals for improving social programmes in the eyes of policy analysts, economists, engineers and other professionals who are trained to think about such issues. In drafting my modest policy suggestions above, I have been conscious of these issues, and have tried to suggest where to trim the Plan’s ambitions as well as where to reinforce it. Policy makers have to grapple with difficult questions of financing social and other services in a country with constrained fiscal capacity, no access to international financial markets, and a severely constrained local financial system. There will also be complicated questions of the public-private mix in service delivery, community participation (including the participation of children), equity between rural and urban areas as well as between various social classes and the phasing of interventions (e.g. rebuilding primary education before universalising secondary education). As important as it will be to make progress towards the Plan’s specific sectoral targets, it is equally important to nurture a culture of constant improvement and progressive realisation of rights.

One final cautionary note, for the generation of Zimbabweans who remember the better days of the 1980s and early 1990s, there is sometimes a

³The phrase was in common usage in UNICEF for some years.

desire to re-build the Zimbabwe of that era. The Medium Term Plan contains several examples of such thinking: the emphasis on health tourism, the focus on early childhood development programs as part of the official primary education programme, the commitment to renovate all 14 public service training centres⁴ (GoZ, 2011: 181, 188, 177). One has to wonder about the advisability of such measures, and whether they can be successfully implemented with Zimbabwe's current fiscal capacity and the enormous demands on that fiscal capacity to deal with other public investment needs such as roads, railways, electrical power, water supply and sewage treatment. Most economists see the current economic boom as a "rebound" phase that will end soon and that will be followed by more modest growth, if all goes well. Even if the economic recovery continues and if fiscal capacity reaches or exceeds what it was in the 1980s and early 1990s, it will be difficult to fund everything in the Plan. Zimbabwe's reduced human capacities cannot recover as quickly as fiscal capacity can recover.

Instead of trying to re-build the old, Zimbabwe has the opportunity to re-build with the best elements of the old and the new. The successes of Zimbabwe's health and education systems in the years after Independence can be used as the basis for recovery and further progress. During the long crisis in Zimbabwe, new low-cost information and communication technologies have arrived on the scene, and these can be used in creative ways for distance education, for telemedicine, for monitoring human rights abuses, for collecting, analysing and using data on health, nutrition, poverty, and agriculture, for better public sector management, and many other things. Advances in science have led to new vaccines (e.g. for meningitis and hepatitis), the latest low-cost diagnostic tools, new medicines, and new treatment protocols. Policy innovations such as conditional cash transfers have been tested in other countries and proved successful. Often, these social and technological innovations are synergistic. For example, smartphones can be used in monitoring conditional cash transfers so that vulnerable groups can be more effectively reached.

⁴The Government of Zimbabwe had trouble maintaining these centres even when its fiscal position was much better than it is now.

Tough public policy choices will have to be made, and in a constrained political environment. But Zimbabweans have proven themselves to be resilient, dynamic and innovative in the past and they will continue to be so in the future. The key to a better future for Zimbabwe's children lies in focusing resources on a few high impact interventions, using the best available evidence, and combining traditional strengths with the latest innovations. Breaking the cycle of harm to children, preventing future harms to children and dealing with past traumas will all have to be part of the solution.

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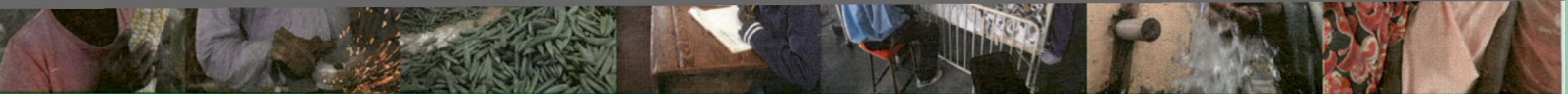
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