Southern Africa Labour and Development Research Unit

ZIMBABWE :
THE LESSONS FOR US IN SOUTH AFRICA

Mamphela Ramphele

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INTRODUCTION

Zimbabwe is like a child born in an environment of high infant and child mortality, where everybody is anxiously watching its development. Africa with its turbulent history and recent economic and political disasters has placed high hopes on Zimbabwe as a newly independent country to restore her lost pride and instill confidence in her future. As South Africans with a future still very much in the balance, our keen interest in this country is intensified by our interrelatedness geographically and economically. There are also many similarities between South Africa and Zimbabwe in terms of history and patterns of economic development.

Five years after independence is an opportune moment for evaluation in terms of ideals feverishly expressed at independence and the limitations of practical realities of running a country. It is difficult to draw conclusions from observations made over eight days in a complex society like this one, but a broad outline of these observations will be given below, which hopefully will enable readers to get a feel of what Zimbabwe is like today. The author has taken the liberty of drawing from documents, research reports and memoranda prepared by those working for development in Zimbabwe.

1. LAND

The independence war in Zimbabwe was essentially about the question of ownership of land as a basic natural resource. Today the redistribution of this resource is a hot political issue and its final resolution will have a significant impact on the future of economic and power relations in Zimbabwe. The total population of Zimbabwe is estimated at 8 million, 78% of whom live in rural areas. Of these, 63% inhabit communal areas (District Council Areas) and the rest are on commercial farming areas (Rural Council Areas). The District Council Areas have 2,9 times greater population than the Rural Council Areas, although the densities vary from province to province.[1] The country is divided into seven provinces with the following population ratios:-

Table 1

District Council : Rural Council Population Ratios			
Province	Ratio District Council:		Rural Council
Matebeleland	4,8	:	1
Mashonaland Central	1,5	:	1
Mashonaland East	2,1	:	1
Mashonaland West	0,8	:	1
Masvingo	5,5	:	1
Midlands	6,5	:	1
Manicaland	3,5	:	1
Total	2,9	:	1

Source: Rural Council Social Service Assessment by R. Lowenson, University of Zimbabwe and Save the Children Fund.

In addition to the higher population densities, the communal areas are significantly less fertile and are drier than commercial farm areas. Traditionally and historically the communal areas are for black occupation, whilst commercial farm areas are white owned.

Life on the commercial farms for the 1,5 million labourers remains unchanged in the post imdependence period except in those areas where development work has been initiated by non-governmental organisations. The majority of farm labourers are foreign-born with Mozambique and Malawi making the biggest contribution. Most of these people were registered as voters during the last election and it remains to be seen whether they would have been assisted to meet the November 30th deadline for renouncing foreign status and becoming full Zimbabwean citizens. The provision of basic social services on farms for labourers is grossly inadequate and has lagged behind that of the communal areas, where the government has greater control and has allocated resources for that purpose. There have been some attempts to encourage co-operative ownership of farms in line with the government's socialist policy, but progress has been slow. The resources to buy off white owners are limited. There are however encouraging signs of successful co-operatives emerging in some areas.

White farmers are still on the whole entrenched as a conservative element in society. Their importance as growers of food and other crops for both local consumption and export places the government in an invidious position - it cannot kill the goose that is laying the golden egg whatever political ideals it might have.

Another bone of contention with respect to land ownership is the question of discrimination against women. The Zimbabwean constitution of 1979 bans laws that discriminate against people on the basis of colour, creed, race etc. but it is silent on the issue of discrimination based on gender. In the debate on this clause it was argued at the time that a ban on sex discrimination would be contrary to the culture, religious principles and the conduct of good business.[2] The implication of this state of affairs is that women are still banned by tradition from owning or inheriting land in communal areas. There is a strong pressure group amongst women activists which is calling for a new Land Act to redress this.

2. HEALTH

The provision of social services is the biggest challenge facing developing countries. The desire on the one hand to redress inequalities perpetrated by previous administrations and the limited resources available to run the country on the other, create a dilemma for the governments of these countries. The Zimbabwean government has adopted the primary health care approach which is defined by the World Health Organisation as: 'Essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford ... it is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where the people live and work, and constitutes the first element of continuing health care process'.[3]

Great strides have been made in the provision of health for all in Zimbabwe as the following statistics show:[4]

- The infant mortality rate dropped from 140/1000 in 1980 for most rural areas to 80/1000 in 1985. In some urban areas it is as low as 18/1000.
- Immunisation coverage in some rural areas assessed in 1982 to be as low as 25%, rose to 42% in 1984.
- In 1984 89% of mothers had received some ante-natal care and 80% of them knew of oral rehydration treatment for children with diarrhorea, with 50% of them being confident of how to make up the salt, sugar and water solution.
- The health care system is organised from the lowest to the highest level on a referral chain thus: the village or farm health worker refers problems encountered to the local health centre, where medical assistants manage those problems they can deal with and refer the rest to the district hospitals, which in turn refer problem cases to the provincial hospitals, and finally the most difficult problems land in the central teaching hospitals. This ideal referral system is sometimes rendered ineffective by the maldistribution of health care resources, some areas being better covered than others, and some provinces having more hospitals than others. Access to care is also influenced by the quality of roads and transportation systems. Like all post colonial countries all roads lead to the capital - there was never any consideration given at the planning stage of the needs of the various communities for interrelationships and communication.
- The quality of services also differs from area to area depending on the nature of the hospital buildings, the quality of staff members and the degree of overcrowding. Limited resources also create problems of maintenance especially for former mission hospitals recently taken over by the government, where the deterioration in the physical structures and basic equipment is extreme in some cases.
- Farm workers are the most disadvantaged in this respect, because the government cannot provide services for them through the erection of physical structures on private property owned by farmers. These people thus have to walk long distances to the communal areas to gain access to care, except in those areas like Bindura in the north where non-governmental organisations have helped organise health care programmes as will be explained later in the text.

The principle of community participation which is central to the primary health care approach is still an ideal not yet realised. Although in theory the selection of village and farm health workers is left to the community, powerful families still have a way of influencing decisions in their favour. Be that as it may, there can be no way the community can have control over the quality of care they receive unless they have access to controlling the resources that pay the health workers; they should be able to evaluate the worker and pay him/her accordingly. As things are, these health workers are mini-civil servants, paid by the district councils from funds from the treasury. The farm health worker is more directly under the control of the community, because his/her pay is made up of contributions by the community and a beer levy (the final irony of alcohol paying for health).

Indigenous Health Care

It is important to note the central role that traditional healing occupies in the lives of most Zimbabweans. People relate with pride how the traditional healers kept the freedom fighters healthy, both physically and emotionally, during the war period. They have also been credited with healing the post war mental and emotional wounds through the performance of rituals and an emphasis on reconciliation between the various factions and interest groups, e.g. the Mjibas (young boys who acted as messengers during the war) had to be assisted to overcome nightmares and neuroses stemming from their complicity in some atrocities perpetrated by those involved in the war. Professor Charunduka of the department of Sociology at the University of Zimbabwe, who is also the leader of the Traditional Healers Association, is emphatic that this type of health care should be accorded the recognition it deserves, both at policy level and in financing, e.g. why shouldn't medical aid societies pay traditional healers bills he asks.[5] He also believes that proper research and standardisation of treatment regimens can only take place with the co-operation of the healers themselves once they are made to feel that they are active participants in research rather than objects of research as is the case now.

It is also fair to recognise the fears of those 'western practitioners' relating to compromised patient care especially in highly infectious and

potentially fatal diseases, through delays in referal to hospital by traditional healers. There is need for a better understanding and the formulation of a realistic modus operandi to demystify both the traditional healing system and 'western type' care to enable the people themselves to make their own informed choices.

The Role of Non-Governmental Organisations (NGOs)

These have played a very important role both pre- and post-independence, especially the following groups:

(i) Silvera House Community Development Programme

This group specialises in skills training at village level with agriculture as the basic starting point. People are trained in food production, utilization of food stuff through a nutritional programme with an emphasis on indigenous products; co-operative organisational training; art and craft development especially amongst the youth.

(ii) Save the Children Fund (UK) (SCF)

The priorities of this organisation are listed as:

- Expanded programme of immunisation.
- Encouraging use of clean water and proper sanitation.
- Health education.

The area of operation is mainly in the deprived communities e.g. Binga and Kariba in the north, where the Tonga people live, and commercial farm areas amongst farm labourers. They have also been active in helping Mozambiquen refugees or 'displaced people' as they are officially designated. Their most notable project is in the Bindura District with Dr. R. Laing, the medical superintendent of the local General Hospital. Malnutrition amongst the children was tackled vigorously through a feeding programme, immunisation campaign, health education and establishment of child care centres in the farming areas. Feeding concentrated on the use of indigenous foods viz. ground nuts, sunflower oil and maize (see Appendix 1 for details).

(iii) Oxfam (UK)

This organisation works closely with SCF above and together they developed an extensive feeding programme for $\pm$ 100 000 children at numerous feeding

points post independence. Some of those feeding points have developed into self-help projects growing ground nuts and other vegetables.

The importance of NGOs is in being able to build bridges between communities and to operate where the government has political problems in getting involved freely, e.g. commercial farm areas. The government fully recognises and appreciates the important role these groups are playing.

Financing Health Care

The present policy is to provide free medical services to all Zimbabweans earning less than 150 dollars per month. Given the fact that this category constitutes the majority of families, it places an enormous strain on the national economy.

There are ideas being tested out in the country exploring future planning policy directions. One which seems likely to be adopted is Dr. N. Reynolds' idea of mutual health societies modelled along the lines of the American Health Maintenance Organisations.[6] This system operates on the basis of pre-paid medical care which is reputed to lend itself to efficiency; physicians are aware 'that substandard care or the witholding of necessary service for any patient could give rise to a need for more and costlier care in the future'.[7]

The goals of this type of care system are:

- Equal access.
- Demystifying medical knowledge.
- Breaking down the intellectual, authority and status barriers within the medical profession and between medical personnel and clients who now become members.
- Creating an awareness in society of what aspects of social
- and economic life lead to poor health.[8]

The conclusion is inescapable that barring those problem areas like access of farm workers to good quality care, and given a resolution of the financing problem, the Zimbabwean health care system promises to be amongst the best and most equitable in the developing world. Medical training is also made to face up to the challenges of a developing country and curriculae are

being reshaped to meed national needs. Polypharmacy and proliferation of drug brands is being limited to an enforced essential drug list which helps to standardise basic treatment regimens. It will be interesting to revaluate this system in another five years.

3. EDUCATION

In this field as in that of health discussed above, there has been a tremendous demand for resources to cope with the backlog over the pre-independence period and the added disruption of the war.

Enrolment over the period 1979-1983 for primary education increased by 116% and is projected to increase annually by 10% over the next decade. This is in keeping with the policy of making education accessible to all Zimbabwean children. Secondary school education has also been made more accessible with an even greater annual growth rate of 20% projected over the coming decade.[9]

There has also been a deliberate policy of redistributing national education resources to create greater equity as evidenced by the change in the composition of school populations in the northern suburban areas, where the ratio of black to white children is estimated for 1985 at 35:1. This has been achieved by the introduction of a system of bussing children from the high density poor areas to the northern suburbs on a daily basis. Very few incidents of unpleasant racial friction have been reported; the overall impression is that the adjustments have been relatively painless. Those parents still bent on exclusive privilege have the option of sending their children to highly expensive private schools. The urban/rural dichotomy in terms of quality of education is still a problem. Inequalities are reinforced by the current management status system, whereby parents set and pay school levies to help meet some of the capital and running costs. Rural parents, because of their lower incomes, tend to contribute less cash and more labour in building schools etc. This situation leads to a widening of the gap in terms of availability of highly qualified teachers who prefer the urban schools which have better technical and other facilities.

Farm children are the worst off in terms of school buildings, equipment and quality of teachers. The government cannot erect buildings on private property and has asked farmers to provide school buildings according to certain minimum standard specifications. Enforcement of this requirement is difficult, because farmers can always plead lack of capital for this purpose. A visit to one farm in the Bindura district where ± 50 children aged 7 to 16 were crowded in a hot tin shack without benches, a decent blackboard and taught by one teacher, was a shocking experience. The same shack is used in the evenings by the farm labourers as a beer hall. Those children are condemned to a life of poverty and hopelessness. The government is under political pressure to address this issue urgently.

It is in fact true that the advent of Uhuru does not mean that there will be a miraculous change in people's living conditions. People have to learn that nation building is a difficult process that requires hard work on the part of all and that it takes time. As President Nyrere said to the Tanzanians: 'Don't expect miracles, don't expect a better house after midnight ... But one thing must change after midnight: the attitudes of the colonial people, their way of treating Africans as nothing. This must change after midnight. The colonised are now the rulers, and the man in the street must see this! If they have been spitting in his face, now it must stop! After midnight! This cannot take twenty years. We had to drive this lesson home.'[10] It seems to me that the Zimbabwean government must really find a way of giving notice to farmers that 'midnight' has stuck! The recently adopted rural public works programme policy will hopefully redress some of the inequalities between urban and rural families. The gains would be twofold:

- To provide materials to build new schools e.g. bricks.
- To increase rural incomes by an estimated 30-120% thus enabling parents to contribute towards school levies and raise the standard of living generally.[11]

It is also suggested that government funding should be such that urban parents contribute more to running costs which can be made in kind. The introduction of a schools tax of say 30% of levies received would also enable the government to redistribute available resources between the rich and poor areas. A bursary scheme funded on the basis of a 50% tax rebate

on employers, labour, local authorities and provincial authorities would also make additional funds available to meet the ever increasing needs, thus freeing the government to support rural areas more out of the general education budget.

Increasing access to education has, however, brought to the surface another potentially explosive problem - unemployment amongst school leavers with high expectations and aspirations. There has been a shift in emphasis from preparing secondary school leavers for university towards more technical skills training appropriate for the developmental needs of the country. Technical training is thus on the increase to meet this need.

4. RURAL DEVELOPMENT

The majority of the Zimbabwean population of 8 million lives in the rural areas i.e. 78%. The rural area is divided into communal areas administered by District Councils and commercial areas administered by Rural Councils. District Councils are representative of those people living in communal areas, whereas Rural Councils, given their historical development, represent farmers only. Thus farm workers who constitute 22% of the total Zimbabwean population are without representation at local government level.

The neglect of rural development over five years prior to independence is strongly felt by the most vulnerable group viz. the farm workers as evidenced by the following statistics:[12]

- 90% of children under 5 years of age in the Macheke area (a farming district) were found to be undernourished.
- 75% of TB cases in a major sanitorium came from commercial farms although this section comprises only 22% of total population+
- 65% of children of farm workers in the Bindura District were found to be stunted, 40% acutely wasted (1980).

Social services such as health facilities, schools, commercial outlets, water and sanitation facilities were found to be poor in general in the countryside. (1983 Central Statistics Document). The conditions on

commercial farms are the worst, except in the case of roads which are very well developed and tarred. The latter fact reflects the pre-occupation by Rural Councils with road building which is in the farmers interest,with very little attention being paid to social services for the workers. The tables on the following pages illustrate this.

The cornerstone of Zimbabwe's development strategy is to bring the countryside into the mainstream of the economy. Low levels of physical and service infrastructure mean that these areas are characterised by low productivity of both land and labour. Average family incomes are less than half of those wages received at the lowest end of the formal sector and vary considerably.[13] Over the years these areas have come to depend on money transfers from wage earners in urban areas, but at a price - the able-bodied and those who provide leadership are absent. The inability of the formal sector to generate employment at the level needed by the rapid growth in population,and especially for new entrants into the labour market,means that the greater part of the solution will have to be found in the countryside. Declining labour trends on commercial farms place the burden on the small family farm or communal land system in the District Council areas.

Development strategies for the communal areas are necessarily different from those of the commercial farm areas. Considerable effort has been made since independence to improve services in the communal areas and success has been achieved in some parts of the countryside which have emerged as major producers of cotton and maize.

District Council Areas Development Strategy[14]

This strategy is based on three approaches, some still at proposal level and others at implementation stage:

(i) District Management and Services Programme

- It is recognised here that the growing constraint on development in the countryside is lack, and in some cases complete absence, of managerial experience and skills. Government officials are themselves not equipped to give management advice and few careers are open to key skills such as cost accountants,

TABLE 2: COMMERCIAL AND COMMUNICATION SERVICES (1984/85)

Name of Province	Roads (km)		Roads(Tar)	COMMERCIAL OUTLETS							Population
	Tar	Earth	Per 100km²	Whole Sale	Gen. Dealer	Bottle Store	Butcher	Baker	Green Grocer	Total	Per Facility
RURAL COUNCILS										+++	
Matabeleland	**196	3951	1,01	10	247	40	43	3	58	401	264
Mashonaland Central	159	1113	2.40	2	261	30	32	1	1	327	483
Mashonaland East	*641	2084	7.00	5	326	49	63	1	0	444	482
Mashonaland West	710	3637	2.80	9	336	61	98	3	3	510	719
Masvingo	++ 50	1104	0.39	39	218	7	37	3	1	305	507
Midlands	+ 259	2063	2.20	4	174	28	23	3	0	232	318
Manicaland	+ 205	1580	2.90	12	298	29	25	4	0	368	574
TOTAL	2220	15532	2.56	81	1860	244	321	18	63	2587	478
DISTRICT COUNCILS											
Matabeleland	311	5299	0.56	1	1115	183	128	5	25	1457	544
Mashonaland Central	161	1686	1.00	1	607	114	162	0	0	884	377
Mashonaland East	182	2054	1.30	7	962	285	267	5	4	1530	319
Mashonaland West	34	1805	0.26	0	502	124	116	2	6	750	375
Masvingo	187	3588	0.80	4	1482	298	242	5	16	2047	411
Midlands	72	3569	0.30	5	1664	359	269	7	7	2311	334
Manicaland	207	2651	1.01	11	1748	365	272	12	12	2420	330
TOTAL	1154	20652	0.75	29	8080	1728	1456	36	65	11399	378
SSCFA's											
Mashonaland Central	55	15	6.90	0	0	3	1	0	0	4	2817
Mashonaland East	62	++140	6,10	0	6	6	0	0	0	12	1109
Midlands	0	1000	-	0	25	8	0	0	0	33	426
TOTAL	117	1155	6.50	0	31	17	1	0	0	49	1451
TOTAL ALL PROVINCES	3491	37339	3.27	110	9971	1989	1778	54	128	14035	2313

*ONLY FIVE RESPONSES
** ONLY FOUR RESPONSES
+ ONLY THREE RESPONSES
++ONLY TWO RESPONSES
+++ ONLY SIX RESPONSES

Source: R. Lowenson, University of Zimbabwe and Save the Children Fund (UK)

TABLE 3: SCHOOLS

Name of Province	Registered Primary	People/ 1° School	Registered Secondary	People/ 2° School	Rural Council 1° and 2°
RURAL COUNCILS					
Matabeleland	57	2263	10	12897	11
Mashonaland Central	9	17550	7	22564	12
Mashonaland East	59	3624	12	17816	24
Mashonaland West*	49	6941	16	21256	31
Masvingo	35	4418	4	38660	2
Midlands	22	3351	6	12288	2
Manicaland	31	6815	10	21127	8
TOTAL	262	6423	65	20944	90
DISTRICT COUNCILS					
Matabeleland	686	1155	63	12581	not applicable
Mashonaland Central	190	1754	44	7573	
Mashonaland East	307	1592	93	5256	-
Mashonaland West	183	1539	62	4542	-
Masvingo	500	1682	100	8410	-
Midlands	505	1526	107	7203	-
Manicaland	544	1469	79	10115	-
TOTAL	2915	1531	548	7954	
SSCFA's					
Mashonaland Central	11	1024	2	5634	13
Mashonaland East	12	1109	6	2218	7
Midlands	17	827	3	4685	20
TOTAL	40	987	11	4179	40
TOTAL ALL PROVINCES	3217	2980	624	11026	
* One R.C. Area Non-Response					

Source: R. Lowenson, University of Zimbabwe and Save the Children Fund (UK).

Table 4: Health Services

Name of Province	No. Clinics Static	Mobile	Population/ Static Clinic	SRN'S& MA's*	No. Areas With FHW'S	CARRYING OUT EPI[1]	MAL[2]	TB[3]	FP[4]
RURAL COUNCILS									
Matabeleland	7	4	18425	21	+1	**3	1	1	4
Mashonaland Central	4	2	39487	24	2	2	1	0	2
Mashonaland East	13	4	16445	38	1	+ 5	2	1	4
Mashonaland West	18	12	20373	49	6	6	4	0	7
Masvingo	9	2	17182	14	1	3	2	2	2
Midlands	2	6	36864	10	1	2	1	0	3
Manicaland	**5	2	31794	16	1	++1	0	0	1
TOTAL	58	32	25796	172	13	22	11	4	23
DISTRICT COUNCILS									
Matabeleland	51		15541	NOT	AVAILABLE				
Mashonaland Central	30		11108						
Mashonaland East	42		11637						
Mashonaland West	24		11732						
Masvingo	32		26281						
Midlands	67		11504						
Manicaland	78		10245						
TOTAL	324		14007						
SSCFA's									
Mashonaland Central	1	0	11267	2	1	0	1	0	0
Mashonaland East	3	1	4435	3	1	1	1	0	1
Midlands	4	0	3514	5	1	1	1	1	1
TOTAL	8	1	6405	10	3	2	3	1	2
TOTAL ALL PROVINCES	390	33	15403	182	24	24	14	5	25

++ Only one Response

\+ Non Response From One R.C. Area

** Non Response From R.C. Areas

1. Expanded Programme Of Immunisation
2. Malaria Spraying
3. TB Control and Monitoring
4. Family Planning

* Information Possibly Not Accurate In Responses

Source: R. Lowenson, University of Zimbabwe and Save the Children Fund (UK)

marketing specialists, production managers etc. The countryside has to be vibrant first before it can provide such managers itself.

- Training programmes will thus have to be conducted to expose local leadership and District Council staff to economic realities of the country - enabling them to see how they link up with the national economy.

The programme will also have to address local demands for analyses of problems e.g. markets, transport, banking, retail trade, management of irrigation schemes etc.

Provision of credit through the proposed Agricultural Credit Union System, as set out by Dr. N. Reynolds in a document bearing the same title,[15] must be an integral part of this programme.

There is also a need for executive training of District Administrators. Special leadership training based mainly on private sector management training experience has to be implemented in addition to the current government run training programmes.

(ii) Rural Market Societies[16]

The prime purpose of forming rural market societies is to bring together all the parties who can implement and make successful a periodic market system in the commercial areas initially, but later in resettlement and commercial farm areas. The Three-year National Transitional Plan endorses the formation of periodic market systems, as a central strategy for servicing the countryside and as the economic process that would govern the location and size of investment in rural service centres:

- At least 600 rural service centres have been identified with a commitment by government to investment in an initial 120 centres. the next generation of centres should follow a greater realization of local market development and with it a better demonstrated mapping of present and potential economic activity. It is believed that communal areas alone require and can support upward of 1 400 periodic markets. These would be created by the upgrading of facilities and services at existing business centres on certain days in a cycle.

(iii) Common Property Management[17]

There is a large demand in the rural areas at village level for assistance in the management of common property: grazing, forestry, wildlife and water. The National Transitional Development Plan responded to this need by pledging government investigation into the legal, institutional, social and economic aspects of the traditional communal system with a view to its modification to achieve the following:

(a) Membership of a local community expressed principally in terms of management of common assets; the individual right to share in the communal assets, separated from individual, group or communal exploitation of them;
(b) establishment of equal membership rights for men and women;
(c) a control system, overseen by government but managed by the members, to prevent overexploitation and misuse of natural assets; and
(d) realisation of an agrarian system able to optimise land use patterns and maximise group and individual investment and effort.

Positive legislation has not yet emerged from the government's side to address the above issues, but there is hope that a bill to that effect will be published shortly.

(iv) Rural Council Areas Development Strategy[18]

Given the limitation imposed by private ownership of commercial farms and the dilemma the government finds itself in, in terms of social service provision for this sector of the population, NGOs notably Save the Children Fund (UK) have taken the initiative in addressing this urgent area of need. Health problems being the most prominent and easily identified are used as entry points.

Aims and Objects (Outputs)

(i) Creation of a central farm health worker training team based in Bindura comprising a field health worker trainer (Project leader); pre-school/ nutrition educator and builder cum driver.

(ii) Creation of farm health worker training mobile clinic teams consisting of 3-4 members viz. medical assistant/midwife; pre-school nutrition educator; nurse aid and builder.

(iii) Training Farm Health Workers (FHW) in one month courses.

(iv) Training farm builders in 4 week courses in water and sanitation techniques.

(v) Preparation of a technical evaluation of drinking water resources and options for their development and improvement.

(vi) Improvement of all farm sanitation, drinking water and domestic hygiene.

(vii) Creation of pre-schools in each farm community.

Inputs

1. By Government

(i) Support for the project through the Ministries of Health, Local Government, Economic Planning and Development.

(ii) Assistance in selection of suitable rural councils.

(iii) Making the Bindura Team Leader available to be employed as project manager.

(iv) Provision of vaccines, medicines, dressings etc.

(v) Support for running costs of vehicles.

2. By Local Authorities

(i) Provide a site for training centre and be responsible for its maintenance.

(ii) Responsible for 50% of salaries initially, up to 2 years thereafter being fully responsible.

3. By Community

(i) Selection of women as health workers.

(ii) Construction of clinic.

(iii) Construction of pre-school area (these are simple enclosures under big shady trees utilising local materials e.g. grass and reeds.

(iv) Payment of FHW.

(v) Construction of Blair VIP latrines. These are pit latrines constructed such that they ensure the trapping of flies through a ventilation pipe painted black, these latrines are also odourless and have covered seats.

(vi) Construction of wells and water points.

(vii) Construction of refuse disposal facilities.

(viii) Selection of builders and payment for their services.

(ix) Support for FHW.

4. By NGOs

(i) Assist Rural Councils with planning and motivation.

(ii) Assist in administration of the scheme.

(iii) Assist in reporting and evaluation.

(iv) Act as employing agency for central support team.

This scheme is very successful in those areas where it has been implemented especially where farmers are well-motivated and supportive. There is evidence of declining levels of malnutrition, infant mortality rates and general improvement of environmental and domestic hygiene. There are problems, however, in those areas where farmers are un-co-operative especially in relation to water and sanitation.

5. HOUSING

This is an important issue especially in urban areas of Zimbabwe as it is in most developing countries. The urban areas are divided by historical factors into high density (previously black areas) and low density areas (previously white areas). The land available to each family in the low density area is 1 - 1½ acres, compared to the tiny space barely adequate to accommodate a four-roomed dwelling in the high density areas. There are a few single sex hostels in Harare's high density area - a legacy of exploitation - which are currently used by families with varying degrees of overcrowding. Squatting is also a problem that rears its ugly head now and again, but the ruthlessness with which the government deals with those involved discourages this phenomenon. Squatters are promptly moved to areas away from cities - resettlement areas, where unfortuantely employment opportunities are nil. It is indeed a problem that needs innovative solutions which have so far eluded many countries.

The present policy of the government is to encourage a minimum standard of housing by stipulating that a family dwelling should have at least 2 bedrooms, a kitchen, living-room and inside toilet and bathroom. People are assisted with loans by the government to put up such dwellings in and around cities. No make-shift housing is allowed during the construction period to discourage squatting, but this also has the unfortunate effect of increasing costs and construction time for the owners who have to travel to and from the site. Losses are also suffered through theft of building materials while the owners are away.

The old houses in the high density areas have had ownership rights transferred from local authorities to the occupants and are treated as fully paid up.

The housing issue is also tied up with land ownership and the need to reduce the blatant inequalities between the different sectors of society. There are suggestions of redividing the current huge private plots in the low density areas, coupled with the establishment of a co-operative home building scheme, but it remains to be seen whether the 'have's' will let the 'have not's' share in the existing resources.

The current government housing policy and its insistence on minimum standards is regarded by some people as counter-productive and unrealistic given the limited ability of the ordinary people to afford a housing loan and to build a house successfully away from the present place of abode. There is even greater criticism of the intention to extend the same standards to the rural areas in the designated service centres referred to above.

GENERAL COMMENTS

There is still a wide gap between the government's socialist policy and practice. The commitment is there, especially on the part of the Prime Minister and some of his cabinet colleagues, but there are problems with the implications of this policy for those who have promoted their own personal interests and amassed wealth through their official positions. The lack of control over the economic resources of the country also limits the pace at which the government can move in implementing its ideals. The recent dispute over minimum wages for agro-industrial workers has proved just how vulnerable the government is to pressure by the private sector.

The other weak link in the socialist chain is the lack of powerful workers organisations which can effectively represent the interests of workers. The trade union movement has abrogated its responsibility to fight for workers rights to the government, and has thus become emasculated. The rhetoric about workers democracy and control sounds very hollow indeed in relation to the reality.

Another sad aspect of Zimbabwean social organisation is the problem of the youth. As Mrs. S. Mugabe, the Prime Minister's wife, put it: 'as long as the family relations of Zimbabweans are guided by traditionalist, sexist notions, younger people will have no role models to help them develop into the kind of adults Zimbabwe desires'.[19] No amount of orientation in youth brigades or clubs can make up for good upbringing in the home. Teenage pregnancy and sex experimentation are far too common for comfort. The experience of sitting in parliament and watching the speakers' procession with all the British pomp complete with two black ladies with white wigs made me doubt the validity of Frantz Fanon's assertion that: 'It is not alone the success of the struggle which afterwards gives validity and vigour to culture; culture is not put into cold storage during the conflict. The struggle itself in its development and in its internal progression sends

culture along different paths and traces out entirely new ones for it. The struggle for freedom does not give back to the natural culture its former value and shapes; this struggle which aims at a fundamentally different set of relations between men cannot leave intact either the form or the content of the people's culture. After the conflict there is not only the disappearance of colonialism, but also the disappearance of the colonised man'.[20]

The value system in Zimbabwe, especially amongst the elite and educated is certainly very British. Colonialism has disappeared, but the 'colonised man' is still very evident in all walks of life. The educational system and the ethos of most of those schools in the low density areas is still similar to that of the colonial era. Even the mannerisms of the pupils and teachers, most of whom are black, reflect the various traditions of the schools. It seems to me that the question of a value system for any post-conflict society needs to be actively addressed to avoid the pitfalls of continuing with the same values that one despises in the society that one seeks to change.

Another problem facing this newly independent state is that of prestige; the need as a nation to be seen to be as good as any. Africa is full of sad examples of prestigious projects which bear no relation to the needs of the country as a whole. The Kenyata Conference Centre in Nairobi, for example, is underutulised and inappropriate in a city where ordinary citizens don't have adequate housing. Zimbabwe is also sadly showing signs of falling prey to the temptations of prestige. The new Sheraton Hotel and adjacent conference centre in Harare is one such example. Harare's hotels are not fully utilised as it is, so where is the logic of providing additional hotel beds in such a situation, except that the prospect of the Prime Minister hosting the O.A.U. conference is enhanced thereby? Another example is the new stadium being built just outside Harare when there is a huge stadium in Ambare (high density area in Harare) which adequately hosted the independence celebrations.

To conclude on a personal note, I visited the Kopje (a hill just outside Harare) where the independence flame burns continuously. Looking straight across the valley in a north-westerly direction one encounters Heroes' Acre

with its imposing monument - a constant reminder to all of the heavy price that had to be paid for the freedom of the people of Zimbabwe. I was overwhelmed and wondered how long we in South Africa would have to wait before we would bid farewell to 'midnight' and light that eternal flame marking the dawn of a new era.

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APPENDIX 1

DEPARTMENT OF PAEDIATRICS AND CHILD HEALTH

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast	mealie meal porridge + dovi egg	mealie meal porridge + dovi egg	mealie meal porridge + dovi egg	mealie meal porridge + dovi egg	mealie meal porridge + dovi egg	mealie meal porridge + dovi egg	mealie meal porridge + dovi egg
a.m. snack	brown bread + dovi, jam or margarine milk						
Lunch	sadza meat vegetables porridge + egg	sadza beans mashed beans	sadza chicken vegetables scrambled eggs	sadza meat vegetables porridge + skim milk powder	sadza vege-tables + dovi sadza dovi soup	sadza beans mashed beans	sadza chicken vegetables scrambled eggs
p.m. snack	milk fruit						
Supper	sadza vegetables + dovi sadza dovi soup	sadza Lacto nhopi sadza lacto or nhopi	sadza vegetables + dovi sadza dovi soup	sadza beans mashed beans	sadza lacto nhopi sadza lacto or nhopi	sadza vegetables + dovi sadza dovi soup	sadza muriwo porridge + skim milk powder

Appendix 1 Continued

NUTRITIONAL VALUES OF SOME COMMON LOCAL FOODS
(Figures are applicable to 100 gms. of the edible portion of food)

COMMODITY	WATER (g)	CALORIES	PROTEINS (g)	FAT (g)	CARBO-HYDRATES
CEREALS					
Maizemeal (dry)	12	340	9,5	4	65
Sadza	70	115	3	1	24
Bota (porridge)	>70	<100	<3		
STARCHY ROOTS					
Sweet Potatoes	70	117	1,3	0,4	26
Irish Potatoes	78	82	2	0,1	18
PULSES, NUTS, SEEDS					
Peanut butter	4	560	29	48	6
Cowpea (nyemba) Seeds	11	342	23	2	59
Pumpkin	5	535	27	43	8
VEGETABLES					
Pumpkin	90	28	1	-	6
FATS AND OILS					
Vegetable oil	0	900	0	100	0
Margarine	15	720	0,2	81	0
INSECTS					
Caterpillars	80	83	14	3	0
Termites	60	125	25	3	0
Locusts	48	220	30	10	0
ANIMAL PRODUCTS					
Meat - Beef	66	207	19	14	0
Poultry - Eggs	74	163	12	12	0
MILK PRODUCTS					
Milk	87	65	3,5	3,5	4,5
Skimmed milk	4	360	36	1	?
SYRUPS AND SUGAR					
Sugar	0	389	0	0	100
COMMERVIAL BABY FOODS					
Pronutro	0	413	22	12	56

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